DEPARTMENT of CHILDREN and FAMILIES
Making a Difference for Children, Families and Communities

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Commissioner

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Connecticut Department of Children and Families

Statewide Assessment

for the

Child and Family Services Review

July 22, 2008

Statewide Assessment Instrument

Section I – General Information

Name of State Agency

Connecticut Department of Children and Families

Period Under Review
Onsite Review Sample Period: April 1, 2007 - November 30, 2007
Period of AFCARS Data: April 1, 2006 - March 31, 2007
Period of NCANDS Data (or other approved source; please specify if alternative data source is used): April 1, 2006 - March 31, 2007

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TABLE OF CONTENTS

INTRODUCTION

Agency Structure

The mission of the Department of Children and Families is to protect children, improve child and family well-being and support and preserve families. These efforts are accomplished by respecting and working within individual cultures and communities in Connecticut, and in partnership with others.

The Department of Children and Families, established under Section 17a-2 of the Connecticut General Statutes, is one of the nation's few agencies to offer child protection, behavioral health, juvenile justice and prevention services under one umbrella. This comprehensive approach enables DCF to offer quality services regardless of how a child's problems arise. Whether children are abused and/or neglected, are involved in the juvenile justice system, or have emotional, mental health or substance abuse issues, the Department can respond to these children in a way that draws upon community and state resources to help them.

DCF recognizes the importance of family and strives to support children in their homes and communities. When this is not possible, a placement that meets the child's individualized needs in the least restrictive setting is pursued. When services are provided out of the child's home, whether in foster care, residential treatment or in a DCF facility, they are designed to return children safely and permanently back to the community.

The Connecticut Department of Children and Families is a state administered agency that supports in-home and community based services through contracts with service providers. The Department itself is comprised of fifteen Area Offices; five facilities: a secure facility for boys who are committed to the Department as delinquents by the juvenile courts (the Connecticut Juvenile Training School); a children's psychiatric hospital (Riverview Hospital); two residential facilities (Connecticut Children's Place and High Meadows); and an experiential program for youth in Connecticut (the Wilderness School). On any given day the DCF workforce of approximately 3400 provides services to 37,000 children and their families.

Connecticut's Population

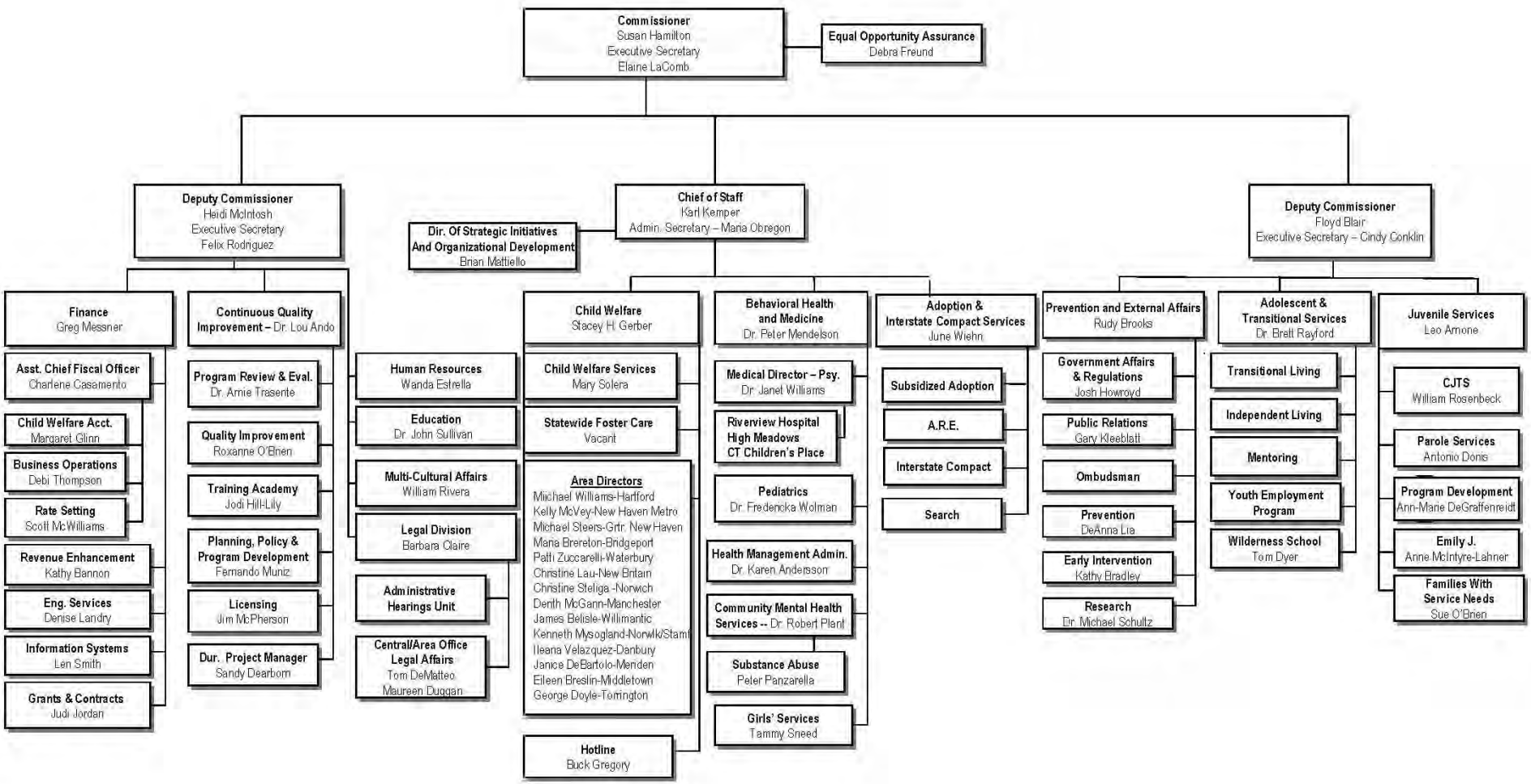
Connecticut is New England's second smallest and southernmost state. Its 5,009 square miles are bordered by New York State on the west, Rhode Island on the east, Massachusetts on the north and Long Island Sound on the south.

Connecticut's eight geographical counties are comprised of 169 municipalities, with an estimated population of 3,510,787 as of July 1, 2006. Considered an affluent state, the per capita income is the second highest in the nation. However, in 2006 11% of our children were living in poverty, 28% were living in a single parent household and 28% were living in families where no parent had full time, year round employment.

Overall, Connecticut's population identifies itself as 79.9 percent Caucasian, 11.2 percent Latino and 9.5 percent Black or African American, according to the US Census Bureau.

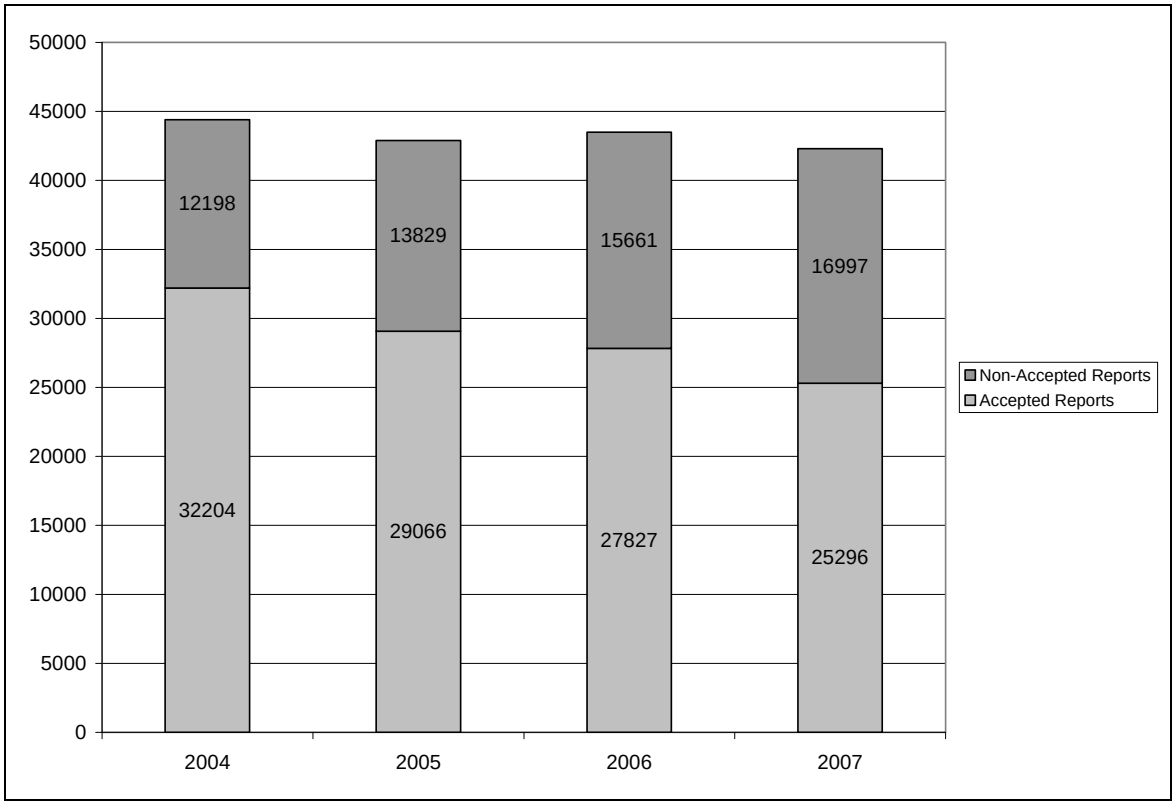
Connecticut is home to two federally recognized Indian tribes: The Mashantucket Pequot Nation and the Mohegan Tribe; and three tribes which are not federally recognized: The Eastern Pequot Tribal Nation, The Pawcatuck Eastern Pequot Tribe, and the Schaghticoke Indian Tribe.

DCF Organizational Chart



DCF Case Trends

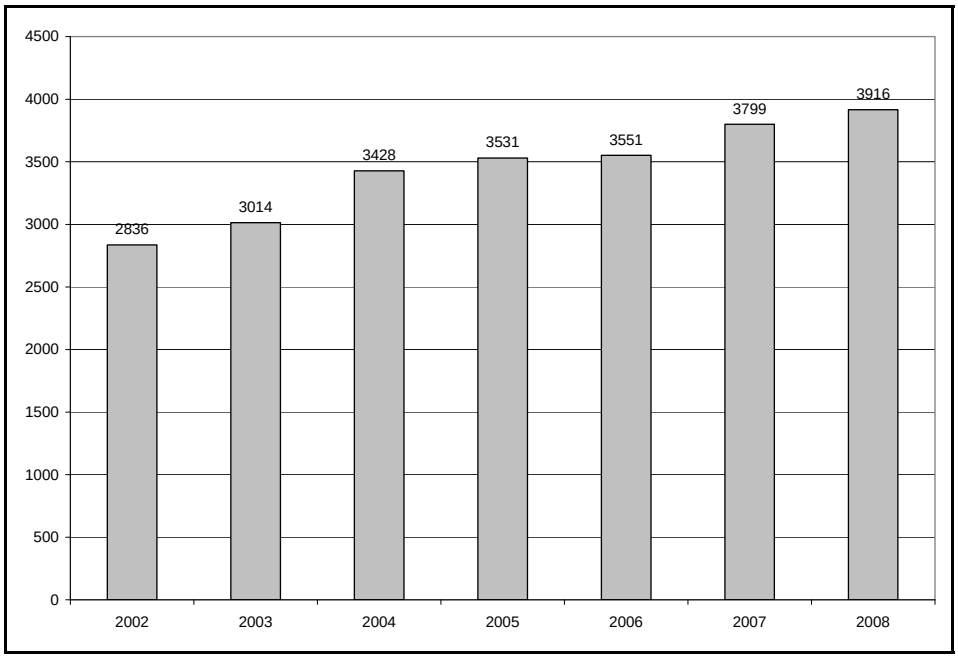
The Department operates a 24-hour child abuse and neglect Hotline. The Hotline is the centralized intake operation for the state and is generally the initial contact for persons making reports of abuse and/or neglect, the families we serve, and the public at large. The Hotline is responsible for child protection after normal working hours and on holidays which requires supervisory staff to supervise investigations requiring immediate response or to meet response time requirements as outlined by DCF policy and the Juan F. Exit Plan. Hotline receives approximately 90,000 calls per year, of which approximately 42,000 are reports of abuse and neglect:



Hotline Accepted and Non-Accepted Reports

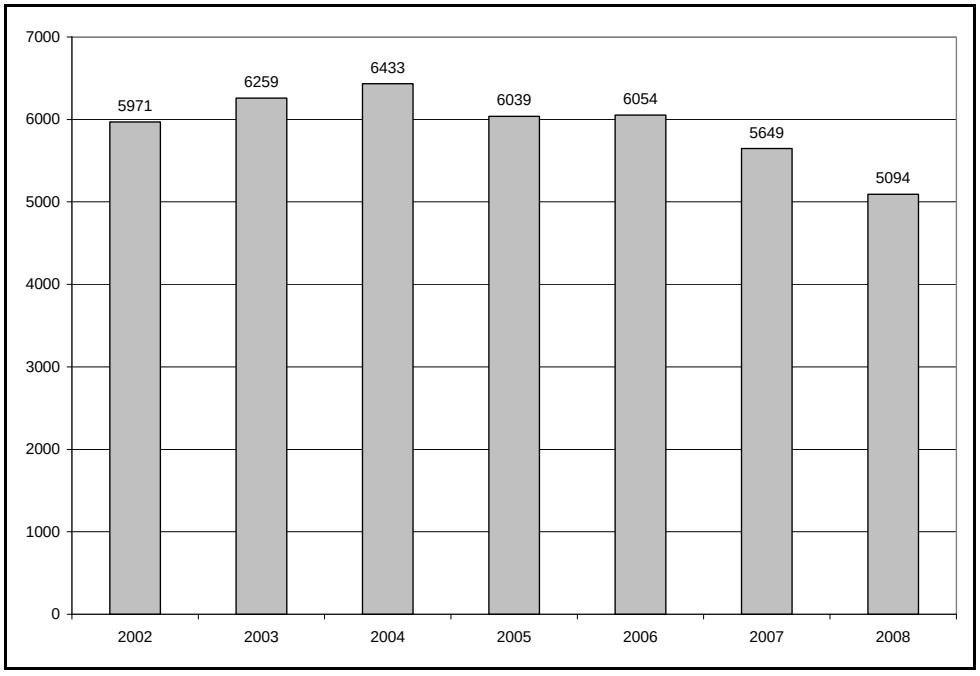
The decreasing number of accepted reports of abuse and neglect can be attributed to Hotline supervisors more closely reviewing reports on open cases to determine if the issues being reported are ongoing in the life of the case; close collaboration with Area Office staff regarding information already known to the Area Office; and to ensure that reports regarding the same incident are accurately recorded.

The Department's average daily caseload for all types of cases is 17,000. Recent years have also brought about significant change in the caseload trends for several case types with which DCF is involved. The focus on improved assessments and on reducing the state's reliance on residential care that is associated with the Juan F. Exit Plan has resulted in an increase in in-home cases and a decrease in out-of-home cases. In 2002, the Department's average daily in-home caseload was 2,836 cases. For the first 6 months of 2008, that figure is now 3,916 cases:



Average Daily In-Home Caseload

The increase in in-home cases has corresponded with an overall reduction in the average daily out-of-home caseload from a high of 6,433 in 2004 to 5094 so far in 2008:



Average Daily Out-of-Home Caseload

Key Agency Initiatives

On February 2, 2004, DCF established thirteen Area Offices with local management teams overseeing operations in their catchment area. Each Area Office has a Mental Health Program Director and increased Area Resource Group staff to help assure that we are responsive to the behavioral health needs of children and families. The Department also added Quality Assurance staff to each Area Office so that we can more readily recognize what we are doing well, what is working, why it is working and what needs improvement.

Local community systems of care are essential for providing quality and responsive services to children and families. The Area Offices provide leadership in the continued development and operations of the local systems of care. An important component of that leadership is to ensure integration of the protective services, behavioral health and juvenile justice work.

In February of 2005, the New Haven Area Office, one of the larger metropolitan offices, was split into two separate offices. One Area Office, Metro New Haven, focuses its attention and resources specifically in the city of New Haven while the second Area Office, Greater New Haven, serves the surrounding suburban communities.

In an effort to enhance our practice and achieve better outcomes for children relative to safety, permanency and well-being, the department made the decision to implement Structured Decision Making (SDM) in the spring of 2007. SDM provides the framework to increase consistency and validity of decision-making in child protection; 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.

The department is in the process of planning for the implementation of a Differential Response System. This alternative response to low level accepted reports of abuse and/or neglect is a major initiative that has been proven effective in 30 jurisdictions nationwide. DRS will focus not on the specific allegations reported, but will work to determine the underlying causes that bring families to the attention of DCF. This approach will have positive impact on what is now an often adversarial relationship between DCF and the reported families and allows engagement; does not require a finding of maltreatment; does not identify an individual as a perpetrator or victim; and allows the family to guide the process and empowers them to make change. Moreover, studies have shown that the child is as safe in this response as in the standard CPS approach, and that families and social workers are happier in this environment of cooperation. This initiative is expected to rollout statewide in July 2009.

Litigation Affecting the Department

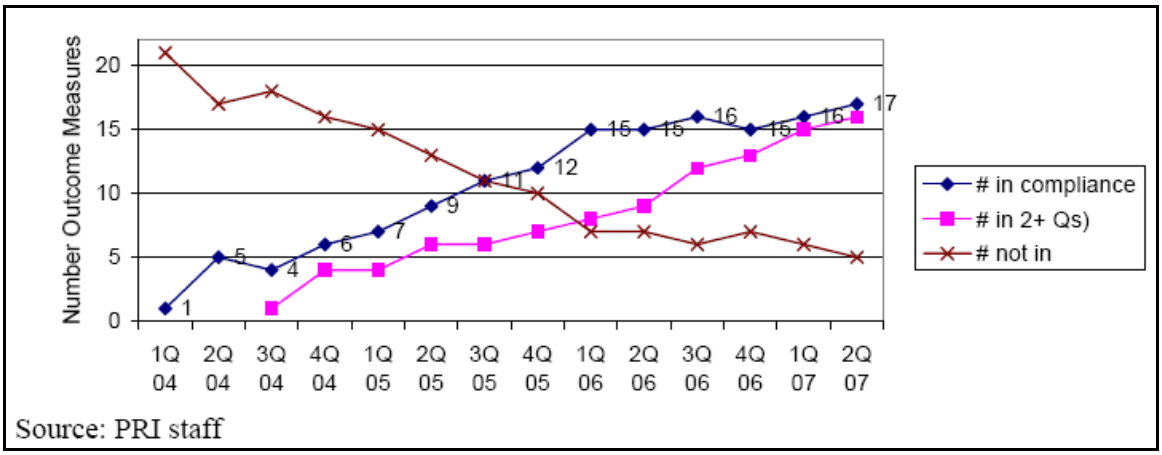
Juan F. Exit Plan

In 1991, the State of Connecticut entered into an agreement with lawyers representing children in the *Juan F.* class to improve services provided by DCF. The agreement was filed as a Consent Decree order in the United States District Court of Connecticut. That agreement stayed in effect until 2002 when the parties established an initial plan to achieve exit from Federal Court jurisdiction. That plan resulting from negotiations between the State of Connecticut and the plaintiff attorneys set out 22 outcome measures, which, if met, would terminate the Federal Court jurisdiction in 2003.

In the fall of 2003, after all parties, including the Court Monitor, agreed that the Exit Plan outcomes were not met, a new Exit Plan was established. In this plan, the Court Monitor took an active role in setting 22 Outcome Measures. The Department's success in meeting these measures has been rapid and substantial; six goals were met after the first year; 14 goals after two years; and now 17 goals were reported as having been met in the 3rd Quarter of 2007.

While the Department sustains these improvements and demonstrates the capacity to meet 20 of the 22 measures, greater emphasis is now being placed on ensuring appropriate placements, achieving more timely permanency for children, and improving treatment plans in order to meet the remaining challenges. A detailed action plan to achieve these critically important areas was established in March 2007 in a collaborative effort with Children's Rights, which continues to represent the plaintiffs.

Over the last three-and-a-half years, the department has shown improved compliance with the *Juan F.* Exit Plan outcome measures. During the first quarter of Exit Plan compliance monitoring (January 1 through March 31, 2004), DCF met the standard for just one outcome. Since the first quarter of 2006, the department has met or exceeded compliance goals for at least 15 measures. In addition, targets for 15 measures have been maintained for at least one year, and for two or more years for 8 measures.



Source: PRI staff

Juan F. Exit Plan Outcome Measures

1.	Commencement of Investigation:	At least 90% of all reports[1] must be commenced same calendar day, 24 hours or 72 hours depending on response time designation.
2.	Completion of Investigation:	At least 85% of all reports[1] shall have their investigation completed within 45 calendar days of acceptance by Hotline.
3.	Treatment Plans:	At least 90% of cases[2] shall have treatment plans that are clinically appropriate, individualized, developed with family and community members and approved within 60 days of opening in treatment, or a child's placement out of home.
4.	Search for Relatives:	For at least 85% of children in placement, DCF shall conduct searches for relatives, extended or informal networks, friends, family, former foster parents or other significant persons known to the child. Excludes Voluntary cases.
5.	Repeat Maltreatment:	No more than 7% of children[1] who are victims of substantiated maltreatment during a 6-month period shall be the substantiated victims of additional maltreatment within 6 months.
6.	Maltreatment of Children in Out-of-Home Care:	No more than 2% of children[1] in out-of-home care shall be the victims of substantiated maltreatment by a substitute caregiver while in out-of-home care.
7.	Reunification:	At least 60% of children who are reunified with parents/guardians shall be reunified within 12 months of their most recent removal from home. Excludes Voluntary cases.
8.	Adoption:	At least 32% of children who are adopted shall have their adoptions finalized within 24 months of their most recent removal from home. Excludes Voluntary cases.
9.	Transfer of Guardianship:	At least 70% of all children whose custody is legally transferred shall have their guardianship transferred within 24 months of their most recent removal from home. Excludes Voluntary cases.
10.	Sibling Placement:	At least 95% of siblings currently in or entering out-of-home placement shall be placed together unless there are documented clinical reasons for separate placements. Excludes Voluntary cases and children for whom TPR has been granted.
11.	Re-Entry into DCF Custody:	No more than 7% of all children entering DCF custody shall re-enter care within 12 months of a prior out-of-home placement. Excludes Voluntary cases.
12.	Multiple Placements:	At least 85% of children in DCF custody shall experience no more than 3 placements during any 12-month period, excluding respite, hospitalizations lasting less than 7 days, runaways, home visits, and CJTS. Excludes Voluntary cases.
13.	Foster Parent Training:	Foster parents shall be offered 45 hours of post-licensing training within 18 months of initial licensure and at least 9 hours each subsequent year. However, relative, special study and independently licensed foster parents require 9 hours pre-service.
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 siblings.
15.	Needs Met:	At least 80% of all families and children shall have their medical, dental, mental health and other service needs provided as specified in the most recent treatment plan.[2]
16.	Worker-Child Visitation, Out-of-Home:	**All** children must be seen quarterly by a DCF social worker. At least 85% of children[2] in out-of-home care shall be visited at least once monthly. Private agency social worker visits may count for monthly visits if the content of the visit is documented in LINK.[3]
17.	Worker-Child Visitation, In-Home:	At least 85% of all in-home cases[2] shall have a social worker visit at least twice a month. All visits must be documented in LINK.
18.	Caseload Standards:	No DCF social worker's caseload shall exceed the standard for more than 30 days.
19.	Residential Reduction:	No more than 11% of the total number of children in out-of-home care shall be in residential placements. Includes Voluntary cases.
20.	Discharge Measures:	At least 85% of children age 18 or older shall achieve specified educational/vocational goals prior to discharge (e.g. high school diploma, full time employment).[3]
21.	Discharge of Mentally Ill or Mentally Retarded Children:	DCF shall submit a written discharge plan to DMHAS or DMR for all committed or dually committed children[3] who are mentally ill or retarded and require adult services, within 180 days prior to anticipated discharge date.
22.	Multi-Disciplinary Exams (MDE):	**All** children entering DCF custody must have an MDE. At least 85% of these must have had their MDE completed within 30 days of placement.

[1] Except Probate and Voluntary cases
[2] Except Probate, Interstate and Subsidy-only cases
[3] Except Probate, Interstate and Voluntary cases

Emily J.

Emily J. v. Rell, another federal class action lawsuit, was brought by the Connecticut Civil Liberties Union, Center for Children's Advocacy, Yale University Jerome N. Frank Legal Services Organization, and Center for Public Representation on behalf of seven children placed in juvenile detention centers operated by the Judicial Branch. Originally filed in 1993 as a "conditions of confinement" case, it sought to address serious problems of overcrowding, unacceptable housing, sexual and other assaults of detainees, and inadequate medical, mental health, educational, and recreational services found in the Bridgeport, New Haven, and Hartford Juvenile Detention Centers.

In February 1997, the court approved a consent agreement reached by all parties. The members of the defense (which included the governor, the DCF commissioner, the State Department of Education commissioner, administrators from the Judicial Branch) signed off on the settlement, although most of the stipulations applied primarily to the Judicial Branch. The settlement established requirements for juvenile detention centers concerning: living conditions; housing; recreation and programming; staffing and staff training; education; medical and mental health services; behavior management and family support and interaction. The agreement also required the Judicial Branch to establish a minimum number of residential and nonresidential community placements as alternatives to detention and pretrial community support services. In addition, the 1997 settlement required that if a detainee was a DCF client, the assigned caseworker visit that youth at least once a month and work closely with the youth's attorney and probation officer to assist in placement decisions that involve alternatives to detention center confinement. The settlement also required that an independent monitor be appointed to ensure the above mentioned requirements were met.

A revised stipulated agreement and a corrective action plan that the Judicial Branch and DCF had developed was approved by the court in June 2002 and replaced the 1997 agreement. The court acknowledged the accomplishments of the Judicial Branch in improving conditions within the detention centers; however, it ordered the defendants to focus on four main areas for children with mental health needs: screening; assessment; planning; and services.

Unlike the original agreement, where the Judicial Branch had primary responsibility for compliance, DCF and the Judicial Branch were jointly responsible for making improvements under the revised stipulated agreement and corrective action plan. In addition, a written memorandum of agreement (MOA) between the Judicial Branch and DCF was developed to reserve 20 beds at Riverview Hospital for psychiatric evaluations of court ordered children.

The 2002 agreement again specified that an independent monitor be appointed to conduct general inspections and program reviews that result in a summary report to be done more than twice a year. As a mechanism to ensure compliance, the monitor hired mental health consultants who made recommendations to both DCF and the Judicial Branch Court Support Services Division (CSSD). For example, the mental health consultants reviewed and proposed changes to the Juvenile Justice Intermediate Evaluation (JJIE) program. As a result, DCF developed a more comprehensive child assessment program with stronger family and community involvement.

In June 2005, just before the 2002 agreement was set to expire, a third agreement was negotiated by the parties and approved by the court. The purpose of this settlement was to provide supplemental, community-based services that would reduce the number of children placed in detention. Examples include but are not limited to: multidimensional treatment foster care slots; therapeutic mentors; and comprehensive, home-based behavioral health treatment and other supports known as "wraparound" services.

Under the 2005 agreement, DCF was also required to conduct a comprehensive review of a child's needs prior to adjudication. Better needs assessments were intended as another effort to divert juveniles from detention and long-term, out-of-home placement by providing wraparound services in the community.

The agreement further required DCF to provide outcome reports that contain statistical information for evaluating the success of the various additional services on a quarterly basis to the plaintiffs and the Court Monitor. These reports provide both program and child-specific outcome measures for the following programs: wraparound services; group homes; adolescent substance abuse; outpatient; multidimensional treatment foster care; flex funding for educational success; general flex funding; wraparound training; protocols for DCF-involved detainees; and general outcome measures. Examples of some of the reported outcome measures are:

- 80 percent of targeted class members who are admitted into wraparound services will not be discharged to residential treatment or other higher levels of care;
- 75 percent of participants will have a discharge based on their discharge plan;
- the discharge plan will be developed within 14 days of admission; and,
- targeted class members receiving Flex Funding for Educational Success will experience a decrease in arrests leading to conviction and delinquency commitment.

The independent Court Monitor responsible for reviewing compliance with the *Emily J.* agreement found satisfactory progress had been achieved by the state. The case was closed by the federal court in October 2007.

W.R.

The *W.R. v. Connecticut Department of Children and Families* lawsuit was filed as a federal class action in 2002 on behalf of a group of children with mental health needs in the care of DCF. The group certified by the court as the *W.R.* class is described as all mentally ill children aged 0-21 and/or youth with serious behavioral issues, who are in the care of DCF, and:

- whose needs cannot be met in traditional foster home placements or institutions;
- are in need of community-based placements; and/or
- have experienced or are at high risk of experiencing multiple failed placements.

The plaintiffs, several youth in DCF care and/or their parents, were represented by Connecticut Legal Services and joined by the Area Office of the Child Advocate. They claimed that the department failed to provide a continuum of placements appropriate to the class members' clinical needs and was relying on overly restrictive institutional placements and foster care placements that lacked adequate clinical supports. DCF denied the allegations, and for a number of years the parties were unable to reach agreement on any issues, including the definition of the class.

The trial judge appointed an outside mediator to work with the plaintiffs and the department in 2006. With the mediator's help, the parties reached a three-year settlement agreement in April 2007. The agreement requires the department to put in place policies and procedures to improve services for all *W.R.* class members as well as address the specific needs of several individual plaintiffs. The final agreement also required that implementation of its provisions be monitored by an outside consultant agreed upon by the parties.

On August 8, 2007, the U.S. District Court held a fairness hearing to review the terms of the approved agreement and allow class members an opportunity to object. The settlement agreement went into effect for a three-year period that concludes June 30, 2010.

SECTION II:

Safety and Permanency Data

Connecticut Child and Family Services Review Data Profile: June 17, 2008

CHILD SAFETY PROFILE	Fiscal Year 2006ab						12-Month Period Ending 03/31/2007						Fiscal Year 2007ab (In process of validation)					
	Reports	%	*Duplic. Childn.*[2]	*%*	Unique Childn.[2]	%	Reports	%	*Duplic. Childn.*[2]	*%*	Unique Childn.[2]	%	Reports	%	*Duplic. Childn.*[2]	*%*	Unique Childn.[2]	%
I. Total CA/N Reports Disposed[1]	28,500		42,286		35,059		27,831		41,989		35,222							
II. Disposition of CA/N Reports[3]																		
Substantiated & Indicated	7,175	25.2	10,174	24.1	9,375	26.7	7,049	25.3	10,579	25.2	9,732	27.6						
Unsubstantiated	21,325	74.8	32,112	75.9	25,684	73.3	20,782	74.7	31,409	74.8	25,490	72.4						
Other									1	0								
III. Child Victim Cases Opened for Post-Investigation Services[4]			3,342	32.8	2,935	31.3			3,575	33.8	3,131	32.2						
IV. Child Victims Entering Care Based on CA/N Report[5]			1,306	12.8	1,225	13.1			1,253	11.8	1,190	12.2						
V. Child Fatalities Resulting from Maltreatment[6]					3	0					4	0						
STATEWIDE AGGREGATE DATA USED TO DETERMINE SUBSTANTIAL CONFORMITY																		
VI. Absence of Maltreatment Recurrence[7] **[Standard: 94.6% or more; national median = 93.3%, 25th percentile = 91.50%]**					4,472 of 4,817	92.8					4,682 of 5,062	92.5						
VII. Absence of Child Abuse and/or Neglect in Foster Care[8] **(12 months) [standard 99.68% or more; national median = 99.5, 25th percentile = 99.30]**					9,400 of 9,459	99.38					9,290 of 9,364	99.21						

Connecticut Child and Family Services Review Data Profile: June 17, 2008

Additional Safety Measures For Information Only (no standards are associated with these):

	Fiscal Year 2006ab						12-Month Period Ending 03/31/2007						Fiscal Year 2007ab (In process of validation)					
	Hours				**Unique Childn.[2]**	**%**	**Hours**				**Unique Childn.[2]**	**%**	**Hours**				**Unique Childn.[2]**	**%**
VIII. Median Time to Investigation in Hours (Child File)[9]	>24 but<48						>24 but<48											
IX . Mean Time to Investigation in Hours (Child File)[10]	39.5						41.5											
X. Mean Time to Investigation in Hours (Agency File)[11]	39.9[A]						NA											
XI. Children Maltreated by Parents While in Foster Care.[12]					79 of 9,459	0.84					77 of 9,364	0.82						

CFSR Round One Safety Measures to Determine Substantial Conformity (Used primarily by States completing Round One Program Improvement Plans, but States may also review them to compare to prior performance)

	Fiscal Year 2006ab						12-Month Period Ending 03/31/2007						Fiscal Year 2007ab (In process of validation)					
	Reports	%	*Duplic. Childn.[2]*	*%*	Unique Childn.[2]	%	Reports	%	*Duplic. Childn.[2]*	*%*	Unique Childn.[2]	%	Reports	%	*Duplic. Childn.[2]*	*%*	Unique Childn.[2]	%
XII. Recurrence of Maltreatment[13] [Standard: 6.1% or less)					345 of 4,817	7.2					380 of 5,062	7.5						
XIII. Incidence of Child Abuse and/or Neglect in Foster Care[14] (9 months) [standard 0.57% or less]					49 of 8,737	0.56					52 of 8,638	0.60						

Connecticut Child and Family Services Review Data Profile: June 17, 2008

NCANDS data completeness information for the CFSR			
Description of Data Tests	**Fiscal Year 2006ab**	**12-Month Period Ending 03/31/2007**	**Fiscal Year 2007ab (In process of validation)**
Percent of duplicate victims in the submission [At least 1% of victims should be associated with multiple reports (same CHID). If not, the State would appear to have frequently entered different IDs for the same victim. This affects maltreatment recurrence]	7.70	7.90	
Percent of victims with perpetrator reported [File must have at least 95% to reasonably calculate maltreatment in foster care]*	97.60	100	
Percent of perpetrators with relationship to victim reported [File must have at least 95%]*	100	99.30	
Percent of records with investigation start date reported [Needed to compute mean and median time to investigation]	99.60	99.50	
Average time to investigation in the Agency file [PART measure]	Reported	Not Reported	
Percent of records with AFCARS ID reported in the Child File [Needed to calculate maltreatment in foster care by the parents; also. All Child File records should now have an AFCARS ID to allow ACF to link the NCANDS data with AFCARS. This is now an all-purpose unique child identifier and a child **does not have to be in foster care to have this ID**]	100	100	

*****States should strive to reach 100% in order to have maximum confidence in the absence of maltreatment in foster care measure.

FOOTNOTES TO DATA ELEMENTS IN CHILD SAFETY PROFILE

Each maltreatment allegation reported to NCANDS is associated with a disposition or finding that is used to derive the counts provided in this safety profile. The safety profile uses three categories. The various terms that are used in NCANDS reporting have been collapsed into these three groups.

Disposition Category	Safety Profile Disposition	NCANDS Maltreatment Level Codes Included
A	Substantiated or Indicated (Maltreatment Victim)	"Substantiated," "Indicated," and "Alternative Response Disposition Victim"
B	Unsubstantiated	"Unsubstantiated" and "Unsubstantiated Due to Intentionally False Reporting"
C	Other	"Closed-No Finding," "Alternative Response Disposition – Not a Victim," "Other," "No Alleged Maltreatment," and "Unknown or Missing"

Alternative Response was added starting with the 2000 data year. The two categories of Unsubstantiated were added starting with the 2000 data year. In earlier years there was only the category of Unsubstantiated. The disposition of "No alleged maltreatment" was added for FYY 2003. It primarily refers to children who receive an investigation or assessment because there is an allegation concerning a sibling or other child in the household, but not themselves, AND whom are not found to be a victim of maltreatment. It applies as a Maltreatment Disposition Level but not as a Report Disposition code because the Report Disposition cannot have this value (there must have been a child who was found to be one of the other values.)

Starting with FFY 2003, the data year is the fiscal year.

Starting with FFY2004, the maltreatment levels for each child are used consistently to categorize children. While report dispositions are based on the field of report disposition in NCANDS, the dispositions for duplicate children and unique children are based on the maltreatment levels associated with each child. A child victim has at least one maltreatment level that is coded "substantiated," "indicated," or "alternative response victim." A child classified as unsubstantiated has no maltreatment levels that are considered to be victim levels and at least one maltreatment level that is coded "unsubstantiated" or "unsubstantiated due to intentionally false reporting." A child classified as "other" has no maltreatment levels that are considered to be victim levels and none that are considered to be unsubstantiated levels. If a child has no maltreatments in the record, and report has a victim disposition, the child is assigned to "other" disposition. If a child has no maltreatments in the record and the report has either an unsubstantiated disposition or an "other" disposition, the child is counted as having the same disposition as the report disposition.

1. The data element, "Total CA/N Reports Disposed," is based on the reports received in the State that received a disposition in the reporting period under review. The number shown may include reports received during a previous year that received a disposition in the reporting year. Counts based on "reports," "duplicated counts of children," and "unique counts of children" are provided.

2. The duplicated count of children (report-child pairs) counts a child each time that (s)he was reported. The unique count of children counts a child only once during the reporting period, regardless of how many times the child was reported.

3. For the column labeled "Reports," the data element, "Disposition of CA/N Reports," is based on upon the highest disposition of any child who was the subject of an investigation in a particular report. For example, if a report investigated two children, and one child is found to be neglected and the other child found not to be maltreated, the report disposition will be substantiated (Group A). The disposition for each child is based on the specific finding related to the maltreatment(s). In other words, of the two children above, one is a victim and is counted under "substantiated" (Group A) and the other is not a victim and is counted under "unsubstantiated" (Group B). In determining the unique counts of children, the highest finding is given priority. If a child is found to be a victim in one report (Group A), but not a victim in a second report (Group B), the unique count of children includes the child only as a victim (Group A). The category of "other" (Group C) includes children whose report may have been "closed without a finding," children for whom the allegation disposition is "unknown," and other dispositions that a State is unable to code as substantiated, indicated, alternative response victim, or unsubstantiated.

4. The data element, "Child Cases Opened for Services," is based on the number of victims (Group A) during the reporting period under review. "Opened for Services" refers to post-investigative services. The duplicated number counts each time a victim's report is linked to ongoing services; the unique number counts a victim only once regardless of the number of times services are linked to reports of substantiated maltreatment.

5. The data element, "Children Entering Care Based on CA/N Report," is based on the number of victims (Group A) during the reporting period under review. The duplicated number counts each time a victim's report is linked to a foster care removal date. The unique number counts a victim only once regardless of the number of removals that may be reported.

6. The data element "Child Fatalities" counts the number of children reported to NCANDS as having died as a result of child abuse and/or neglect. Depending upon State practice, this number may count only those children for whom a case record has been opened either prior to or after the death, or may include a number of children whose deaths have been investigated as possibly related to child maltreatment. For example, some States include neglected-related deaths such as those caused by motor vehicle or boating accidents, house fires or access to firearms, under certain circumstances. The percentage is based on a count of unique victims of maltreatment for the reporting period.

7. The data element "Absence of Recurrence of Maltreatment" is defined as follows: Of all children who were victims of substantiated or indicated maltreatment allegation during the first 6 months of the reporting period, what percent were not victims of another substantiated or indicated maltreatment allegation within a 6-month period. This data element is used to determine the State's substantial conformity with CFSR Safety Outcome #1 ("Children are, first and foremos7t, protected from abuse and neglect.")

8. The data element "Absence of Child Abuse/or Neglect in Foster Care" is defined as follows: Of all children in foster care during the reporting period, what percent were not victims of substantiated or indicated maltreatment by foster parent of facility staff member. This data element is used to determine the State's substantial conformity with CFSR Safety Outcome #1 ("Children are, first and foremost, protected from abuse and neglect.") A child is counted as not having been maltreated in foster care if the perpetrator of the maltreatment was not identified as a foster parent or residential facility staff. Counts of children not maltreated in foster care are derived by subtracting NCANDS count of children maltreated by foster care providers from AFCARS count of children placed in foster care. The observation period for this measure is 12 months. The number of children not found to be maltreated in foster care and the percentage of all children in foster care are provided.

9. Median Time to Investigation in hours is computed from the Child File records using the Report Date and the Investigation Start Date (currently reported in the Child File in mmddyyyy format). The result is converted to hours by multiplying by 24.

10. Mean Time to investigation in hours is computed from the Child File records using the Report Date and the Investigation Start Date (currently reported in the Child File in mmddyyyy format). The result is converted to hours by multiplying by 24. Zero days difference (both dates are on the same day) is reported as "under 24 hours," one day difference (investigation date is the next day after report date) is reported as "at least 24 hours, but less than 48 hours," two days difference is reported as "at least 48 hours, but less than 72 hours," etc.

11. Average response time in hours between maltreatment report and investigation is available through State NCANDS Agency or SDC File aggregate data. "Response time" is defined as the time from the receipt of a report to the time of the initial investigation or assessment. Note that many States calculate the initial investigation date as the first date of contact with the alleged victim, when this is appropriate, or with another person who can provide information essential to the disposition of the investigation or assessment.

12. The data element, "Children Maltreated by Parents while in Foster Care" is defined as follows: Of all children placed in foster care during the reporting period, what percent were victims of substantiated or indicated maltreatment by parent. This data element requires matching NCANDS and AFCARS records by AFCARS IDs. Only unique NCANDS children with substantiated or indicated maltreatments and perpetrator relationship "Parent" are selected for this match. NCANDS report date must fall within the removal period found in the matching AFCARS record.

13. The data element, "Recurrence of Maltreatment," is defined as follows: Of all children associated with a "substantiated" or "indicated" finding of maltreatment during the first six months of the reporting period, what percentage had another "substantiated" or "indicated" finding of maltreatment within a 6-month period. The number of victims during the first six-month period and the number of these victims who were recurrent victims within six months are provided. This data element was used to determine the State's substantial conformity with Safety Outcome #1 for CFSR Round One.

14. The data element, "Incidence of Child Abuse and/or Neglect in Foster Care," is defined as follows: Of all children who were served in foster care during the reporting period, what percentage were found to be victims of "substantiated" or "indicated" maltreatment. A child is counted as having been maltreated in foster care if the perpetrator of the maltreatment was identified as a foster parent or residential facility staff. Counts of children maltreated in foster care are derived from NCANDS, while counts of children placed in foster care are derived from AFCARS. The observation period for these measures is January-September because this is the reporting period that was jointly addressed by both NCANDS and AFCARS at the time when NCANDS reporting period was a calendar year. The number of children found to be maltreated in foster care and the percentage of all children in foster care are provided. This data element was used to determine the State's substantial conformity with Safety Outcome #2 for CFSR Round One.

Additional Footnotes:

A. The FFY2006 Agency File computation was based on commencement date/time minus report received date/time. Staff enters commencement date/time-based on the point at which they first made or attempted to make contact. In some cases a report is tied to an already existing investigation resulting in negative response times. Negative response times were not included in this calculation. In-house response time is measured from the point of report acceptance to commencement date/time. Mean time is 21.8 hrs, median is 17.1 hours. (Negative response times excluded.)

Connecticut Child and Family Services Review Data Profile: June 17, 2008

POINT-IN-TIME PERMANENCY PROFILE	Federal FY 2006ab		12-Month Period Ending 03/31/2007 (06b07a)		*Federal FY 2007ab*	
	# of Children	***% of Children***	***# of Children***	***% of Children***	***# of Children***	***% of Children***
I. Foster Care Population Flow						
Children in foster care on first day of year[1]	6,207		6,161		6,305	
Admissions during year	3,252		3,203		2,680	
Discharges during year	3,043		3,164		3,149	
Children discharging from FC in less than 8 days (These cases are excluded from length of stay calculations in the composite measures)	149	4.9% of the discharges	174	5.5% of the discharges	161	5.1% of the discharges
Children in care on last day of year	6,416		6,200		5,836	
Net change during year	209		39		-469	
II. Placement Types for Children in Care						
Pre-Adoptive Homes	477	7.4	527	8.5	540	9.3
Foster Family Homes (Relative)	1,141	17.8	1,043	16.8	958	16.4
Foster Family Homes (Non-Relative)	2,719	42.4	2,664	43.0	2,435	41.7
Group Homes	493	7.7	495	8.0	469	8.0
Institutions	1,065	16.6	1,090	17.6	1,010	17.3
Supervised Independent Living	17	0.3	14	0.2	15	0.3
Runaway	32	0.5	36	0.6	35	0.6
Trial Home Visit	209	3.3	134	2.2	192	3.3
Missing Placement Information	263	4.1	197	3.2	182	3.1
Not Applicable (Placement in subsequent year)	0	0.0	0	0.0	0	0.0
III. Permanency Goals for Children in Care						
Reunification	1,286	20.0	1,378	22.2	1,508	25.8
Live with Other Relatives	658	10.3	577	9.3	497	8.5
Adoption	867	13.5	1,138	18.4	1,248	21.4
Long Term Foster Care	0	0.0	0	0.0	0	0.0
Emancipation	1,956	30.5	1,855	29.9	1,664	28.5
Guardianship	47	0.7	45	0.7	44	0.8
Case Plan Goal Not Established	0	0.0	0	0.0	0	0.0
Missing Goal Information	1,602	25.0	1,207	19.5	875	15.0

Connecticut Child and Family Services Review Data Profile: June 17, 2008

POINT-IN-TIME PERMANENCY PROFILE	Federal FY 2006ab		12-Month Period Ending 03/31/2007 (06b07a)		*Federal FY 2007ab*	
	# of Children	***% of Children***	***# of Children***	***% of Children***	***# of Children***	***% of Children***
IV. Number of Placement Settings in Current Episode						
One	2,107	32.8	2,004	32.3	1,874	32.1
Two	1,596	24.9	1,571	25.3	1,401	24.0
Three	838	13.1	832	13.4	794	13.6
Four	486	7.6	472	7.6	460	7.9
Five	346	5.4	313	5.0	327	5.6
Six or more	871	13.6	861	13.9	853	14.6
Missing placement settings	172	2.7	147	2.4	127	2.2
V. Number of Removal Episodes						
One	5,133	80.0	4,937	79.6	4,620	79.2
Two	1,075	16.8	1,062	17.1	1,016	17.4
Three	167	2.6	163	2.6	159	2.7
Four	35	0.5	34	0.5	35	0.6
Five	3	0.0	4	0.1	5	0.1
Six or more	3	0.0	0	0.0	1	0.0
Missing removal episodes	0	0.0	0	0.0	0	0.0
VI. Number of children in care 17 of the most recent 22 months[2] (percent based on cases with sufficient information for computation)	1,637	43.5	1,560	42.9	1,569	46.0
VII. Median Length of Stay in Foster Care (of children in care on last day of FY)	16.7		16.7		17.9	
VIII. Length of Time to Achieve Perm. Goal	**# of Children Discharged**	**Median Months to Discharge**	**# of Children Discharged**	**Median Months to Discharge**	**# of Children Discharged**	**Median Months to Discharge**
Reunification	1,386	9.3	1,504	8.5	1,437	8.8
Adoption	475	32.0	477	33.6	565	30.9
Guardianship	404	19.1	457	17.9	437	14.9
Other	629	38.1	636	40.2	613	36.8
Missing Discharge Reason (footnote 3, page 16)	137	17.6	79	18.0	85	18.0
Total discharges (excluding those w/ problematic dates)	3,031	18.0	3,153	17.7	3,137	17.1
Dates are problematic (footnote 4, page 16)	12	N/A	11	N/A	12	N/A

Connecticut Child and Family Services Review Data Profile: June 17, 2008

Statewide Aggregate Data Used in Determining Substantial Conformity: Composites 1 through 4			
	Federal FY 2006ab	**12-Month Period Ending 03/31/2007 (06b07a)**	***Federal FY 2007ab***
IX. Permanency Composite 1: Timeliness and Permanency of Reunification [standard: 122.6 or higher]. Scaled Scores for this composite incorporate two components	State Score = 92.3	State Score = 96.6	State Score = 100.0
National Ranking of State Composite Scores (see footnote A on page 12 for details)	42 of 47	40 of 47	40 of 47
Component A: Timeliness of Reunification The timeliness component is composed of three timeliness individual measures.			
Measure C1 - 1: Exits to reunification in less than 12 months: Of all children discharged from foster care to reunification in the year shown, who had been in foster care for 8 days or longer, what percent was reunified in less than 12 months from the date of the latest removal from home? (Includes trial home visit adjustment) [**national median = 69.9%, 75th percentile = 75.2%**]	54.5%	56.8%	57.9%
Measure C1 - 2: Exits to reunification, median stay: Of all children discharged from foster care (FC) to reunification in the year shown, who had been in FC for 8 days or longer, what was the median length of stay (in months) from the date of the latest removal from home until the date of discharge to reunification? (This includes trial home visit adjustment) [**national median = 6.5 months, 25th Percentile = 5.4 months (lower score is preferable in this measure[B])**]	Median = 10.6 months	Median = 10.1 months	Median = 10.2 months
Measure C1 - 3: Entry cohort reunification in < 12 months: Of all children entering foster care (FC) for the first time in the 6 month period just prior to the year shown, and who remained in FC for 8 days or longer, what percent was discharged from FC to reunification in less than 12 months from the date of the latest removal from home? (Includes trial home visit adjustment) [**national median = 39.4%, 75th Percentile = 48.4%**]	28.7%	27.9%	27.2%
Component B: Permanency of Reunification The permanency component has one measure.			
Measure C1 - 4: Re-entries to foster care in less than 12 months: Of all children discharged from foster care (FC) to reunification in the 12-month period prior to the year shown, what percent re-entered FC in less than 12 months from the date of discharge? [**national median = 15.0%, 25th Percentile = 9.9% (lower score is preferable in this measure)**]	15.6%	15.3%	13.3%

Connecticut Child and Family Services Review Data Profile: June 17, 2008

	Federal FY 2006ab	12-Month Period Ending 03/31/2007 (06b07a)	*Federal FY 2007ab*
X. Permanency Composite 2: Timeliness of Adoptions [standard: 106.4 or higher]. Scaled Scores for this composite incorporate three components.	State Score = 99.8	State Score = 100.0	State Score = 104.7
National Ranking of State Composite Scores (see footnote A on page 12 for details)	21 of 47	20 of 47	16 of 47
Component A: Timeliness of Adoptions of Children Discharged From Foster Care. There are two individual measures of this component. See below.			
Measure C2 - 1: Exits to adoption in less than 24 months: Of all children who were discharged from foster care to a finalized adoption in the year shown, what percent was discharged in less than 24 months from the date of the latest removal from home? [**national median = 26.8%, 75th Percentile = 36.6%**]	32.8%	32.1%	36.6%
Measure C2 - 2: Exits to adoption, median length of stay: Of all children who were discharged from foster care (FC) to a finalized adoption in the year shown, what was the median length of stay in FC (in months) from the date of latest removal from home to the date of discharge to adoption? [**national median = 32.4 months, 25th Percentile = 27.3 months(lower score is preferable in this measure)**]	Median = 32.0 months	Median = 33.6 months	Median = 30.9 months
Component B: Progress Toward Adoption for Children in Foster Care for 17 Months or Longer. There are two individual measures. See below.			
Measure C2 - 3: Children in care 17+ months, adopted by the end of the year: Of all children in foster care (FC) on the first day of the year shown who were in FC for 17 continuous months or longer (and who, by the last day of the year shown, were not discharged from FC with a discharge reason of live with relative, reunify, or guardianship), what percent was discharged from FC to a finalized adoption by the last day of the year shown? [**national median = 20.2%, 75th Percentile = 22.7%**]	12.0%	12.4%	13.9%
Measure C2 - 4: Children in care 17+ months achieving legal freedom within 6 months: Of all children in foster care (FC) on the first day of the year shown who were in FC for 17 continuous months or longer, and were not legally free for adoption prior to that day, what percent became legally free for adoption during the first 6 months of the year shown? Legally free means that there was a parental rights termination date reported to AFCARS for both mother and father. This calculation excludes children who, by the end of the first 6 months of the year shown had discharged from FC to "reunification," "live with relative," or "guardianship." [**national median = 8.8%, 75th Percentile = 10.9%**]	7.0%	8.7%	9.5%
Component C: Progress Toward Adoption of Children Who Are Legally Free for Adoption. There is one measure for this component. See below.			
Measure C2 - 5: **Legally free children adopted in less than 12 months:** Of all children who became legally free for adoption in the 12 month period prior to the year shown (i.e., there was a parental rights termination date reported to AFCARS for both mother and father), what percent was discharged from foster care to a finalized adoption in less than 12 months of becoming legally free? [**national median = 45.8%, 75th Percentile = 53.7%**]	63.9%	67.3%	64.3%

Connecticut Child and Family Services Review Data Profile: June 17, 2008

	Federal FY 2006ab	12-Month Period Ending 03/31/2007 (06b07a)	*Federal FY 2007ab*
XI. Permanency Composite 3: Permanency for Children and Youth in Foster Care for Long Periods of Time [standard: 121.7 or higher]. Scaled Scores for this composite incorporate two components	State Score = 94.8	State Score = 96.3	State Score = 101.7
National Ranking of State Composite Scores (see footnote A on page 12 for details)	44 of 51	43 of 51	40 of 51
Component A: Achieving permanency for Children in Foster Care for Long Periods of Time. This component has two measures.			
Measure C3 - 1: Exits to permanency prior to 18th birthday for children in care for 24 + months. Of all children in foster care for 24 months or longer on the first day of the year shown, what percent was discharged to a permanent home prior to their 18th birthday and by the end of the fiscal year? A permanent home is defined as having a discharge reason of adoption, guardianship, or reunification (including living with relative). **[national median 25.0%, 75th Percentile = 29.1%]**	18.6%	20.8%	20.8%
Measure C3 - 2: Exits to permanency for children with TPR: Of all children who were discharged from foster care in the year shown, and who were legally free for adoption at the time of discharge (i.e., there was a parental rights termination date reported to AFCARS for both mother and father), what percent was discharged to a permanent home prior to their 18th birthday? A permanent home is defined as having a discharge reason of adoption, guardianship, or reunification (including living with relative) **[national median 96.8%, 75th Percentile = 98.0%]**	89.4%	88.6%	90.7%
Component B: Growing up in foster care. This component has one measure.			
Measure C3 - 3: Children Emancipated Who Were in Foster Care for 3 Years or More. Of all children who, during the year shown, either (1) were discharged from foster care prior to age 18 with a discharge reason of emancipation, or (2) reached their 18th birthday while in foster care, what percent were in foster care for 3 years or longer? **[national median 47.8%, 25th Percentile = 37.5% (lower score is preferable)]**	58.7%	59.4%	54.6%

	Federal FY 2006ab	12-Month Period Ending 03/31/2007 (06b07a)	*Federal FY 2007ab*
XII. Permanency Composite 4: Placement Stability [national standard: 101.5 or higher]. Scaled scored for this composite incorporates **no components** but three individual measures (below)	State Score = 97.3	State Score = 98.1	State Score = 98.3
National Ranking of State Composite Scores (see footnote A on page 12 for details)	17 of 51	14 of 51	13 of 51
Measure C4 - 1) Two or fewer placement settings for children in care for less than 12 months. Of all children served in foster care (FC) during the 12 month target period who were in FC for at least 8 days but less than 12 months, what percent had two or fewer placement settings? **[national median = 83.3%, 75th Percentile = 86.0%]**	86.2%	86.8%	86.5%
Measure C4 - 2) Two or fewer placement settings for children in care for 12 to 24 months. Of all children served in foster care (FC) during the 12 month target period who were in FC for at least 12 months but less than 24 months, what percent had two or fewer placement settings? **[national median = 59.9%, 75th Percentile = 65.4%]**	65.4%	66.9%	68.6%
Measure C4 - 3) Two or fewer placement settings for children in care for 24+ months. Of all children served in foster care (FC) during the 12 month target period who were in FC for at least 24 months, what percent had two or fewer placement settings? **[national median = 33.9%, 75th Percentile = 41.8%]**	31.2%	30.4%	29.9%

Special Footnotes for Composite Measures:

A. These National Rankings show your State's performance on the Composites compared to the performance of all the other States that were included in the 2004 data. The 2004 data were used for establishing the rankings because that is the year used in calculating the National Standards. The order of ranking goes from 1 to 47 or 51, depending on the measure. For example, "1 of 47" would indicate this State performed higher than all the States in 2004.

B. In most cases, a high score is preferable on the individual measures. In these cases, you will see the 75th percentile listed to indicate that this would be considered a good score. However, in a few instances, a low score is good (shows desirable performance), such as re-entry to foster care. In these cases, the 25th percentile is displayed because that is the target direction for which States will want to strive. Of course, in actual calculation of the total composite scores, these "lower are preferable" scores on the individual measures are reversed so that they can be combined with all the individual scores that are scored in a positive direction, where higher scores are preferable.

Connecticut Child and Family Services Review Data Profile: June 17, 2008

PERMANENCY PROFILE FIRST-TIME ENTRY COHORT GROUP	**Federal FY 2006ab**		**12-Month Period Ending 03/31/2007 (06b07a)**		***Federal FY 2007ab***	
	# of Children	***% of Children***	***# of Children***	***% of Children***	***# of Children***	***% of Children***
I. Number of children entering care for the first time in cohort group (% = 1st time entry of all entering within first 6 months)	1,184	81.4	1,454	81.8	1,140	81.7
II. Most Recent Placement Types						
Pre-Adoptive Homes	31	2.6	43	3.0	40	3.5
Foster Family Homes (Relative)	216	18.2	258	17.7	196	17.2
Foster Family Homes (Non-Relative)	336	28.4	458	31.5	271	23.8
Group Homes	32	2.7	45	3.1	22	1.9
Institutions	161	13.6	182	12.5	132	11.6
Supervised Independent Living	0	0.0	1	0.1	2	0.2
Runaway	1	0.1	6	0.4	1	0.1
Trial Home Visit	31	2.6	35	2.4	37	3.2
Missing Placement Information	376	31.8	426	29.3	439	38.5
Not Applicable (Placement in subsequent yr)	0	0.0	0	0.0	0	0.0
III. Most Recent Permanency Goal						
Reunification	443	37.4	547	37.6	508	44.6
Live with Other Relatives	105	8.9	139	9.6	93	8.2
Adoption	77	6.5	195	13.4	163	14.3
Long-Term Foster Care	0	0.0	0	0.0	0	0.0
Emancipation	131	11.1	141	9.7	89	7.8
Guardianship	15	1.3	25	1.7	11	1.0
Case Plan Goal Not Established	0	0.0	0	0.0	0	0.0
Missing Goal Information	413	34.9	407	28.0	276	24.2
IV. Number of Placement Settings in Current Episode						
One	595	50.3	772	53.1	649	56.9
Two	374	31.6	463	31.8	312	27.4
Three	143	12.1	157	10.8	125	11.0
Four	42	3.5	35	2.4	35	3.1
Five	15	1.3	13	0.9	11	1.0
Six or more	13	1.1	11	0.8	8	0.7
Missing placement settings	2	0.2	3	0.2	0	0.0

Connecticut Child and Family Services Review Data Profile: June 17, 2008

PERMANENCY PROFILE FIRST-TIME ENTRY COHORT GROUP (continued)	**Federal FY 2006ab**		**12-Month Period Ending 03/31/2007 (06b07a)**		***Federal FY 2007ab***	
	# of Children	***% of Children***	***# of Children***	***% of Children***	***# of Children***	***% of Children***
V. Reason for Discharge						
Reunification/Relative Placement	285	79.2	336	82.0	334	79.5
Adoption	5	1.4	6	1.5	1	0.2
Guardianship	21	5.8	34	8.3	49	11.7
Other	44	12.2	28	6.8	34	8.1
Unknown (missing discharge reason or N/A)	5	1.4	6	1.5	2	0.5
	Number of Months		**Number of Months**		**Number of Months**	
VI. Median Length of Stay in Foster Care	9.9		12.0		not yet determinable	

AFCARS Data Completeness and Quality Information (2% or more is a warning sign):

	Federal FY 2006ab		**12-Month Period Ending 03/31/2007 (06b07a)**		**Federal FY 2007ab**	
	N	**As a % of Exits Reported**	**N**	**As a % of Exits Reported**	**N**	**As a % of Exits Reported**
File contains children who appear to have been in care less than 24 hours	0	0.0 %	0	0.0 %	1	0.0 %
File contains children who appear to have exited before they entered	12	0.0 %	11	0.0 %	11	0.0 %
Missing dates of latest removal	0	0.0 %	0	0.0 %	0	0.0 %
File contains "Dropped Cases" between report periods with no indication as to discharge	50	1.6 %	44	1.4 %	54	1.7 %
Missing discharge reasons	137	4.5 %	79	2.5 %	85	2.7 %
	N	**As a % of adoption exits**	**N**	**As a % of adoption exits**	**N**	**As a % of adoption exits**
File submitted lacks data on Termination of Parental Rights for finalized adoptions	11	2.3 %	7	1.5 %	5	0.9 %
Foster Care file has different count than Adoption File of (public agency) adoptions (N= adoption count disparity).	6	1.2% more in the unofficial adoption file*.	3	0.6% more in the unofficial adoption file*.	4	0.7% more in the unofficial adoption file*.
	N	**Percent of cases in file**	**N**	**Percent of cases in file**	**N**	**Percent of cases in file**
File submitted lacks count of number of placement settings in episode for each child	172	2.7 %	147	2.4 %	127	2.2 %

* The adoption data comparison was made using the discharge reason of "adoption" from the AFCARS foster care file and an *unofficial* count of adoptions finalized during the period of interest that were "placed by public agency" reported in the AFCARS Adoption files. This *unofficial* count of adoptions is only used for CFSR data quality purposes because adoption counts used for other purposes (e.g. Adoption Incentives awards, Outcomes Report) only cover the federal fiscal year, and include a broader definition of adoption and a different de-duplication methodology.

Connecticut Child and Family Services Review Data Profile: June 17, 2008

Note: These are CFSR Round One permanency measures. They are intended to be used primarily by States completing Round One Program Improvement Plans, but could also be useful to States in CFSR Round Two in comparing their current performance to that of prior years:

	Federal FY 2006ab		12-Month Period Ending 03/31/2007		*Federal FY 2007ab*	
	# of Children	**% of Children**	**# of Children**	**% of Children**	**# of Children**	**% of Children**
IX. Of all children who were reunified with their parents or caretakers at the time of discharge from foster care, what percentage was reunified in less than 12 months from the time of the latest removal for home? (4.1) **[Standard: 76.2% or more]**	817	58.9	924	61.4	894	62.2
X. Of all children who exited care to a finalized adoption, what percentage exited care in less than 24 months from the time of the latest removal from home? (5.1) **[Standard: 32.0% or more]**	156	32.7	153	32.0	207	36.6
XI. Of all children served who have been in foster care less than 12 months from the time of the latest removal from home, what percentage have had no more than two placement settings? (6.1) **[Standard: 86.7% or more]**	3,184	87.1	3,207	87.6	2,764	87.4
XII. Of all children who entered care during the year, what percentage re-entered foster care within 12 months of a prior foster care episode? (4.2) **[Standard: 8.6% or less]**	263	8.1 (81.6% new entry)	239	7.5 (81.7% new entry)	209	7.8 (80.5% new entry)

Connecticut Child and Family Services Review Data Profile: June 17, 2008

FOOTNOTES TO DATA ELEMENTS IN THE PERMANENCY PROFILE

[1]The FY 06, 06B07A, and FY 07 counts of children in care at the start of the year exclude 83, 74 and 60 children, respectively. They were excluded to avoid counting them twice. That is, although they were actually in care on the first day, they also qualify as new entries because they left and re-entered again at some point during the same reporting period. To avoid counting them as both "in care on the first day" and "entries," the Children's Bureau selects only the most recent record. That means they get counted as "entries," not "in care on the first day."

[2]We designated the indicator, *17 of the most recent 22 months,* rather than the statutory time frame for initiating termination of parental rights proceedings at *15 of the most 22 months*, since the AFCARS system cannot determine the *date the child is considered to have entered foster care* as defined in the regulation. We used the outside date for determining the *date the child is considered to have entered foster care*, which is 60 days from the actual removal date.

[3]This count only includes case records missing a discharge reason, but which have calculable lengths of stay. Records missing a discharge reason and with non-calculable lengths of stay are included in the cell “Dates are Problematic”.

[4]The dates of removal and exit needed to calculate length of stay are problematic. Such problems include: 1) missing data, 2) faulty data (chronologically impossible), 3) a child was in care less than 1 day (length of stay = 0) so the child should not have been reported in foster care file, or 4) child's length of stay would equal 21 years or more. These cases are marked N/A = Not Applicable because no length of stay can legitimately be calculated.

[5]This First-Time Entry Cohort median length of stay was 9.9 in FY 06. This includes 0 children who entered and exited on the same day (who had a zero length of stay). Therefore, the median length of stay was unaffected by any 'same day' children.

[6]This First-Time Entry Cohort median length of stay was 12.0 in 06B07A. This includes 0 children who entered and exited on the same day (who had a zero length of stay). Therefore, the median length of stay was unaffected by any 'same day' children.

[7]This First-Time Entry Cohort median length of stay is Not Yet Determinable for FY 07. This includes 1 child who entered and exited on the same day (the child had a zero length of stay). If this child was excluded, the median length of stay would still be Not Yet Determinable. The designation, Not Yet Determinable occurs when a true length of stay for the cohort cannot be calculated because fewer than 50% of the children have exited.

SECTION III:

Narrative Assessment of Child and Family Outcomes

A. SAFETY

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

In 2002, Round One of the CFSR, Connecticut did not achieve substantial conformity with Safety Outcome 1. Although in 91.1 percent of the cases the reviewers determined that this outcome had been substantially achieved, the State did not meet the national standard for either repeat maltreatment or maltreatment of children in foster care.

Connecticut did not achieve substantial conformity with Safety Outcome 2. This determination was based on the finding that the outcome was substantially achieved in 87 percent of the cases reviewed, which is less than the 90 percent required for a rating of substantial conformity.

Item 1: Timeliness of initiating investigations of reports of child maltreatment. How effective is the agency in responding to incoming reports of child maltreatment in a timely manner?

Policy Description

The initiation or commencement of an investigation occurs when the DCF investigator attempts to make face-to-face contact with the parent responsible for the child's care, and/or with the child(ren) who is the subject of the abuse and neglect referral. Investigators must commence investigations in accordance with response times designated by the DCF Centralized Abuse and Neglect Hotline. DCF Policy does not specifically define what constitutes an "attempt" to make contact but does indicate that in those situations when a child is "believed to be in imminent danger, the investigator shall make every effort to see the child immediately." Policy also explains that if a parent refuses entry to the home and there is reasonable cause to suspect the child is in danger, the worker shall contact police for assistance." Despite this guidance, there remains a degree of ambiguity with regard to what constitutes an attempt.

A report of alleged abuse, neglect, or a child in danger of abuse or neglect comes into existence when the DCF Hotline accepts a complaint for investigation and designates a response time for the commencement of the investigation. Hotline screeners use the Structured Decision Making (SDM) Screening Criteria instrument to determine the acceptability of a complaint for investigation. Once the report is accepted for investigation, it is then prioritized for response.

During normal hours of operation the reports are forwarded to the designated Area Office for investigation commencement.

After hours, and on weekends, there is a unit of nine investigators, called Primary Investigators, whose sole responsibility is to commence investigations during non operating hours. These nine investigators are supplemented by one volunteer from each Area office, on a weekly rotating basis. These workers are referred to as After Hours Investigation Workers. The Primary Investigator or the After Hours Investigation Workers remain involved in the investigation until the Area Office reopens. The case is then transitioned to the Area Office for completion of the investigation.

DCF Hotline Annual Reports dating back to 2003 document the number of calls to the centralized Hotline as well as the number of reports that are screened out or not accepted for investigation. The following table documents the number of calls received annually by the Hotline since 2003 and also indicates the acceptance rates for each year.

Calls to DCF Hotline and Acceptance Rates[4]

Year	Total Number of Calls	Accepted	Not-Accepted	Calls Not Related to Reports of CA/N *
2003	95,224	31,548	14,534	49,142
2004	90,247	32,204	12,198	45,845
2005	87,958	29,066	13,829	45,063
2006	91,129	27,827	15,661	47,641
2007	89,726	25,296	16,997	47,433

The data show that since 2003, the number of accepted reports has declined each year. The increased number of non-accepted reports can be attributed to Hotline supervisors more closely reviewing reports on active cases to determine if the issues being reported are ongoing in the life of the case and to ensure that reports regarding the same incident are accurately recorded so that Exit Plan Outcome Measure 5 (repeat maltreatment) is met. The Hotline Annual Report also credits closer collaboration between Hotline supervisors and Area Office staff with the decrease in accepted reports because they can better determine what information is already known to the Area Office as part of the active cases.

DCF has three designated response times for reports of abuse and neglect: same day, 24 hour and 72 hour. Hotline screeners use the SDM Response Priority Instrument to generate response times by which investigations must be commenced. Reports designated as same day response are those situations in which failure to respond immediately could result in the death of or serious injury to a child. Prior to August of 2004, reports requiring a same-day response were designated as 2 hour response times. Referrals involving a non-life threatening situation that is severe enough to warrant a response within 24 hours in order to secure the safety of the child and to access the appropriate and available witnesses are prioritized as 24 hour responses. Response times of 72 hours are designated to those situations determined to be non-life threatening, taking into account the age and condition of the child involved.

While the DCF Hotline staff utilizes the SDM Response Priority Instrument to determine response times for new referrals, they also have the ability to upgrade or downgrade the response times by utilizing the SDM Policy or Discretionary Override Process. Such overrides are relevant when considering variables which may impact response time such as knowledge of a family's history. In the Management Report covering the period between August 2007 and October 2007, the Children's Research Center (CRC) reported that 38.9% of investigations were initially recommended for a response within 24 hours and 61.1% were recommended for a response within 72 hours. Following overrides, 7.2% of investigations were assigned a same-day response; 32.4% were assigned a 24-hour response; and 60.4% were assigned a 72-hour response time. During the report period, hotline workers exercised response priority overrides in 7.8% of investigations. The response priority was overridden 448 times to a same-day response, 22 times to a 24-hour response, and 16 times to a 72-hour response. Of the 486 investigations in which a response priority override was exercised, 87.4% were policy overrides and 12.6% were discretionary. The relatively small number of discretionary overrides indicates that workers tended to agree with the decisions recommended by the response priority tool. A closer examination of the response priority levels for investigations in which an override was exercised shows that most changes tended to move investigations into a more urgent response level category.

[4] Calls not Related to reports of Child Abuse/Neglect (CA/N) can be any of a variety of calls. These include, but are not limited to: supervision of staff working after hours; medical permission to treat a committed child; community follow up or inquiries; worker messages and foster home emergencies or support.

As indicated previously, DCF policy requires that investigations commence in accordance with the designated response times and if the child is believed to be in imminent danger, the investigator must make every effort to see the child immediately. Policy also dictates that "all children in the home and, if applicable, any other children of the parent or person responsible who does not reside in the home, shall be seen within three working days of the start of the investigation." If the worker is not successful in meeting this timeframe, then continued efforts shall be made to interview the children in a timely manner until a supervisory conference decision determines that no additional attempts are required. Policy does dictate that workers must make daily attempts to make face-to-face contact with the parent or person responsible for the child victim's care.

In cases related to alleged serious physical abuse, serious neglect, sexual abuse or the death of a child, CT policy requires notification to the local or state police within 24 hours and all efforts must be made to coordinate the investigation in an effort to minimize the number of interviews of the child victim. While coordination with external agencies can present challenges in terms of meeting the required timeframes for investigation commencement, most Area Offices have investigators out-posted in various police departments across the state, and feedback from workers and police departments indicates this has assisted in the timely coordination of and response to investigations which require police involvement.

According to the Hotline Annual Reports covering 2003 through 2007, DCF has seen a decline in the number of substantiated allegations of abuse and neglect. In 2004, the substantiation rate was 30.1% and by 2007, the rate was down to 25.3%.

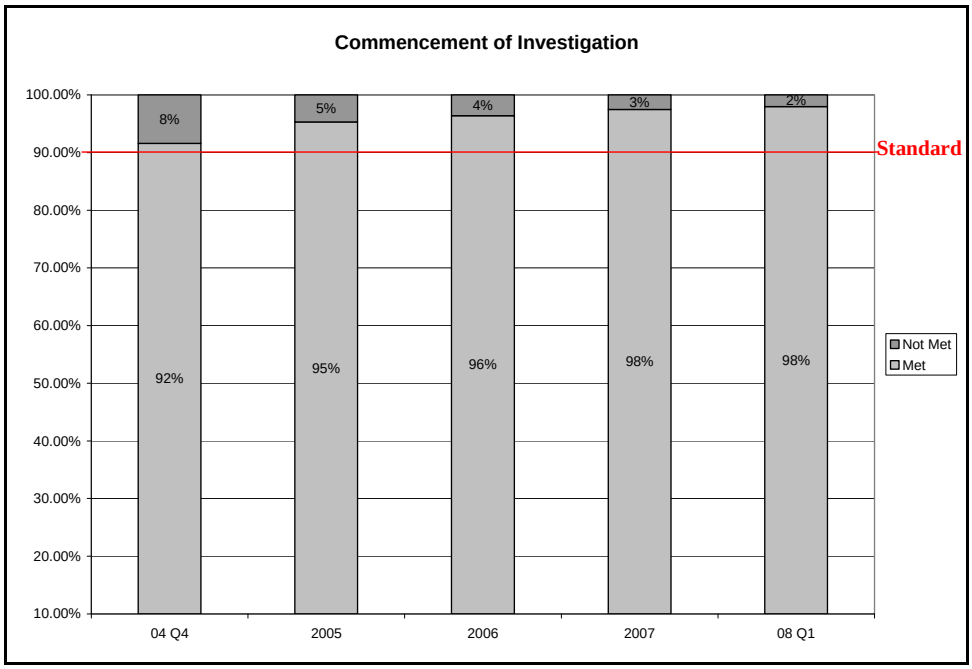
Summary of Performance in Round One of the CFSR

In the 2002 CFSR Item 1 was assigned an overall rating of Strength because reviewers determined that in 89 percent of the applicable cases DCF responded to reports in a timely manner. Stakeholders were in general agreement that the agency initiated and conducted investigations in a timely manner. Some indicated that DCF investigations are thorough and incorporate multidisciplinary assessments when necessary, including domestic violence and substance abuse assessments. Other stakeholders noted that DCF provides feedback to reporters in a timely manner. One concern voiced by stakeholders was that callers to the Centralized Hotline are often put on hold for extended or long periods of time, while others expressed concerns that Hotline calls were being screened out locally.

Measures of Effectiveness

DCF, as outlined in the Juan F Consent Decree Exit Plan, must commence investigations within the specified timeframes in at least 90 percent of the reports. According to the Positive Outcomes for Children (POC) Report, the Department has maintained substantial conformity with this measure for 15 consecutive quarters dating back to September 2004, and has often exceeded the measure.

The following chart and table illustrate yearly trend views of the Department's performance in this area from the last quarter of 2004, when the data first became available, up through 2007.



Outcome Measure 1: Timely Commencement of Investigation (Yearly Trend View)

Report Period	2004 September-December		2005 January-December		2006 January-December		2007 January-December		2008 January-March	
Investigation Commenced on Time (Met)	9291	**91.9%**	28189	**95.3%**	27334	**96.4%**	25052	**97.5%**	5955	**98.0%**
Not Met	817	8.1%	1392	4.7%	1015	3.6%	637	2.5%	121	2.0%
Total	10108	100%	29581	100%	28349	100%	25689	100%	6076	100%

According to the data, the Department experienced the largest performance improvement for investigation commencement from December 2004 to June 2005 (a 4% increase in performance). This improvement occurred immediately following the systemic and practice improvements implemented subsequent to the Court Monitor's Exit Plan (2003) and the Department's Positive Outcomes for Children (POC) plan (2004), both of which included strategies for achieving and maintaining Exit Plan Outcome Measure 1 (Commencement of Investigation). Additionally, as indicated previously, Connecticut's investigation rates have steadily decreased since 2003 as the number of accepted reports has decreased.

Factors Affecting Performance

Utilizing Data Management Tools and Monitoring: Area Office management and staff have been trained to utilize automated reports from the Department's electronic case records, such as LINK and Results Oriented Management (ROM), to track timeliness of investigations. It is expected that these reports are routinely reviewed in supervision with staff. In the recent Connecticut Comprehensive Outcomes Review (CCOR), which is Connecticut's internal qualitative review using the CFSR methodology, Area Offices

specifically identified LINK data reports as critical tools for case management and ROM reports for the purpose of managerial oversight as related to timeliness of investigations.

Mobile Telephone Usage: The Department's use of mobile technology, transitioning from pagers in 2004 to Nextel cellular phones, has helped to ensure the Department's ability to respond to referrals and commence investigations in a timely manner. Prior to 2004, only CPS investigators had pagers, allowing them to be contacted in the field. In 2004, DCF issued cellular phones to all CPS staff, including ongoing services workers. In 2004, DCF deployed roughly 1,500 phones, and today, the Department has almost 2,400 Sprint/Nextel phones in use by its workers. The availability of cell phones allows supervisors to contact workers immediately in emergent situations, having a positive impact on timeliness of investigations.

Out-posted employees: Since Round One of the CFSR, the Department has utilized and plans to increase its out-posting of investigation staff into the community in order to better respond and meet the needs of the families and communities served. Six of the Department's fourteen Area Offices currently outpost workers in various venues with other Area Offices reporting plans to do so in the near future. These venues include police departments, schools, courts, and youth programs such as Headstart. Feedback to this program has been positive with benefits of improved communication and response times cited. In March 2008, stakeholders who participated in a focus group during the Connecticut Comprehensive Outcome Review (CCOR) of our Manchester Area Office called the out-posted worker initiative "the best idea DCF ever had." All 18 focus group participants agreed that the out-posted workers are an asset to the community and help facilitate positive relations between the local DCF offices.

Hotline Calls: Stakeholders in Round One identified being placed on hold for significant amounts of time when calling the Hotline as an issue. Considerable efforts were made by Hotline administration to decrease the amount of time callers spend on hold. The Hotline Annual Report documents the average answer speed per call in 2003 was 1 minute 8 seconds and in 2004 wait time peaked at 2 minutes 1 second. Between 2004 and 2005, the average wait time significantly decreased to 32 seconds and then to 31 seconds in 2006. There was a slight increase to 49 seconds in 2007, which Hotline administration attributed to the roll-out of SDM and the additional steps required of screeners in processing a report.

Hotline After-Hours Investigations: In order for DCF to meet Exit Plan Outcome Measure 1 on long weekends (Commencement of Investigation) the Area Offices provide at least two investigators per "region" to assist Hotline in responding to 72-hour priority reports that would not otherwise be met because local offices are closed. The Hotline Annual Report indicates that Area Office investigators were needed 55 times during holiday weekends in 2007 and were needed a total of 125 times in 2007 to meet Outcome Measure 1 (Commencement of Investigation).

Item 2: Repeat Maltreatment: How effective is the agency in reducing the recurrence of maltreatment of children?

Policy Description

There is no specific DCF policy that directly relates to repeat maltreatment; however, there are a number of protocols and practices established that address and seek to reduce the occurrence of repeat maltreatment in the Area Offices. For example, several of the DCF Area Offices have implemented monthly case reviews on those cases in which there have been multiple reports received in one year, or more than five reports in the life of a case in an effort to identify trends related to repeat maltreatment. Similarly, in 2006, the Bureau Chief of Child Welfare directed Area Offices to conduct Critical Case

Summaries on those cases which experienced a re-opening for services within six months of closure and in the case of fatalities. These Critical Case Summaries require the Area Office staff to reflect on the trends seen in practice and identify lessons learned. DCF has also conducted several reviews in an effort to better understand repeat maltreatment; these are discussed under measures of effectiveness.

Summary of Performance in Round One of the CFSR

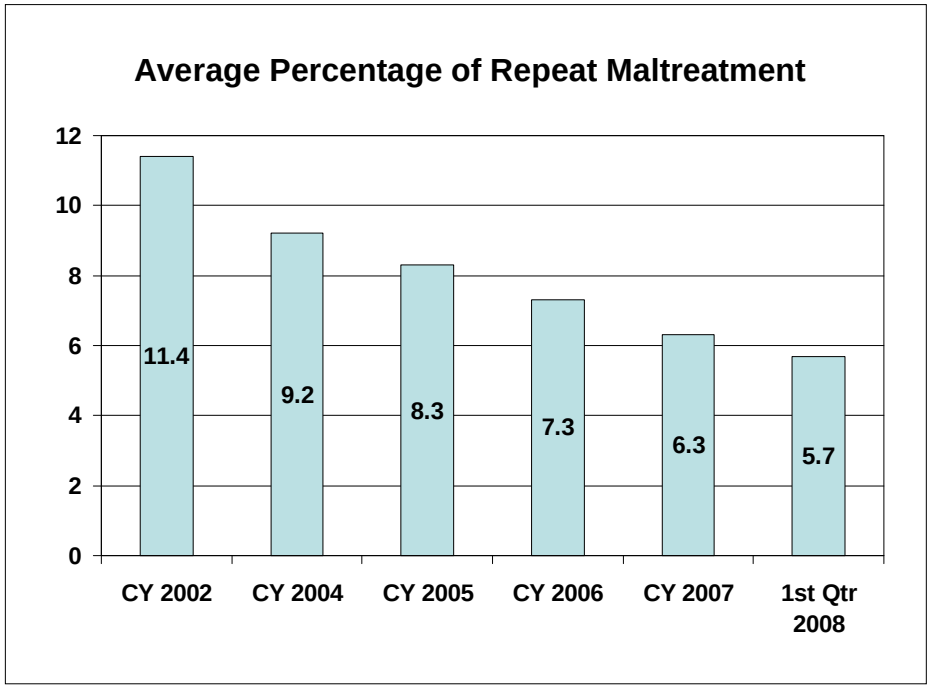
In the 2002 CFSR, Item 2 was assigned an overall rating of Area Needing Improvement for two primary reasons: the incidence of repeat maltreatment reported in the State Data Profile was 11.4 percent, which exceeded the national standard of 6.5 percent and there was repeat maltreatment in 3 of the 15 cases in which there was at least one substantiated maltreatment during the period under review.

In Round One of the CFSR, some stakeholders suggested that DCF has been effective in preventing recurrence of maltreatment because of its access to a wide array of services for families, particularly Intensive Family Preservation (IFP) and targeted or specialized assessments and services. However, a few stakeholders noted that there were often waiting lists for services and sometimes repeat maltreatment may occur while families wait are waiting to access services. Other stakeholders expressed concern that DCF lacks the legal authority to intervene with non-compliant families prior to a case being adjudicated by a court. A few stakeholders noted that in many instances, DCF will close a case or return a child home when parents complete services, without assessing whether parents' behaviors changed as a result of service participation.

Measures of Effectiveness

In the CFSR conducted in 2002, Repeat Maltreatment was identified as an area needing improvement. At that the time, the incidence of repeat maltreatment in the State was 11.4% which exceeded the then national standard of 6.1%. There has been a decrease in the recurrence of maltreatment since the 2002 CFSR. As indicated earlier, the DCF Hotline supervisors more closely review reports on open cases to determine if the issues being reported are ongoing in the life of the case and Hotline staff collaborate with Area Office staff regarding information that may already be known to them related to a family already receiving services in an effort to minimize the duplication of reports or investigations on the same incident(s).

Below is a graph displaying the statewide repeat maltreatment percentages since 2002 which was gathered from the POC reports:



Despite the decrease in rates of maltreatment recurrence, Connecticut's Data Profile indicates that performance on the Absence of Maltreatment Recurrence during a 12-month period ending March 31, 2007 is 92.5 %, which falls below the national standard for this safety indicator which is 94.6% or more.

Connecticut DCF has made efforts to better understand factors impacting the likelihood of both maltreatment and repeat maltreatment through various studies which have been conducted between 2002 and 2008. In the August 2005 repeat maltreatment report involving the Middletown DCF Area Office, three factors proved to be significant with regard increasing the likelihood of repeat maltreatment: 1) presence of substance abuse, 2) the absence of any social worker visits, and, 3) cases open for services at the time of the study.

In January 2007, the Quality Improvement Division conducted a study related to repeat maltreatment and reviewed 98 cases. Neglect was found to be the most common allegation substantiated in both the first and second reports on families and in at least 85% of the cases reviewed, the parent/guardian was the most commonly found perpetrator in both reports. The majority of the repeat maltreatment cases, 59% of the victims were between the ages of 0 and 5.

Factors Affecting Performance

There have been a number of efforts to improve case practice as a whole which have contributed to the decrease of repeat maltreatment. The efforts have not only been statewide but specific to Area Offices as well.

In 2004, there was an initiative to educate and train the Area Office staff as to how repeat maltreatment is measured and how to interpret the automated reports regarding this measure. As a result of this initiative, the following efforts were achieved:

Collaboration with the DCF Hotline

- Area offices are working in concert with the Hotline to prevent the acceptance of duplicate reports or reports with similar allegations from being accepted if the case is open for services and the new report refers to ongoing concerns being addressed by the assigned social worker. Any report not accepted for investigation on an active case is sent to the assigned worker for review and follow-up so that information is not lost. Similarly, if a case is open for investigation and a new report is made within five days, with similar allegations, those reports are consolidated by the assigned investigator. If the report is not accepted for investigation, a copy is still sent to the assigned investigator for review.

- Area offices are closely assessing referrals on active cases and will request that the Hotline reconsider the decision to accept if the allegations are the same as the initial referral or if the allegations are the same as the reason why the case was opened. As per DCF policy 33-6-31, Area Office staff cannot administratively screen out cases that have been accepted by the Hotline for investigation. If the Area Office disagrees with the Hotline decision to accept a case for investigation, based on additional information that would merit a reconsideration by Hotline, the manager in that Area Office shall request a review from Hotline. The Hotline administrator has the final decision on the report acceptance. If the Hotline manager reverses the decision to accept or non-accept a report, the Hotline manager will notify the mandated reporter, if any, in writing, explaining how the decision was made and how the information will be followed-up.

Case Review

- Reports on an open case are reviewed by a team which includes Investigations and Treatment staff including the social worker, the supervisor and program supervisor. The review includes an examination of the services that were implemented subsequent to the initial substantiation and what led to the most recent substantiation (repeat maltreatment). The Area Resource Group (ARG), in-house consultants for domestic violence, substance abuse and mental health-related issues, and legal staff are also involved in the review if deemed necessary.

- The Investigations program supervisor reviews all reports where there have been three reports in the last year or five in the lifetime of the case. There is also a conscious effort to reassign those investigations to the Investigation Social Worker that had the investigation in the past for continuity purposes.

- If a social worker believes a report should be made regarding a family already on his/her caseload, that worker must discuss the situation with his/her supervisor and program supervisor prior to calling the Hotline. The value of another investigation, especially if related to ongoing issues, is weighed against the matter being addressed by the caseworker most knowledgeable with the family. Staff have been encouraged to shift their thinking from believing that an additional substantiation is necessary to confirm that there are concerns within the family that warrant further Department intervention.

Utilizing Data Management Tools and Monitoring

- Area Office management and staff have been trained to utilize automated reports from the Department's electronic case records, such as LINK and the ROM management reporting system, to identify any patterns related to repeat maltreatment.

- Cases experiencing repeat maltreatment are logged and closely assessed and monitored. Many of the Area Offices have engaged in self-studies to improve this area. The Manchester and Norwich Area Offices, for example, have both developed internal systems for ensuring they are meeting the Exit Plan Outcome Measure in this area.

- Quality Improvement Teams (QIT's) in the Area Offices have conducted studies related to cases of repeat maltreatment. A review of 38 cases in the Manchester Area Office between February 2005 and August 2005 identified several factors leading to repeat maltreatment including:

    - timeliness of services
    - lack of follow up with community providers
    - parental minimization of substance abuse
    - children with serious behavioral health challenges
    - unmet behavioral health needs were a stressor for parents

In an effort to support foster parents, DCF contracts with five agencies to provide Foster and Adoption support Teams who provide in-home respite and support to DCF foster families who are caring for behaviorally-challenged children. Additionally, agency social workers may also use flex funding to purchase services, such as behaviorial health, respite, or mentoring as appropriate. For those children who require a higher level of care, DCF refers them out to Therapeutic Foster Care providers (TFC). TFC programs recruit, train and support foster families caring for children requiring higher levels of care. These programs must have bi-weekly contact with the child and foster family and make monthly home visits. The program also assigns a case manager, in addition to the already assigned DCF social worker.

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

Item 3: Services to family to protect children in the home and prevent removal or re-entry into foster care. How effective is the agency in providing services, when appropriate, to prevent removal of children from their homes?

Policy Description

In an effort to safely maintain children in their homes whenever possible and appropriate, DCF has multiple policies which help guide practice in order to achieve this goal. These policies cover several key areas such as an increased availability of services to families, referrals for those services and financial support in certain circumstances. It is the expectation that DCF social workers demonstrate reasonable efforts in providing services to children in their homes, provided any safety concerns are addressed. Additionally, workers shall make every effort to provide services to prevent out-of-home placement and to facilitate reunification of those children in placement, which would also include post-reunification services. Some of the services available to the Department include intensive family preservation, daycare, parent aide services, mental health services and substance abuse treatment.

DCF policy also directs staff to consider and utilize alternatives to removal if appropriate based on a current risk assessment. Under this policy, parents or guardians are able to arrange for the child's temporary placement with a relative, or at times, the parent agrees to remove him or herself from the home. Other alternatives include the non-offending parent or guardian obtaining a Restraining Order to

prevent the offending household member from returning to the home or having other contact with the child.

DCF Policy 39-21, Respite Care for Intact Families, allows for in-home care of the child identified with emotional and/or behavioral special needs in order to increase the family's ability to provide home care to avoid "burnout" and prevent family disruption.

DCF staff work closely with the Area Resource Group (ARG) staff in their offices to facilitate and expedite the referral process for families and children in need of specific services.

Each DCF Area Office, under Policy 36-100, has discretionary/flexible funds to obtain needed services and/or goods which are intended to enhance family preservation, but are time-limited and individualized. Some examples identified by two Area Offices reviewed during the CCOR include post-licensing training, support groups, 1:1 services and support services offered by the foster care unit or the Connecticut Association of Foster and Adoptive Parents (CAFAP). Per policy, these funds cannot be used to supplement existing services.

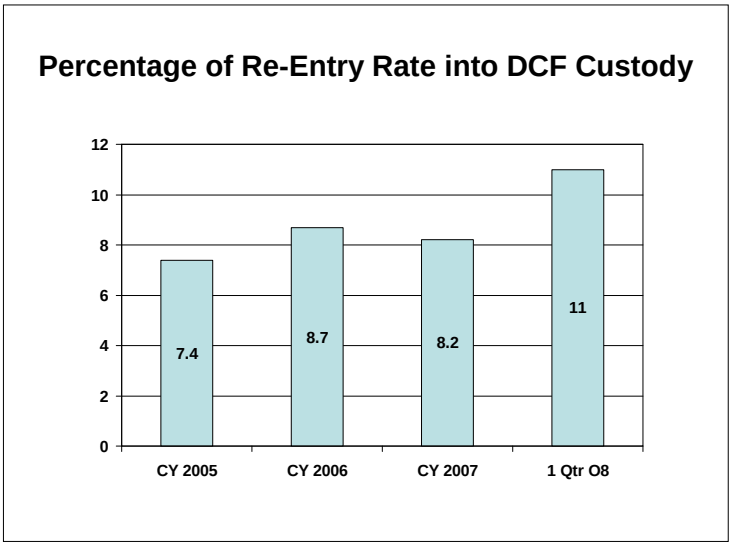
Summary of Performance in Round One of the CFSR

In Round One of the CFSR for Connecticut in 2002, Item 3 was assigned an overall rating of Strength because in 87.5 percent of the 32 applicable cases, reviewers determined that the agency had made diligent efforts to maintain children safely in their homes. Item 3 was rated as an Area Needing Improvement (ANI) in 4 of the applicable cases (12.5%)

In the CFSR, Stakeholders raised concerns about the length of time between the investigation and the provisions of services to families (sometimes up to 2-3 months).

Measures of Effectiveness

The Juan F. Federal Consent Decree Exit Outcome Measure standard states that "no more than 7% of all children entering DCF custody shall re-enter care within 12 months of a prior out-of-home placement." As shown below, the Department continues to fall short of this mark, although there have been quarters in which the Department has achieved this standard, for example, in the first and third quarters of 2006. The Department has looked for ways and strategies to build upon these successes. These are discussed in the next section.



Factors Affecting Performance

There have been a number of practice changes and enhancements since 2002 that have impacted and improved services to families while protecting children in home and helping to reduce entry and re-entry to out of home care.

LINK e-Help

The current LINK e-Help provides staff with information and guidance on all aspects of case practice including adoption, adolescent services, documentation of case activities, treatment planning, and so forth. The treatment planning guides were made available in LINK in January 2005 to assist social workers in the development of case specific treatment plans with the direct collaborative input of families.

Structured Decision Making (SDM)

In March 2005, the DCF began development a Structured Decision Making® system for Child Protective Services (CPS) with the help of the Children's Research Center (CRC). Connecticut DCF designed this SDM® system to reflect the service needs of children and families affected by child abuse and neglect. The SDM system was formally introduced to staff in January 2007 when training began. In February 2007, the system was implemented throughout the state. The goals of the SDM system for Connecticut CPS are to reduce subsequent maltreatment to children and families, including subsequent referrals, subsequent substantiations, subsequent injuries, foster placements, and to expedite permanency for children.

Between May and October 2007, Children's Research Center (CRC) conducted SDM case reading training sessions for DCF staff in the fourteen Area Offices to help supervisors/program managers increase their skills in ensuring the quality implementation of the SDM system and related best practices. Based on the cases reviews, CRC found that workers are completing the safety and risk assessments in LINK for almost all cases, but there are still some areas in which practice can be improved including the proper use of safety plans and service agreements, clear documentation of all risk factors, more consistent definitions in safety and risk assessment, and the correct identification of primary and secondary caregivers.

Structured Treatment Planning (STP)

In September 2006, STP was introduced in an effort to facilitate the treatment planning process between supervisors, social workers and the families we serve. STP was particularly developed to structure the supervisory conference in regard to the discussion of treatment plans. The basic tenets for effective treatment planning are that treatment plans should: 1) be completed in a way that engages the family, 2) be written in a timely manner, and 3) meet the standard for compliance of Exit Outcome Measures. The supervisor is accountable for assuring that the treatment plan is acceptable, and that the plan itself becomes a living breathing document that informs the purpose of the worker's visitation and associated contacts with all parties. The supervisor should use the Plan to guide and direct the social worker in the provision of services to families, which will be discussed in the supervisory conference.

Despite the use of STP, the e-Help Guide, and other interventions, the writing of effective treatment plans continues to be one of the Juan F. Consent Decree Outcomes DCF struggles to achieve. The development of goals and action steps, an integral part of the treatment plan process, continues to be an area in need of improvement. Also, with the transition of the Department from the consent decree via the current Exit Plan, treatment plans are at times reviewed by the Court Monitor and the Administrative Case Review staff in the Area Offices. This dual review process has led to some discrepancies in the rating process and how case information should be documented, which has resulted in some confusion and difficulty for staff learning to write appropriate plans.

Family Conferencing

The goal of DCF Family Conferencing is to increase kin involvement in the lives of children and parents served by the Department. Child protection social workers rely on professionals and on kin to provide supports and services that will help parents keep children safe and help children find alternative homes when they cannot live with their parents. Kinship casework prioritizes searching for potential kin resources and proactively engaging kin in helping families as a first step to be completed before turning to private providers to help families. The Family Conference provides an opportunity to brainstorm needs and develop solutions with kin who likely have substantial knowledge about the parents and children. DCF Family Conferencing embodies strengths-based and family-centered practice and enhances client engagement and empowerment.

The initial DCF Family Conferencing model began its development in July 2004. The basic model requires workers statewide to offer parents a Family Conference every time a Family Treatment Plan is due, and encourages workers to convene a Conference on any case whenever it would be useful. Family Conferences are recorded in a database when a DCF worker meets with a minimum of one parent and one non-household kin member, and then completes a Family Conferencing data form. Training in all DCF Area Offices regarding the Family Conference Model was completed in October 2005.

The following discusses first year (April 1, 2006 - March 31, 2007) data for DCF Family Conferences. Family Conferences were documented in every Area Office and steadily increased in number throughout the year, as shown below:

TABLE ONE Frequency of DCF Family Conferences (April 1, 2006-March 31, 2007)				
Quarter	**Total Family Conferences**	**FCs held to develop a Treatment Plan**	**Percent of TPs with a FC**	**Event-driven FCs as a percent of total FCs**
April-June	175	111	5%	37%
July-Sept	160	95	5%	41%
Oct.-Dec.	253	143	7%	44%
Jan.-March	491	239	11%	51%
Total	**1,079**	**588**	**8%**	**46%**

Data collected also includes the reasons why a family conference was convened. These reasons are detailed in the table below:

TABLE TWO Reasons Family Conferences Were Convened		
Reason	**Number of Responses**	**Frequency of response in total 1,079 FCs**
Family TP due	588	55%
Support an in-home placement	453	42%
Support a kinship placement	328	30%
Support a reunification plan	115	11%
Support a permanency plan	131	12%
Strategize case options	108	10%
Case closing	76	7%
*Please note that workers can indicate multiple reasons for a given conference leading to a total for this item that exceeds the total number of Family Conferences convened.		

Supporting placements with parents or kin was part of the rationale for convening over 70% of Family Conferences, suggesting that this work supports efforts not to place children in stranger care.

The type of assistance offered during Family Conferences is shown in table 3 below:

TABLE THREE **Type Of Help Offered In Family Conference Agreements**			
Type of Help Offered	**All Family Agreements**	**Treatment Plan FC Family Agreements**	**Event-Driven FC Family Agreements**
Placement resource	34%	32%	36%
Emergency respite	34%	41%	26%
Housing	25%	27%	23%
Visitation supervision	25%	25%	26%
Transportation	44%	48%	38%
Emotional support	76%	80%	70%
Overnight respite	27%	34%	19%
Financial support	24%	27%	20%

The most common form of assistance offered was emotional support (76% of Family Agreements), and nearly half the agreements addressed transportation needs. Roughly one-quarter of Family Agreements included offers to assist with housing, supervised visitation, overnight respite and financial support, and one-third of agreements addressed assistance with child placements and emergency respite.

The Department's development and utilization of Family Conferencing clearly illustrates another avenue by which the Department is committed to providing services to the family to protect children in the home and to prevent their removal. In an effort to elicit feedback from parents regarding their overall satisfaction with the Family Conferencing process, workers were provided with consumer satisfaction surveys to be distributed to participants following each Family Conference. Between 2/8/06 and 10/25/06, DCF received completed surveys from 220 parents with an overall mean score of 3.5, reflecting mean responses halfway in between 'Agree' and 'Strongly Agree' in terms of satisfaction with the preparation for the meetings and the meetings themselves.

DCF Training Academy

In response to the above initiatives and changes in practice, the DCF Training Academy responded by updating pre-service training for all newly hired staff and in-service trainings for veteran staff. The updates consisted of incorporating SDM, Family Conferencing, and the E-help Guide into the trainings offered to reinforce the changes in practice and further enhance the staff’s familiarity and expertise in these subject areas.

Specialization of Case Assignments

Area offices divide their social work staff into areas of specialization in an effort to more effectively meet the needs of the families and children we serve. The three main divisions are Investigations, Ongoing Services/Treatment, and the Foster care and Adoptive Services Units.

Within these divisions, there is further specialization of worker assignments to better tailor and match child and family needs with the Department's and community services available. These specialized units for investigations include Group Care Units responsible for investigations on daycare and school personnel; Sexual Abuse/Severe Physical Abuse Units in-depth collaboration with law enforcement; and High Risk Newborn Units in which investigations are conducted on infants born with complex medical and substance abuse issues, and often require collaboration with the Department's Area Resource Group nurses and external hospital staff to ensure the safety of these infants. Similar specialization occurs with the Ongoing Services/Treatment Division including Permanency Units, Mental Health Units, Adolescent Units, Probate Units, and Voluntary Units where parents or caretakers have contacted the Department to request casework services, not related to issues of abuse or neglect, but often related to issues of emotional or behavioral difficulties of the involved child.

While overall feedback has been positive regarding the specialization of worker assignments, a concern was raised by members of the Area Advisory Council during the Manchester CCOR with regard to case transfers. Members reported that cases are transferred between social workers within the same Area Office too frequently and this can result in a lack of continuity for clients and for the providers delivering services. Area Advisory Council members expressed concern that the specialty units may be adding to the case transfer rate, as cases are transferred at critical points by design. Some instances of this would be when the decision is made to terminate parental rights, the case would be transferred to a Permanency Unit to prepare the Court petition and to prepare the child or children for adoption. Another example would be when the Department and Courts approve the Permanency Plan of APPLA for an adolescent. The case would then be transferred to an Adolescent Services Worker to prepare the youth for Independent Living.

Service Needs Assessment

DCF social workers assess the strengths and needs of families using the SDM Family Strengths and Needs Assessment to insure that services are geared toward addressing the underlying issues faced by they family. As needs are identified, social workers refer the family for appropriate services. Workers also have the ARG available for consult as needed, which also assists them in referring families to appropriate services to address identified needs. These strengths and needs are assessed on an ongoing basis.

Item 4: Risk Assessment and Safety Management. How effective is the agency in reducing the risk of harm to children, including those in foster care and those who receive services in their own homes?

Policy Description

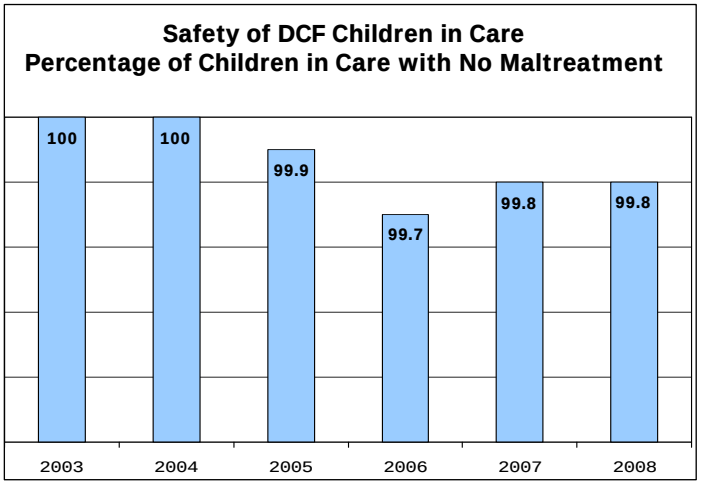
DCF Policy 34-13-3 dictates that DCF social workers and supervisors utilize the risk assessment tool at key decision points during the life of the case, including but not limited to the completion of an investigation, when making a decision to remove a child or reunify a child, and case closing. During the time of the last CFSR in 2002, up until February 2007, the aforementioned policy guided protective service practice around risk assessments. With the statewide implementation of Structured Decision Making (SDM) in 2007, DCF began assessing and reassessing both risk and safety as two distinct items which had not been the practice previously.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR for Connecticut in 2002, Item 4 was called Risk of Harm to Child and was assigned an overall rating of Strength because reviewers determined that in 87 percent of the applicable cases (47 of 50), DCF made sufficient efforts to reduce risk of harm to children. Item 4 was rated as an ANI in 6 (13%) of the 47 applicable cases.

Measures of Effectiveness

With regard to the percentage of children in care with no maltreatment, the most recent data (Quarter 1 of 2008), shows the state's performance at 99.8%:



The ongoing work of the State of Connecticut and its implementation of services show the effectiveness of our ongoing efforts to reduce risk of harm.

Social workers are required to visit children in out-of-home care at least once monthly and it is the expectation that ongoing informal assessments be conducted to assess safety in placement. Social workers are also expected to interview children privately as part of their assessment.

The Juan F. Consent Decree Exit Outcome Measure standard for maltreatment of children in out of home care is less than 2%. The national standard for the incidence of CAN in Foster Care is 0.32% or less. Connecticut's Data Profile indicates that performance on the Absence of Child Abuse and/or Neglect in Foster Care during a 12-month period ending March 31, 2007 is 99.21%, falling below the national standard of 98.68% or more.

Although Connecticut did not meet the national standard for the 12-month period ending March 31, 2007, it is important to note that the agency continues to meet the Exit Outcome Measure related to maltreatment in out of home care and has also made progress with regard to the national standard.

Factors Affecting Performance

Since Round One of the CFSR in 2002, there have been many changes within the DCF which have impacted the agency's effectiveness in assessing risk and managing safety as related to CPS cases. As previously stated, up until the statewide implementation of SDM in February 2007, the DCF did not have separate and distinct tools for risk and safety assessments. As a result, workers and supervisors often did

not distinguish between the two. Since the introduction of SDM, there is a clear distinction between risk and safety and there are tools specific to each. SDM emphasizes the importance of conducting ongoing assessments throughout the life of the case, beginning with investigations. The DCF investigator utilizes the safety and risk assessment tools, as well as the family strengths and needs assessment tool, to determine the level of risk in the home in order to make a recommendation for case closing or transfer. These assessments continue to be utilized by ongoing services workers during key decision points in the case, while adhering to the specific timelines dictated by SDM policies and procedures. Some key decision points include investigation, and change in household composition, prior to case closing.

SDM training has also now been incorporated into the pre-service training for all newly hired social worker staff within the Department.

DCF workers also have access to the Area Resource Group (ARG), specialty staff resources who are able to provide case consultation related to a number of issues such as domestic violence, substance abuse, medical complexities and mental health. Although this resource existed in 2002, it has since been expanded to include domestic violence consultants in the Area Offices. Just as the sizes of Area Offices vary, so does the size of the ARG within each Area Office. Overall, staff provided positive feedback related to the expansion of ARG resources in the offices, specifying that the ARG have been helpful in identifying and recommending services for clients while also negotiating with providers when necessary.

Since Round One of the CFSR, DCF has changed the way in which foster care investigations are conducted. Prior to November 2005, foster care investigations were conducted by Area Office investigators. As of November 2005, these cases are investigated by the Special Investigation Unit (SIU) which consists of nine investigators, one supervisor and a program supervisor all of whom are centrally located in the Central Office Satellite office in Meriden. The SIU investigates alleged abuse and neglect by foster parents, DCF employees and congregate care staff. The DCF centralized foster care investigations in an effort to standardize the process and lend a level of objectivity to the cases since these investigators, who are not affiliated with Area Offices, do not have ongoing contact or relationships with the foster families as providers or resources. Since this transition, staff have reported strengths in that the regulatory interpretations are much more consistent than previously when the foster care investigations were conducted by each Area Office. While centralization of foster care investigations has overall been identified as a positive, it has also presented an issue with regard to travel times. Because the SIU covers the state, they may travel significant distances in order to respond to reports of abuse and neglect. This has not negatively impacted their commencements of investigations.

DCF has continued to strive to reduce the risk of harm to children who remain either in their homes or in alternate care settings through partnering and collaborating with law enforcement and judicial agencies. An expansion of resources has made this possible, specifically those resources providing access to critical background information on parents/guardians, prospective foster parents and/or other substitute caregivers. In accordance with Conn. Gen. Stat. § 51-5c (2003), a Protection Order Registry was created in order to track all Protective and Restraining Orders issued by or registered with Connecticut courts. By July 26, 2002, all courts were entering this information into the database and in December of 2003, all active standing criminal restraining orders were included. In working with law enforcement and judicial departments, DCF has been granted permission to access this and other key registries. Each DCF Area Office currently has two or more support staff identified as having permission to access this Registry. This access is often utilized when the Department is assessing the immediate safety or ongoing risk on behalf of children entering DCF's purview through a report of suspected abuse or neglect at the investigations level.

The Adam Walsh Child Protection Act of 2006 (Public Law 109-248), which was enacted on July 27, 2006 included sections that require the Attorney General to ensure access to FBI criminal history record

information by (1) governmental social service agencies with child protection responsibilities, (2) child welfare agencies, and (3) public and private secondary and elementary schools and state and local educational agencies.

Since the act took effect in 2006,it has been used when the Department is assessing the immediate safety or ongoing risk on behalf of children entering DCF's care and/or custody.

Due to the delicate nature of the confidential information contained in this database, each Area Office ensures there is a single secured terminal which only authorized staff can access to conduct searches. With this additional resource, DCF is able to quickly and accurately research an individual's criminal background in order to better inform their assessments for both safety and risk.

In accordance with Connecticut General Statute § 14-10, as amended, and the federal Driver's Privacy Protection Act, 18 U.S.C. § 2721 et seq. the Department accesses DMV records via the submission of a signed request for information.

The Amber Alert protocol is a voluntary partnership between law enforcement agencies, broadcasters, and transportation agencies to activate an urgent bulletin in the most urgent child(ren) abduction cases. Broadcasters use the Emergency Alert System (EAS) to air a description of the child(ren) and suspected abductor. This is the same concept used with weather emergencies. The goal of an Amber Alert is to instantly notify the entire community to assist in the search for and safe recovery of the child(ren) in question.

In December 2004, an Amber Alert was activated for three children from the Willimantic DCF Area Office. Due to the Alert and the actions of the DCF staff, the children were found, came to no physical harm, and were returned to the care of their foster parents. The debriefing of this incident with the Governor's Office yielded valuable security improvements that will be necessary to assure appropriate action is taken when security is breeched at an Area Office. The DCF has implemented directions through collaboration with the Department of Public Safety regarding an Amber Alerting protocol and the agency's responsibility to utilize the directives when necessary.

To facilitate the search and safe recovery of children, Area Office Directors have been instructed to assure that investigators immediately begin gathering specific information, such as information on custodians' cars, and note this in the case record at every intake.

Additionally, every DCF Area Office has created or re-formatted their sign-in logs to include this same information. When an individual comes to an Area Office to visit it will be necessary to sign in and note the required information. Central Office contract staff have been instructed to assure that contracted visitation centers adhere to the same process.

While it is difficult for anyone to know precisely how many incidents of child maltreatment were prevented, or by what percentage risk of harm was reduced, the DCF continues to work toward reducing the rates of abuse and neglect of children. In accordance with Public Act 00-207, "An Act Concerning Safe Havens," a parent or lawful agent of the parent may voluntarily surrender physical custody of an infant age thirty (30) days or younger to the nursing staff of a hospital emergency room. Since the Safe Havens law took effect on Oct. 1, 2000, eight babies have been brought to hospital emergency rooms under the law.

In 2008, the Department formulated an informational brochure outlining frequently asked questions pertaining to Safe Haven Act guidelines. As part of a public service effort to bolster awareness of agency staff, community providers, and stakeholders, the Department disseminated pamphlets to various agencies

including all Connecticut Hospitals including 24 Emergency rooms, and birthing centers, all 169 Connecticut middle and high school district superintendants, all magnet schools and in all DCF Area Offices for staff and community distribution.

In addition to the aforementioned awareness efforts, the Department received a $50,000 appropriation from the 2007-2008 State Budget for a radio ad campaign. The ads, which began in late March and ran through April, included a press conference that was extensively covered by TV and radio as well as two daily newspapers.

Since the 2002 CFSR, DCF has changed the way in which child fatalities are reviewed. Previously, fatality reviews were perceived as punitive in nature and often focused on agency failures. In April of 2004, the Department contracted with the Child Welfare League of America (CWLA) to conduct Special Reviews. In conjunction with the Office of Planning and Evaluation, and the Division of Research and Development the fatality review provides a comprehensive case analysis and timely systemic consultation in the aftermath of a child fatality or critical incident. The Special Review Team (SRT) seeks to establish constructive relationships across all DCF Bureaus and Divisions, while establishing cooperative interactions with external sources such as the Office of the Child Advocate (OCA), community service providers and other state agencies.

The Fatality Review process has been structured to be distinct from employee investigations conducted by Human Resources (HR), which have tended to dominate the child welfare field across the country. If indicated, Human Resources issues are managed prior to the Fatality Review.

Upon completion of the review, a written report with recommendations is generated for review and consideration.

B. PERMANENCY

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

Item 5: Foster care re-entries. How effective is the agency in preventing multiple entries of children into foster care?

Policy Description

The Department of Children and Families has emphasized the need to provide permanency and stability in the lives of the children by preventing multiple entries into foster care. Per policy 36-55-1.4, the Social Worker has the responsibility to work with the biological (or adoptive) parents to help them rectify the problem(s) which resulted in the abuse or neglect of their child. Workers are trained to maintain professional contact with the child in placement, continually evaluating the home and maintaining an awareness of the parent's psychosocial circumstances in order to successfully oversee the objectives of the service plan. The Social Worker provides information to the parents, child and caretakers relative to the reason for the placement and establishes and maintains an ongoing relationship with the parents through planned appointments and contacts. During these interactions, goals for family reunification are jointly identified.

According to the policy, there should be supports in place to allow the parents to fully participate with the treatment planning process, while encouraging their involvement in the development of the service plan. When appropriate, support should be provided in order to encourage the ongoing relationship between the parent and child by encouraging planned contacts such as formal visitation plans, telephone conversations, correspondence and gifts on appropriate occasions. The Social Worker is expected to assist, support, and facilitate the use of services by the parent and provide the parent with ongoing information regarding the child and all aspects of the child's foster care experience.

Summary of Performance in Round One of the CFSR

In the 2002 CFSR Item 5 was assigned an overall rating of An Area Needing Improvement 60 percent of the applicable cases, children did re-enter care re-enter foster care within 12 months of discharge from a prior foster care episode. In 2002, Connecticut did not achieve substantial conformity with Permanency Outcome 1. Although the State met the national standards for foster care re-entries and stability of foster care placements, the state did not meet the national standards for reunifications within 12 months of entry into foster care and adoptions within 24 months of entry into foster care. Fifty percent of the cases reviewed were rated as having substantially achieved Permanency Outcome 1, which is less than the 90 percent required for substantial conformity.

Measures of Effectiveness

According to the Connecticut's data profile, DCF's performance in the area of re-entry is close to the national median. Of all children discharged from foster care to reunification in the 12-month period prior to the 06b07a year, 15.3% re-entered FC in less than 12 months from the date of discharge (Permanency Composite 1, Component 2, Measure 1). The national median for this measure is 15%.

One of the Juan F. Exit Plan Outcome Measures is designed to monitor the Department's performance on re-entry into foster care. While this measure is a slightly different calculation of re-entry than the one used for the CFSR permanency composites, it is the standard measure used internally by DCF to monitor the system's performance in this area. According to Outcome Measure 11, no more than 7% of all

children entering DCF custody shall re-enter care within 12 months of a prior out-of-home placement. DCF has had challenges in meeting this measure and, in fact, has met the measure only two times in the last nine quarters for which reliable data has been available:

	4Q 2005	4Q 2005	1Q 2006	2Q 2006	3Q 2006	4Q 2006	1Q 2007	2Q 2007	3Q 2007	4Q 2007
Percent of Children Re-entering Care within 12 Months	7.2%	7.6%	6.7%	7.5%	4.3%	8.2%	7.5%	8.5%	9.0%	7.8%

Re-Entry into DCF Custody - Quarterly Trend View

	2004		2005		2006		2007		2008	
Report Period	September-December, 2004		2005		2006		2007		January-March, 2008	
Met Standard	804	90.1%	2637	91.8%	2446	90.8%	2456	92.1%	599	90.9%
Not Met	88	9.9%	237	8.2%	248	9.2%	210	7.9%	60	9.1%
Total	892	100%	2874	100%	2694	100%	2666	100%	659	100%
Cohort	2003		2004		2005		2006		2007	

Re-Entry into DCF Custody - Yearly Trend View

Factors Affecting Performance

The Department has made considerable efforts to improve performance in the area of reducing the number of children who re-enter into foster care, such as the development of a new Intensive Reunification Service that offers an array of services to families along a continuum that promotes reunification/permanency for children utilizing federal funds. There has been an expansion of intensive in-home services such as IICAPS and MST for those children with behavioral health issues in order to avoid re-entry into care. Parent /Child Centers have been developed to provide screening and assessments, providing hands-on parent education and family support services to parents, caregivers, family members and children up to eight years of age who are referred by the department. In addition to these services, there are a number of other interventions that are affecting the Department's performance in reducing re-entry into foster care:

The Family Conferencing Model

The initial DCF Family Conferencing model developed out of conversations between Central Office and Area Office staff beginning in July, 2004. Area Office staff were presented with a general framework and developed a model of Family Conferencing that best fit local practice. The basic model requires workers statewide to offer parents a Family Conference each time a Family Treatment Plan is due. Workers are

encouraged to convene a Conference on any case whenever it would be useful in case planning. Investigators are required to inform parents as to the benefits of bringing about change by agreeing to a Family Conference. Each Area Office decides when a Family Conference is scheduled, where the conferences will be held, and whether social workers or supervisors have primary responsibility for facilitating them.

Area office social workers are the primary facilitators of Family Conferences. Most offices target the traditional review date of 15 days before a treatment plan is due as the most likely Family Conferencing date, though some target an earlier date, while others leave the date entirely up to the social worker on a case-by-case basis. Some offices encourage investigators to convene Family Conferences before transfer to an on-going worker. Family Conferences can be convened in a client or kin member's home, in a neutral community setting, or in the Area Office, with most expressing a preference for conferences in a home whenever safety allows.

Because family conferences and other strength-based interventions are geared to increasing the support system around families, they are seen as a promising practice for reducing re-entry. Once the natural support system is in place, it can serve as an additional mechanism for preventing re-entry into care.

Structured Decision Making

In early 2007, in an effort to enhance practice and achieve better outcomes for children relative to safety, permanency and well-being, the Department implemented Structured Decision Making (SDM). SDM provides the framework to increase consistency and validity of decision making in child protection; 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 provides staff with a framework for making informed decisions relative to all components of a case, from initiating an investigation, to case closing.

In the Spring of 2008, the Department implemented the Connecticut Comprehensive Outcomes Review (CCOR) using the CFSR On-Site Review Instrument. This review indicated that Structured Decision Making (SDM) and Family Conferencing, when utilized together, can have a positive effect at preventing foster care re-entries. Prior to returning a child home, the SDM assessments can be effective tools for making an informed decision and defining the issues that would require services and support to prevent a child from re-entering foster care. Family Conferences allow for the engagement of family and kin in the development of a plan that promotes stability when a child returns home while supporting the family to prevent a re-entry into the foster care system.

Item 6: Stability of foster care placement. How effective is the agency in providing placement stability for children in foster care (that is, minimizing placement changes for children in foster care)?

Policy Description

The Department of Children and Families recognizes the need to provide placement stability for children in care. The Juan F. Exit Plan sets a performance target for placement stability in Outcome Measure 12, "Multiple Placements." This measure says that at least 85% of children in DCF custody shall experience no more than 3 placements during any 12-month period.

The Department has established mechanisms for ensuring children are not experiencing multiple placements. Per DCF policy 36-55-20, a case conference shall occur if any child has experienced two (2) foster home disruptions within an eighteen (18) month period for reasons related to the child's behavior or condition. The disruption conference must be attended by the child's worker, the worker's supervisor, any appropriate community service provider, a foster care worker, any member of the Area Resource Group or community consultant whose expertise is needed to plan for the child.

Summary of Performance in Round One of the CFSR

In the 2002, CFSR Item 6 was assigned a rating of Area Needing Improvement. In 73 percent of the cases, children were found to have stability in their foster care placements. However in 27 percent of the cases, reviewers determined that children did not have placement stability and/or that placement changes were not for the purpose of meeting children's needs. The State Data Profile at the time indicated that 92.8 percent of children in foster care in the state for 12 months or less had no more than two placement settings (which meets the national standard of 86.7 percent).

Measures of Effectiveness

According to the 2008 Data Profile, Connecticut's score on Permanency Composite 4, Placement Stability, was 98.1. The national standard for this composite measure is 105.1 or higher. While Connecticut did not meet the standard, the state did perform well on some of the underlying measures. For children in care for less than 12 months, 86.8% experienced two or fewer placement settings. This places Connecticut slightly above the 75th percentile of 86.0%. For children in care for 12 to 24 months, 66.9% experienced two or fewer placement settings. Again, this performance places Connecticut above the 75th percentile. For children in care for 24 or more months, however, only 30.4% experience two or fewer placements. This is below the national median of 33.9% and is the primary reason Connecticut did not meet the national standard on this Permanency Composite overall.

Placement stability has been one of the primary areas of focus for the Department. According to the Exit Plan outcome measures, in the last 14 quarters we have continued to perform well in reducing the number of placement changes for children in our care. During that time, 94% to 96.6% of the children in our care have experienced less than three placements in the previous twelve-month period.

DCF utilizes the measures and the methodology developed by the Juan F. Court Monitor to evaluate our effectiveness in this area of practice. Beginning on January 1, 2004, at least 85% of the children in DCF custody shall experience no more that three (3) placements during a 12 month period. According to the most recent quarterly report provided by the Federal Court Monitor, the Department has met the outcome measure associated with placement stability for sixteen (16) consecutive quarters.

While preparing for the CFSR, a focus group was conducted regarding the issue of multiple placement episodes of children in foster care. The group consisted of adolescents who have been in care ranging from two to thirteen years. One adolescent stated that she had been in care for seven years and was maintained in the same home. Another young man who was nineteen stated that he had been in care for the last thirteen years and had numerous placements with none lasting more than one year. One young lady stated that she has been in care for five years in the same home and was adopted by her foster parents.

The overall consensus of the youth was that the multiple placements had a "tremendous affect" on them, both socially and academically. They felt that some of the homes that they were placed in were not meant to be long term, which only added to their level of stress. Participants agreed that there is some long-term negative affect to having had multiple placements and some don't have a feeling stability now.

Factors Affecting Performance

Since the 2002 CFSR, the Department has continued to improve its capacity to promote placement stability by expanding its available services and community-based supports:

SAFE Homes

In the DCF Policy Manual Chapter 36-52-2, the agency introduces the philosophical framework of the SAFE Homes. The Department of Children and Families believes that whenever possible, children should grow and develop in the most family-like, least restrictive setting possible.

The purpose of a SAFE Home is to provide a safe and stable environment for children who experience out-of-home placement for the first time. SAFE Homes provide services and assist in timely planning for permanency, including determinations regarding reunification or adoption. SAFE Homes should facilitate keeping sibling groups together, provide the opportunity for children to remain in close proximity to their own communities and allow children to attend their own schools. The goal of the SAFE Homes is to successfully plan for permanent and secure homes for children. Providers and DCF staff are expected to do so within an average of thirty (30) days, with a maximum of forty-five (45) days, so that children are not exposed to excessive uncertainty or needless delay.

Children who are removed from their homes due to abuse or neglect are often traumatized by the rapid removal from familiar surroundings as well as by the damaging behavior of their parents or guardians. These children require an initial placement in which they will feel as secure and stable as possible. If children cannot be returned home, another permanency plan should be achieved as quickly as possible. Further, multiple placements should be avoided to reduce disruptions in a child's life.

To reduce the incidence of multiple placements, a thorough evaluation is required when the child first comes into care. SAFE Homes meet children's immediate needs for medical, dental, mental health and counseling services, and also manage the emotional and behavioral challenges that may arise when a child must be removed from home. SAFE Homes provide clinical and case management services, including a consulting psychiatrist, a medical liaison and a clinical social worker.

In establishing plans for each child, SAFE Homes work to include and involve family members, significant others, local providers, school personnel and DCF. Children also receive educational programming including a full range of special education services, when needed. SAFE Homes also provide recreational activities as well as appropriate play areas and equipment.

Over the last four years the use of SAFE Homes has changed to meet the placement needs of the Area Offices. While SAFE Homes were originally designed for first time placements and were limited to a forty five day maximum length of stay, children sometimes remain in SAFE Homes for longer periods due to a lack of placement options in certain cases. The Office of Foster Care Services has begun an aggressive campaign to return the SAFE Homes to the original purpose for which they were intended.

Foster and Adoptive Services Unit (FASU) Support

The relationship between the FASU support worker and the licensed foster family is instrumental to the success of a placement. When a family is licensed, the FASU support worker develops a Foster Family Profile (DCF-2157). The child's social worker gives the child the Foster Family Profile prior to placement in the foster home and contacts the family to discuss placement support needs and available services, including the provision of written information regarding day care.

The FASU support worker makes a minimum of quarterly in-person contacts and monthly telephone contacts with the licensed foster family. Such contacts must be documented in LINK. Within thirty (30) days of licensure, the support worker will meet with the family to develop the Resource Family Support Plan, which outlines available support groups and a plan for how to deal with a possible foster care disruption.

Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)

IICAPS provides home-based treatment to children, youth and families in their homes and communities. Services are provided by a clinical team which includes a Master's-level clinician and a Bachelor's-level mental health counselor. The clinical team is supported by a clinical supervisor and a child & adolescent psychiatrist. IICAPS services are typically delivered for an average of six months. IICAPS staff also provides 24-hour/7-day emergency crisis response. The program provides in-home services to foster families. The program gives the family and the child the opportunity to address immediate issues, therefore, increasing the family's ability to maintain a child in their home. The foster family is able to acquire tools during the process that can be utilized to maintain the stability of the child's placement, which allows for stability for the child and the foster family.

Respite Care

Respite care is a support service for all licensed foster families which provides a scheduled period of rest and relief from ongoing parental responsibilities. Respite is usually, but not necessarily, for an overnight period. Respite care allows for the planned care of foster children by alternative providers with no disruption to the licensed parent's reimbursement, and assists in decreasing placement disruptions. Respite care can maintain the stability of a placement when issues exist that would otherwise cause a child to be removed from their placement.

FAST Program

The Foster and Adoption Support Teams (FAST) provide assessment, behavioral management, support, respite and other therapeutic services to foster and adoptive children, their caretakers and/or parents in order to stabilize the living situation and avoid disruption. The target population includes children active with DCF who are currently in foster and/or pre/post adoptive living arrangements that are at risk of placement disruption. The primary target population includes children involved in all types of foster family care and pre-adoptive care, excluding children placed in private agency specialized foster care.

Birth to Three

Birth to Three is a private non-profit organization that provides parenting education and support to families with young children. The Department is able to bring parents of young children together to share parenting experiences, increase their knowledge of early childhood development, learn about community resources, and create support networks among themselves. Other community services assist in developing a contingency plan in the event a placement cannot be maintained. The program allows providers to work in the foster home, along with the child and the family. The program is able to provide services that maintain or improve the child's health and development, which allows for the foster family to learn the tools used by the provider, thus increasing the potential for the child remaining in a stable environment.

Item 7: Permanency goal for child. How effective is the agency in determining the appropriate permanency goals for children on a timely basis when they enter foster care?

Policy Description

The Department of Children and Families has strived to assure that permanency goals are established in a timely manner for children who enter foster care. Policy 48-14-6, maintains that all children and youth need enduring, positive relationships with adults who can provide necessary supports. The Department requires that all children and youth in foster care require timely permanency planning. The assigned Social Worker and Supervisor are primarily responsible for determining the appropriate goal. This is done through supervisory conferences, as well as discussions with all service providers to determine the parents' compliance with services and achievement of goals set. The first permanency goal is established no later than 45 days after placement. The preferred permanency goals are reunification, adoption, guardianship, or permanent and legal placement with a relative.

The Permanency Planning Team (PPT) is the decision-making group for the selection of an adoptive family unrelated to the child, and/or approval of relative adoptions/guardianships for children in placement less than six (6) months. The PPT also assures that relevant policy and licensing requirements have been met before approval of the Another Planned Permanent Living Arrangement (APPLA) goal for children less than 14 years of age. APPLA is a non-preferred permanency goal and is to be regularly re-evaluated through the treatment planning process to determine if a more appropriate legally permanent goal can be achieved. The purpose of the permanency planning team is to lend expertise and provide consultation for the timely determination, development and implementation of permanency and concurrent plans for children and youth in the care of the Department. The PPT is also available to advise Social Workers who may be struggling to identify the most appropriate permanency plan for a child or when the permanency goal is to change from adoption to a less desirable APPLA goal, or to approve the relative adoption of a child who has been in that placement for less than six months.

A Motion for Review of Permanency Plan is filed in Superior Court for Juvenile Matters to ensure that progress is made in implementing the written permanency plan and the concurrent plan. It is required to ensure that children do not linger in foster care. Federal and state laws require that a permanency plan hearing be held at least annually on every child in the care and custody of the Commissioner.

Summary of Performance in Round One of the CFSR

Item 7 was assigned an overall rating of Area Needing Improvement. In 73 percent of the cases, appropriate permanency goals were established in a timely manner. Concerns were raised in 27 percent of the cases, however, where reviewers determined that DCF had not established appropriate permanency goals for children in a timely manner.

Measures of Effectiveness

The Connecticut Comprehensive Outcomes Review (CCOR) for the Bridgeport, Manchester, Norwich and New Britain Area Offices indicated that out of the thirty-two cases reviewed for this item, there were 21 cases where Item 7 was rated as an area of Strength, 10 cases were rated as an Area Needing Improvement, and 1 case that was not applicable. The CCOR employs the methodology of the federal Child and Family Service Review (CFSR), including reviews of the case record and interviews with key case participants. In the cases that were rated as Area Needing Improvement, the most common issues

identified by reviewers were that goals were not established according to expected timeframes or that APPLA was being used inappropriately.

The Permanency Profile for the First Time Entry Cohort Group in Connecticut's 2008 CFSR Data profile indicates that 28% of children in the cohort had missing permanency goal information in Department's AFCARS submission for the 06b07a time period. This is not consistent with what was observed during the CCOR process and may be an artifact of the AFCARS mapping.

Factors Affecting Performance

The Juan F. Exit Plan and the availability of management exception reports have greatly improved the Department's performance in identifying appropriate permanency goals in a timely fashion. The Administrative Case Review (ACR) process and the quarterly case review conducted by the Juan F. Court Monitor are also methods for the Department to improve performance on this item. In addition to the statewide focus on this issue, local Area Offices have also developed their own mechanisms for ensuring permanency goals are established and documented appropriately.

A promising practice in the Meriden Area Office is that once a child is placed in care, a Treatment Planning Conference (TPC) is held within forty-five days and the permanency goal is required to be identified for the child. If the permanency goal is not identified, the social work supervisor is contacted to assure that the goal is then identified. The social worker supervisor has ten days to remedy the initial treatment plan that was presented at the TPC. The CIP (Child in Placement) Treatment Plan is due six months after the TPC and if the identified goal has not been identified by this time, they have not met the time frame of identifying a permanency goal within the first forty-five days of a child's placement. The staff in the Meriden Area Office has made this item a priority in their practice and have seen positive results since the Area Office has adopted the process.

The Bridgeport Area Office indicated that they have no children in care for a period of more that three months who do not have an identified permanency goal. This is in part due to supervisory conferences, the process of approving the Treatment Plan, only if there is an identified permanency plan and the Multidisciplinary Assessment for Permanency (MAP) consultation where the goal is identified and the progress is reviewed.

Item 8: Reunification, guardianship, or permanent placement with relatives. How effective is the agency in helping children in foster care return safely to their families when appropriate?

Policy Description

The Department of Children and Families is committed to the process of assisting children in care achieve reunification, guardianship or being placed permanently with relatives. DCF policy 36-30-1 states that social workers shall make every effort to provide services to prevent out-of-home placement and to facilitate reunification of children in out-of-home care with their families.

According to policy 34-9, Investigative Social Workers and child protection service workers shall offer services to prevent out-of-home placement and to facilitate the reunification of children in out-of-home care with their families.

Summary of Performance in Round One of the CFSR

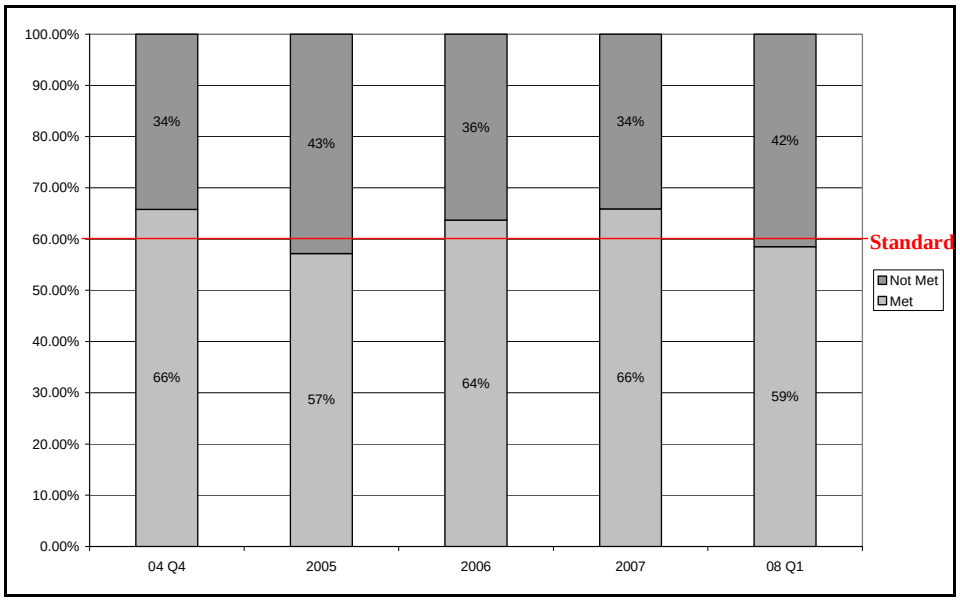
This item was assigned an overall rating of Area Needing Improvement because, according to the State Data Profile, the State's percentage for reunifications occurring within 12 months of entry into care was 55.1 percent, which did not meet the national standard of 76.2 percent.

It was noted that in 64 percent of the applicable cases, reviewers found that diligent efforts to bring about permanency had been made. In 36 percent of the applicable cases, however, reviewers rated this item as an Area Needing Improvement because they determined that the agency had not made diligent efforts to bring about permanency for children with a goal of reunification, permanent placement with relatives, or guardianship. The primary issue observed during the 2002 CFSR was that timely attainment of guardianships was problematic. For most of the cases in which the goal was reunification, reviewers noted that DCF workers were effective in their efforts to achieve timely permanency.

Measures of Effectiveness

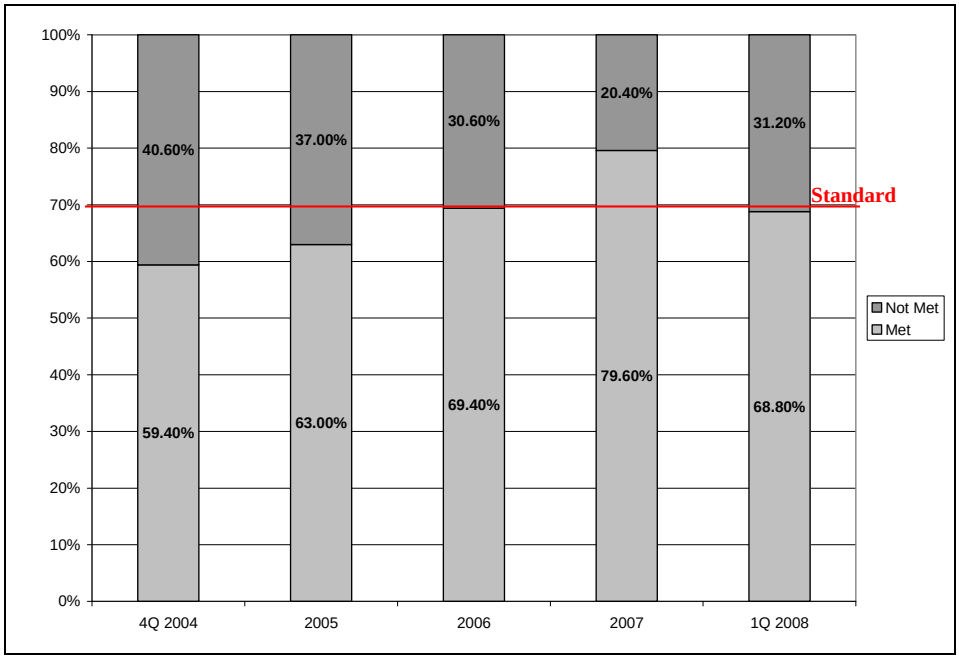
According to the state's 2008 Data Profile, 56.8% of children discharged from foster care are reunified in less than 12 months from the date of the last removal. The national median for this measure is 69.9%. The median stay for children who exited to reunification during this time period was 10.1 months, which is higher than the national median of 6.5 months. Overall, the state's score on Permanency Composite 1, Timeliness and Permanency of Reunification, was considerably lower than the standard. The state scored a 96.6 and the national standard is 122.6.

Reunification is also an outcome measure in the Juan F. Exit Plan. Outcome Measure 7 sets DCF's performance target by stating that 60 percent of children who are reunified with parents/guardians shall be reunified within 12 months of their most recent removal from home. In 2006 and 2007, DCF demonstrated good performance on this outcome measure, although performance in the first quarter of 2008 did not meet the measure:



Outcome Measure 7: Reunification

A companion to Outcome Measure 7 is Outcome Measure 9, Transfer of Guardianship. For this measure, at least 70% of all children whose custody is legally transferred shall have their guardianship transferred within 24 months of their most recent removal from home. While the Department's performance on this measure has not been as consistent as in some of the other outcome measures, since 2004 DCF's performance in this area is generally trending upward:



Outcome Measure 9: Transfer of Guardianship

Factors Affecting Performance

The Department has invested in several family preservation/reunification services as a strategy for promoting reunification, guardianship or permanent placement with relatives. These services often include assessment and case management, counseling, daycare, emergency caretaker/homemaker services, emergency shelter, intensive family preservation, psychiatric and/or psychological evaluation, and transportation. Among the services credited with promoting reunification and transfer of guardianship at DCF are:

Family Visitation Centers

Eleven contractors provide an array of services to support biological families during the reunification process. This service provides site-based supervised visitation services for families who have children placed by the Department of Children and Families in out-of-home care with a permanency goal of reunification. Family Visitation Centers were also designed to provide a range of support, advocacy and parenting education services for foster and adoptive parents.

To improve outcomes for children in out-of-home care, the department established a team consisting of Area Office staff to redesign this service utilizing a Logic Model framework. The enhanced model is primarily home-based and designed to engage, support and intervene with family members through a

short-term, intensive service model in order to promote and effect successful reunification and reduce the risk for further abuse and neglect.

The Reconnecting Families Program

The Reconnecting Families Program is primarily designed for families with children (from birth through age 17), who were removed from their home due to CPS concerns and for whom supervised visits are required. Referrals can be initiated immediately following removal or at any time during the placement. The goal of the program is to create a viable permanency plan for reunification or transfer of guardianship. The service is both site- and home-based, but primarily home-based. A team approach is utilized and includes, Reconnecting Families Provider, DCF, Family, Placement resource, as well as, Family Conferencing meetings held at critical junctures. The service is four to six months in duration and there is mandatory after-hours/weekends and transportation.

The Reconnecting Families Program for Preparation for Reunification is for sixty days and the core elements of the service include, utilization of family conferencing meetings to actively engage the family in the treatment planning process, to initiate therapeutic visitation, while focusing on strengthening and improving communication, in order to repair relationships. The program administers the North Carolina Family Assessment tool (NCFAS-R) to assess parental readiness for reunification and parent/child ambivalence.

Item 9: Adoption. How effective is the agency in achieving timely adoption when that is appropriate for a child?

Policy Description

The Department of Children and Families is dedicated to achieving timely adoption for children for whom it is appropriate. Various policies provide the framework for DCF's ongoing recruitment and practice in this area. Policy 41-40-5.1, Specialized Recruitment, states that the DCF Public Affairs and Information Office and the Office of Foster and Adoption Services shall coordinate efforts to implement specialized adoption recruitment when an adoptive home has not been found for a child through photo listing within a reasonable amount of time, and the child's age, race, membership in a sibling group and/or handicaps are significant enough to warrant multi-media exposure.

Policy 41-40-5.2, "Wednesday’s Child," states that the Department maintains a specialized recruitment effort for children waiting for adoption whereby children are featured in a short segment during a television newscast to facilitate recruitment of a special family for that child. The purpose of the "Wednesday’s Child" feature is to recruit an adoptive family for a specific child and indirectly recruit families for other special needs children. The goal is to generate interest and to educate the community about special needs children who are in need of permanent homes.

In order to encourage families to adopt, Policy 48-20, Post-Adoption Services, states that adoptive families are eligible for continuing services after finalization of an adoption through the Department of Children and Families. This may include services directly from the Department, the Adoption Assistance Program (AAP), and the Permanency Placement Services Program (PPSP) or from different community agencies/private providers via the referral process. After the finalization of an adoption, post-adoption services may focus on supportive contact, re-addressing questions regarding the child's past, assessing attachment and behavioral issues, as well as open adoption issues. Other services include coping with issues/difficulties not apparent at the time of adoption, and dealing with cultural, religious, sexual orientation, disability or other identity issues the child and/or family may be experiencing.

Post-adoption services offered by or contracted for by the Department include, subsidized adoption, financial support (until the age of 18) and medical coverage (until the age of 21) for those children adopted from the foster care system who have special needs. College assistance/post secondary education assistance is available for those children and youth adopted from the foster care system after December 31, 2004. The post-secondary education expenses that are covered include tuition, fees, and room and board equivalent to the cost of tuition, fees, and room and board at the University of Connecticut, Storrs campus.

DCF policy 48-22-4.7 describes supportive services that are available to the adoptive family following the legal finalization of the adoption. The services are available to the family until the child reaches the age of 18. The purpose of these services is to assist the family with resolving or addressing issues experienced in adopting a child from the Connecticut Department of Children and Families. The family may need or wish these support services for previously identified issues or because new issues have surfaced after finalization of the adoption.

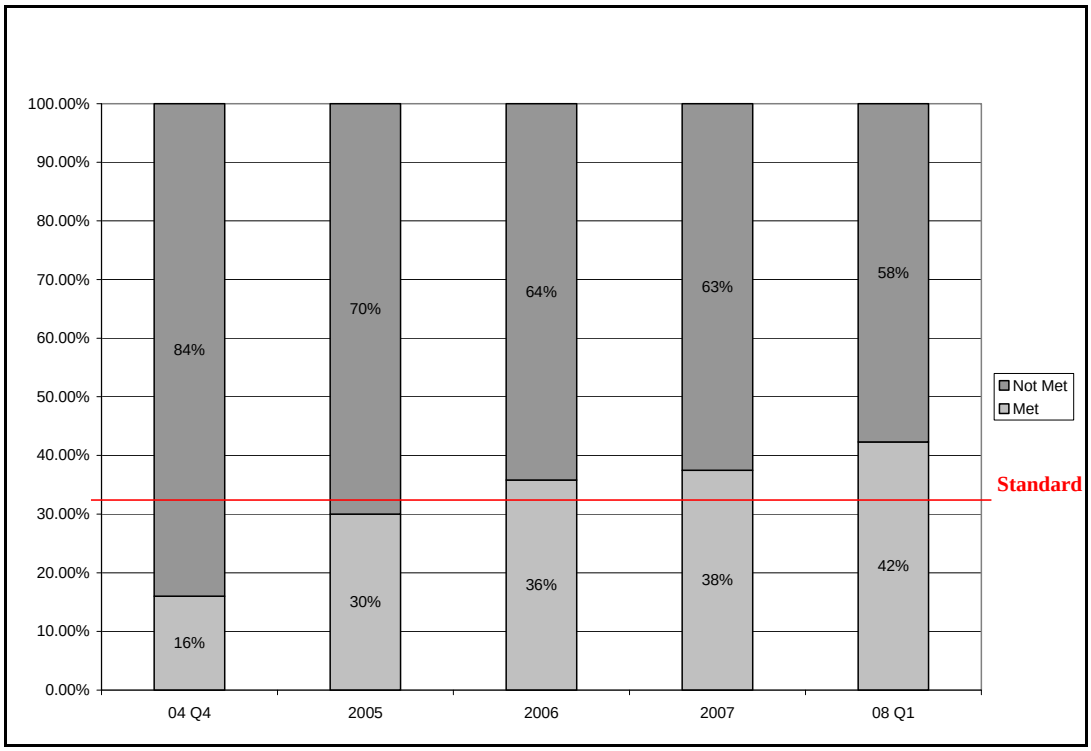
Summary of Performance in Round One of the CFSR

Item 9 was assigned an overall rating of Area Needing Improvement based on the fact that in 50 percent of the applicable cases, reviewers determined that the agency was not engaging in sufficient efforts to achieve finalized adoptions for children in foster care. The State Data Profile indicated that the percentage of finalized adoptions in FY 2000 that occurred within 24 months of removal from home was 6.5%, which was less than the national standard of 32.0.

Measures of Effectiveness

According to the 2008 Data Profile, Connecticut scored 100.0 on Permanency Composite 2, Timeliness of Adoptions. The national standard for this composite is 106.4 or higher. Connecticut's improved performance in this area can be attributed to strong performance in some of the underlying measures. For example, 32.1% of children who were discharged from foster care to a finalized adoption did so within 24 months from the date of their latest removal from home. This is above the national median of 26.8%. However, Connecticut continues to struggle in achieving timely adoptions for children in care for 17 or more months.

In addition to the Data Profile, Exit Plan Outcome Measure 8, Adoption also provides a measure of DCF's effectiveness in this area. The outcome measure calls for at least 32% of children who are adopted to have their adoptions finalized within 24 months of their most recent removal from home. DCF has met the Exit Plan goal in 9 of the last 17 quarters and have met the goal in each of the last six quarters, demonstrating improved performance since the inception of the Exit Plan:



Outcome Measure 8: Adoption

Factors Affecting Performance

The Department has a number of programs and interventions designed to facilitate timely adoptions:

Post-adoption services via the Adoption Assistance Program (AAP)

This program is housed at the University of Connecticut's Health Center in Farmington, Connecticut with contracted staff located in different parts of the state. This program is available to all families who have adopted children from the Department of Children and Families. AAP provides confidential assessment, brief counseling, and referral services. AAP can arrange these services for a family up until the child reaches the age of 18. Providing this service during post-adoption, reduces the number of dissolutions of adoptions, therefore, reducing the need for foster care placements of children once they are adopted.

DCF Voluntary Services

A network of services is available to adoptive parents (and all parents) on a voluntary self-referral basis consisting of casework, community referrals, and treatment services including residential placement. Parents may request help from DCF for their children who have emotional or behavioral difficulties. The DCF Voluntary Services Program is a service that provides an intervention to an adoptive family that is not related to issues of abuse or neglect, but geared toward maintaining a child in home by providing mental health services that could prevent the dissolution of an adoption and in some cases, provide the resources for extended care for a child in residential care and by providing a multitude of services to the family.

Interstate Title IV-E Medicaid services

The Interstate Compact on Adoption and Medical Assistance (ICAMA) requires that each special needs adopted child with a valid subsidy agreement who moves across state lines be provided with Medicaid assistance in the state in which they reside.

Permanency Placement Teams

Permanency Placement Teams in each Area Office have taken a more prominent role over the last three years. The purpose of the permanency planning team is to lend expertise and provide consultation for the timely determination, development and implementation of permanency and concurrent plans for children and youth in the care of the Department. The Permanency Planning Teams are multidisciplinary in membership to ensure the necessary expertise is available to best inform the discussion and decision of the team. The Permanency Planning Teams include the child's Social Worker and Social Work Supervisor, adoption resource specialist, Office of Foster Care Services (OFCS) Social Worker, CAFAP or adoptive parent representative, an Area Office manager, a member of the Area Resource Group (ARG) and others as deemed appropriate, including those who are knowledgeable and experienced in selecting adoptive placements or who are informed about the child and their specific needs/challenges.

The Heart Gallery

The Heart Gallery is a photo art display featuring remarkable children and youth in state care who need an adoptive family. Volunteer professional photographers give their time and talent in capturing each child's and youth's personality in a photographic portrait. The Heart Gallery is now in its fifth year.

The Department works with each child and youth in preparing for the Heart Gallery. If they agree to be featured, the children are connected with a volunteer professional photographer for a photo session. These photos are assembled into a traveling photo exhibit that moves throughout the year. It travels across Connecticut in bringing these inspiring photograph portraits to theaters, children's museums, galleries, local hospitals, area malls, libraries, and town halls and other public exhibit space and gathering places.

Subsidized Adoption

The subsidized adoption program was created to provide a means to facilitate the adoption of children both in DCF care and in the care of private Connecticut licensed child-placing agencies who have special needs, thereby achieving permanency for children who might otherwise remain in foster care. The majority of children placed by DCF for adoption receive some kind of adoption subsidy benefit (CT Gen. Stat. 17a-117, DCF Policy 48-18-18).

Item 10: Other planned permanent living arrangement. How effective is the agency in establishing planned permanent living arrangements for children in foster care, who do not have the goal of reunification, adoption, guardianship, or permanent placement with relatives, and providing services consistent with the goal?

Policy Description

The Department of Children and Families has placed a major emphasis on permanency planning and on monitoring the appropriateness of plans on behalf of all children who have the goal of Another Planned Permanent Living Arrangement (APPLA). It is the expectation of the Department that any such goal

must be reviewed and approved by a Permanency Planning Team, and designated as a permanency goal only after all other options have been exhausted.

Connecticut requires that concurrent plans be developed and worked towards for all children for whom DCF is the guardian and or for those children in DCF care and custody except for those children for whom the permanency plan is adoption. This requirement is not conditional. If the TPR petition is denied, the goal reverts back to reunification, with a concurrent plan of adoption. Once the child is eligible for adoption it is expected that, regardless of the child's circumstances, the social worker will make continuous efforts to locate an appropriate adoptive family

Both plans are documented in the treatment plan with the primary plan being considered the "permanency plan" and the secondary plan termed "the concurrent plan." The concurrent plan must be developed within 60 days of placement.

Another Planned Permanency Arrangement or (APPLA) is a non-preferred permanency goal in that APPLA should not be an option for any child and not recommended for any child under the age of 16. Per DCF Policies 30-5, 36-80, 42-20-1, 42-5-3, the Department considers several critical variables when designating the permanency goal of APPLA.

The reasons for use of APPLA must be compelling and made only after the Agency has made and documented reasonable efforts to reunify the child with parents, place the child with kin for adoption or guardianship or pursued adoption with non-related resources regardless of the age or special needs of the child. In rare cases, APPLA could be considered as a short-term interim option while the more permanent concurrent plans of reunification, adoption or guardianship are being pursued.

The agency gives careful consideration in each case when making the determination of why APPLA is in the child's best interest. The goal of APPLA must be reassessed every six months and careful consideration and documentation must be developed to verify that such a goal remains in the child's best interest. In addition, the other more permanent plans of reunification, adoption, or guardianship must be re-considered each time based on the child's circumstances.

Case Plans including APPLA as a permanency goal are developed with the youth's active participation and include implementation of services and supports necessary to maintain the child in the least restrictive, most permanent placement. Each plan must outline steps to ensure the youth has enduring relationships with positive, supportive adults who are committed to maintaining such a relationship beyond the child's involvement in the child welfare system.

The goal may be recommended for children 14 or younger in rare cases, based on a child's unique circumstances and after ruling out the more permanent goals of reunification, adoption, and guardianship, APPLA should be considered as a short term interim option while more permanent concurrent plans are pursued.

The goal may be recommended for children 14 or younger only if needed to preserve placement of a sibling group together. In each case plan, steps must be outlined to ensure the youth has enduring relationships with positive, supportive adults who are committed to maintaining such a relationship beyond the child's involvement in the child welfare system. All APPLA goals for children under 14 are to be approved by the Area Director.

If an APPLA goal is determined to be necessary, it must be understood that permanent concurrent goals of reunification, adoption or guardianship will continue to be pursued or reconsidered.

Summary of Performance in Round One of the CFSR

Item 10 was assigned an overall rating of Area Needing Improvement. Although in 75 percent applicable cases, reviewers determined that DCF made concerted efforts to explore alternative permanency options, in 25 percent applicable cases reviewers determined that these efforts had not been made.

Measures of Effectiveness

The Office of the Juan F. Court Monitor conducts quarterly reviews of cases assessing the Department's effectiveness and progress in achieving and maintaining all 22 Exit Plan Outcome Measures. This includes emphasized analysis in particular areas needing the most improvement.

Of the six cases with the goal of APPLA included in the Monitor's review, three identified a concurrent goal. In the three cases with no concurrent plan, there was appropriate consideration given to more permanent goals prior to the ACR. Ongoing work was underway to promote permanency, such as referring to supportive services and conducting ongoing efforts to search for relative resources.

The review revealed that there are a large number of adolescents (approximately 1,300) who currently have the non-preferred permanency goal of Another Planned Permanent Living Arrangement (APPLA). While some of these children are in stable placements and may have stated their desire for no further adoption efforts, ongoing reviews conducted by the Court Monitor have found that in addition to placement and permanency needs, other needs remain unmet at a higher rate than other children in care. These include appropriate mental health treatment, education services, medical/dental treatment and transitional services.

DCF policy requires concurrent planning when reunification or APPLA are the designated as the primary permanency goals. Of the five cases with the goal of APPLA, only one case identified a concurrent goal. In two of these instances, teenagers indicated that they did not wish to pursue adoption or transfer of guardianship. The remaining cases did not document such clear rationale for the APPLA goal and were scored marginally or poor as a result of the failure to identify a concurrent plan to the APPLA goal.

In the recent Connecticut Comprehensive Outcomes Review (CCOR) of four DCF Area Offices using the CFSR methodology and On-Site Review Instrument (OSRI), 3 of 9 applicable cases were rated as a Strength for OSRI Item 10, which explores the agency's ability to effectuate planned permanent living situations for children in foster care, and delivery of services conducive to the attainment of this goal. Reviewers noted strong documentation outlining APPLA rationale, pursuit of both primary and concurrent goals when applicable, and appropriate utilization of Area Office administrative consultations supporting these decisions.

Conversely, 6 of the 9 applicable cases were rated as an Area Needing Improvement. The prevalent issues reviewers found were that APPLA was incorrectly selected or applied in case situations when other permanency goals could have been explored: the child was under age 14 without a compelling reason for selecting APPLA as a permanency goal: and concurrent goals were identified but not both actively pursued. The additional 23 cases were rated as not applicable.

The Department continues to make concerted efforts to improve its treatment planning process and ability to meet the needs of youth in care striving to meet and exceed the standards set forth in policy and in the Juan F. Exit Plan. There are some areas needing improvement which are still present in our performance relative to the Department's ability to secure planned permanency living arrangements for children in foster care, in addition to practices surrounding the designation and pursuit of APPLA as a primary and concurrent permanency goal.

The CFSR Data profile submitted on 7/17/08, (C3-1) indicates that the Department achieves permanency on behalf of children who have been in care for 24+ months (exit cohort) at a rate of 20.8%. This is well below the national median of 25.0%. Further, (C3-12) indicates that the Department achieves permanency on behalf of children with TPR (exit cohort) at a rate of 88.6%, below the national median of 96.8%. These data demonstrate the need for increased efforts to examine case planning practices, particularly, permanency planning, including timely and appropriate permanency goal designation, (as with APPLA) and achievement.

Factors Affecting Performance

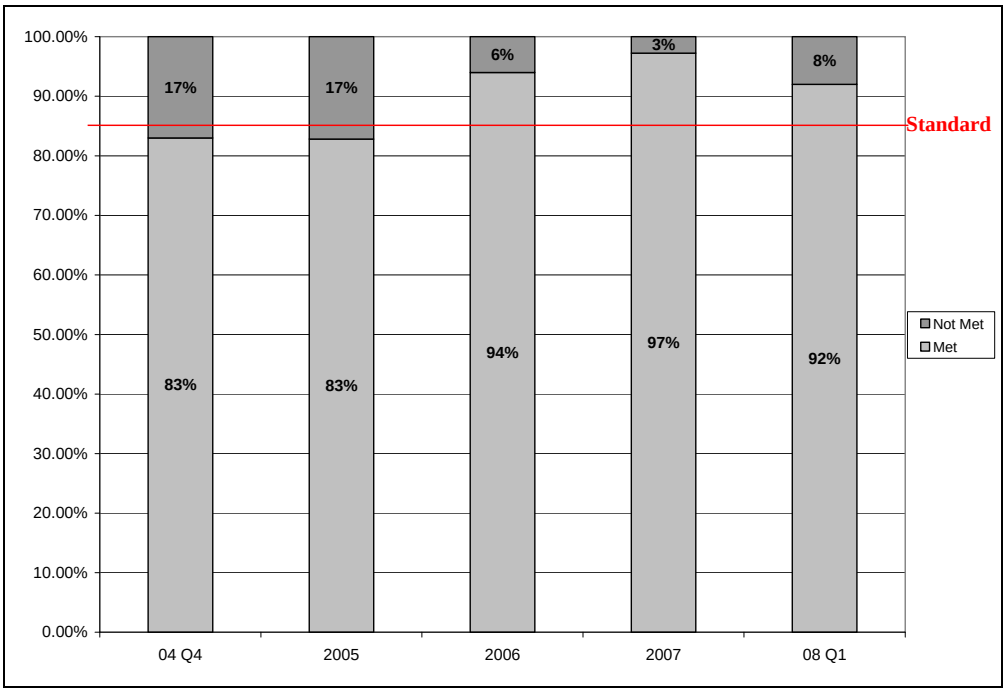
Much work has been done in Connecticut to reduce the use of APPLA as a permanency goal and improve service provision for older youth in foster care. Several programs have been developed so that youth leave foster care with a permanent family or, when that is not possible, with meaningful connections to at least one adult resource. A positive sign is that more youth are choosing to stay in foster care after the age of 18 and often until the age of 23.

Life Long Family Ties (LLFT), for example, is a program designed to identify life connections for adolescents in DCF care who have no identified permanency resource. The program began in January 2004. LLFT is child-centered and moves outward from the child's perception of people important to him/her to identify life connections through current and past family and community ties. Those who have been identified come forward to form the child's "team". The goal of the team is to create life long connections for the child in the following way: either through a permanent placement resource, a mentoring relationship, a supportive relationship and/or other positive connections to the child's family, foster family and/or community.

Children/youth identified for this program are those who have been legally free for adoption or who have an APPLA permanency goal. The Department continues to have contracts with two (2) community providers. Each provider has three (3) fulltime Master's level Social Work staff. A LLFT worker has an average caseload of ten (10) children/youth.

As of May 15, 2008, forty-nine (49) children are currently being served. Since February, 2004 a total of one-hundred-and-thirty (130) children and youth have received LLFT services. An additional twenty (20) children and youth were withdrawn from the program since 2004 without receiving services at their request. Of the 130 children and youth who have received services, 75% have had connections found for them from within their related family, current or past foster families, previous community or a faith-based relationship.

For youth who age out of the system, the Juan F. Exit Plan sets targets for goal attainment by the time of discharge. At least 85% of children age 18 or older are expected to achieve specified educational/vocational goals prior to discharge (e.g. high school diploma, full time employment). The Department's focus on this area and the expansion of services available to adolescents has greatly improved adolescents' goal attainment prior to discharge from DCF care, with over 90% attaining such goals:



Outcome Measure 20: Discharge Measures

For youth who choose to leave the Department's care and wish to return to complete their education, DCF created the Re-Entry Program. Youth between the ages of eighteen and twenty-one who have left the care of the Department may be eligible to re-enter the Adolescent Services Program in order to continue their education. Many young people have chosen to return to DCF care to avail themselves of the opportunity to pursue post-secondary education and receive other supportive services and each request is considered on a case-by-case basis.

Permanency Outcome 2: The Continuity of Family Relationships and Connections is preserved for Children.

Item 11: Proximity of Foster Care Placement. How effective is the agency in placing foster children close to their birth parents or their own communities or counties?

Policy Description

The Department of Children and Families has placed a major emphasis on placing children within their geographic and cultural communities and in close proximity to parents and siblings. Agency policy and mandatory training components guide Area Office Foster and Adoptive Services staff to focus matching efforts on relative placement resources whenever possible, followed by resources within the family's community, county, and state. Consideration is only given to placements outside the closest proximity to parents and siblings when special circumstances arise i.e. a placement with an out of state relative resource via interstate compact.

Per DCF Policy 41-19-2, the following policies guide the Department when making concerted efforts to place children in close proximity of parents and siblings:

Placement Proximity/Matching

Children are matched by social workers in the Area Office Foster and Adoption Services Units.

At the time the child comes into care, all efforts are made to place the child with family whenever possible. Preference is given to placement with relatives or extended family if the family:

- can meet the needs of the child;
- can meet licensing requirements; and,
- lives in the same community where the child had been living at the time of removal, unless it is in the best interests of the child to be placed with relatives in another community.

Non-Relative caretakers are also considered in the event that the foster care setting serves the best interests of the child, based on individual needs. When a child is placed into foster care, the child is placed in a foster home that is in the least restrictive, most family-like setting and in close geographic proximity to the child's own home whenever such a placement is available..

Siblings shall be placed in the same foster home unless the documented special needs of one or more siblings preclude placing them together. If there is a conflict between proximity of the foster home to the child's parents and keeping siblings together, the principle that siblings should be placed together takes precedence, and DCF shall ensure visitation with the biological family.

Out of State Placement Guidelines

The Department places children and youth in the closest proximity to their home as possible. This philosophy guides agency placement of children and youth into residential placements. In all cases, Area Office social work staff must explore placement options that operate within the boundaries of Connecticut. Only after a full exploration that results in a finding of no available beds or the lack of a program that will meet the needs of a particular child/youth, shall out-of-state placement be given any consideration. This exploration must include discussions with appropriate in-state programs.

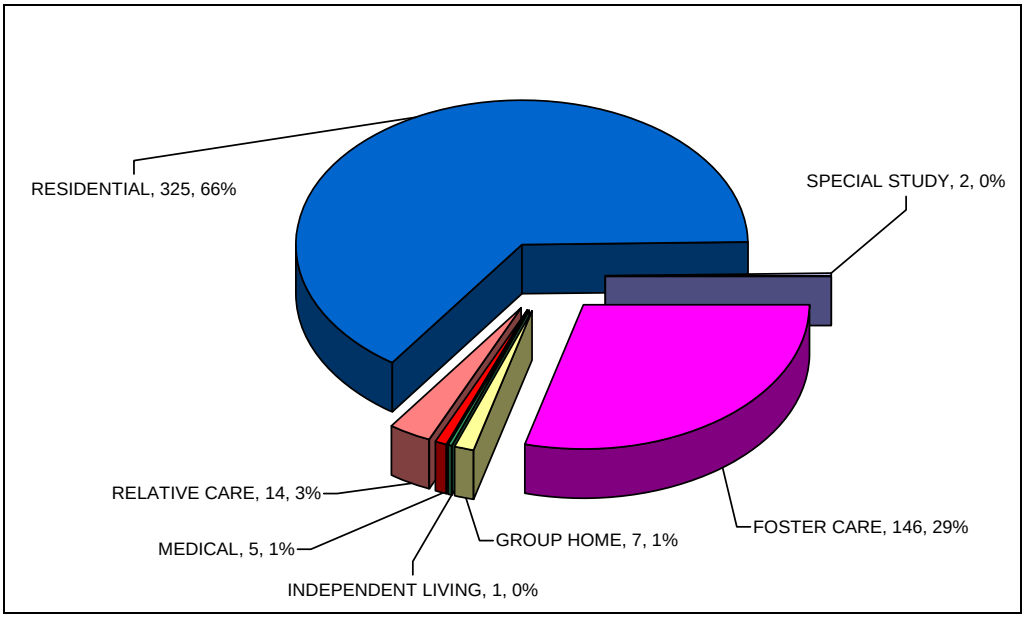
Summary of Performance in Round One of the CFSR

In 2002, Connecticut did not achieve substantial conformity with Permanency Outcome 2. This determination was based on the finding that the outcome was rated as substantially achieved in only 80.8 percent of the cases, which is less than the 90 percent required for substantial conformity. Although the state did not achieve substantial conformity with this outcome, there were many strengths including placement proximity.

Item 11 was assigned an overall rating of Strength because in 96 percent of the applicable cases, reviewers determined that children had been placed in foster care homes that were in close proximity to their parents or, when children were placed far away from parents, the placement was necessary to meet the special needs of the child.

Measures of Effectiveness

Currently, there are approximately 5,700 children in DCF placement, with 500 residing in various out of state placements:



Children in Out-of-State Placements, July 2008

Of the 500 children placed out-of-state by DCF, a large number currently reside in out of state residential placements. As outlined in DCF policy, every effort is made to reduce the number of out-of-state placements and such placements are only made when a placement that can meet the child's needs is not available in Connecticut.. Out-of-state placements are reviewed on an ongoing basis to ensure they are appropriate. In spite of the fact that approximately 9% of children in DCF care are placed out of state, the Department's recent review of practice highlighted good practice in terms of placing children in close proximity to their homes.

In the recent Connecticut Comprehensive Outcomes Review (CCOR) of four DCF Area Offices using the CFSR methodology and On-Site Review Instrument (OSRI), reviewers rated 31 of 32 cases as a Strength for OSRI Item 11, which explores the effectiveness of the agency in placing foster children close to their birth parents or their own communities. Reviewers noted that the vast majority of children were placed within their community unless issues specific to the needs of the child required them to be placed outside their community of origin.

Factors Affecting Performance

The Juan F. Exit Plan focus on measuring the Department's efforts surrounding relative resource searches, and the utilization of flex funding to support placements has had an overall positive impact on the agency's ability to undergo and sustain improvements in this area.

For in-state placements, a statewide Private Foster Care Referral Protocol was established by the Office of Foster Care Services (OFCS) to track referrals to the statewide foster care network and monitor diligent efforts to place children in their communities whenever possible. The Department's efforts surrounding the placement of children within their geographic and cultural communities are reviewed by Area Office managers prior to a statewide referral being submitted. The Program Lead in Central Office tracks utilization of the statewide referrals to identify potential resource gaps and inform improvements to the private foster care system.

The Connecticut Association of Foster and Adoptive Parents (CAFAP) works collaboratively with DCF to develop, implement and support programs for foster, adoptive and relative families. Services provided include a buddy system, post-licensing training, a Helpline, a quarterly newsletter, an annual conference, workshops and respite care authorization. These supportive services help DCF maintain a strong statewide network of foster families, thereby facilitating the placement of children close to their home communities.

The Minority Recruitment Council was established by State legislation in 1999 to study and make recommendations to the legislature in order to promote adoptions and improve services for minority children and children who are hard to place. In 2002, this council was integrated into the statewide Community Collaborative monthly meetings. The Collaboratives meets monthly to plan activities to further explore ways to ensure children are placed in and maintain connections to their geographic and cultural communities.

Item 12: Placement with Siblings. How effective is the agency in keeping brothers and sisters together in foster care?

Policy Description

The Department of Children and Families has placed a major emphasis on placing children with their siblings whenever possible. Per DCF Policy 36-55-6, siblings are placed in the same foster care setting unless the documented special needs of one or more siblings preclude placing the siblings in the same foster care setting. Concerted efforts are made to reunite siblings who are not initially placed together in the same foster care setting, unless exceptional reasons exist that preclude reunification.

Reasons for not reuniting siblings must be exceptional. For example, reunification would not occur if one sibling has been in the continuous care of his/her foster parent since birth, and the foster parent cannot or will not accept the care of another child, and it is not in the best interest of the child to be moved to a new foster home.

Efforts to reunite siblings must be addressed in each sibling's individualized case plan and case record including:

- the reasons the reunification to a single foster care home did not occur;
- discussion of the child's best interest considerations that led to this decision; and ,
- the signature of all parties who participated in the decision not to reunite the sibling group including the social worker, supervisor, Regional Resource Group, or others.

Summary of Performance in Round One of the CFSR

Item 12 was assigned an overall rating of Strength based on the finding that in 87.5 percent of the cases, siblings were either placed together or there was a justifiable reason for their separation.

Measures of Effectiveness

The Juan F. Exit Plan sets standards for outcome measures that must be met in the area of sibling placements. The standard for Outcome Measure 10, Sibling Placement, is that at least 95% of siblings

currently in or entering out-of-home placement shall be placed together unless there are documented clinical reasons for separate placements. This measure excludes Voluntary Services cases and children for whom TPR has been granted.

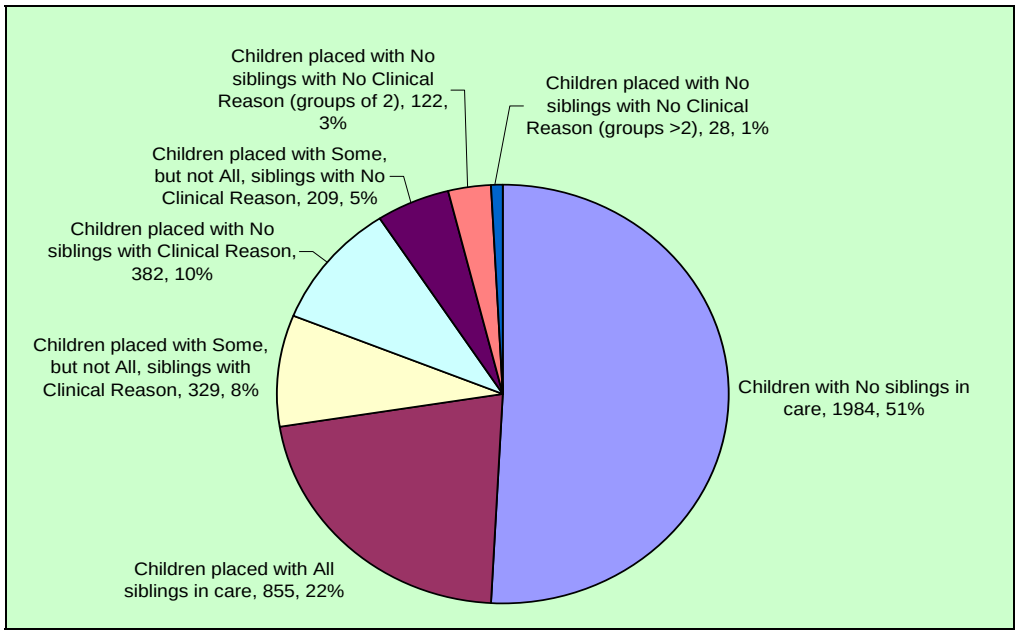
The Monitor's quarterly review of the Department for the period of January 1, 2008 through March 31, 2008 indicates that the Department did not achieve compliance with the Sibling Placement measure (86.7%). The Department continues to refine its efforts to achieve and maintain this measure, as the only quarter in which the measure was met was the 3rd quarter of 2005.

Beginning in the 4th quarter of 2006, the Bureau of Continuous Quality Improvement began internally conducting quarterly sibling placement reviews as the method of monitoring compliance with Exit Plan Outcome Measure #10. These reports are available to agency staff via the DCF intranet. To date, the most compelling emergent reasons impacting the agency's ability to place siblings together are sibling group size and needs of the children being placed, specifically siblings requiring varying levels of specialized foster care.

The following information is outlined in the pie chart below. There were a total of 3,909 Juan F. children in placement (excluding youth over age 18 and children with legal status of "Statutory Parent") on 01/02/08 when the most recent data was drawn. Of these children, 1,984 (50.8%) did not have any other siblings in placement on that date, and so were excluded from the measurement of this outcome. The remaining 1,925 (49.2%) were all members of sibling groups where at least two siblings were in placement on that date. These 1,925 children represent the sibling population on 01/02/08.

Of the sibling population, 855 (44.4%) siblings were placed with the same provider as all of their other siblings. The remaining 1,070 (55.6%) children had at least one sibling in the group placed with a different provider than the rest.

Staff from the Bureau of Continuous Quality Improvement reviewed the cases of the siblings placed apart from each other to determine whether or not a clinical reason existed for these children to be separated, and whether or not there were documented plans to re-unite the children in the future. There were clinical reasons documented in 27.9% of these cases. The remaining cases were found to have only non-clinical reasons for separating the child from his/her siblings.



Juan F. Children in Placement by Sibling and Clinical Reason Status

Connecticut Comprehensive Outcomes Review

In the recent Connecticut Comprehensive Outcomes Review (CCOR) of four DCF Area Offices using the CFSR methodology and On-Site Review Instrument (OSRI), reviewers rated 11 of 18 applicable cases as a Strength for Item 11. Reviewers noted that the vast majority of children were placed with siblings citing the utilization of Special Study Licensing Services, community based service provision entities, internal consultative Area Resource Group (ARG) and external agencies resources, effective family engagement, and family conferencing services as contributing factors.

In the 7 cases rated as an Area Needing Improvement, the predominant issues reviewers found were sibling group size and specialized needs contributed to children being placed separately. The remaining 14 cases were rated as not applicable.

In preparation for the CFSR, the Department held focus groups with a group of adolescent youth currently in the foster care system in which questions from the CFSR stakeholder framework were asked pertaining to this item. The respondents noted sibling group size and varying specialized needs of siblings significantly impacting this item. One respondent indicated that their sibling group of 5 was initially placed together in a Safe Home, but separated when entering foster care due to lack of placements for groups of that size. Another respondent noted the agency's diligent efforts surrounding successfully placing him and his sister together, but that they were later placed separately due to her specialized behavioral health needs. The respondents highlighted the importance of the agency's initial and ongoing efforts surrounding sibling placement due to their feeling that the sibling bond is not able to be supported by a monthly visitation schedule. One youth suggested recruitment and retention efforts focusing on foster families specializing in larger sibling groups.

Factors Affecting Performance

The Department's internal sibling placement reviews have suggested that two of the major variables impacting this area are sibling group size and needs of the children and family. When considering these factors, the availability of foster care services across Connecticut's regions, counties, and Area Office catchment areas could potentially impact the agency's ability to place sibling groups together. Particularly, factors surrounding service array and availability when comparing densely populated, service rich areas opposed to more sparsely populated rural locations.

The Juan F. Exit Plan, and internal sibling placement review focus on measuring the Department's efforts surrounding sibling placement, has had a positive impact on the agency's ability to frame the efforts needed to undergo and sustain improvements in this area.

Recently, the Department and the plaintiffs in the Juan F. case developed a new agreement that sets specific goals related to:

- Recruiting additional foster homes;
- Placing more children in family settings and fewer children in congregate facilities;
- Reducing the length of time children remain in temporary congregate care placement settings; and,
- Providing services to meet the health care needs of children in foster care, including medical, dental, mental health, vision, hearing and developmental treatment as needed.

The agreement highlights the Department's investment in increasing the number of foster homes to provide the family resources needed to keep children with families whenever possible. In addition, the agreement includes a goal of increasing the percentage of children entering care who are placed into a family setting by 7 percentage points in the first year and by an additional 3 percentage points in each successive year while the agreement remains in effect. Currently, approximately 70 percent of children entering state care are placed into a family setting as opposed to a congregate setting. It is anticipated this agreement will significantly impact the Department's ability to place siblings together.

Item 13: Visiting with parents and siblings in foster care. How effective is the Area Office in planning and facilitating visitation between children in foster care and their parents and siblings placed separately in foster care?

Policy Description

The Area Office social worker facilitates visits with parents and siblings on behalf of children in placement including instances when siblings groups are separated. This is often accomplished through the utilization of multiple staff resources facilitating these services. Foster families are encouraged both at the initial PRIDE training, as well as subsequent trainings and support groups to assist in facilitating visits whenever possible and safe for the family. In addition, foster families are encouraged to discuss with the child's worker the whereabouts of siblings not placed with them, and the feasibility of visitation should the families become acquainted with one another.

The Department of Children and Families has placed a major emphasis on improving visitation between children and families receiving placement services. Per DCF Policies 36-55-1.2, 36-55-7, 34-10-7.1, social workers are responsible for facilitating frequent, quality visits between parents and children as follows:

Visitation with Parents and Siblings

The Department shall ensure that children under the Commissioner's care and custody be provided with visitation with their parents and siblings. The child's Social Worker shall ensure that:

- all children placed under an Order of Temporary Custody (OTC) or commitment have visitation with parents and siblings unless a court orders otherwise;
- visits occur as frequently as reasonably possible based upon the consideration of the bests interests of the child, including age and developmental level of the child;
- visits be of sufficient number and duration to ensure continuation of the relationship between the child and his/her parents and siblings;
- siblings with an existing relationship who are separated due to the Department's intervention be provided with ongoing visitation throughout the length of the separation taking into account the best interests of each sibling, the ages, developmental levels and the continuation of the sibling relationship.

Visitation between children and parents are generally once per week, but can be more frequent depending on the needs of the child or the orders of the court. Visitation occurs at the convenience of the parents, so evening and weekend visits are not uncommon. DCF provides transportation to the visits for all of the children and for the parents, if needed.

Most visitations are supervised in order for the social workers to assess the relationship between the parents and the children. As the reunification date approaches, the visits are increased and will be unsupervised.

The Area Office social worker establishes a rapport with the child(ren) in placement and family throughout the continuum of services. The Area Office social worker explains the purpose of the Service Plan and visitation activities to the child, as appropriate for the child's level of understanding. Whenever possible, the social worker helps the child understand the reasons for and the realities of placement and visitation without violating the positive aspects of the child's feelings about his/her parents, keeping the child informed about the his/her case planning, family situation and siblings.

Written visitation plans are developed and immediately implemented for parents and all siblings not placed in the same foster care setting unless a written and signed statement from a professional (e.g., psychologist, psychiatrist) states that visiting is not in the best interests of the sibling needing special care.

Sibling visits that are deferred for more than sixty (60) days must be re-certified in writing by the mental health professional. Thereafter, sibling visits shall be reviewed and the deferring of visits re-certified by the professional every ninety (90) days.

Summary of Performance in Round One of the CFSR

In the 2002 CFSR, Item 13 was assigned an overall rating of Area Needing Improvement. In 72 percent of the applicable cases reviewers determined that the agency had made diligent efforts to facilitate visits between the child and his or her parents and siblings. There were concerns, however, because in 28 percent of the applicable cases reviewers determined that DCF had not made, or was not making, concerted efforts to facilitate visitation, particularly between siblings in foster care.

Measures of Effectiveness

In the recent Connecticut Comprehensive Outcomes Review (CCOR) of four DCF Area Offices using the CFSR methodology and On-Site Review Instrument (OSRI), reviewers rated 16 of 32 applicable cases as a Strength for OSRI Item 13. Reviewers noted placement proximity and localized visitation services as factors that positively impacted visitation. In the 15 cases rated as an Area Needing Improvement for this item, the predominant issue reviewers found was that although placed in close proximity of parents and siblings, visitation was not observed to be of sufficient frequency or quality to meet children's needs. Other issues noted included the lack of meaningful connections between half-siblings in care, sporadic visits, and lack of engagement and visitation with fathers.

In preparation for the CFSR, the Department held focus groups with adolescent youth currently in the foster care system in which questions from the CFSR stakeholder framework were asked pertaining to this item. The respondents noted frequency, quality, and proximity of placement impacting this item significantly. Specifically, they noted that the distance of the foster placement from parents and siblings increased the likelihood their visitation would be negatively impacted. The majority of the respondents indicated that the agency facilitated monthly visits with parents and siblings, however they also noted that they did not feel this was enough to maintain their bond with family.

Factors Affecting Performance

In addition to the practice improvements in the area of facilitating visitation between children in foster care and their parents and siblings, the Department also has invested in a number of programs designed to improve visitation:

Although varied throughout the state, Family Center programs provide core services to support family reunification efforts. The services may include: assessment; orientation for children, biological and foster parents; supervised, therapeutic visitation; support groups; reunification; and aftercare. Many family centers also provide foster family and post-adoption support, including: social/recreational activities; parent education workshops; informal respite; support groups; and information and referral services. Eleven (11) programs serve all Area Offices statewide.

The Reconnecting Families Program is designed for families with children (from birth through age 17) who were removed from their home due to CPS concerns and for whom supervised visits are required. The program provides a staged model consisting of pre, interim, and post reunification services, home based service delivery, Post Reunification Crisis intervention – address safety/re-entry issues, a Team approach including Reconnecting Families Provider, DCF, Family, and Placement resource, Family Conferencing meetings held at critical junctures, and after-hours/weekends and transportation provided.

Item 14: Preserving Connections. How effective is the agency in preserving important connections for children in foster care, such as connections to neighborhood, community, faith, family, tribe, school, and friends?

Policy Description

The Department of Children and Families has placed a major emphasis on preserving connections on behalf of children and families receiving placement services. Per DCF Policy 36-55-1.2, the Department is responsible for preserving connections on behalf of children and families receiving placement services to both geographic and cultural communities.

Preserving Connections

In addition to efforts surrounding proximity and sibling placement issues, ensuring frequent and quality visitation with parents and siblings the Department ensures:

- that family photographs and other mementos of the child's life are gathered and preserved. These items shall reflect the various family and life experiences of the child and should be maintained in a Life Book format.
- ensure that arrangements are made for the child to attend church and receive religious instruction in his/her own faith
- foster families receive mandatory PRIDE training, which outlines the importance of assist in facilitating visits and extracurricular activities in the child's community of origin.

In December 2005, the Department revised policy on working with Native American families. The major revision provided clarity that the federally recognized tribes have certain rights separate and distinct from the rights of parents, including the right to intervene in child protection cases involving Indian children.

Summary of Performance in Round One of the CFSR

Item 14 was assigned an overall rating of Strength because in 92 percent of the cases, reviewers determined that children's connections to family and community, particularly to their biological families, were maintained.

Measures of Effectiveness

Compliance with Indian Child Welfare Act: The Department has taken several measures in order to comply with the Title IV-B, subpart 1 Child Welfare Services Plan addressing the Indian Child Welfare Act of 1978 for the Federal Fiscal Years 2006-2007, including policy implementation, and memorandum of understanding development, resulting from active collaborations between DCF and local federally recognized tribes.

In the recent Connecticut Comprehensive Outcomes Review (CCOR) of four DCF Area Offices using the CFSR methodology and On-Site Review Instrument (OSRI), reviewers rated 24 of 32 cases as a Strength for OSRI Item 14. Reviewers noted that the cases reflected evidence of agency staff making concerted efforts to facilitate parent involvement in sports, medical appointments and other activities. In the 8 cases rated as an Area Needing Improvement, the predominant themes reviewers found were that parents were not encouraged to participate in child related activities outside of visitation, and a lack of child engagement in community based activities.

Factors Affecting Performance

There are a number of programs and promising practices in Connecticut that are impacting the Department's ability to preserve connections for children. In one Area Office that took part in the CCOR, for example, The Life Long Family Ties (LLFT) Program is being piloted. The program operates on a "preserving connections" paradigm. Area office staff have adopted an intense focus on and dedication to helping children stay connected to their peer groups, social activities, churches or friends and family.

This was evidenced in the investigations, ongoing service, and permanency phases of service delivery through the following practices:

- Use of Genograms to determine family constellations.
- Kin/community outreach to identify additional resources for the child and family.
- Gathering pertinent relative resource information during interviews with the child and family
- Relative resource review and consultation at the time of case transfers.
- Use of Locate Plus to locate potential relative resources identified by the family.
- Ongoing assessment of frequency, quality, and appropriateness of visitation.
- Thorough and timely documentation of relative search efforts including
- Collaborative treatment planning.
- Ongoing partnership with Casey Family Services via the ACTR Program to continue refining process.

The Department is also cognizant of its responsibility to promote connections for children who may be members of a Native American tribe. There are two federally recognized tribes in Connecticut. At the outset of any case, the DCF Social Worker is required inquire whether there is any possibility of Native American heritage and documents the response in LINK.

Federally recognized Native American tribes have certain rights separate and distinct from the rights of the parents, including the right to intervene in child protection cases that involve Indian children. The Social Worker must immediately consult with the DCF Legal Division if informed that it is possible that a family has Native American heritage so that proper legal notice can be provided to the tribe. Not all children whose parents are tribal members are necessarily eligible themselves. It is the tribe's role, and not the Department's, to determine whether a child meets the tribe's eligibility criteria. For example, a child's membership status is not affected if the tribe banishes his or her parent.

In 2007, the Department participated in The Life Long Family Ties (LLFT) Permanency Project to explore and identify potential permanency options for DCF youth who otherwise have no viable community connection. Casey Family Services provided supervision and technical assistance for the project. In 31 cases of the 47 cases referred to the program, resources were located and developed for the youth. There were several cases in which the youth connected with more than one resource. Of the 31 cases, 7 were reconnected with birth parents, 9 with older siblings, 11 with extended family members, 2 with previous foster parents, 2 with family friends and 3 were referred for mentoring services in the community. Casey Family Services has agreed to provide ongoing case consultation to Area Office staff to further support this work.

Item 15: Relative Placement. How effective is the agency in identifying relatives who could care for children entering foster care, and using them as placement resources when appropriate?

Policy Description

Per DCF Policy 36-60, 41-17-15.2, 41-17-15.3, social workers are responsible for collecting information regarding and conducting searches for relatives whenever possible.

Relative Placements

Agency policy states that when considering foster care placement for a child, preference is always given to placement with a relative or extended family.

The relative or extended family may be considered:

- if the relative or extended family member is able to meet foster care licensing requirements

- if the placement permits the child to remain in their home community, or
- if the relative placement, although in another community, is determined to be in the child's best interest.

There is no distinction made between maternal or paternal relatives, and social workers are encouraged and repeatedly reminded to consider both maternal and paternal relations.

Searches for relatives begin at the time of the investigation commencement. The Department added a Placement Resource Icon to the electronic LINK record. Both investigations and Ongoing Services Social Workers are expected to maintain a record of relative resources in this location. The Department has also supplied each Area Office with LocatePlus Software to execute more sophisticated searches for relatives when necessary.

Licensing of Relatives

When a child must be removed from his/her own home and placed in out-of-home care, preference must be given to placement with relatives if the relative family

- can meet the needs of the child
- can meet licensing requirements, including a criminal background check and a CPS check
- lives in close geographic proximity to where the child had been living at the time of removal, unless it is in the best interest of the child to be placed with relatives in another location.

A child may be placed with a relative who is not licensed for up to 90 days when such placement is in the best interests of the child provided that:

- a satisfactory home visit is conducted
- a basic assessment of the family is completed, as specified below
- the relative attests that the relative and any adult living within the household have not been convicted of a crime against a person, for injury or risk of injury to or impairing the morals of a child or for the possession, use or sale of a controlled substance.

It should be noted relatives are frequently identified for children coming into care as well as for children already in care. Whenever appropriate, and meeting licensing requirements, families are licensed to care for kin.

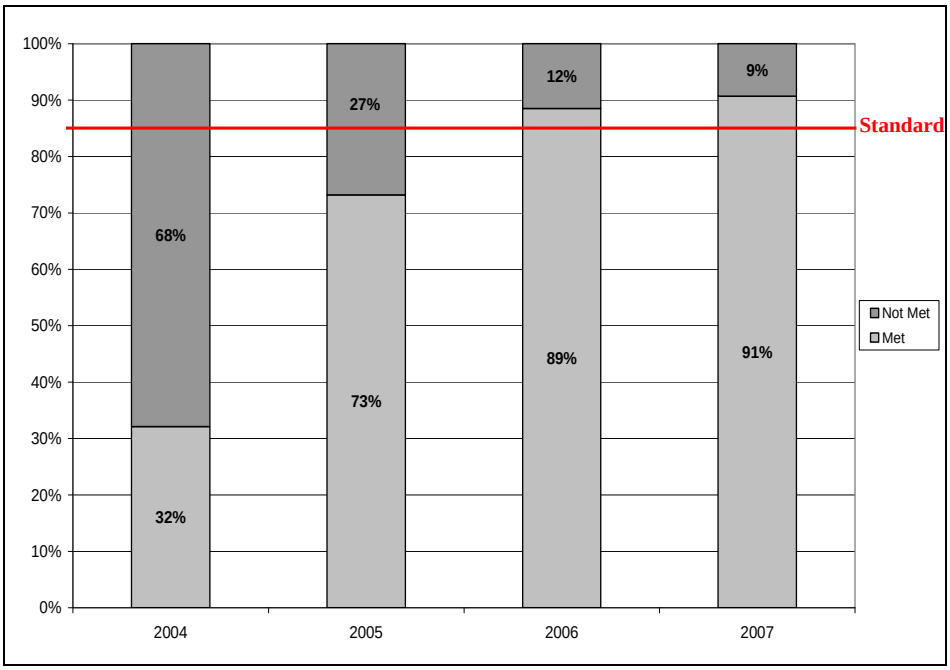
Summary of Performance in Round One of the CFSR

In the 2002 CFSR, Item 15 was assigned an overall rating of Area Needing Improvement. In 78 percent of the cases, reviewers determined that efforts to locate and assess relatives as potential placement resources had been made. Concerns were raised in 22 percent of the cases because the agency had not made diligent efforts to locate and assess relatives as potential placement resources. In particular, insufficient efforts were found with regard to seeking appropriate paternal relatives as placement resources.

Measures of Effectiveness

The Juan F. Exit Plan sets standards for outcome measures that must be met in the area of relative resource searches on behalf of all children in placement. An area of focus of the Juan F. Exit Plan has been to ensure that immediate and ongoing relative resource inquiries are made throughout the life of the case. The standard for Outcome Measure 4 is that if a child(ren) must be removed from his/her home, DCF must 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 begins at the time of the child's removal from the home and extends through the life of the case. Search efforts must be conducted and documented in at least 85% of the cases.



Outcome Measure 4: Relative Search

The Annual Trend View graph above outlines the Department's efforts regarding relative search from a longitudinal perspective spanning from 2004 to 2007. The Department has achieved, maintained, and exceeded the Outcome Measure since the first quarter of 2006. The Department is now consistently meeting the standard set forth in policy and in the Juan F. Exit Plan, and has done so for 9 consecutive quarters. The noted improvement in this area can be partially attributed to enhancements in the Department's LINK case management software which allows the Department to document and monitor efforts in this area.

In preparation for the CFSR, the Department held focus groups with adolescent youth currently in the foster care system in which questions from the CFSR stakeholder framework were asked pertaining to this item. The respondents noted the agency's concerted efforts surrounding the search for and utilization of family as placement options as a strength. The majority of respondents indicated that immediate, but not ongoing efforts were made in this area. Respondents also noted that in some cases relative resources were unable to fulfill the agency's licensing requirements. Two of the respondents noted that the agency made immediate and ongoing relative resource assessment efforts which lead to the youth being placed with licensed family members in both instances.

Finally, in the recent Connecticut Comprehensive Outcomes Review (CCOR), reviewers rated 21 of 32 cases as a Strength for OSRI Item 15. Reviewers noted diligent collection and documentation of efforts to identify relative resources and documenting those discussions in LINK placement narrative. Reviewers also noted an emphasis to identify all potential relatives through the Family Conferencing model. In the 7 cases rated as an Area Needing Improvement, the predominant issue reviewers found was that concerted efforts were not made to search for relatives, especially paternal relatives.

Factors Affecting Performance

Relative placement is a core value in the Department's practice. DCF has conducted specialized foster parent training in the area of preserving connections and facilitated collaborative initiatives with community entities in an effort to preserve family, community, and cultural connections. The Department continues to support relative licensing efforts for children in care and is making strides to increase the number of licensed relative homes through continuation of the following efforts:

- A Licensing Review Team (LRT) advises the Commissioner in matters concerning granting of certain waivers to prospective foster and adoptive parents when they fail to meet specific criteria set forth in the Connecticut General Statutes and the Department of Children and Families' Agency Regulations, particularly when a prospective foster or adoptive parent has a child protection services or criminal history. Use of the Licensing Review Team serves to reduce barriers to licensing appropriate relative resources to care for children in the care of the Department, thus promoting optimal permanency options.

- The Office of Foster Care Services in conjunction with the Office of Legislative Affairs and the Legal Division modified the existing licensing regulations in order to be more inclusive of foster and adoptive families and to more fully comply with the Adoption and Safe Families Act (ASFA). These proposed regulations are currently moving through the approval process.

Since the last CFSR, the Department began conducting License Review Team Meetings, which convene monthly to review and guide decisions surrounding licensure on behalf of submitted requests.

A request to the LRT may be made when all of the following circumstances exist:

- the applicant for foster or adoptive parent has completed application and submitted all supporting documents;
- the Area Office FASU/CPA staff have reviewed the application and supporting documents in its entirety;
- the Area Office Central Registry Appeal Review has been conducted on any existing Central Registry findings;
- the Area Office FASU/CPA staff have deemed applicant to be fit with the exception of elements being presented to the LRT;
- Area Office child protective staff, when applicable, believe applicant to be fit to care for children despite presenting barrier **and** FASU staff endorse the approval of a waiver;
- no safety concerns are noted; and,
- approval of the application will not place a child's safety in jeopardy and is in the child's best interests.

Item 16: Relationship of child in care with parents. How effective is the agency in promoting or helping to maintain the parent-child relationship for children in foster care, when it is appropriate to do so?

Policy Description

The Area Office social worker facilitates visits and other activities between parents and siblings which will positively impact the parent/child relationship. Foster families are also encouraged to assist in bolstering parent/child connections whenever possible and safe for the family.

The Department of Children and Families has placed a major emphasis on maintaining and improving parent/child relationships. Per DCF Policy 36-55-1.2:

In addition to facilitating placement proximity, sibling placement, visitation, preserving connections, and relative resource search services, the agency promotes a positive, healthy, relationship between parents and children in placement through:

- keeping the child informed about the his/her case planning, family situation and siblings;
- ensuring the child's visitation with parents, siblings and significant persons according to the Service Plan;
- ensuring that family photographs and other mementos of the child's life are gathered and preserved. These items shall reflect the various family and life experiences of the child and should be maintained in a Life Book format;
- ensuring that arrangements are made for the child to attend church and receive religious instruction in his/her own faith; and
- documenting the child's progress by maintaining the uniform case record and LINK computer record.

Summary of Performance in Round One of the CFSR

In 2002, Item 16 was assigned an overall rating of Strength because in 90 percent of the cases, reviewers determined that the agency had made sufficient efforts to support or maintain the bond between parents and their children while the children were in foster care.

Measures of Effectiveness

In the recent Connecticut Comprehensive Outcomes Review (CCOR), reviewers rated 17 of 32 cases as a Strength for OSRI Item 16. Reviewers noted placement proximity, localized visitation services and parental involvement in extracurricular activities and medical appointments as positive factors contributing to the Department's ability to promote a positive relationship between children and their parents. In the 14 cases rated as an Area Needing Improvement, the predominant issue reviewers found was that although placed in close proximity of parents and siblings, concerted efforts were not seen to maintain and improve the parent/child bond.

Factors Affecting Performance

Several factors positively impact the Department's ability to facilitate positive relationships between children in care and their parents. These include:

- Proximity of Placement: DCF social work staff have made diligent efforts to ensure children are placed close to their community of origin whenever possible and appropriate. Placement proximity is a core value of DCF's work and is embedded in our policy and practice. Because most children are placed in close proximity to their parents, social workers are able to ensure visitation is consistent and that parents are able to participate in activities with their child.

- Services for Incarcerated Parents: Two (2) programs, serving Waterbury, Danbury, Torrington, Norwalk, Stamford, and Bridgeport, provide transportation for DCF children so they can visit their parents while in prison. Additionally, DCF staff are out-posted to the York Correctional

Institution, the state's only institution for female offenders. DCF staff facilitate visitation and communication between female inmates and their children in DCF care or custody.

- Family Visitation Centers: Eleven contractors provide an array of services to support biological families during the reunification process. This service provides site based supervised visitation services for families who have children placed by the Department of Children and Families in out of home care with a permanency goal of reunification. This service was also designed to provide a range of support, advocacy and parenting education services for foster and adoptive parents. A challenge for these programs is that the funding level and service delivery vary considerably throughout the state.

While the Department has made significant improvements in the consistency of visitation and other connections between children in care and their parents, there remain challenges in this area. In the CCOR review, reviewers noted that the quality of visits was often insufficient to meet children's and parents' needs. A greater focus must be placed on supporting visitation programs and practices that are strength-based and offer parenting skills necessary to support the parent-child relationship.

C. Child and Family Well-Being

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

Item 17: Needs and services of child, parents, foster parents. How effective is the agency in assessing the needs of children, parents, and foster parents, and in providing needed services to children in foster care, to their parents and foster parents, and to children and families receiving in-home services?

Policy Description

Meeting the service needs of children, parents and foster parents is a core component of the mission of the Department of Children and Families. DCF Policy 36-5 through 36-10, *Treatment Planning*, outlines the legal basis for treatment planning, the preparation for and development of treatment plans, as well as the frequency required for updating plans. Policy requires that "Every effort will be made to make this process and the development of the plan inclusive. Children, parents and all appropriate service providers will be given the opportunity to participate."

Per DCF Policy 36-5-3, a Treatment Planning Conference (TPC) "shall occur within thirty (30) calendar days of the time a case is assigned to a treatment/voluntary services worker or a new case is opened in a treatment/voluntary services unit." Treatment plans must be completed within 10 days of the TPC. Ongoing treatment plans must be completed and dated no later than ninety (90) calendar days beyond the initial treatment plan and must be completed every six (6) months (date to date) from the previous plan.

The function of the treatment plan is described as the opportunity to identify in a time-limited and goal-oriented manner the problems, needs and services for all involved participants, the description of reasonable efforts to prevent placement or reunify children, the mutual responsibilities of the parties to achieve the identified goal and the evaluation of case progress towards goals. Education, physical health and mental health are included in the assessment.

Family plans include an assessment of initial reasons for DCF involvement, the present situation, a discussion of strengths and weaknesses and services offered, utilized and results. Service availability is also noted.

Since the inception of the Juan F. Exit Plan, a significant focus has been placed on effective treatment planning and on appropriate service delivery. Exit Plan Outcome Measure 15 requires that at least 80% of all families and children shall have all their medical, dental, mental health and other service needs provided as specified in their most recently approved clinically appropriate treatment plan.

Summary of Performance in Round One of the CFSR

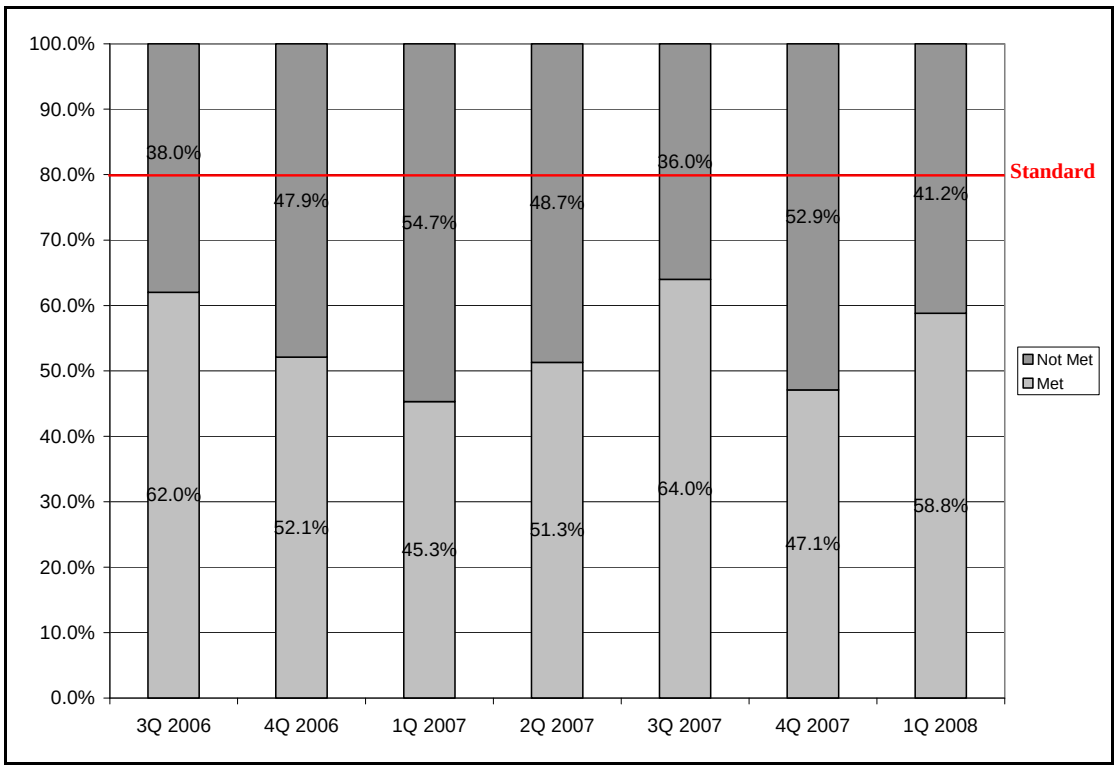
In the 2002 CFSR, Item 17 was assigned an overall rating of Area Needing Improvement because in 30 percent of the cases reviewers determined that the needs and services of children, parents, and/or foster parents had not been or were not being adequately addressed by DCF. The key issue observed through the case reviews was an inconsistency in the quality of assessments and service provision. In some cases, workers conducted in-depth comprehensive assessments and identified services that were appropriate to address identified needs. In other cases, assessments did not focus on potential underlying problems or needs, and services were not sufficient to resolve the problems that brought the family to the attention of

the agency or to ensure the children's well-being. Finally, case reviews indicated a lack of consistency with regard to assessing and serving fathers and engaging resistant parents in services.

Measures of Effectiveness

The Juan F. Exit Plan Outcome Measure 15 requires that "at least 80% of all families and children shall have all their medical, dental, mental health and other service needs met as set forth in the "DCF Court Monitor's 2006 Protocol for Outcome Measures 3 and 15" dated June 29, 2006, and the accompanying 'Directional Guide for OM3 and OM15 Reviews dated June 29, 2006."

Compliance with outcome measure 15 is determined via a quarterly case review conducted by staff from the Office of the DCF Court Monitor. In the most recent quarter, the case review data indicates that the Department of Children and Families attained the designation of "Needs Met" in 58.8% of the 51-case sample.



Outcome Measure 15: Needs Met

In the recent Connecticut Comprehensive Outcomes Review (CCOR) of four DCF Area Offices using the CFSR methodology and On-Site Review Instrument (OSRI), reviewers rated 30 of 47 cases as Area Needing Improvement for OSRI Item 17, "Needs and Services of the Child, Parent and Foster Parents." Overall, reviewers found that when quality assessments were done that appropriate services were provided to families involved with DCF. However, the reviewers noted that in the majority of the cases the Department had not done an adequate job of assessing and addressing the needs of fathers and foster parents.

This is consistent with information gathered through a series of focus groups conducted with foster parents. In preparation for the CFSR and for the process of re-procuring Connecticut's therapeutic foster

care services, the Department held a series of focus groups involving over 100 foster parents across the state. Foster parents reported that while DCF maintains an adequate system of supports to meet their needs, the agency does not do a good job of informing foster parents of everything that is available to them. Focus group participants also reported that in order to get their service needs met, they have to advocate for themselves and that their needs as foster parents are not assessed and addressed consistently by DCF's social workers.

Factors Affecting Performance

Effectively meeting the needs of children, parents and foster parents has been a major focus of the Department's activities since the 2002 CFSR. In particular, DCF has made many policy and program enhancements in the areas of supports for families and foster parents and non-traditional services for children.

In January 2006, the Department contracted with the National Council on Crime and Delinquency (Children's Research Center) to develop and implement Structured Decision Making (SDM) in Connecticut. SDM is a research, evidence-based practice model used by child welfare workers that provides a comprehensive set of assessment tools that promotes consistency and accuracy in decision making at critical junctures throughout the life of a case. The two primary goals of SDM are to: 1) reduce harm to children, and 2) expedite permanency for children in out-of-home care. It accomplishes these goals through five key objectives:

- Identifies and structures critical decisions in the life of a case. SDM helps workers gather, document and evaluate the right information to make informed decisions.
- Increases consistency and reliability in decision making.
- Increases accuracy and reliability of critical decisions.
- Targets resources to families most at risk. SDM recommends families be treated differentially based on risk level and need.
- Uses case level data gathered by social workers about our families to guide decision making at all levels of the agency. It aggregates data to enable management to make appropriate decisions about resource development and allocation, staffing and workload management.

One of the SDM tools that was implemented in Connecticut is the Family Strength and Needs Assessment (FSNA). The FSNA is used to evaluate the presenting strengths and needs of the primary and, if applicable, secondary caregiver in the household of each parent assessed in preparation for the development of a treatment plan. The tool is used to systematically identify critical family needs, and it helps plan effective service interventions. The strengths and needs assessment serves several purposes:

- It ensures that all social workers consistently consider each family's strengths and needs in an objective format when assessing need for services.
- It provides an important treatment planning reference for workers and supervisors.
- The initial strengths and needs assessment, when followed by periodic reassessments, permits social workers, their supervisors, and families to easily assess changes in family functioning and thus assess the impact of services on the treatment/permanency plan.
- Needs assessment data are aggregated and provide DCF managers with information on the problems families are facing. These aggregate data can then be used to help inform program development to meet family needs.

The FSNA is administered prior to the development of the treatment plan, within 45 days of the investigation disposition or the date of removal. The FSNA is also administered when a social worker is considering reunifying a child.

Another way in which the Department is assessing family needs is through the administration of the Global Appraisal of Individual Needs Short Screen (GAIN-SS). The GAIN-SS is designed for use in "general populations" and assesses 20 symptoms/items across 4 domains:

1. Externalizing
2. Internalizing
3. Substance Abuse
4. Crime/Violence.

The GAIN-SS is a particularly valuable assessment instrument because parental substance abuse is one of the major issues facing families involved with the Department of Children and Families. This issue has been identified through several DCF needs assessments and was a theme in many of the 47 cases reviewed in the Connecticut Comprehensive Outcomes Review (CCOR). In response to this pervasive need, DCF has expanded parental substance abuse programs and developed several pilot programs to test promising practices in this area.

For example, Family Based Recovery (FBR) is a treatment model that provides intensive in-home services to DCF-involved families with infants (0-2) where parental substance abuse is contributing to increased risk for abuse/neglect. The program focuses on early screening, assessment and intervention with the child, work with the parent and child dyad regarding attachment and language development and in-home treatment of parental substance abuse. The program blends the highly recognized Coordinated Intervention for Women and Infants (CIWI) program that originated at the Yale Child Study Center with an evidence-based treatment for parental substance abuse – Reinforcement Based Therapy (RBT) out of John's Hopkins University.

There are six family-based Recovery Programs operating throughout the state including New Britain, Waterbury, New Haven (2 sites), Bridgeport, and Norwich. Each program has the capacity to serve approximately 12 families per year. Typical involvement with the program is for one year or longer before a transition to other community services.

Another issue that is present in many of the families that come of the attention of the Department of Children and Families is domestic violence. Starting in July 2006, the Department established a statewide, full time network of expert consultants to address the prevalence of domestic violence. This initiative consists of 13 domestic violence consultants (DVCs) embedded within each Area Office throughout the state and overseen by the Statewide Service Administrator (SSA). The SSA is responsible for providing the consultants with a best practice model, overseeing the statewide effectiveness of the initiative and developing a data collection system to evaluate the initiative. The SSA also consults with Area Office and Central Office managers on policy and practice issues.

With the social work staff as their client, the consultants' mission is to help the Department better identify if domestic violence is a factor in a case and enhance the Department's response to safety and risk factors when domestic violence is identified. The SSA guides the consultants in connecting their domestic violence expertise to the child welfare mission and social work practice.

The Safe and Together consultation model, developed specifically for domestic violence cases involving children, is used by the consultants to address the entire family. The consultants help the social work staff identify the impact of the domestic violence on children and develop plans that a) intervene with the domestic violence perpetrator, b) create the most effective partnership possible with the protective parent, c) meet the needs of the children in the home and d) are sensitive to the role of mental health issues, substance abuse and culture. Whenever possible, the consultants work to support the maintenance of the children safe and together with the domestic violence survivor.

The model centers on five critical building blocks to improve case practice and decision making in domestic violence cases. With the goal of safety, permanency and well-being of children at its core, the model is guided by the following concepts: 1) batterers' behavior needs to be clearly identified and documented in order to make good decisions regarding risk and safety, 2) safe and together with the non-offending parent is ideal from the perspective of children exposed to batterers' behavior, and 3) that children have the potential for the best outcomes when the Department can actively partner with non-offending parents.

In addition to substance abuse and domestic violence services, DCF recognizes the need to provide non-traditional community-based supports to families. In 2007, the Department began the process of credentialing these services to ensure families are provided with the highest quality programs and that the Department is consistently providing quality interventions. The kinds of services that are now being credentialed include mentoring, therapeutic staff supports and other in-home supportive programs.

In addition to the credentialing of these services, the Department also maintains a significant array of services available to Area Office social work staff in their work of meeting families' needs. DCF intends to build on this existing array of services by implementing a Differential Response System (DRS). The DRS will focus on providing services to lower-risk cases that come to the attention of the Department with the goal of preventing further penetration into the child welfare system.

In another effort to help support families, the Connecticut Behavioral Health Partnership (CT BHP) has implemented a Peer/Family Specialist unit whose focus is to work side-by-side with departments within CT BHP, especially Intensive Case Management (ICM), to ensure recovery orientation into the delivery system and to work with consumers and family members to strengthen family's capacity to help their children with behavioral health needs. A Peer Specialist is an individual who understands mental illness and/or substance abuse and behavioral health services in the community as a result of personal experience. A Family Peer Specialist is an individual who is a family member of a child or adult who has received mental health and/or substance abuse service treatment. The role of either the Peer Specialists or the Family Peer Specialist is to provide education and outreach to members and families, and to assist in navigation of the service system.

The Department has also continued to focus on assessing and meeting the needs of foster parents. Support services include training, support services and programs designed to help foster parents in their role of caring for children in the child welfare system:

- Foster and Adoptive Support Team (FAST): These programs, designed to assist in the retention of foster parents, provide assessment, behavioral management, support, respite and other therapeutic services to foster and adoptive children, their caretakers and/or parents in order to stabilize a child's living situation and avoid disruption. Services are provided in-home, at the provider agency and in the community. Five (5) programs serve all DCF Area Offices.

- Foster Care Clinics: This program provides clinical services for children placed in DCF care for the first time. Their purpose is to provide a comprehensive multidisciplinary evaluation including comprehensive mental health, medical and dental evaluations. All 14 DCF Area Offices are served through this program.

- The Connecticut Association of Foster and Adoptive Parents, Inc.: This non-profit organization is funded by the Department and offers a wide range of support services throughout the state to foster and adoptive parents including Kid Hero centralized inquiry line, newsletter, conferences, support and retention activities, and post licensing training. Many activities are open to any foster or adoptive parent. Legal services are available to foster parents interested in pursuing

open adoption. CAFAP liaisons are out-posted to the DCF Area Offices allowing for a more effective partnership between CAFAP staff and DCF foster care staff in serving foster and adoptive parents. CAFAP also provides assessment, study, and training for those interested in becoming approved respite providers for DCF foster parents.

Item 18: Child and family involvement in case planning. How effective is the agency in involving parents and children in the case planning process?

Policy Description

Per DCF policy, "every effort will be made to make this [treatment planning] process and the development of the plan inclusive. Children, parents and all appropriate service providers will be given the opportunity to participate." The Juan F. Exit Plan sets performance targets for the development of treatment plans and further specifies that the development of treatment plans is intended to be an inclusive process. The Exit Plan standard is that in at least 90% of the cases, except probate, interstate, and subsidy only cases, clinically appropriate individualized family and child specific treatment plans shall be developed in conjunction with parents, children, providers and others involved with the case. In addition, the plan must be approved by a DCF supervisor within 60 days of case opening in a treatment unit, or a child's placement out-of-home, whichever comes sooner, and for every six (6) month period thereafter.

The individualized family and child specific treatment plans are the written working agreement between the child, family, caretakers if any, service provider(s) and DCF. The agreement describes and documents the child and/or family's service needs as well as what DCF, the family, and/or the child is required to do to achieve the goals of the plan.

Additionally, DCF policy calls for an Adolescent Planning Conference (APC) to be held with all DCF youth fourteen (14) years of age or older who are placed in out of home care including those receiving Voluntary Services. This conference is expected to be held yearly until the youth's eighteenth (18th) birthday. The APC is held separately from, and prior to, the Administrative Case Review (ACR) scheduled before the youth's fourteenth (14th) birthday.

The conference is held prior to any assignment of a goal of another permanent planned living arrangement (APPLA) as it relates to youth 16 or older who are participating in an independent living program and who refuse a family setting living arrangement.

The purpose of the conference is to determine the permanency goal for the youth, and to discuss services to be provided by the Department and others to meet that goal.

In order to facilitate family and child involvement in treatment planning, social workers are instructed to ensure treatment plans are written in the primary language of the family and/or child. Furthermore, every effort is made to ensure treatment planning conferences are conducted in the primary language of the family and/or child through the expanded use of interpretative services.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 18 was assigned an overall rating of Area Needing Improvement because in 38 percent of the applicable cases, reviewers determined that DCF had not appropriately involved parents or children in the case planning process. This finding and the stakeholder comments suggested that there was an inconsistency in DCF regarding workers' compliance with the policy requirements pertaining to parent involvement in case planning.

Measures of Effectiveness

Adolescent Planning Conferences (APCs) are held annually for all youth aged 14 and older who are placed in DCF care. DCF currently does not have a statewide system for tracking the implementation of APCs. However, 8 of 14 DCF Area Offices maintain their own logs to ensure these conferences are happening as outlined in policy and that adolescents are attending the conferences. Data provided from these 8 Area Offices shows that 979 APCs were held in state fiscal year 2008, with the adolescent in attendance 28% of the time. Because these data are being collected in separate systems across the 8 Area Offices, it is unclear what percentage of the adolescent population is represented in these 979 APCs. There are no comparative data available from previous years as the data collection system is not uniform across the DCF Area Offices.

In the recent Connecticut Comprehensive Outcomes Review (CCOR) of four DCF Area Offices using the CFSR methodology and On-Site Review Instrument (OSRI), reviewers rated 26 of 47 cases as a Strength for OSRI Item 18, "Child & Family Involvement in Case Planning." In the cases rated Area Needing Improvement, engagement of fathers was seen to be an area of weakness. Fathers' participation in treatment planning, family conferences and administrative case reviews were noted to be significantly lower than mothers' participation.

Factors Affecting Performance

The Department has invested significant resources in ensuring families and children are actively involved in case planning. Training in effective treatment planning, revisions to the Administrative Case Review Process, the advent of Adolescent Planning Conferences and the expansion of translation services can all be credited with improved performance in this area.

The DCF Training Academy provides a number of required pre-service courses that serve as the foundation for effectively engaging families in treatment planning. A required two-day training entitled "Casework process and Case Planning in Child Protective Services" prepares DCF social work trainees with the knowledge and skills necessary to write effective treatment plans. Participants learn important social work skills critical to the success of the treatment plan. These include the basic concepts of concurrent planning and strength-based interventions and how they relate to the treatment plan. It is at this training that the concept of family engagement in treatment planning is first addressed with new social work trainees. An additional two-day training, "Overview of Permanency Planning" also reinforces the importance of the planning process and the values associated with engaging clients in the development of their own treatment plans.

Beyond training to ensure social workers are engaging parents in treatment planning, the Department has also done a lot of work toward encouraging parental participation in the Administrative Case Review (ACR) process. In 2004, DCF implemented an audio conferencing service to allow greater participation in ACRs. ACR staff report the addition of audio conferencing as an option has increased parental involvement in the process. In 2004, the ACR staff also implemented a reminder telephone call system to ensure all invited participants had notice of upcoming ACRs.

In 2005, the ACR process was amended to reflect a new directive that when a parent is not invited, it is not considered an administrative review. When this happens, ACR reviewers are instructed to reschedule the review at a time when the parent is available. That year, training materials were developed for use during the pre-service training of new social workers.

Additional changes in the ACR process since the 2002 CFSR have included the development of a process, called the FYI, to notify Child Welfare Services staff of areas of strength and areas needing improvement

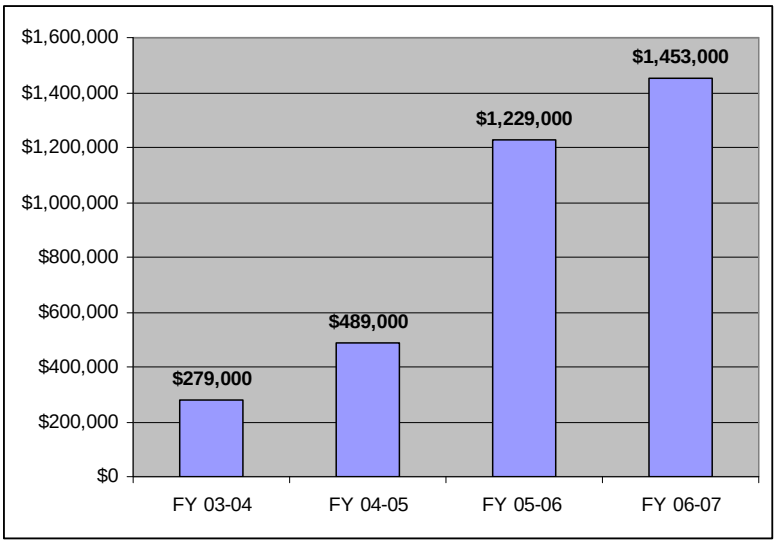
noted in the cases reviewed by ACR staff. Additionally, DCF has also focused on clarifying the role of the ACR supervisors as 3rd party objective independent reviewers, focusing on the case review determinations and on improving other aspects of the review process.

An ongoing challenge for DCF is how to engage youth in a meaningful way in their treatment planning. The Adolescent Planning Conferences (APCs) are viewed as a positive change in DCF policy intended to increase youth involvement, although the implementation of the APCs is not consistent throughout the state. Policy directing social workers to ensure APCs are happening for adolescents in our care was first published in 2006, making this a relatively new practice at the Department. In the last fiscal year, youth attended their APC approximately 28% of the time.

This is consistent with feedback received directly from youth through the Department's youth advisory boards and during a recent focus group conducted with adolescents in DCF care. Many youth report not having a meaningful role in treatment planning or not understanding the process fully. While some youth do report attending ACRs and APCs, the practice is not consistent across the state.

While the Department has made strides in increasing youth and parent involvement in treatment planning, we are still challenged with identifying and involving absent parents. Since June 2005, DCF has been utilizing LocatePlus to conduct relative resource searches and find the whereabouts of absent parents for the purposes of engaging them in treatment planning and services. LocatePlus facilitates searches of databases of public records and business information. This information is used to locate individuals, to verify identities, and also useful in performing background checks.

Beyond efforts to increase attendance at the various treatment plan meetings, the Department has also focused on ensuring translation services are available so all parents can understand the process and associated documents. These services include oral translation services, sign language interpreters and written translations of documents (treatment plans, case related and legal documents, etc.). Additionally, Braille and some oral readings of treatment plans onto cassettes or compact disc are provided for people who are unable to read. The Department's investment in these services has grown considerable over time, from $279,000 in fiscal year 03-04 to $1,453,000 in fiscal year 06-07:



Translation Services Expenditures, FY 03-04 to 06-07

Item 19: Caseworker visits with child. How effective are agency workers in conducting face-to-face visits as often as needed with children in foster care and those who receive services in their own homes?

Policy Description

The Department of Children and Families has placed a major emphasis on improving social worker visits with children in foster care and those receiving services in their own homes. Per DCF Policy 36-15-1.1**,** social workers are responsible for ongoing contact with children in foster care as follows:

Treatment (0-30 days)	Treatment (31st day through 1st ACR)	After ACR Minimum Contact
In-person contact shall occur within two (2) working days of placement. In-person contact shall occur at least one (1) time each week thereafter.	In-person contact one (1) time every other week with telephone contact on every alternating week.	In-person contact one (1) time a month. Telephone contact two (2) times a month.
Contact with residential, SAFE Home, and group home caretakers shall occur at the placement setting.		

When the child lives in his/her biological parents' home, the social worker is required to visit the child as follows:

Treatment (0-30 days)	Treatment (31st day through 1st ACR)	After ACR Minimum Contact
In-person contact one (1) time each week	In-person contact one (1) time every other week with telephone contact on every alternating week	In-person contact two (2) times a month

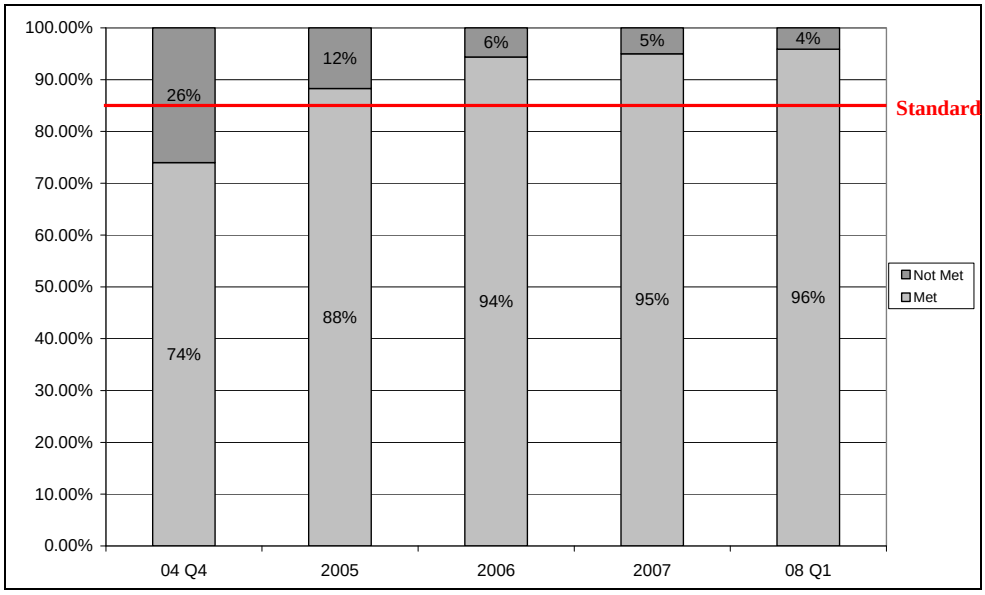
The Juan F. Exit Plan sets standards for outcome measures that must be met in the area of social worker visits with children. The standard for Outcome Measure 16, Worker-Child Visitation (Out-of-Home), is that DCF shall visit at least 85% of all out-of-home children at least once a month, except for probate, interstate or voluntary cases. All children must be seen by their DCF social worker at least quarterly. The standard for Outcome Measure 17, Worker-Child Visitation (In-Home), is that DCF shall visit at least 85% of all in-home family cases at least twice a month, except for probate, interstate or voluntary cases.

Summary of Performance in Round One of the CFSR

In the 2002 CFSR, Item 19 was assigned an overall rating of Strength because in 87 percent of the cases, reviewers determined that the frequency of caseworker visits with children was sufficient to ensure adequate monitoring of the child's safety and well-being. Stakeholders commenting on this issue generally expressed concern that DCF's visitation policy appeared to focus more on compliance with frequency of visits rather than on the quality of the visits.

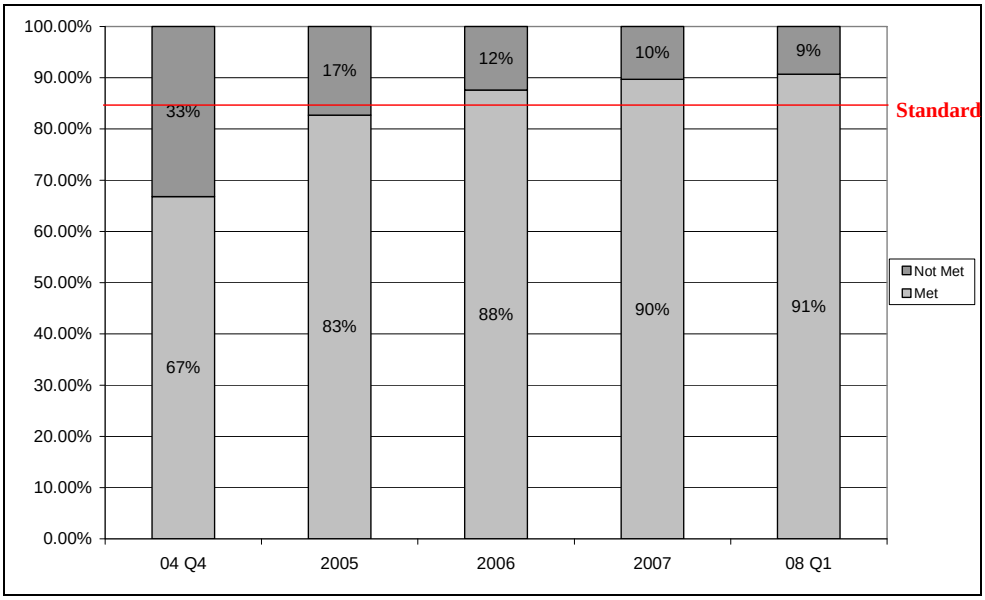
Measures of Effectiveness

A major focus of the Juan F. Exit Plan has been to improve the frequency and quality of social worker visits with children. In the fourth quarter of 2004, shortly after the inception of the Exit Plan, worker-child visitation for children placed out of the home was happening within the required timeframes 74% of the time. This was well below the standard of 85% monthly visitation for children placement. By 2005, however, the Department was consistently meeting this benchmark and has continued to perform above the minimum standard for visitation outlined in the Exit Plan:



Outcome Measure 16: Worker-Child Visitation (Out-of-Home)

In-home visitation has followed a pattern similar to that of our-of-home visitation, with the Department now consistently exceeding the Exit Plan visitation standard:



Outcome Measure 17: Worker-Child Visitation (In-Home)

While the Department is now consistently meeting the visitation standard set forth in policy and in the Juan F. Exit Plan, some areas needing improvement are still present in our performance relative to visitation of children. In the recent Connecticut Comprehensive Outcomes Review (CCOR) of four DCF Area Offices using the CFSR methodology and On-Site Review Instrument (OSRI), reviewers rated 36 of 47 cases as a Strength for OSRI Item 19, social worker visits with the child. In the 11 cases rated as an Area Needing Improvement, the predominant issue reviewers found was that while the frequency of visitation was meeting expected standards, the quality of visitation was insufficient to meet children's needs.

Factors Affecting Performance

The Juan F. Exit Plan focus on measuring the frequency of visitation has had an overall positive impact on reinforcing visits with children as a cornerstone of effective case practice. As noted in the *Measures of Effectiveness* above, the Department is consistently meeting the Juan F. visitation standards. In addition to the focus on this as an important part of case practice, the Juan F. caseload standard has also had a positive impact on social workers' ability to visit the children on their caseload in a consistent manner.

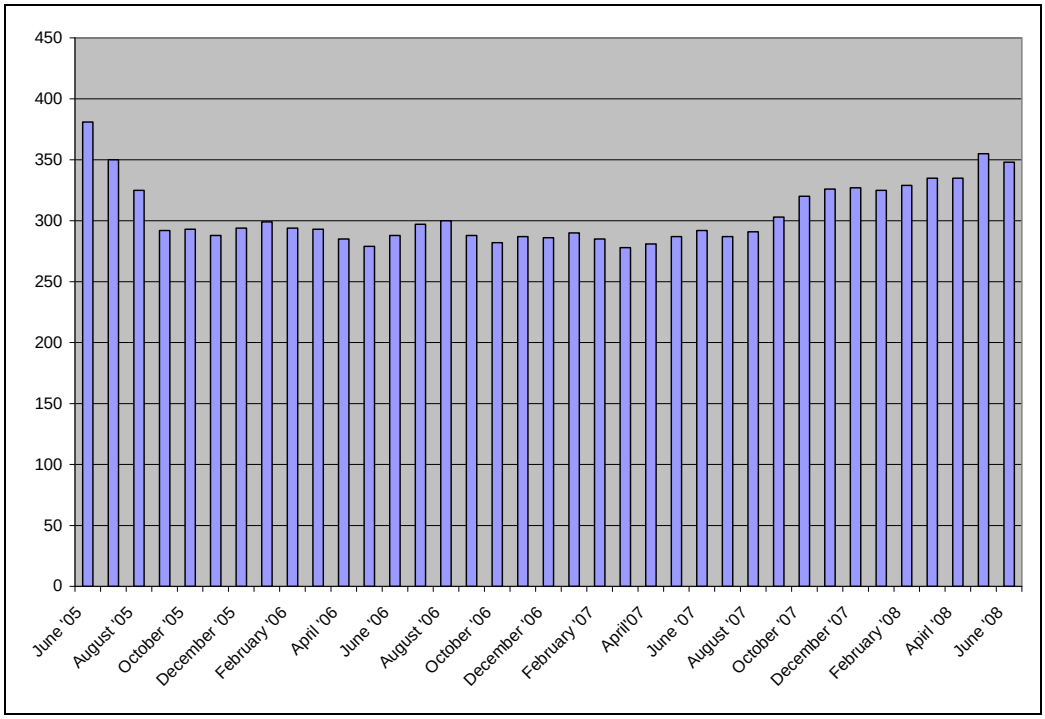
The Juan F. Exit Plan requires that no DCF social worker exceed the following caseload standards, with exceptions for emergency reasons on caseloads, for more than 30 days:

A. Investigators shall have no more than 17 investigative cases at any time.
B. In-Home treatment workers shall have no more than 15 cases at any time.
C. Out-of-Home treatment workers shall have no more than 20 individual children assigned to them at any time. This includes voluntary placements.
D. Adoption and adolescent specialty workers shall have no more than 20 cases at any time.
E. Probate workers shall have no more than 35 cases at any time. When the probate or interstate worker is also assigned to provide services to the family, those families shall be counted as in home treatment cases with a ratio of 1:20 cases.
F. Social workers with in-home voluntary and interstate compact cases shall have no more than 49 cases at any time.
G. A worker with a mixed caseload shall not exceed the maximum weighted caseload derived from the caseload standards in A through F above.

The Department has maintained 100% compliance with the caseload standards Exit Plan Outcome Measure for 10 consecutive quarters and for 15 of the last 17 quarters. Social workers' caseloads, which are significantly lower than at the time of the 2002 CFSR, contribute to workers ability to visit children consistently because they are able to devote more time to each individual case.

A challenge for the Department in the area of visitation of children is maintaining the visitation standard with children who are placed in facilities outside of Connecticut. Because residential reduction has been a focus of the Juan F. Exit Plan, no more than 11% of the children in care at any time may be placed in private residential settings. However, DCF does continue to use an increasing number of out-of-state specialized programs when it is in the child's best interest and no adequate placement exists in-state.

The Department's Program Review and Evaluation Unit (PREU) maintains a monthly census of all children placed in out-of-state facilities. Over the past three years, the out-of-state residential census has ranged from a high of 381 in June 2005 to a low of 278 in March 2007. Recently, the number of children placed out of state and the number of placement settings in which they are placed have both increased. This presents a challenge for our out-of-state visitation unit, as they are required to maintain the monthly and quarterly visits with children in more settings in more states with no additional staff.



Monthly Out-of-State Residential Census

Item 20: Worker visits with parents. How effective are agency workers in conducting face-to-face visits as often as needed with parents of children in foster care and parents of children receiving in-home services?

Policy Description

DCF Policy 36-15-1.1 outlines responsibilities of social workers for maintaining contact with case participants, including the biological parents of children in foster care and children receiving in-home services. This policy states that the social worker is required to contact the caretaker and/or biological parent as follows:

Treatment (0-30 days)	Treatment (31st day through 1st ACR)	After ACR Minimum Contact
In-person contact shall occur within two (2) working days of placement. In-person contact shall occur at least one (1) time each week thereafter.	In-person contact one (1) time every other week with telephone contact on every alternating week.	In-person contact one (1) time a month. Telephone contact one (1) time a month.

For in-home cases, it is expected that the social worker conduct visitation with the parent(s) at the same frequency as is outlined in policy for visiting children receiving services in the home. Expected visitation frequency for parents receiving in-home services is:

Treatment (0-30 days)	Treatment (31st day through 1st ACR)	After ACR Minimum Contact
In-person contact one (1) time each week	In-person contact one (1) time every other week with telephone contact on every alternating week	In-person contact two (2) times a month

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 20 was assigned an overall rating of Area Needing Improvement because in 22 percent of the cases, reviewers determined that visits with parents were not sufficiently frequent or of sufficient quality to promote the safety and well-being of the child or increase movement toward permanency for the child. Although many workers visited parents on a fairly frequent basis, this practice was not consistent across cases, particularly with respect to fathers. The lack of contact with fathers was a concern voiced by both reviewers and stakeholders.

Measures of Effectiveness

Unlike social worker/child visitation, the Department currently does not have a standard outcome measure or existing management report to track overall visitation with parents. While visitation with parents is expected as a key component of social work practice at DCF, the lack of a standard outcome measure in this area makes it a challenge to ascertain overall system performance in this area. However, recent case reviews conducted in the DCF Area Offices point to visitation with parents as a potential area needing improvement.

In the Connecticut Comprehensive Outcomes Review (CCOR) of four DCF Area Offices using the CFSR methodology and On-Site Review Instrument (OSRI), reviewers rated 26 of 47 cases as an Area Needing Improvement for OSRI Item 20, social worker visits with parents. There were two predominant issues reviewers found for rating these cases as areas needing improvement. Visitation and engagement of fathers was observed to be significantly less than that of mothers. Secondly, in some of the cases where visitation frequency with parents met expected standards, the quality of the visits was not judged to be sufficient to meet the parents' and children's needs.

Factors Affecting Performance

As with other child welfare systems nationwide, the majority of cases opened at DCF in any given year are opened in the name of the mother. In a review of LINK data on open cases in fiscal year 2007, less than 2% of all cases were opened in the name of the father. Because of the traditional focus on the mother in the case and because of the large number of absent fathers in the cases served by the Department, visitation with fathers continues to be a challenge for our system.

The DCF Training Academy offers a two-day course designed to provide DCF staff with the skills needed to assess fathers and engage fathers in the development of the case plan. In this training, participants utilize different communication techniques required in working with fathers. Participants also learn about the different roles fathers have and the potential impact these roles have on service delivery.

In order to improve in this area moving forward, the Department will need to develop ongoing measures of worker-parent visitation and incorporate said measures into our continuous quality improvement.

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

Item 21: Educational needs of the child. How effective is the agency in addressing the educational needs of children in foster care and those receiving services in their own homes?

Policy Description

The Department of Children and Families is responsible for addressing the educational needs of children in foster care as well as many children who are receiving services in their own home. Educational needs of children are addressed by the Department's Unified School District II and by educational consultants in our 14 Area Offices.

Unified School District II (USD II) operates under the mandates of CONN. GEN. STAT. §17a-37, which requires the Commissioner of the Department of Children and Families (DCF) to establish and maintain a school district within the agency. This District, in operation since 1977, serves children whose needs require that their educational program be provided within one of the DCF institutions or facilities in which they reside or receive day treatment services.

Under the supervision of the Superintendent of Schools, the Unified School District II consists of four (4) schools which are located within the following Department of Children and Families institutions and facilities:

- High Meadows - Hamden, CT
- Connecticut Juvenile Training School - Middletown, CT
- Riverview Hospital for Children - Middletown, CT
- Connecticut Children's Place - East Windsor, CT

In addition, the School District's No-nexus Unit serves children who have been placed by DCF in a private residential facility or in the residential component of a regional education service center and attend the facility school and when one of the following conditions exists:

- parental rights have been terminated and the Commissioner of the Department of Children and Families has been appointed the statutory parent (including children turning eighteen (18) years old subsequent to termination of parental rights); or
- the whereabouts of the parent(s) or guardian(s) is unknown; or
- the parent(s) or guardian(s) is residing (as patient or inmate) in a state correction or mental health facility and does not maintain a Connecticut residence; or
- the parent(s) or guardian(s) does not reside in Connecticut and the child is committed to the care and custody of the Commissioner of the Department of Children and Families; or
- the parent(s) or guardian(s) does not reside in Connecticut and the Department of Children and Families has certified that procedures to commit the child to the care and custody of the Commissioner of the Department of Children and Families has been initiated for that child and will be finalized within three months of the date of initiation.

Outside of USD II, the educational needs of children receiving services in their homes or children in foster care attending local schools are addressed through the work of our Educational Consultants. Per DCF Policy 38-16-3, Educational Consultants are professionals who are experienced in assessing

children's educational needs and progress, including the child's eligibility for special educational services. Duties assigned to Educational Consultants may include:

- general consultation with staff in person or by telephone regarding educational matters;
- advising staff regarding whether a child's difficulties may be education related such that the local education agency has responsibility for particular costs and then advocating at Pupil Placement Team (PPT) meetings to secure appropriate services for children in such circumstances;
- review of client educational records to evaluate the appropriateness of the present education program, assess progress and make recommendations for educational programming;
- provision of priority access for educational testing and evaluation services when requested by the ARG;
- observation of the child and consultation with foster parents and other involved professionals in the school which the child attends, or in the home or facility where he or she resides, when this is appropriate;
- participation in special education planning when children are referred for PPT's and interaction with a social worker and/or surrogate parent when requested by the ARG supervisor or case supervisor;
- participation in statewide or regional meetings when requested to consult on education-related policy, procedures or program development facilitating a liaison between DCF and the school/regional educational community and then in a complex case (at the request of the ARG or the case supervisor) providing direct liaison with the school on behalf of the child;
- establish a liaison with the education community to improve coordination and access to facilitate resolution of difficulties, and provide in-service training to staff (including ARG), foster and/or adoptive parents when requested by DCF.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 21 was assigned an overall rating of Strength because for 90 percent of the cases, reviewers determined that DCF had effectively and appropriately addressed children's educational needs. This finding was consistent with information in the Statewide Assessment regarding DCF's emphasis on the importance of addressing children's educational needs. The Statewide Assessment also noted that during the period under review in Round One, each region had an Educational Consultant to assist caseworkers with educational planning and services for the children in their caseloads.

Measures of Effectiveness

In the recent Connecticut Comprehensive Outcomes Review (CCOR) of four DCF Area Offices using the CFSR methodology and On-Site Review Instrument (OSRI), reviewers rated 24 of 47 cases as a Strength for OSRI Item 21, "Educational Needs of the Child." Of the remaining cases, 9 were rated as an Area Needing Improvement and 14 were rated as Not Applicable. Overall, CCOR reviewers found evidence in the cases of appropriate educational assessments, education records present in the DCF case record and of effective partnerships with most Connecticut school districts.

Factors Affecting Performance

DCF has continued to build on the strengths noted in this area during the 2002 CFSR by adding educational consultants to our Area Offices, increasing DCF staff participation in school meetings and continuing to expand services available in our Unified School District II.

The Department maintains a cadre of Education Consultants in the Area Offices. The consultants work under the supervision of USDII and provide the DCF Area Offices with expert advice on education issues. Their duties include participating in PPT meetings, helping plan students' educational programs and ensuring comprehensive educational assessments are given to children on the DCF caseload. In recent focus groups, Area Office social workers indicated that the educational consultants are a valued resource for helping meet children's educational needs.

In order to continue to improve educational services for children on DCF's caseload, a significant emphasis has been placed in collaboration between DCF social workers and school local personnel. If a child in DCF is eligible for special education services, school staff are invited to participate in the child's Administrative Case Review to ensure coordination of services. Also, DCF social workers routinely attend Planning and Placement Team (PPT) meetings at local schools.

Because Connecticut's schools are largely municipally-run with no county government or strong statewide oversight, each DCF Area Office must maintain individual relationships with a number of local Boards of Education. In the 9 cases rated as an ANI in the recent CCOR, challenges in maintaining effective partnerships with the local school districts were noted by reviewers. For example, there were some cases where DCF social workers were not informed of school meetings or where the local school district did not provide the Department with timely information regarding children's educational assessments or services. The Department must continue to improve its partnerships with local school districts in order to effectively meet the needs of children, especially those receiving services in their own homes.

Educational services for children in DCF's four facilities are provided by Unified School District II. USD II is committed to preparing and developing children to function in a variety of life roles, which include those of individual, citizen, producer, consumer, learner, and family member. Many of these children have demonstrated inadequate functioning in one or more of these roles and may have experienced educational difficulties as well. As a group, they exhibit diverse functioning levels and learning styles.

In order to accommodate the varied and often dissimilar needs of this population, an educational program is designed to accommodate the uniqueness of each student. A functional focus to skill acquisition enables the student to apply these skills to a variety of life roles. By modifying the traditional academic setting, the School District provides an opportunity for its students to encompass cognitive, affective and psychomotor development; maximize potential; foster creative growth; and fulfill personal aspirations.

The purpose of education is to prepare the learner to function and grow in a world of expanding technology, where roles, values, social norms and expectations constantly change. Through an integrated approach to the educational experience, USD II focuses on helping students attain:

- an awareness of and an ability to evaluate and adapt to society's norms and values;
- a mastery of basic skills necessary for successful life functioning;
- the ability to apply the interpersonal skills needed to communicate, make decisions and solve problems;
- the realization of creative potential; and
- optimal development of physical well-being.

In addition to educational services provided to children in foster care and receiving services in their home, the Department has recently expanded the scope of services it provided to children who choose to stay in DCF care after their 18th birthday. Per DCF Policy 42-20-21, which was issued in 2007**,** the Department pays higher education expenses until a young adult’s twenty-third (23rd) birthday. However, a young

adult may complete the full school year if started prior to the twenty-third (23rd) birthday. Currently, nearly 500 DCF youth are enrolled in post-secondary education through this expanded program.

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

Item 22: Physical health of the child. How does the State ensure that the physical health and medical needs of children are identified in assessments and case planning activities and that those needs are addressed through services?

Policy Description

DCF policy describes several responsibilities that the Department has to ensure that the physical health and medical needs of children are appropriately assessed and addressed. Per policy 36-45-1, social workers are required to ensure that all children placed in out-of-home care have an appropriate plan to meet their physical and mental health care needs, and that the plan is carried out.

Prior to any non-emergency placement of a child, the available parents are interviewed to gather information and asked to sign a release of information form permitting DCF to seek all information that pertains to the child's health needs and treatments provided. The assigned worker also gathers genetic information at this point. In emergency situations, every effort is made to obtain releases of information and data required within one (1) week of the emergency placement.

The assigned worker is also responsible for completing health forms in the child's Placement Portfolio as fully as possible with available information. As new information is obtained; e.g., from physician contacts, medical records, interviews of parents and previous care providers, the worker updates the health content in the Placement Portfolio and share the information with the current provider.

Per DCF Policy 44-4-3, each child placed in an out-of-home setting receives an initial health screening examination within five (5) days of placement. The purpose of the screening is to identify immediate medical, emotional and developmental needs, including, but not necessarily limited to:

- communicable or infectious diseases;
- nutritional status;
- signs of recent physical or sexual abuse or neglect;
- indications of previous injuries or scars;
- obvious physical handicapping conditions or the need for special equipment.

The screening includes:

- a review of the child's medical history;
- a complete physical examination, specifically encompassing all skin surfaces and external genitalia;
- the child's diagnosis relative to "Well Child," or a list of any problems or illnesses;
- the proposed treatment, encompassing plans for further care, written prescriptions or immunizations given.

It is the responsibility of Department staff, foster parents and institutional staff to work together to assure that each child's health and medical needs are determined and that professional services are provided as necessary to promote and maintain good health and proper physical and mental development of the child.

At the time of the child's placement, the social worker is required to:

- provide the Medical Passport to the caretaker at the time of placement or as soon after placement as possible
- inform the foster parents or appropriate institutional staff member that:
    - it is their responsibility, unless there is need for other arrangements, to take the child to the doctor, dentist, or other provider of medical care
    - doctors, dentists, hospitals, pharmacists and other providers have the standards, fee schedules, instructions and billing forms issued by the Department of Social Services for medical services
    - the foster parent or institution may use its own physician or dentist provided the doctor conforms to the fee schedules established by the Department of Social Services
    - it is the responsibility of the foster parents or the institutional staff to inform the provider of service that: the child is covered by Title XIX; present the child's medical card (which contains the child's medical eligibility number); and to sign the bill for services rendered
    - the foster parent or institutional staff are not to pay for or accept any bill for the child's medical services as they will not be reimbursed
    - it is the responsibility of the foster parent or institutional staff to inform the worker of any concerns about the child's health or medical problems and the results of the medical services provided.
- give foster parents or appropriate institutional staff member, the date and findings of the child's last physical, dental or other examinations and plan with them for required follow-up on recommendations, shots, subsequent examinations, etc.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 22 was assigned an overall rating of Area Needing Improvement because in 16 percent of the applicable cases, reviewers determined that DCF was not adequately addressing the health needs of children in both foster care and in-home services cases. A key concern was that while services and policies are in place, DCF workers are not always consistent in following these policies.

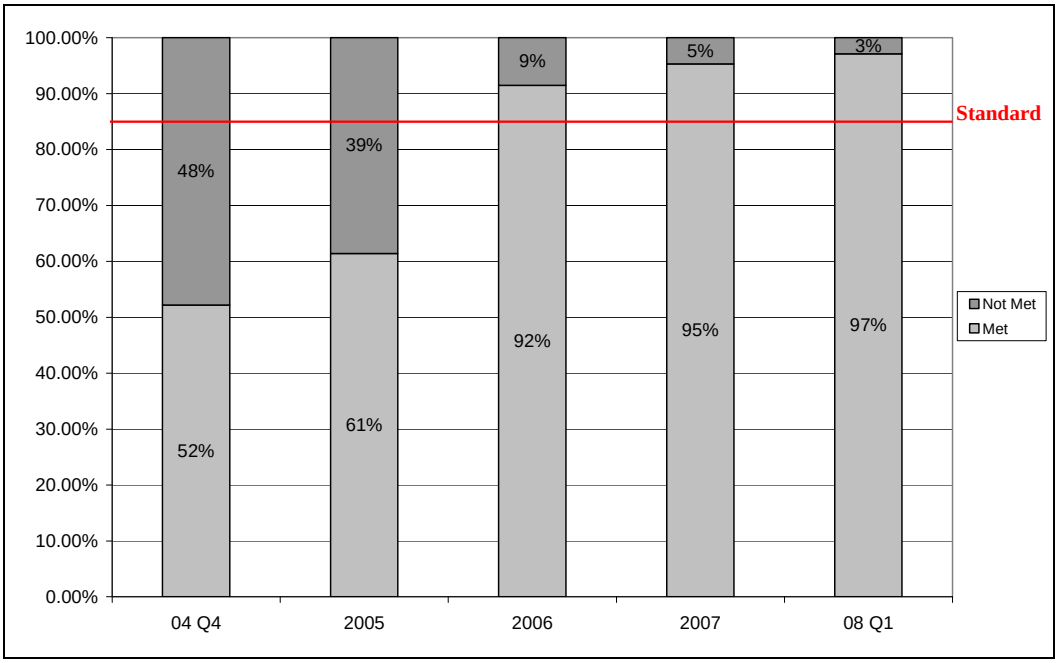
Measures of Effectiveness

As part of the Juan F. Exit Plan, the Department is required to conduct a Multi-Disciplinary Exam (MDE) within 30 days of a child entering the custody of DCF for the first time. The MDE includes:

- Comprehensive and age appropriate mental health assessment;
- Psychosocial and educational history;
- Comprehensive medical history and physical assessment;
- Dental assessment;
- Determination of all medical and mental health needs; and
- Set of recommendations for DCF.

The Exit Plan standard is that MDEs be conducted within 30 days for at least 85% of the children that enter care for the first time. The outcome data was first available for the fourth quarter of 2004. At that

time, the Department was only completing the MDE within specified timeframes 52% of the time. In 2005, the Department continued to struggle with this outcome measure, completing MDEs within specified timeframes only 61% of the time. Since 2006, however, the Department has consistently exceeded the 85% threshold, with data from the most recent complete quarter showing performance at a rate of 97%.



Outcome Measure 22: Completion of Multi-Disciplinary Exams

In the recent Connecticut Comprehensive Outcomes Review (CCOR) of four DCF Area Offices using the CFSR methodology and On-Site Review Instrument (OSRI), reviewers rated 34 of 47 cases as a Strength for OSRI Item 22, "Physical Health of the Child." Of the remaining cases, 5 were rated as an Area Needing Improvement and 8 were rated as Not Applicable. Reviewers noted that MDEs were consistently completed within required timeframes and that social workers were able to connect children with appropriate medical and dental services to meet their needs. In the CCOR stakeholder focus groups and in meetings with our CFSR Well-Being Work Group, however, service providers reported that MDE recommendations are not always followed-up on and that service gaps exist in the state, especially when it comes to dental care for children.

Factors Affecting Performance

In response to issues identified through the MDEs and through consultation with medical professionals across Connecticut, The Department of Children and Families has greatly expanded medical services and plans for the medical care of children in the care DCF. The Department currently has three (3) child and adolescent physicians and three (3) APRN staff who provide psychotropic medication approval, mental health consultation, and training and support to fourteen DCF Area Offices. The goals for these new staff include caring for the needs of medically complex children, implementing medical homes for DCF committed children and also creating a more efficient permission process for the approval of psychotropic medications.

A statewide group of public and private clinicians, physicians, nurses and pharmacists meet monthly to review guidelines, policies and practices regarding the use of all psychotropic medication in DCF-

involved children. This group also provides pharmacy utilization review for all DCF children involved in the state Medicaid plan. DCF has designed and developed a new Medical Profile that will capture all relevant medical information in an integrated database that will be implemented in 2009.

The Department Medical Director and the Director of Pediatrics provide statewide telephone and in-person consultation (including after hours rotation for support of the Child Abuse and Neglect Hotline) to medically and behaviorally complex children across the state and supervise the medical staff working for the Department throughout the state. There are currently nineteen (19) physicians working for the Department in the capacities of staff psychiatrists and pediatricians. Most of these physicians work in DCF facilities meeting the medical needs of children living in congregate care.

A quarterly review is performed for all children with complex medical needs by nurses and specialized medical units within Area Offices. These children's medical status is tracked and monitored within an integrated database. Nurses provide visitation and monitoring of children living with natural families, in hospitals, residential and foster homes.

The Medical Director and Director of Pediatrics have revised DCF medical policies to ensure that children in out-of-home care receive initial screenings, multi-disciplinary evaluations and ongoing well child care. The Medical Directors have met with all state stakeholders to identify opportunities to improve, enhance and standardize MDE practices, including the development of a quality assurance process. Plans include the development of continuity between the MDE process and primary care providers. Efforts are being made to obtain additional resources for care coordination in the development and implementation of Medical Homes.

The Director of Pediatrics provides monthly supervision and oversight for the clinical nurses throughout the state that are part of the Area Resource Groups. Monthly educational meetings have occurred for all ARG clinical staff and provide educational credits. A Central Office group of physicians and nurses meet quarterly to identify best practices in each Area Office and to develop protocols for statewide nursing practice, coverage and orientation.

Item 23: Mental/behavioral health of the child. How does the State ensure that the mental/behavioral health needs of children are identified in assessments and case planning activities and that those needs are addressed through services?

Policy Description

As part of the Juan F. Exit Plan, the Department is required to conduct a Multi-Disciplinary Exam (MDE) within 30 days of a child entering the custody of DCF for the first time. In addition to an assessment of physical health needs, the MDE includes a comprehensive and age-appropriate mental health assessment, Psychosocial and educational history and a determination of all mental health needs. Recommendations are provided to DCF for follow-up. The Exit Plan standard is that MDEs be conducted within 30 days for at least 85% of the children that enter care for the first time.

In order to facilitate follow-up with issues identified through the MDE process and through other assessments, DCF policy 38-16-2 requires the Department to maintain Mental Health Consultants in its Area Offices. Mental Health Consultants include psychiatrists, psychologists, and Master's level Social Workers who are licensed for independent practice in the State of Connecticut and/or who are board-certified. Duties assigned to Mental Health Consultants include:

- case-specific consultation with staff in person or by telephone regarding mental health matters
- participating, as scheduled, in meetings with social work staff to:
    - discuss selected cases;
    - recommend referrals and needed services;
    - assess the effectiveness of services provided; and,
    - where necessary, make recommendations for amendments to the mental health portions of a child's service plan.
- facilitating immediate access to mental health evaluation and treatment in emergency circumstances when referred by the ARG supervisor
- observation, consultation and/or treatment in-home, or in-facility when deemed appropriate by the Social Work Supervisor, ARG Supervisor, or practitioner
- when language is a barrier to effective delivery of service, cooperate with the translator during diagnostic or treatment interviews
- participation in service planning, placement planning assessment, or case review meetings when requested by ARG or case supervisor (pursuant to consultant's involvement with child)
- assistance in the development of the Assessment (pursuant to parental release when appropriate), including interviews with child/family, and review of DCF records to gather required information for the Assessment
- participation in statewide and regional meetings to develop mental health related policy, procedures or programs
- establish a liaison between DCF and mental health care providers in difficult or complex cases
- establish and facilitate with the professional mental health community to improve coordination and access to mental health resources in the region, and to facilitate resolution of misunderstandings or difficulties
- attend regular meetings with regional counterparts in association with Health Management Unit, and provide staff in-service and foster parent training regarding mental health related matters when requested by Area Directors and managers of the Training Academy

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 23 was assigned an overall rating of Area Needing Improvement because in 28 percent of the applicable cases, reviewers determined that DCF was not adequately addressing children's mental health assessment and service needs. Of particular concern was the fact that mental health needs were not met at all in 8 cases and were only partially met in 7 cases. While multi-disciplinary exams, including a behavioral health assessment, were required for all children entering care, the case review finding suggested that DCF may have been inconsistent in providing services suggested by the assessments.

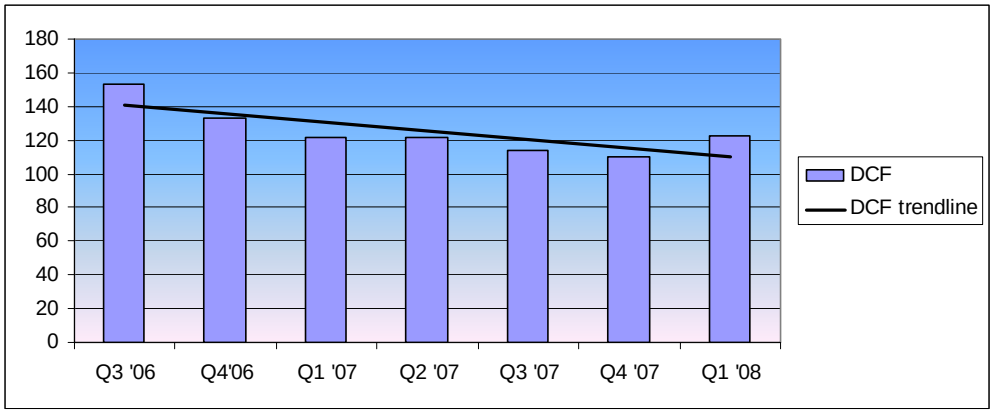
Measures of Effectiveness

The Exit Plan standard is that MDEs be conducted within 30 days for at least 85% of the children that enter care for the first time. The outcome data was first available for the fourth quarter of 2004. At that time, the Department was only completing the MDE within specified timeframes 52% of the time. In 2005, the Department continued to struggle with this outcome measure, completing MDEs within specified timeframes only 61% of the time. Since 2006, however, the Department has consistently exceeded the 85% threshold, with data from the most recent complete quarter showing performance at a rate of 97%.

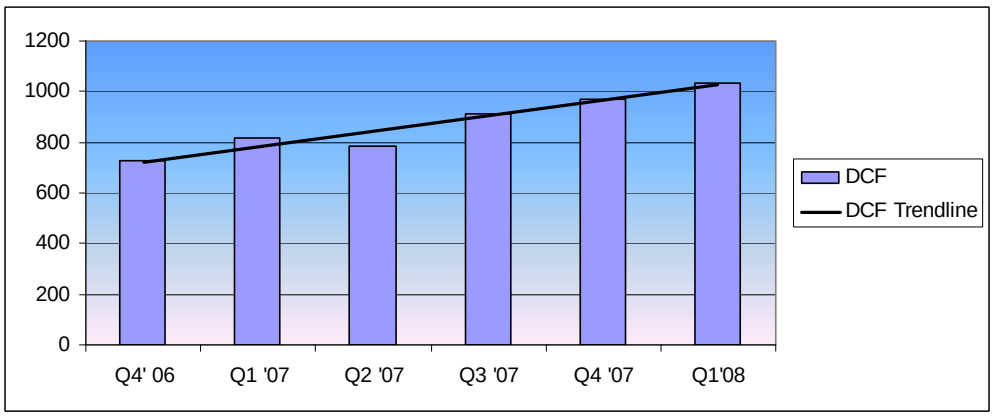
In the recent Connecticut Comprehensive Outcomes Review (CCOR) of four DCF Area Offices using the CFSR methodology and On-Site Review Instrument (OSRI), reviewers rated 29 of 47 cases as a Strength

for OSRI Item 22, "Mental/Behavioral Health of the Child." Of the remaining cases, 8 were rated as an Area Needing Improvement and 10 were rated as Not Applicable. Reviewers noted that quality mental health assessments were provided in most of the cases and that appropriate services were provided to meet children's needs. Reviewers also noted that social workers in the DCF Area Offices were making appropriate use of flexible funding dollars to supplement the existing service array available for children.

Since the creation of the Connecticut Behavioral Health Partnership, the Department has increased its capacity to track behavioral health services utilization data and to use data to make improvements in the service system. A goal of the Department and the BHP is to increase community-based behavioral health services and reduce the need for residential-level care. Data provided to DCF by the BHP suggests improvements to the service system in recent years have begun to have this desired effect, with an overall trend in the reduction of use of Psychiatric Residential Treatment Facilities (PRTFs) and an increase in the use of home-based services:



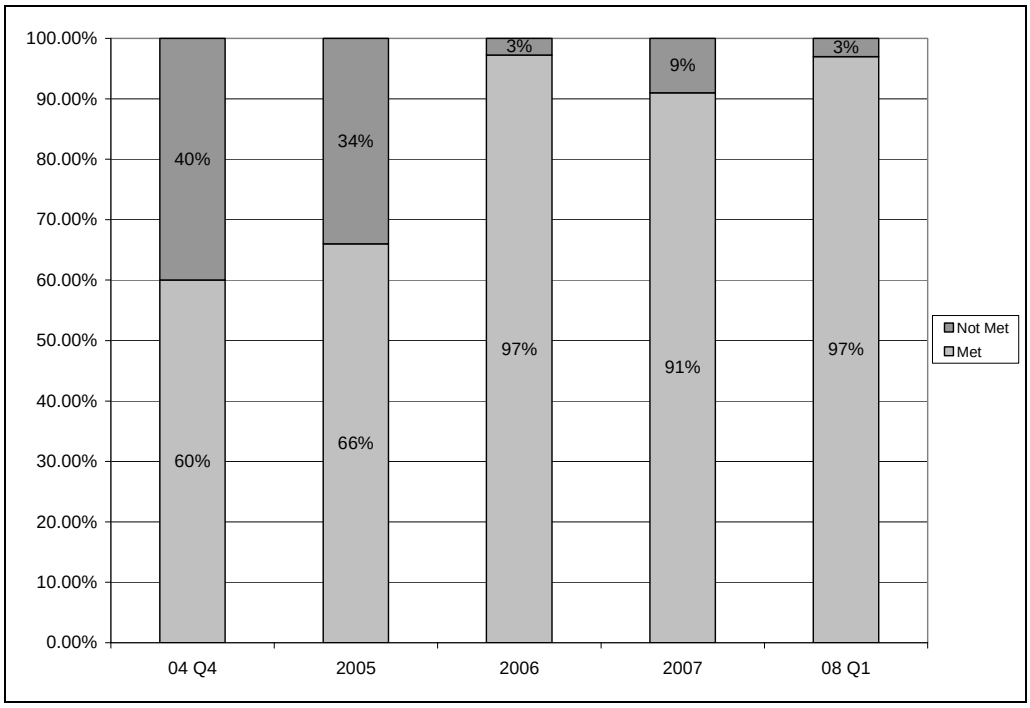
DCF PRTF Days/1000 (age 0-18)



DCF Home Based Services Days/1000 (age 0-18)

In addition to the overall trend toward more utilization of home-based services for children in DCF care or those receiving voluntary services from the Department, DCF has also improved its performance in transitioning children from our system to the adult services systems. Per the Juan F. Exit Plan, DCF is required to submit a written discharge plan to either/or DMHAS or DMR for all children who are mentally ill or mentally retarded and require adult services. While the Department has met the standard

of 100% in 1 of the 17 quarters since the inception of the Exit Plan, overall performance has increased greatly from 60% in the fourth quarter of 2004 to 97% in the first quarter of 2008.



Outcome Measure 21: Discharge of Mentally Ill and Mentally Retarded Children

Factors Affecting Performance

The most significant change in Connecticut's behavioral health system since the 2002 CFSR is the development of the Connecticut Behavioral Health Partnership (BHP). DCF and the Department of Social Services (DSS), Connecticut's Medicaid agent, in conjunction with a legislatively mandated Oversight Council, formed BHP with ValueOptions serving as the Administrative Service Organization (ASO). The Partnership was initiated January 1, 2006 and serves as a redesign of the behavioral health service delivery system for low-income parents and children. The program emphasizes families as partners in care planning, to enhance cultural competency within the service system, and to improve the quality and availability of community-based services and supports.

The Partnership is a reform initiative designed to help children and parents with serious behavioral challenges remain in their homes and communities, through the use of targeted, individualized clinical and support services. The ultimate goal under the initiative is to allow children and parents to function independently, to restore or maintain family integrity, improve family functioning, to achieve a better quality of life, and to avoid unnecessary hospital and institutional care.

The Partnership services include behavioral health services under Connecticut's Medicaid Program, including but not limited to outpatient treatment, extended day treatment, intensive outpatient, partial hospitalization, home health, detoxification, psychiatric residential treatment facility services, inpatient psychiatric hospitalization, emergency mobile psychiatric services, and intensive home-based behavioral health services.

In addition, the network of services available to covered youth and families include DCF-funded community services such as crisis stabilization beds, care coordination, behavioral health consultation and

therapeutic support staff services. Residential and therapeutic group home treatment services are also included within the Partnership's array of services.

The development of the BHP and continued program expansion within DCF has resulted in a more robust service array than was present in Connecticut at the time of the 2002 CFSR. In particular, the implementation of evidence-based trauma-informed practices across the state, the expansion of the therapeutic group home system and the addition of community-based support services are seen by DCF's stakeholders as factors leading to improved performance in this area.

In response to the level of trauma seen in the children we serve, ongoing training is being provided to social workers in the field to help them identify and appropriately assess trauma symptoms in both adult and children survivors of domestic violence and witnessing trauma, to discuss implications for case work practice, such as safety planning with the non-offending parent and children, and to assist with documentation and treatment planning with families that involve direct trauma, witness to trauma, and domestic violence. In addition to the enhanced training in this are, trauma-informed services have been added to the DCF service continuum. These include Dialectical behavioral therapy (DBT) and Cognitive Behavioral Therapy (CBT).

In the past three fiscal years, the Department has also expanded the available group home service array to better meet the unique needs of children in Connecticut. These include both short-term assessment homes and longer-term therapeutic group homes:

Short-Term Assessment and Respite (STAR) Homes - DCF redesigned the emergency shelter level of care. The new model of care, Short Term Assessment and Respite (STAR) Homes offers children and youth many advantages over the previous system. There are now 10 shelters that provide smaller, home-like settings. Each shelter has a six-bed maximum capacity and is located in geographic proximity to where the children live and/or the DCF Area Office that supports them. An array of on-site clinical services are provided, which are gender-specific and trauma- informed.

Preparing Adolescents For Self-Sufficiency (PASS) Group Homes - DCF converted the former Level 1.5 Group Homes to a newly designed model of care, known as PASS Group Homes. These are community-based residences, serving 6 to 10 youth, ages 14 to 21 who present with mild to moderate emotional problems including, but not limited to trauma histories. Programming focuses primarily on the acquisition of independent living skills such as interpersonal awareness, community awareness and engagement, knowledge and management of medical conditions, maximization of educational, vocational and employability/employment skills, and community reintegration. Staff includes transitional living coordinators, educational/vocational specialists, transitional coaches, and registered nurses.

Therapeutic Group Homes - As of June 2008, 54 therapeutic group homes have been opened with the capacity to serve 255 youth. These youth are of both genders, various age cohorts, and present with a broad range of challenges including multiple psychiatric diagnoses, behavioral difficulties, developmental delays, relationship issues, and trauma histories. The therapeutic group home expansion was informed by a needs assessment DCF conducted in 2004 that identified specific cohorts of children who need this level of care.

Therapeutic Group Homes are small (4-6 bed) programs located throughout the state in residential neighborhoods that are indistinguishable from private residences. The goal is to facilitate community integration through public education, recreation, volunteer activities, vocational opportunities, and social activities. In addition, the homes provide a living setting that is far closer to a "normal" family existence than is possible to provide in larger campus residential settings. A youth's ability to live in a manner that

is closer to normal allows greater possibility for successful transition back to a family setting or to some form of independent living as young adults.

Providers deliver an array of clinical and related services within the home including: therapy, nursing supports, ongoing psychiatric assessment and intervention, recreational activities, integration with community, life skills taught within the context of the home. Since close to 100% of the youth being served have some history of trauma, all homes have some focus on addressing the history of trauma that these youth bring with them. The model being used in the homes is relational, geared toward repairing and improving relationships that these youth have with those around them.

Enhanced Care Clinics (ECCs) are another relatively new program designed to improve access to and quality of behavioral health care. ECCs are specially designated mental health and substance abuse clinics serving adults and children. There are 39 ECCS throughout CT with approximately 100 sites. All HUSKY A & B members are eligible for ECC services. ECCs offer individual therapy, group therapy, family therapy, psychiatric evaluation and medication management, case management and other routine outpatient services. ECCs offer a centralized point of access wither via telephone or on a walk-in bases. Clients with emergent needs are seen within 2 hours. A follow-up visit is scheduled within two weeks of the initial visit.

Another community-based support available to families of children with behavioral health needs is Emergency Mobile Psychiatric Services (EMPS). EMPS provides emergency services including mobile response; psychiatric assessment; medication consultation, assessment, and short-term medication management; behavioral management services; substance abuse screening and referral to traditional and non-traditional services for any family with a child in crisis.

Emergency mobile psychiatric services (EMPS) deliver a range of crisis response and crisis stabilization services to children, youth, their families and caregivers including children residing in relative, adoptive and foster care homes. For children currently involved in clinical treatment, the EMPS first assesses the capability of that clinical service to handle the intervention. The EMPS provider is responsible for assuring that the client receives appropriate care during the crisis period.

The target population is any child or youth in crisis including any HUSKY A or B or Voluntary Services Program enrollee and any other child or youth in their designated towns. The EMPS service will be available across child welfare, juvenile justice, prevention and behavioral health systems.

Statewide EMPS providers have a centralized, toll-free phone number to serve as a point of entry and to provide person-to-person assistance and connection to crisis services. The centralized number is accessible 24 hours per day, 7 days per week, 365 days per year. In the event of a psychiatric emergency, a trained screener will, within 15 minutes, facilitate direct contact with a licensed EMPS staff member or other emergency service as necessary. When clinically appropriate, and following risk and decision making protocols, the EMPS will dispatch a mobile team to the point of the crisis. Contractors have the capacity to respond to all crises in the towns as listed in their catchment areas.

In focus groups with service providers, DCF social workers and foster parents, the majority of participants report that the DCF behavioral health service continuum is greatly improved over the past five years. While there are still areas of the state that do not have access to the full continuum of services, the expansion of these services and the advent of the Behavioral Health Partnership are generally regarded as positive steps by our stakeholders.

SECTION IV:

Systemic Factors

A. Statewide Information System

Item 24: Statewide Information System. Is the State operating a statewide information system that, at a minimum, can readily identify the status, demographic characteristics, location, and goals for the placement of every child who is (or within the immediately preceding 12 months, has been) in foster care?

Policy Description

Pursuant to the Budget Reconciliation Act of 1993, Connecticut maintains LINK as its federal Statewide Automated Child Welfare Information System (SACWIS). The Department of Children and Families implemented LINK in June 1996. The LINK system replaced a legacy Case Management System (CMS) that had been in operation since the early 1980s. Data from 1993 was converted into the LINK system. Specific information pertaining to closed child protection cases was not converted, but designated staff can access the CMS system for information pertaining to previous reports, dispositions, perpetrators, legal history and child placement history.

Summary of Performance in Round One of the CFSR

In the 2002 CFSR, Item 24 was rated as an Area Needing Improvement because functional enhancements to ensure LINK's capacity to identify the goals for the placement of every child who is in foster care were not fully implemented at the time of the review. Although the 2002 Statewide Assessment noted that LINK had the functionality to identify the status, demographic characteristics, location, and goals for the placement of all children in foster care, stakeholders questioned the accuracy and reliability of the data.

Stakeholders attributed their continuing concerns about LINK to incomplete data entry in the field. LINK was perceived by staff to be non-intuitive and difficult to use. The need to re-enter the same data in numerous places, and the time required to fully comply with data entry requirements were sited as obstacles to use. Stakeholders also identified the lack of longitudinal outcomes reports as a potential weakness in the system, as only point-in-time reports were available from LINK data at the time of the last CFSR.

Measures of Effectiveness

Federal legislation established functional system requirements for SACWIS systems. Since 1996, Connecticut has been working diligently to incorporate these requirements into LINK. In the 2006 SACWIS Assessment Review, Connecticut's LINK system was found to have incorporated 78 of the 87 SACWIS components (61 components conformed to federal standards and 17 conditionally conformed to federal standards).

In a recent focus group of front-line DCF social workers and social work supervisors, all of the participants agreed that there has been great improvement over the last ten years in using the statewide information system. The respondents stated that the legal information is straightforward and easily updated in the LINK system. It was reported that the demographics of a child and family are easy to access, as long as the information is entered as it is gathered. However, group expressed concern that the goals for children can only be accessed by reading the treatment plan and this is cumbersome.

Factors Affecting Performance

Many changes have been made to the LINK system in response to the increased need for accurate and timely information about the clients we serve and the outcomes we are achieving. The principal driving factors for these changes have been the requirements of the Juan F. Consent Decree Exit Plan, findings from the 2002 CFSR and recent SACWIS assessment reviews.

The following enhancements have been made to LINK since 2002:

- Enhancement of the Title IV-E eligibility processing infrastructure in LINK;
- Migration of all electronic legacy CMS data to LINK;
- Enhancement of LINK search engine capacity;
- Upgrades of the PowerBuilder application used to design and enhance the LINK application;
- Enhancement of the "Person Merge" function of LINK, to decrease the number of duplicate persons that appear across multiple investigations and cases;
- Enhancement of the background check functionality to allo for a more efficient process;
- Modification of LINK to ensure compliance with HIPAA;
- Development of an interface between LINK and the state's Behavioral Health Partnership;
- Development of a central registry of all individuals who have received a substantiation of abuse and neglect, in order to comply with Connecticut Public Act 05-207;
- Upgrade to the appeals management process, to improve the efficiency of appeals of substantiations of abuse and neglect.

There are additional enhancements currently underway intended to improve the system's capacity to track client data across the agency's various mandates. Overall, the response to these modifications and enhancements has been positive, with staff in recent focus groups reporting improved confidence in the LINK system.

In response to the need for additional information about our client population, staff from DCF's Information Systems Division and the Bureau of Continuous Quality Improvement have developed management reports with the capacity to track both demographic and child-specific outcomes.

A series of LINK reports are available to track the current status, demographics, current location and permanency goals for children in care. Reports on placement and permanency goals for children in care, which were seen as an area needing improvement in 2002, have been enhanced to assure greater accuracy. There are over 100 available point-in-time management reports, including:

- *Caseload Capacity Reports* - daily management reports showing the caseload for each social worker to ensure they are within the standards established in the Juan F. Exit Plan;
- *Caseload trend reports* (statewide and for each of the 14 Area Offices);
- *Daily Children in Placement Report* - includes demographic and placement information on every child in a DCF placement;
- *First Time Placements* - Shows children who have entered care for the first time;
- *KidPix Report* - summary report of which children in placement have an up-to-date picture on file;
- *Medically Complex Reports* - monthly summaries of children in placement who have a complex medical need;
- *Removals from Home* - monthly report showing demographic information for all children who have been removed from home that month;
- *Runaways database* - shows point-in-time view and aggregate yearly numbers, by Area Office, of children who are absent from care;
- *CPS reports* - shows information on total reports and allegations received;

- *Completed Investigations* - shows completed abuse and neglect investigations;
- *Substantiation Rate Trends* - shows substantiation rates over time by Area Office;
- *Foster Care Reports* - a suite of reports showing demographic information on children in foster care as well as management reports on licensed foster homes;
- *Permanency Exception Reports* - a suite of management reports showing children for whom there is no identified permanency goal, no TPR filing date recorded in LINK and other barriers to permanency.
- *Treatment Plan Exception Report* - Shows which cases are open with no current treatment plan.

These reports are used by managers and supervisors to ensure compliance with Exit Plan and policy standards for the completion of work by their units and to ensure accurate data entry into the LINK system. Most of the LINK reports are formatted as pivot tables, allowing staff in the field to customize the report view and filter by Area Office or other variable.

In addition to point-in-time management reports and trend reports of process outcomes, Connecticut has also invested significant resources in developing the capacity to track outcomes at a child-specific level. Since 2005, Connecticut has been working in partnership with the University of Kansas to implement a Results-Oriented Management (ROM) reporting system. The ROM system uses LINK data to track results of various outcomes for Exit Plan reporting and other reports for which a cohort view is most appropriate. Currently, the ROM system is used to track the following indicators:

- Exit Plan Indicators:
    - Commencement of Investigation
    - Completion of Investigation
    - Placement Resource Search
    - Child Safety Maintained 6 months (no recurrence)
    - Child Safe in Out-of-Home Care (no abuse/neglect)
    - Reunification
    - Adoption
    - Transfer of Guardianship
    - Sibling Placement
    - Maintain Permanency (no re-entry)
    - Monthly Worker-Child Visitation Out-of-Home
    - Twice Monthly Worker-Case Visitation In-Home
    - Multidisciplinary Exams
- Other Indicators:
    - Timely Permanency (24 months)
    - Timely Reunification (12 months)
    - Timely Adoption (24 months)
    - Timely Guardianship (24 months)
    - Maintain Permanency 12 months (no re-entry)
    - Placement Stability
    - Child Safe in Out-of-Home Care (no maltreatment) 12 months
- Structured Decision Making (SDM) Reports:
    - Completion of SDM Initial Safety Assessments
    - Completion of SDM Initial Risk Assessments
- Informational Reports:
    - Pending Investigations
    - Missing Removal/Discharge Data
    - Children in DCF Placement by Length of Stay

- CFSR Permanency Composites:
    - CFSR Composite 1 - Timeliness and Permanency of Reunification
    - CFSR Composite 2 - Timeliness of Adoptions
    - CFSR Composite 3 - Achieving perm. for children in foster care for long time periods
    - CFSR Composite 4 - Placement Stability

Both LINK and ROM reports are available to the entire DCF staff through the agency's intranet. All reports can be filtered by Area Office and drill-down capability exists such that outcomes can be analyzed at the statewide, Area Office, unit and worker level. Ongoing training is provided for social workers and supervisors on using the system to understand performance on outcomes.

In addition to standard reports, DCF has been developing the internal capacity to conduct ad-hoc analysis of our data using datasets from LINK and ROM tables, as well as the Chapin Hall Multistate Foster care Data Archive. These ad-hoc analyses are used by senior managers to further understand trends in the system and to communicate with external stakeholders regarding the outcomes achieved by the agency.

Finally, DCF also maintains a case management system for the population of children who are committed as delinquent to the Department. The system, CONDOIT, is a web-based case management database for maintaining the case records of committed delinquents and managing the population of the Connecticut Juvenile Training School. CONDOIT has a number of built-in reports that allow for the tracking of the demographics and other characteristics of the juvenile justice population. A direct CONDOIT - LINK interface has never been fully implemented, but LINK is used to track placements of children who are committed delinquent to the Department.

B. Case Review System

Item 25: Written Case Plan. Does the State provide a process that ensures that each child has a written case plan, to be developed jointly with the child, when appropriate, and the child's parent(s), that includes the required provisions?

Policy Description

DCF Policy 36-5 through 36-10, *Treatment Planning*, outlines the legal basis for treatment planning, the preparation for and development of treatment plans, as well as the frequency required for updating plans. Policy requires that "Every effort will be made to make this process and the development of the plan inclusive. Children, parents and all appropriate service providers will be given the opportunity to participate."

Per DCF Policy 36-5-3, a treatment planning conference (TPC) "shall occur within thirty (30) calendar days of the time a case is assigned to a treatment/voluntary services worker or a new case is opened in a treatment/voluntary services unit." Treatment plans must be completed within 10 days of the TPC. Ongoing treatment plans must be completed and dated no later than ninety (90) calendar days beyond the initial treatment plan and must be completed every six (6) months (date to date) from the previous plan.

The function of the treatment plan is described as the opportunity to identify in a time-limited and goal-oriented manner the problems, needs and services for all involved participants; the description of reasonable efforts to prevent placement or reunify children; the mutual responsibilities of the parties to achieve the identified goal; the evaluation of case progress towards; developed in compliance with federal and state requirements. Education, health and mental care are included in the assessment.

Services offered and service provision, availability, utilization and results are assessed in the treatment, as is the appropriateness of the placement, visitation issues, and the permanency plan.

Family plans include an assessment of initial reasons for DCF involvement, the present situation, a discussion of strengths and weaknesses and services offered, utilized and results. Service availability is also noted.

Summary of Performance in Round One of the CFSR

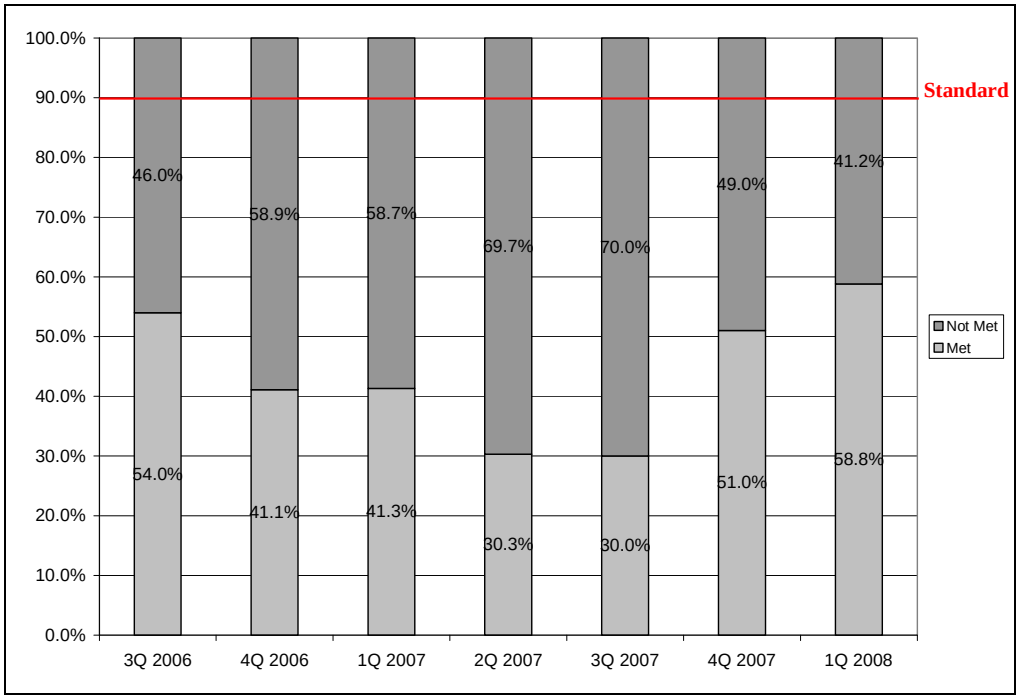
In the 2002 CFSR, Item 25 was rated as an Area Needing Improvement because although DCF was consistent in convening Treatment Planning Conferences (TPC) and Administrative Case Reviews (ACR) to ensure that each child had a case plan, the general consensus of stakeholders was that neither process functioned as a means to engage families in the case planning process and parents were not routinely perceived as partners with the agency in the development of the case plan.

A few stakeholders suggested that one of the difficulties with involving parents in the case planning process, particularly the ACR, is that the ACR was held on a time schedule that does not accommodate family work schedules, or even the schedules of private providers or other invited stakeholders. These stakeholders noted that as a result of the scheduling inflexibility, the ACR tends to be poorly attended by all invitees.

Measures of Effectiveness

One of the standard management reports available through the statewide information system is an exception report to show which cases do not have a current treatment plan as dictated by policy. This report is refreshed on a daily basis and has the capacity to drill down to the social worker and case level. Currently, there are 181 cases with no up-to-date treatment plan. This represents approximately 1.4% of cases which are required to have a treatment plan.

CASES WITH NO CURRENT TREATMENT PLAN July 7, 2008			
Count of Case ID	**CASE TYPE**		
Area Office	**Family**	**Child In Placement**	**Total**
Bridgeport	9	7	16
Danbury	4	3	7
Greater New Haven	2	2	4
Hartford	40	12	52
Manchester	14	4	18
Meriden	7	1	8
Middletown	8	2	10
New Britain	4	5	9
New Haven Metro	6	2	8
Norwalk	3	1	4
Norwich	5	2	7
Stamford	3	1	4
Torrington	8	9	17
Waterbury	12	4	16
Willimantic	1	0	1
Total	**126**	**55**	**181**



Outcome Measure 3: Treatment Plans

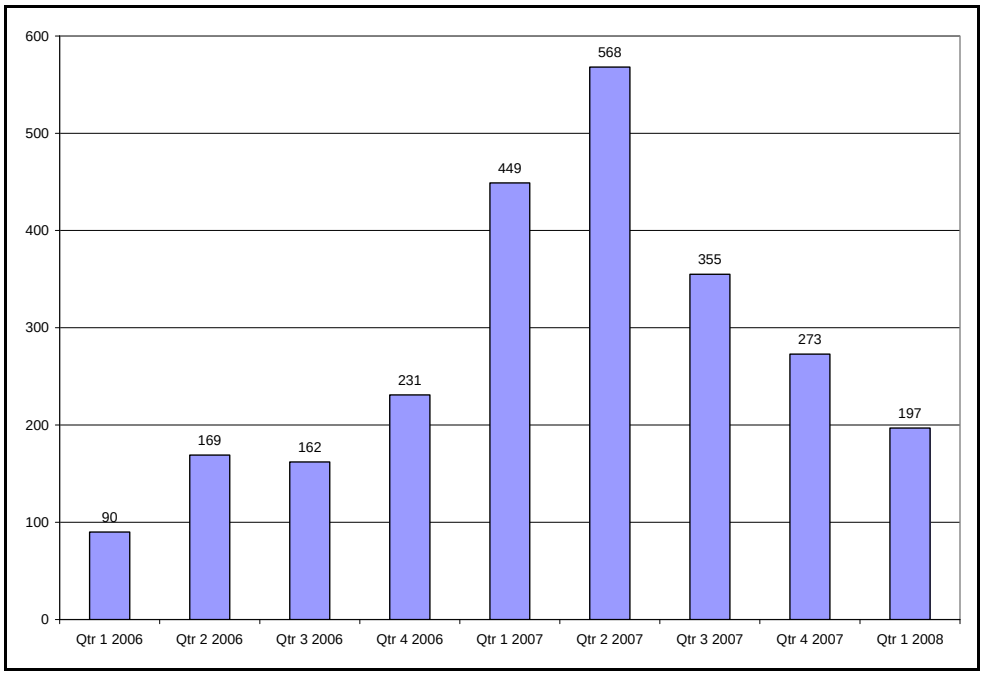
In a recent focus group of front-line social workers and social work supervisors, respondents indicated the Department has made great efforts in the area of written plans that are developed with the child's parents. The success of the timeliness of the plans was attributed to the development of a "tickler" system that ensures that the plan is completed on time and to management reports that show overdue treatment plans. The group stated that the treatment plan is a document that is relied on more than any other instrument in their Area Office.

The respondents also pointed to the required documentation that the family has been asked to participate in a Family Conference as a way to meet the goal of planning with the family. The overall feeling from the respondents was one of a strong philosophy in their offices that motivates them to maintain a high standard of timeliness of developing treatment plans.

Factors Affecting Performance

One of the areas needing improvement regarding treatment planning noted in the 2002 CFSR was that families were not actively engaged in the process. In order to improve performance in this area, the Department instituted Family Conferencing as a mechanism for engaging parents and kin in treatment planning. The primary goal of the DCF Family Conferencing Initiative is to increase the level of extended family involvement in DCF case planning.

The use of family conferencing grew steadily since its inception in Connecticut through the second quarter of 2007. It has decreased slightly over the past few quarters as Area Offices refine the model for use at designated points in the life of a case. The Department's contract for external consultation on the Family Conferencing came to an end in June 2008. The winding down of this formal consultation process may also be affecting the use of the program or data collection regarding its use.



Statewide Family Conferences, 2006-2008

In addition to Family Conferencing, Adolescent Planning Conferences have been implemented to ensure the active participation of children in their own treatment planning process. Since this intervention is relatively new, it is not tracked by the statewide information system. However, 8 of the 14 DCF Area Offices have developed local mechanisms for tracking the conferences. In state fiscal year 2008, they reported a total of 979 adolescent planning conferences held with adolescents present 28% of the time.

Beyond participation in case planning, the Department has also focused on ensuring translation services are available so all parents can understand the process and associated documents. These services include oral translation services, sign language interpreters and written translations of documents (treatment plans, case related and legal documents, etc.). Additionally, Braille and some oral readings of treatment plans onto cassettes or compact disc are provided for people who are unable to read. The Department's investment in these services has grown considerably over time, from $279,000 in fiscal year 03-04 to $1,453,000 in fiscal year 06-07.

Finally, in 2007, Connecticut implemented Structured Decision Making (SDM) in order to standardize the assessment of safety and risk in cases. As part of the SDM roll-out, a Family Strength and Needs Assessment is completed every 90 days on open cases. This is seen as a promising practice for promoting family engagement in treatment planning.

Item 26: Periodic Reviews. Does the State provide a process for the periodic review of the status of each child, no less frequently than once every 6 months, either by a court or by administrative review?

Policy Description

DCF Policy Chapter 24, *Administrative Case Review*, outlines the purpose of the Administrative Case Review, which is the provision of an orderly and structured meeting in which all participants are engaged in discussion focused on the permanency planning needs of the child. ACRs are held every 180 days.

Mandatory participants in the ACR include the administrative case reviewer, the DCF social worker, the social work supervisor, the adoption specialist if there has been a judicial decision to terminate parental rights and any service providers that have participate in the case in the seven months prior to the review. By policy, the child's parents, the child (if age 12 or above), the child's foster parent or residential care social worker, the parents' counsel, the child's counsel and the child's guardian ad litem must be invited to attend the ACR. Additional attendees may be invited as appropriate.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 26 was rated as a Strength because DCF ensured that each child's case plan was reviewed every 6 months through an ACR. There was general consensus among stakeholders that an ACR is held every 6 months for each case. Stakeholders also noted that the current process is more comprehensive than the prior ACR process, and that it now requires advance preparation on the part of the workers. Internal stakeholders indicated that social workers perceive the ACR as a meaningful review and that changes may be made to treatment plans as a result of the ACR. However, some stakeholders also noted that although the ACR may result in specific recommendations, they are not necessarily always implemented.

Measures of Effectiveness

The Internal Quality Improvement (IQI) Division maintains data on the timeliness of ACRs to ensure they are happening within required timeframes. For the time period of January 2006 trough June 2008, there were 39,191 ACRs held. Of those, 2.87% were not held by the expected due date. Another 6.92% were overdue, but completed within 30 days of the due date. Nearly 14% of ACRs in this data set, however, do not have due dates entered into the system. The IQI Division is working to resolve this issue for future monthly reporting.

Factors Affecting Performance

While this was an area of strength for Connecticut in 2002, the Department has continued to invest additional resources in strengthening the ACR process. In 2004, the Department implemented the audio conferencing option in order to facilitate greater participation in the ACR's. In 2006, DCF changed ACR procedures so that when a parent is not invited, it is not considered an administrative case review. In those cases, the reviewer is instructed to reschedule the ACR at a time when the mother and/or the father are available. Additionally, the ACR unit also developed handouts and training materials for all the new social worker trainees to receive during pre-service training.

Beginning in 2006, managers in the ACR unit began to take a closer look at the ACR structure in order to further refine the process. Reviewers began generating "FYI" reports to notify Child Welfare Services staff of areas of strength and areas needing improvement identified during ACRs. Finally, in 2007, the Department hired 2 additional managers and 10 additional reviewers for the ACR unit. These additional staff have been instrumental in ensuring reviews are done in a timely and appropriate manner.

Item 27: Permanency Hearings. Does the State provide a process that ensures that each child in foster care under the supervision of the State has a permanency hearing in a qualified court or administrative body no later than 12 months from the date that the child entered foster care and no less frequently than every 12 months thereafter?

Policy Description

The statutory authority for Permanency Review Hearings for child protection matters may be found in the Connecticut General Statutes (CGS) § 46b-129(k) (1) and 17a-112(o). The Connecticut Practice Book Sec.35a-14 sets forth the procedures for Permanency Review Hearings. PA 06-106 section 8 amended CGS 17a-112(o), clarifying that the post TPR review hearing is a permanency plan hearing. Also, PB Rule 35a-17 will be repealed effective 1/1/09.

The statutory authority for Permanency Review Hearings for juvenile delinquency cases may be found in CGS § 46b-129(k) (1) and 46b-141(c). The Connecticut Practice Book Sec. 31a-19 sets forth the procedures for Permanency Review Hearings in juvenile delinquency cases which result in the commitment of a child to DCF.

The statutory authority for Permanency Review Hearings for children from Families with Service Needs (status offenders) was clarified in law during the 2008 session of the Connecticut General Assembly. The statutory reference may be found in P.A. 08-86, section 2, (j & k). A corresponding Practice Book rule will be incorporated into the Connecticut Practice Book rules (rule has been approved) effective 1/1/09.

The statute and rules are reflected in all orders on which judges make their findings. Additionally, procedures are in place to establish dates for Permanency Review Hearings at the point at which a child is removed from his or her home. For example, if a child is removed as a result of an Order of Temporary Custody, the date for permanency review is set at the first appearance in court following removal, using the date of removal as the "trigger" for the setting of the due date for the plan and the actual hearing date.

The Judicial Branch's child protection automated system provides a report which contains all cases in which a permanency review plan due date and hearing date are set. Due dates for submission of the plan by DCF are scheduled as "docket matters" (do not require appearance by any of the parties). A docket review takes place each day by court staff. If a plan is not filed, the court staff provides that information to the DCF liaison that is then responsible for alerting the Area Office of the need to file the plan. Local standing orders have been established by presiding judges regarding action to be taken when DCF fails to file a plan in a timely manner.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 27 was rated as an Area Needing Improvement because stakeholders suggested that although permanency hearings were routinely held, they frequently led to full evidentiary hearings that resulted in delaying rather than expediting permanency for children.

Measures of Effectiveness

Improvements have been made in the timeliness of filing of Permanency Plans and in holding review hearings. Reviews are held in accordance with statute and rule. Exceptions have been noted when DCF files a permanency plan recommending termination of parental rights and adoption and the parents object to the plan.

Under the auspices of the Court Improvement Program, the Judicial Branch has developed and promulgates a report on nine key performance measures. Those measures include the measure of "Time to First Permanency Hearing: Average (median) time from removal to first permanency hearing." An additional performance measure "Time to Permanent Placement: Average time from filing of the original petition to permanent placement" is used to measure the length of time it takes for a child to reach permanency once the case has entered court. The Key Performance Measures Report is promulgated every six months or as needed for informational purposes.

Data provided by the Judicial Branch shows that in the 18-month period from January 1, 2007 to June 30, 2008 there were 2,656 first-time permanency hearings held in the state's 13 juvenile courts. During that time period, the average number of days from the filing of the original petition to the first permanency hearing ranged from 386 days to 402 days:

Time Period	**Average - Number of Days from Filing of Original Petition to First Permanency Hearing**
Time Period: 1/1/07 to 6/30/07	401
Time Period: 7/1/07 to 12/31/07	386
Time Period: 1/1/08 to 6/30/08	402

Factors Affecting Performance

The Judicial Branch and DCF have worked collaboratively to present and support appropriate statutory and rule changes. On the local court level, court staff works collaboratively with the DCF liaison to assure compliance with filing deadlines.

Under the Court Improvement Program, the Judicial Branch is working collaboratively with DCF to implement a data exchange. The first data elements to be exchanged will be those related to "Contrary to Welfare" and "Reasonable Efforts" findings. Future exchanges will include Permanency Plan due dates and hearing dates.

According to statute effective September 1998, DCF files permanency motions within 9 months of the child's removal from the home. By statute, the motion must be heard within 90 days of its filing to ensure that the permanency hearings are held within 12 months of the removal from home. Hearings are held every 12 months thereafter. The Area Offices track the children in placement requiring permanency hearings through LINK to ensure that the plans are filed in a timely manner. The social work staff, Area Office attorneys, and Area Office specialty staff hold a Multi-Disciplinary Assessment for Permanency meeting on each case at the 7-month mark to identify legal obstacles to permanency and to strategize around these obstacles. These meetings also serve as a forum for finalizing the permanency plan and confirming due dates for court filings. DCF legal staff also follow-up on permanency plans that are not adopted by the court. This is done to identify legal issues that might provide the basis for different legal strategy in the future or for staff training.

According to the Judicial Branch reports, DCF averages 328 Permanency Plan filings a month, and some 3,936 annually. Currently, the filing of the plans is tracked by Judicial, but not the disposition of the hearings, although the capacity exists and future reports will include this data.

Legislation was passed during the 2001 Legislative Session, effective October 1, 2001 that expands the requirement for the filing of permanency plans in Juvenile Court. All children in care, including those with Independent Living Plans and delinquent youth in the care and custody of DCF, now have permanency plans filed on their behalf. Prior to the legislation, the courts were reluctant to hold permanency hearings for delinquent youth, having no state legal requirement to do so. Systems have been established by the courts and DCF's Bureau of Juvenile Justice to ensure that these youth have the required hearings.

The nature of the permanency reviews has been varied. Legislation was recently enacted in an effort to clarify and add focus to the proceedings. Some judges have expressed reluctance to make a decision regarding the permanency plan, particularly if it recommends a Termination of Parental Rights (TPR), as they will likely hear the termination and feel their decision regarding the permanency plan will taint their objectivity. The Judicial Branch is undertaking a review of permanency hearings, as the Court Administrator is committed to holding informative, participatory hearings. The impact of these hearings on timely achievement of permanency goals for children will have to be further researched. In addition to judicial reluctance to decide permanency plans, another reason for delays in permanency hearings include opposition to the plan by the parent's or child's attorney, which leads to a full evidentiary hearing prior to the approval of the permanency plan.

In order to improve the quality of legal representation available to children and their parents involved with DCF, in 2006 the Connecticut General Assembly created the Commission on Child Protection and the Office of the Chief Child Protection Attorney. It is the mission of the Commission on Child Protection to ensure that children and indigent parents who require legal services and guardians ad litem in child protection, child custody and child support cases in Superior Court, receive high quality, competent and zealous representation. The Commission executes a plan of reform, training programs and support services in order to assure that child protection attorneys and guardians ad litem are knowledgeable and trained in the substantive and procedural law applicable to these cases, capable of skilled advocacy and proficient in the subject areas that inform the issues their clients face.

Item 28: Termination of Parental Rights. Does the State provide a process for Termination of Parental Rights (TPR) proceedings in accordance with the provisions of the Adoption and Safe Families Act (ASFA)?

Policy Description

The statutory authority for filing of a termination of parental rights when the court has approved a permanency plan of adoption may be found in the Connecticut General Statutes (CGS) § 46b-129(k)(4)(1). Additional statutory references may be found at CGS § 17a-111a through 113 inclusive, including when the court makes a finding relative to reasonable efforts where aggravated circumstances are present as outlined in ASFA.

Connecticut Practice Book Sec.35a-15 sets forth the procedures for cases in which DCF is seeking a finding of the existence of an aggravating factor.

CGS 17a-111 a (b) provides the statutory references for when DCF may request the court to approve an exception to the required filing of a TPR. The statutory reference for when DCF seeks exceptions to the requirement to file TPR may be found in CGS § 17a-111 a (b). A finding of the existence of an aggravating factor, so that DCF does not have to make further efforts to reunify, requires the court to approve a permanency plan. That plan could require DCF to file the TPR.

CGS 46b-142(d) entitles parties appealing a TPR decision to an expedited hearing before the appellate court.

Summary of Performance in Round One of the CFSR

In the 2002 CFSR, Item 28 was rated as an Area Needing Improvement because although there was a process in place for termination of parental rights proceedings in accordance with the provisions of the Adoption and Safe Families Act, the process was not implemented on a consistent basis. Stakeholders in 2002 indicated that DCF social workers did not always file a TPR petition in a timely manner. This perception was consistent with case review findings that DCF had filed a TPR petition in only 7 of the 17 cases in which children had been in foster care for 15 of the previous 22 months.

Measures of Effectiveness

According to information provided by the Judicial Branch, improvements have been noted in the timeliness in filing of TPR petitions.

Under the auspices of the Court Improvement Program, the Judicial Branch has developed and promulgates a report on nine key performance measures. Those measures include the measure of "Time to Termination of Parental Rights: Average (median) time from filing of original petition to order terminating parental rights." The Key Performance Measures Report is promulgated every six months or as needed for informational purposes.

The child protection automated system provides a report which contains all cases in which a termination of parental rights petition due date and hearing date are set. Due dates for submission of the TPR Petition by DCF are scheduled as "docket matters" (do not require appearance by any of the parties). A docket review takes place each day by court staff. If a petition is not filed, the court staff provides that information to the DCF liaison that are then responsible for alerting the Area Office of the need to file the petition. Local standing orders have been established by presiding judges regarding action to be taken when DCF fails to file a petition in a timely manner.

Factors Affecting Performance

In Connecticut, the majority of TPR cases require a written decision. Judges are required by Practice Book to issue final decisions 120 days after the all parties have rested and all trial briefs have been filled. The Chief Court Administrator requires the promulgation of a report that lists all pending decisions by Judge and jurisdiction. The report is provided to the CCA monthly for review.

Collaborative meetings are being held with the Judicial Branch, DCF, Office of the Attorney General, and the Chief Child Protection Attorney and state advocacy groups to discuss the purchase of technological resources to expedite transcripts for cases that are being appealed.

The Judicial Branch has implemented a Child Protection Mediation program in direct response to the Program Improvement Plan. This program is in addition to the already existing non-adversarial dispute resolution conferencing processes already in place and complements the efforts of DCF to use family conferencing prior to a case entering the court system. The vast majority of cases referred to the Child Protection Mediation Program have been cases where DCF is seeking TPR and adoption. Continuing efforts are being made by the Branch to increase the number of referrals to the mediation program.

A targeted intervention in TPR cases is the Case Management Conferencing process. A conference is held in all TPR cases on the first presentment in court (Plea Hearing). It is at that time that the Court Services Officer meets with all the parties and their attorneys to discuss settlement options, if any, requests for court ordered evaluations, placement options for the child, including any possible adoptive placements, pre-trial motions, potential referral to mediation and sets a schedule for the case including hearings on pre-trial motions, case status conferences, judicial pre-trials, trial dates and any other necessary case management required in the case.

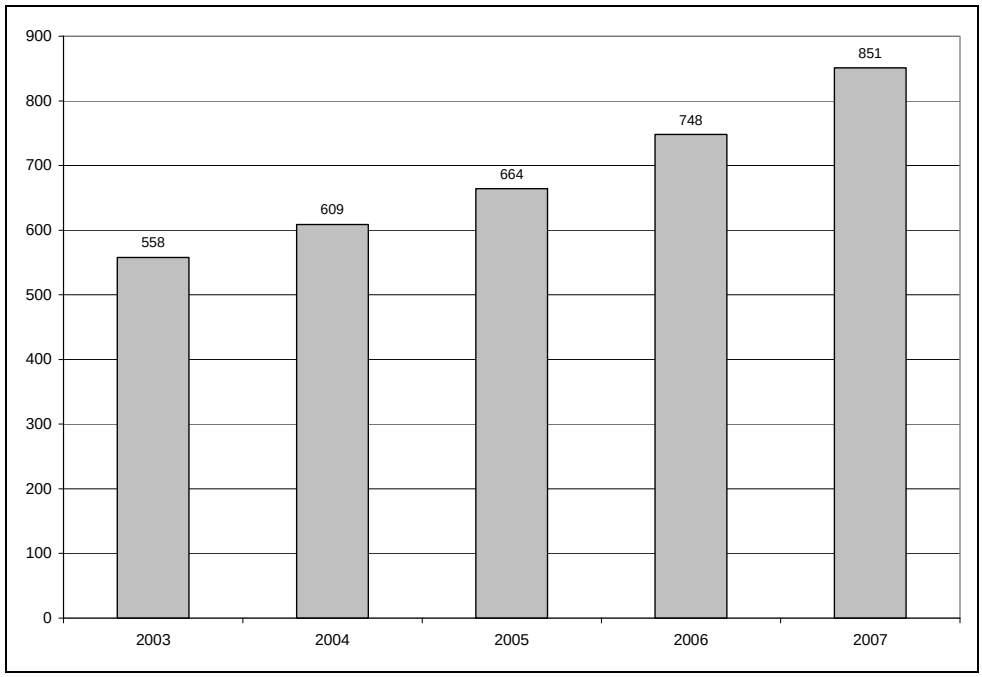
The Judicial Branch has established a second regional Child Protection Session (CPS) in the Superior Court for Juvenile Matters at Willimantic. The CPS in Middletown continues to handle TPR cases for other regions of the state with three full-time judges assigned to the session. The CPS at Willimantic has one full-time judge assigned. The sole purpose of CPS in Willimantic is to handle TPR cases referred from the eastern region of the state and expedite the scheduling and resolution of these cases in a timely manner.

The Department's ability to identify and track children who have been in care for 15 of the past 22 months has greatly improved since the inception of the Juan F. Exit Plan. The Department's Division of Outcome Measure Oversight produces a monthly report that includes the following tables:

- Pre-TPR Children In Placement by Permanency Goal, Status of TPR Filing and Time In Care (Months)
- Pre-TPR Children In Placement by Permanency Goal and Status of TPR Filing
- Pre-TPR Children In Placement by Reason TPR Not Filed and Permanency Goal
- Pre-TPR Children In Placement by Placement Type, Permanency Goal and Time In Care (Numbers Only)
- Pre-TPR Children In Placement by Placement Type, Permanency Goal and Time In Care (Percents Only)
- Pre-TPR Children In Placement by Permanency Goal and Age Group

This data is provided to the Juan F. plaintiffs and to managers in the Bureau of Child Welfare on a monthly basis. In 2006, the Department instituted a review process to use these reports for the promotion of timely filing of TPR and moving children to permanency.

The development of the regional Child Protection Sessions by the Judicial Branch and the Department's use of management reports to identify children for whom we should file a TPR has increased the overall number of filings in recent years:



TPR Filings Statewide

This focus on using data to improve the management of the TPR process is having a positive impact on the achievement of permanency for children in Connecticut, although the state's data profile suggests additional focus is needed on children who have been in foster care for longer periods of time. According to Permanency Composite 2, Component B, Connecticut is performing below the national median for both underlying measures.

For children who have been in care for 17 or more months, 12.4% of the children in care in the first day of the reporting year who were not reunified or had guardianship transferred to a relative were adopted by the end of the year. The national median for this measure is 20.2%. Connecticut's performance in this area is likely impacted by the increasing number of adolescents in care for longer periods of time.

Conversely, for children who have been in care for 17 or more months at the beginning of the reporting year and were not legally free for adoption, 8.7% became legally free for adoption within six months. On this measure, Connecticut's performance for the 06b07a time period is consistent with the national median of 8.8%. For the subsequent 2007ab time period, Connecticut's performance improves to 9.5%. The overall improvement in performance for this measure dating back to the 2006ab year is due to the focus on the timeliness of filing for TPR and the increased availability of management reports to track this issue.

Item 29: Notice of Hearings and Reviews to Caregivers. Does the State provide a process for foster parents, pre-adoptive parents, and relative caregivers of children in foster care to be notified of, and have an opportunity to be heard in, any review or hearing held with respect to the child?

Policy Description

Public Act 07-174 amended CGS § 46b-129(o) to make it consistent with the requirements of the Section 438(b) (1) of the Social Security Act. A change to the Connecticut Practice Book rules has been recommended and has been presented to the rules committee for review.

While the promulgation of a rule is pending, in October 2006 the Chief Administrative Judge for Juvenile Matters has issued a standing order to address the notice requirements. The standing order requires the Department of Children and Families to provide notice of all court proceedings concerning any child in foster care to foster parents, relative caregivers and pre-adoptive parents of such children. Records of such notice shall be kept by the Department of Children and Families and information about the notice given in each case provided to the court.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 29 was rated as an Area Needing Improvement because although there are procedures in place for notifying foster parents, pre-adoptive parents, and relative caregivers regarding hearings and reviews, these procedures are not adhered to on a consistent basis. In particular, there was inconsistent understanding and practice regarding notifying and facilitating foster parents' rights to be heard in court proceedings.

Factors Affecting Performance

Invitations to foster, pre-adoptive and relative caregivers are sent out by DCF for Treatment Planning Conferences as well as to Administrative Case Reviews. While this is an expectation, the Department currently has no standard production management report to track that this is happening across the state. Anecdotal evidence from ACR reviewers suggests, however, that notices of hearings and reviews are consistently given to caregivers.

DCF notifies foster parents of their statutory right to be heard and provides the date of the first hearing. As there are often several court hearings pertaining to one case, DCF and the Judicial Branch are not certain that foster parents are notified of every subsequent court hearing or case status conference.

In the local jurisdictions, judges routinely inquire about foster/adoptive parent notification in court proceedings and document in the court memoranda the outcome of the inquiry. The Court Improvement Project Re-Assessment, however, found that few foster/adoptive parents attend court proceedings. Since many foster parents face challenges in attending hearings, they encouraged them to write to the judge to express their views when they are unable to get to court.

In community focus groups, concern regarding the legal representation of children was raised several times. There is a perception that attorneys, in some instances, are not advocating for children, are not visiting them and do not seek input from the child’s caregivers and providers. This issue has been addressed with the state's Chief Child Protection Attorney, who is taking steps to improve the quality of legal representation afforded to children.

Under the auspices of the Court Improvement Program, an information booklet, "Foster Parents and the Juvenile Court" was prepared and recently updated to reflect the changes to the federal and state law. The booklet is available in all court houses where Juvenile Matters are held. It has been posted on the Judicial Branch website and has been distributed to the Connecticut Association of Foster and Adoptive Parents DCF Liaisons to provide to foster and adoptive parents.

Foster and pre-adoptive parents are invited to participate in child protection mediation in cases involving their foster children. Anecdotal evidence demonstrates that foster and pre-adoptive parents do take part in mediation regularly.

C. Quality Assurance System

Item 30: Standards Ensuring Quality Services. Has the State developed and implemented standards to ensure that children in foster care are provided quality services that protect the safety and health of the children?

Policy Description

Chapter 41 of the DCF policy manual outlines the process for assessing and licensing foster homes. The statutes and regulations of the State of Connecticut give the Department of Children and Families the legal authority and responsibility to provide safeguards for those children who must be removed from their own homes and placed in another family home or child care facility to protect or provide them with specialized care.

Connecticut General Statutes § 17a-114 (a), as amended by Public Act 01-70, states in part, "No child in the custody of the Commissioner of Children and Families shall be placed with any person, unless such person is licensed by the Department for that purpose. Any person licensed by the Department to accept placement of a child is deemed to be licensed to accept placement as a foster family or prospective adoptive family."

Connecticut General Statutes §17a-114(b) as amended by Public Act 01-70 provides an exception for placing a child with a relative who is not licensed for up to 90 days pending completion of the licensing process.

The four (4) types of family care licenses are:

- Foster or Pre-Adoptive Care (General Use)
- Relative Care (Child Specific)
- Special Study Care (Child Specific)
- Independent Interstate Care (Child Specific)

The Connecticut General Statutes also empower the Department to license child-caring facilities, extended-day treatment programs and child-placing agencies.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 30 was rated as a Strength because the State has developed and implemented standards to ensure that children in foster care are provided quality services to ensure their safety and health.

According to the 2002 Statewide Assessment, DCF regulations and policy with regard to children in foster care conformed to nationally recognized guidelines established by the Child Welfare League of America, the Council on Accreditation's Standards for Family Foster Care, the Joint Commission on Accreditation of Healthcare Organizations, and the Program Standards for Treatment Foster Care. The Statewide Assessment also noted that DCF facilities were in conformance with national performance standards. Stakeholders noted that foster parents reported timely licensing visits and health and safety checks and that State licensing staff review out-of-State residential facilities in which Connecticut children are placed.

Factors Affecting Performance

Connecticut's standards for its foster and adoptive homes are governed by both State Regulation and departmental policy and are in accord with nationally recognized guidelines such as:

- Child Welfare League of America Standards of Excellence for Family Foster Care Services
- Council on Accreditation (COA) Standards for Family foster Care
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- Program Standards for Treatment Foster Care (from the Foster Family-based Treatment Association)

Each DCF Area Office has Foster and Adoptive Services Unit (FASU) that licenses foster and adoptive homes in accordance with the federal, state and local regulations. The Office of Foster Care Services (OFCS) in Central Office oversees the FASUs, and is responsible for the interpretation and implementation of federal law, state statutes and regulations that impact on foster and adoptive care.

OFCS monitors the training, licensing and re-licensing of foster, relative and adoptive homes. Regular meetings with Area Office FASUs and private agencies are conducted. Best practices and barriers to effective foster/adoptive caregiving are shared. Quarterly reports and annual plans for foster and adoptive recruitment are developed. These include reports concerning the training of foster care providers, recruitment and licensing activities, foster home investigations and foster parent license revocations. DCF has long had high standards for foster and adoptive care as reflected in regulation and policy, and the OFCS closely monitors related activities.

Regulation and policy establish standards for foster care, including compliance with facility requirements such as fire safety, heating sources and well water. In addition, regulations and policy require an assessment of foster/adoptive parent functioning, history, parenting and interpersonal relationships, children in the home, extended family relationships and demographics, understanding of placement issues and viewpoints of birth parent and foster children, motivation and preparation, evidence of positive parenting, effective individual and family functioning, and ability to seek help and utilize resources.

Recent changes to the operation of the Office of Foster Care Services have improved the Department's ability to license and monitor foster homes. Each DCF Area Office now has the capacity to conduct finger-printing at the local level, greatly increasing the efficiency of the foster parent licensing procedures. The centralization of foster care management into the OFCS, which occurred in the Spring of 2006, has also helped strengthen and standardize these systems across all 14 Area Offices.

In addition to foster homes, DCF operates four facilities, including Riverview Hospital for Children and Youth. This 98-bed facility is the only public psychiatric hospital to serve the under 18 population in

Connecticut. A JCAHO-accredited facility, RHCY has receive d accreditation with commendation in its last four surveys. The hospital was re-accredited by JCAHO in the fall of 2007.

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The Connecticut Juvenile Training School was one of the first twenty-seven programs to pilot the standards developed by the Council of Juvenile Corrections Administrators (CJCA). CJTS is currently pursuing CJCA accreditation.

The Connecticut Children's Place and High Meadows provide brief residential treatment and diagnostic evaluation for children who are awaiting residential treatment or are in crisis. They operate within the standards established by the American Academy on Pediatrics and the Child Welfare League of America.

Item 31: Quality Assurance System. Is the State operating an identifiable quality assurance system that is in place in the jurisdictions where the services included in the Child and Family Services Plan (CFSP) are provided, evaluates the quality of services, identifies the strengths and needs of the service delivery system, provides relevant reports, and evaluates program improvement measures implemented?

Policy Description

Per DCF Policy 19-2, the responsibilities of the Quality Assurance Division, now known as the Bureau of Continuous Quality Improvement (BCQI), include:

- Developing, implementing, tracking and reporting on the Department's quality assurance plan;
- Monitoring the consistency, utility, propriety and accuracy of the Department's self-monitoring activities;
- Promoting coordination of quality assurance activities Department-wide through collaboration with the Quality Assurance liaisons from each region;
- Providing the second level review and tracking of managerial and urgent case practice issues identified through the Treatment Planning Conference/ Administrative Case Review process;
- Providing technical assistance and training to the Department's programs, facilities and regions in order to provide support for quality assurance activities and ensure consistency across programs, bureaus, regions and facility quality assurance committees; and,
- Participating in key strategic planning, program development, implementation and evaluation committees.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 31 was rated as a Strength because DCF had developed a quality assurance system that evaluated the quality of services, identified strengths and needs of the service delivery system, provided relevant reports, and evaluated program improvement measures.

Measures of Effectiveness

The Bureau of Continuous Quality Improvement conducts approximately 18,000 administrative case reviews (ACRs) annually, develops quarterly reports for the Juan F. Consent Decree Exit Plan and has recently reviewed 47 cases in 4 DCF Area Offices using the CFSR On-Site Review Instrument. Additionally, the Bureau routinely performs quality assurance activities at child-placing agencies and facilities through the Licensing Unit and Program Review and Investigations Unit.

Factors Affecting Performance

The Bureau of Continuous Quality Improvement has five major functions. These include Internal Quality Improvement, Workforce Development, External Quality Improvement, Planning and Program Development, and Emergency Response. The Bureau is organized into divisions to address each of these areas.

- Internal Quality Improvement
  The Division of Internal Quality Improvement is responsible for managing and implementing the Administrative Case Review (ACR) process across the Department's 14 Area Office.

- Outcome Measures Oversight Division
  The Outcome Measures Oversight Division is responsible for the completion of quarterly case reviews as described in the Juan F. Exit Plan to determine the extent to which the agency is meeting its performance mandates involving the 22 outcome measures. Areas of strength and those needing improvement are identified and utilized to help govern the agency's practices and resource allocations. This includes our collaborative efforts and liaison work with the Court Monitor's Office in the measurement and assessment in the key areas of treatment planning and needs met for our children and families, with the goal of exiting from the Juan F Consent Decree. The Division also develops and conduct ad hoc reviews and studies involving agency operations statewide and other areas of interest as determined by senior management and other interested parties such as the Court Monitor, the Juan F. plaintiffs, private providers, and the legislature.

- External Quality Improvement
  External Program Review is carried out by the units of Program Review and Evaluation, Licensing, and Medical Review.

  Under State Statute 71a-145, DCF is required to license any agency that cares for or boards children. The Department licenses 242 providers in 5 major categories, including Child Placing Agencies; Residential Treatment Centers (including Safe Homes, Shelters, and Group Homes); Extended Day Treatment; Outpatient Clinics and Residential Education Centers.

  In addition to the licensing function, the Bureau also ensures quality services in congregate care settings through the Program Review and Evaluation Unit (PREU). PREU ensures that providers maintain programs that meet the expectations and standards set by other departmental entities. An additional responsibility includes the approval of out-of-state programs for use by the State of Connecticut.

  The Medical Review Division is a new organization with the responsibility of reviewing, in collaboration with PREU, the medical practices and procedures in place in licensed DCF programs. Areas of improvement are noted and brought to the attention of the Bureau of Behavioral Health and Medicine for remediation.

- Workforce Development
  In-Service and Pre-Service Training is conducted through the Training Academy. This is seen as a major focus of our quality assurance work, as it ensures that all social work staff have a strong foundation in the principles and practice of effective case management and social work practice. A major emphasis of the Training Academy has been the provision of in-service and pre-service training. Currently, however, attention is being paid to ways in which the workforce can be better

recruited, trained and retained through partnerships with nearby institutions of higher education (IHEs). These partnerships are being pursued in order to provide staff with the opportunity to earn advanced degrees and/or acquire additional skills.

The Training Academy strives to provide timely training programs that assist the DCF staff and community providers to respond effectively to children and families needing services. Through the implementation of a competency-based system, training programs and other initiatives relate specifically to the work tasks and ongoing development of DCF staff.

- Division of Planning and Program Development
  The Division of Planning and Program Development includes the units of Policy & Accreditation, Closed Records and Risk Management. Additionally, this Division is responsible for coordinating activities related to the Child and Family Service Review, including implementing the Connecticut Comprehensive Outcomes Review (CCOR) and facilitating planning activities for the CFSR.

  The CCOR, which adheres to the CFSR framework, was piloted during the spring of 2008. The Division of Planning and Program Development, in partnership with the Office of the Court Monitor and staff from various other DCF divisions, reviewed 47 cases and interviewed approximately 150 case participants and stakeholders in four DCF Area Offices. The purpose of the CCOR is to prepare the state for the upcoming CFSR and to develop our own internal capacity to implement a comprehensive case review after the Department exits from federal court oversight.

  The Risk Management Unit is responsible for receiving, processing and coordinating agency response to critical incidents and significant events as defined by DCF policy. The risk management process includes a review of all Critical Incidents, Significant Events and Facility Hotline Reports. The Risk Manager examines trends related to type of incident, provider, areas of concern, Area Office, or follow-up needed.

- Emergency Response
  The Emergency Response Unit serves as a liaison entity between DCF and the Department of Emergency Management and Homeland Security. Staff play a major role in ensuring that appropriate planning occurs to ensure that DCF providers and organizational units develop plans and policies to respond to emergency situations. In addition, staff participate in the CTRP project which provides behavioral health support to individuals who require such services as a result of a local or statewide tragedy.

In addition to the work of the Bureau of Continuous Quality Improvement, the Office of the Ombudsman is also a critical component of the state's quality assurance system. The staff of the Office of the Ombudsman interacts with clients and with the public at large to address concerns about the Department's services. In 2005 the Area Office recorded 2,185 inquires, 3,788 in 2006 to 6,735 in 2007.

D. Staff and Provider Training

Item 32: Initial Staff Training. Is the State operating a staff development and training program that supports the goals and objectives in the CFSP, addresses services provided under titles IV-B and IV-E, and provides initial training for all staff who deliver these services?

Policy Description

Per DCF Policy 11-4-2, new or former employees, or employees transferred into social work staff positions from other disciplines, must complete specialized core pre-service training during their first twelve (12) months with the Department. All training is delivered by the DCF Training Academy, a division of the Bureau of Continuous Quality Improvement. There are a total of 34 days of training. Components of the pre-service training include but are not limited to:

- Child Protective Services
- Casework Process
- Family Engagement
- Effects of Abuse/Neglect on Child Development
- Separation and Placement Process
- Car Seat Installation/Safety Training
- Cultural Competency
- Legal Training
- Substance Abuse
- Domestic Violence
- Mental Health

Initially, new social work staff are integrated into the Department by being placed in Training Units in one of the fourteen area offices. Training Unit supervisors utilize the "Transfer of Learning Guide" developed by Training Academy staff to assess:

- the worker's ability to apply what is being taught in the class
- and further training needs.

Pre and post tests are administered to staff in an effort to assess the learning process and to identify additional learning needs. The Training Unit supervisor and Training Academy staff work together to communicate trainee accomplishments and/or identify areas needing improvement.

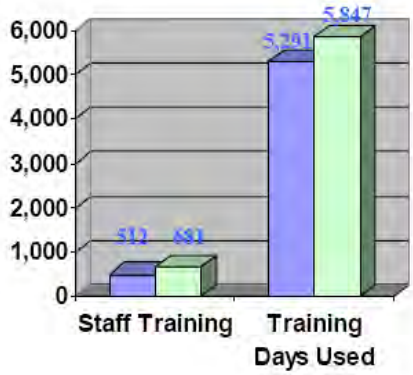
Summary of Performance in Round One of the CFSR

In the 2002 CFSR, Item 32 was rated as a Strength because DCF operated a staff development and training program that supported the goals and objectives in the CFSP and provided initial training for all staff who deliver services provided under titles IV-B and IV-E. The Department operates a Training Academy, which provides pre-service, in-service, and community training to meet the full range of DCF's training needs.

Measures of Effectiveness

During the 06-07 fiscal years, the Training Academy trained 198 new staff and they were broken into 10 Pre-service groups. Each new hire attends 25 classes and receives 33 total days of training. The below chart reflects the total days of training used and the number of staff that were trained during fiscal year 06-07. These totals represent staff that were hired in the prior fiscal year but also attended classes in fiscal

year 06-07. In addition, these totals only reflect those trainings that were attended during fiscal year 06-07 by newly hired staff:



Fiscal Year	Staff Training	Training Days Used
FY05/06	512	5,291
FY06/07	681	5,847

The Training Academy continues to provide Pre- service training with a two-tier system. Cases are assigned on an on going basis, and from the date of hire, new - social workers and social worker trainees carry a 100% caseload at the completion of the first four months of training (Tier 1). The second tier is completed during the 5th to 12th month (Tier II). Tier II training classes build upon the trainee's experience in the region/area office. This approach to Pre-service assisted the area offices with caseload utilization without compromising services to children and families.

Factors Affecting Performance

The Training Academy has made several changes to the Pre-service training curriculum by imbedding new practice changes and incorporating various support mechanisms to ensure the transfer of learning from the classroom to the area office. The trainings below reflect some of the newly incorporated training initiatives:

- The Global Appraisal of Individual Needs (GAIN Short Screen), is an instrument that has been implemented statewide and is now introduced in the pre-service training. This general assessment is to identify various problems among adolescents and adults in the general population with the goal of; identifying those in need of a longer, more detailed assessment, identifying those who may benefit from a brief intervention, and to guide staff to make effective referral and placement decisions.

- The Transfer of Learning activities for pre-service staff were developed to give staff the opportunity to apply the knowledge and skills they learn in training to the day to day performance of their job duties. Over the course of the year, CWLA worked closely with the Training Academy trainers in order to assist with the development of TOL activities for each of the pre-service classes. A manual of the pre-service TOL activities was developed and made available on the Training Academy website. As part of the Retention and Recruitment Grant, Fordham University developed an evaluation tool for TOL. The tool would allow Fordham the opportunity to measure the activity utilization by staff.

CWLA reviewed the pre-service curriculum in order to identify and further develop existing competencies that were embedded into the training program. The competencies were then earmarked as a major focal point for the Transfer of Learning manual.

- During this fiscal year, the Training Academy coordinated a mini focus group with area office training supervisors and academy staff. The focus group discussed the importance of having newly appointed and or promoted training supervisors go through a training that would serve as an orientation to their role, human resources, and the purpose and function of the Training Academy.

- The trainers reviewed the pre-service curriculum in order to determine the appropriate placement of the Structured Decision Making tools within each class. Two Training Academy trainers went through the Train the Trainer Model for Structured Decision Making. They were both certified by the Children's Research Center to train DCF staff and community providers. Since their certification, they have offered three make-up sessions to staff. The training has been restructured so that it is offered in its entirety to pre-service staff and then reinforced throughout the various trainings.

- As part of the ongoing work at the Training Academy, the trainers are expected to review their pre-service curricula in order to update information based on current standards and practices within our agency and Child Welfare. To foster that mindset, weekly staff meetings with the trainers are held to discuss such matters. Many times, guest speakers are invited to meet with the trainers to review changes in practice. To heighten their awareness of the difficulties the area offices are having with reaching compliance with the treatment plans, all the trainers reviewed two cases each for the Hartford office treatment plan audit. This process was extremely enlightening and allowed the trainers to identify areas of strengths and needs to discuss in their trainings.

- The Training Academy meets bi-monthly with all of the area office Training Supervisors and Program Supervisors to disseminate information, and update materials as it relates to the Academy and the newly hired staff. During this period under review, the meetings included more on site training and information that would be beneficial to this audience in their respective roles. A few of the topics included but were not limited to human resources-labor relations, hotline, family conferencing, equal employment opportunity.

Item 33: Ongoing Staff Training. Does the State provide for ongoing training for staff that addresses the skills and knowledge base needed to carry out their duties with regard to the services included in the CFSP?

Policy Description

Per DCF Policy 11-3-1, The Training Academy is tasked with developing an annual training plan which takes into account information provided through training needs assessments, casework evaluations, information from special case reviews and the Commissioner's policies. The plan is intended to establish the Training Academy's priorities for the year. The annual plan includes:

- summary of the major Department staff training needs
- training program planned for the coming year as well as the target dates for delivery
- description of proposed collaborative training efforts between the Training Academy and institutions of higher education

- description of the Training Academy's plan to seek training grants or to recoup funds from the federal government and other sources.

In addition to ongoing training of all staff, per DCF Policy 11-4-1, newly appointed supervisors complete a pre-supervisory training program as soon as possible but no later than one year after appointment. Training must be provided through a formal, educational in-service program and in supervisory sessions with their Program Supervisor.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 33 was rates as an Area Needing Improvement because although there are a wide range of ongoing training opportunities, stakeholders noted that there is no standardized core curriculum for staff beyond the pre-service training. Stakeholders reported that although staff ere entitled to five days of ongoing training, attendance was not required, and there is was no evidence of a coordinated DCF effort to promote ongoing skills development.

Measures of Effectiveness

During FY06-07, the Training Academy provided a number of "In-Service" trainings. Approximately 2,613 staff received the equivalent of 8,496 days of training. This represented approximately 61% of the total DCF workforce receiving in-service training every year. These totals have risen from FY05-06.

Fiscal Year	Staff Training	Training Days Used
FY05/06	2,379	5,214
FY06/07	2,613	8,496

Factors Affecting Performance

In January 2006, the Training Academy launched a new on-line Course Catalog for In-Service Training. This Catalog was created in an effort to provide continual learning opportunities for staff, as well as support Principle Five of the Departments' Mission of Work Force Development; " *The work force is highly qualified, well trained and competent, and is provided with the skills necessary to engage, assess, and intervene to assist children and families achieve safety, permanence and well-being*."

During the FY 07-08, the Training Academy focused its resources again to provide culturally competent and practical in-service training. The Academy offered an array of over 70 classes including but not limited to topics such as: Advanced Supervisory Workshops: Coaching for Improved Performance, Enhancing the Workplace through Better Communication, Emerging Street Gangs and Drug Recognition,

CPR, Human Trafficking and Immigration Issues, Professionalism, Teen Substance Abuse and The Invisible Addiction: Problem and Compulsive Gambling.

The Training Academy has developed and implemented three certification courses: A two day course entitled Engaging Fathers in Child Protection Services, a six day course entitled Permanency Planning, and a two day course for Training Unit Supervisors. These courses were developed to educate, and enhance the skill and competency level of staff from the level of social worker, supervisor and manager.

The Training Academy continued to provide coordination between the Training Academy's pre-service program and the Area Office training units. Academy Trainers are assigned as liaisons to pre-service groups, which consist of trainees from the 14 Area Offices. The Academy trainers provide feedback to the area offices supervisors to enhance the performance of trainees. The Training Academy also took an active role in ensuring transfer of learning by specific activities that training supervisors could conduct with trainees that would re-enforce learning and support best practice. Training supervisors met frequently with the Training Academy staff as well as with the designated liaisons, to ensure that the transfer of learning activities was timely, effective and productive.

The Academy continued to assist the Area Offices in developing and carrying out the Area Office Training Plans. Identified training needs were met by using in-house staff to train or contracting with expert providers. In 2007, the Manchester area office hosted an in house Indian Child Welfare Act training provided national trainer o provide data on the ICWA laws, as well as the case work strategies and supervision needed to effectively meet the mandates of this act in regards to legal and child placement requirements.

Training has been tracked on a statewide basis using a database software program called EZ Tracker. EZ Tracker has also allowed the Training Academy to provide individual reports upon request. Staff seeking promotional opportunities are able to obtain a report that certifies the training accomplished. The Training Academy is currently working towards migrating to a new software program called LMS (Learning Management Software), a web based application that will allow staff to register for classes electronically as well as launch web based training content. The program is designed so that supervisors can create a learning plan for staff and assign specific courses. This new system will also give users the ability to print their own transcripts. LMS can accommodate a Virtual Learning Environment (VLE) which will allow staff to receive training in remote locations and cut down on travel time and cost.

DCF policy dictates that staff receive five days of in-service training per year, however this is not regulated systematically at this point. In the Training Academy's current workforce development plan, a goal is to institute individualized professional development plans that will formalize in-service training.

Evaluation forms are part of all pre-service and in-service training offerings. At the conclusion of in-service training, students have further opportunity to provide feedback. Through training liaisons, the training academy solicits additional feedback about the trainings offered.

Professional Development for Supervisors and Managers

As part of the efforts undertaken under the auspices of the ACF grant funded partnership with Fordham University, the Training Academy provided leadership for several other significant initiatives focused on professional development at the supervisor and manager levels. The strategy to focus on development in these areas was based largely on the results of a job satisfaction survey administered by Fordham University in 2004 which revealed that supervisors were less satisfied on the whole compared to workers

and managers.

Concerning managers, a Leadership Institute for management teams was implemented in four area offices and further development of a behavioral interviewing process and training was held for over sixty hiring managers. Several programs were developed and implemented for supervisors: a Direct Practice Clinical Consultation program was provided to four groups of area office supervisors (35 total), a training program targeting supervisors of training units, and a professional development plan for supervisors, including training and other components.

Critical supervisory competencies were identified in the formation of the professional development plan for supervisors, and training was geared towards these competencies for staff at various stages of professional development. In line with that strategy, training is delivered in four discrete, though overlapping, components: (1) a pre-hire component that outlines the nature and demands of the job and helps potential candidates decide if they are interested and capable of moving into the position; (2) an initial orientation to the position for those just hired to help them make the initial transition into their new role, (3) the core training, which is more extensive training designed to address all the critical competency areas, and (4) advanced training, which is designed to enhance supervisor competency in identified areas. The four training components for supervisors are offered to new field supervisors. New supervisors are expected to and typically take this training.

Fordham University re-administered the job satisfaction survey in 2008. While overall satisfaction scores were mostly consistent with the results in 2004, there was an increase in job satisfaction at the supervisor level. Additionally, the data revealed a positive correlation between satisfaction scores and the amount of training staff received. These results support the current direction of the Department with respect to workforce development.

More advances are expected as the Training Academy is currently working with Human Resources to develop and implement a comprehensive workforce development and succession plan. Efforts are already underway to build a comprehensive management training plan and leadership institute, to develop a process to institute individual development plans in an effort to provide continual learning opportunities for more seasoned staff, and to provide support to staff in their career development including career counseling and interview training.

Mentoring Program – Social Work Staff

The Mentoring Program is a partnership between a mentor and mentee, sponsored by the Department, focusing on interpersonal support, guidance, sharing of ideas, expertise and role modeling. It is a voluntary program in which a social worker or supervisor are matched with a manager. Its objective is to enhance personal and career development of DCF social workers and supervisors by providing them with a mentor to assist them in their overall professional development. This program continues under the Recruitment and Retention Grant with Fordham University. A significant amount of time was spent successfully determining parameters and criteria as it relates to the outcome measures. The challenge in the upcoming fiscal year will be to continue assessing the effectiveness of the program.

The mentoring Program continued in an effort to meet the increased needs of staff. There were 26 matches for the social work staff in the 2007 cohort.

Clerical Mentoring Program

In an effort to meet the needs of non-social work staff, the Academy piloted a mentoring program for clerical staff. On March 31, 2006, the Training Academy kicked-off a pilot with 12 mentor/mentee

matches. The program was very successful. This program which has been uniquely tailored for clerical follows the same structure as the Social Work mentoring program. A second cohort began on March 26, 2007 and ended on February 20, 2008 with 7 matches successfully completing the program. The Training Academy is currently overseeing a third cohort which began on April 25th with 11 matches participating.

Graduate Support Programs

The Department continued to offer an educational un-paid leave program called the Graduate Education Stipend (GES). This stipend program continues to provide an opportunity for a reduced caseload allowing staff the opportunity to complete internships in DCF facilities or social service agencies in other parts of the community. The program requires participates to work a 32 hour work week, and allows one day unpaid for academic studies. The participants were required to give a commitment to remain employed by DCF at least two years following the completion of the program.

In 2004, the Department initiated another graduate support program called the MSW Field Education Program. The program was designed to allow agency staff in graduate programs to do an on-the job internship. The response from the participants was phenomenal, largely because the field supervisor contracted by the Training Academy was a former Director at DCF. The field supervisor possessed the skills and talent to understand how to overcome the specific systemic roadblocks and bureaucracies of the DCF system and systems of care at large.

Post Master's and Other Professional Development Certificate Programs

DCF's Training Academy provided funding for 16 social work staff individuals to participate in post master's programs offered by Springfield College. Twelve staff participated in the program entitled, "Advance Practice with Children and Adolescents," and four staff participated in a program focused on adolescent development. Also, DCF funded one staff to participate in the Latino Community Fellows Program provided by Saint Joseph College, and four staff to participate in the Business Master Program for Public Service Professionals provided by the University Of Connecticut School Of Business Executive Education

Item 34: Foster and Adoptive Parent Training. Does the State provide training for current or prospective foster parents, adoptive parents, and staff of State-licensed or State-approved facilities that care for children receiving foster care or adoption assistance under title IV-E? Does the training address the skills and knowledge base that they need to carry out their duties with regard to foster and adopted children?

Policy Description

Per the DCF policy manual Chapter 41, all foster and adoptive parents participate in the PRIDE training as part of the licensing process. Additionally, this chapter in the policy manual describes specific training that must be provided to foster parents of children with complex medical needs.

The Juan F. Exit Plan requires the Department to offer foster parents 45 hours of post-licensing training within 18 months of initial licensure and at least 9 hours each subsequent year. However, relative, special study and independently licensed foster parents require 9 hours pre-service.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 34 is rated as a Strength because DCF provided adequate training for current or prospective foster parents, adoptive parents, and staff of State licensed or approved childcare facilities.

Measures of Effectiveness

The Department has consistently met the Exit Plan Outcome Measure for foster and adoptive parent training, offering 100% of foster and adoptive parents the required number of training hours for 16 consecutive quarters dating back to the second quarter of 2004.

While we are consistently offering the training as specified in the Exit Plan, foster parents who participated in a recent series of focus groups reported that the ongoing training curriculum should be strengthened in order to better meet their needs. In particular, many of the participants suggested the Department provide more training to help them deal with challenging behaviors and with adolescents.

Factors Affecting Performance

Pre- Service Training: The Department requires all applicants for foster care and adoption to participate in the pre-service course known as "Parent Resources for Information, Development and Education" (PRIDE). The original curriculum was purchased through the Child Welfare League of America. The Department continues to utilize the updated and revised version of PRIDE implemented in 2005. PRIDE uses a group assessment/training format and the trainers are DCF staff from Foster and Adoptive Service Units (FASU) in each of the DCF Area Offices. Groups meet in community venues throughout the state for ten (10) sessions, 2 ½ - 3 hours each.

Post-Licensing Training: Licensed foster parents are required to complete post-licensing training. OFCS recently completed a comprehensive review of the system in place, including the minimum of required hours, and developed a new system. The intent of the revision is to provide multiple opportunities for foster parents to obtain the training they want and need in a manner that suits both their learning style and their life style. Each foster parent is required to attend six (6) trainings a year and there are courses that are strongly recommended, however, they are not mandatory unless done so through a formal process. The Department entered into an agreement with the Foster Parent College, an organization that provides online and DVD interactive courses for foster parents on a wide variety of topics. Foster parents will also be able to count attendance at certain Support Group meetings and community-based trainings.

Foster Parent College: OFCS purchased a pilot program from Foster Parent College to evaluate its effectiveness. Foster Parent College is a training course that is offered online. Foster Parent College's on-line training program can provide DCF with an online management system to allow staff to register members, assign trainings units to participants, monitor usage, create customized reports, view course content, and schedule and teach courses. Foster Parent College also offers a DVD Library of 17 courses and an "Off Road Parenting" Book/DVD in Spanish. Foster Parent College offers training on the following topics: Kinship Care, Positive Parenting, ADHD/ADD/ODD, Reactive Attachment Disorder, Safe Parenting, Self Harm, Running Away, Sexualized Behavior, Lying, Anger Outbursts, Stealing, Wetting and Soiling, Sleep Problems, Fire Setting, and Eating Disorders.

In January 2007, fifty (50) foster parents from the Danbury, Norwich, and Willimantic Offices participated in the pilot program. Due to the positive response, OFCS has purchased 2400 units of on-line

training to be offered to foster/adoptive parents served by each of the Area Offices; 5 DVD Libraries (17 titles); and "Off Road Parenting" book/DVD in Spanish for each Area Office.

E. Service Array and Resource Development

Item 35: Array of Services. Does the State have in place an array of services that assess the strengths and needs of children and families, that determine other service needs, that address the needs of families in addition to individual children to create a safe home environment, that enable children to remain safely with their parents when reasonable, and that help children in foster and adoptive placements achieve permanency?

Policy Description

The Department of Children and Families, established under Section 17a-2 of the Connecticut General Statutes, is one of the nation's few agencies to offer child protection, behavioral health, juvenile justice and prevention services. This comprehensive approach enables DCF to offer quality services regardless of how a child's problems arise. Whether children are abused and/or neglected, are involved in the juvenile justice system, or have emotional, mental health or substance abuse issues, the Department can respond to these children in a way that draws upon community and state resources to help them.

In order to meet its mandates as the state's consolidated children's agency, the Department maintains an extensive service array that includes in-home services, foster care, community-based behavioral health services, group homes and a range of residential settings.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 35 was rated as a Strength because the State had in place an array of services to meet the needs of children and families. There was general consensus among stakeholders commenting on the issue of service array that DCF had access to a wide range of services to assist children and families.

Measures of Effectiveness

The consensus among DCF's various stakeholders continues to be that the Department has access to a wide range of services to meet children's needs. In a recent staff focus group, social workers and social worker supervisors noted that the availability of child welfare services has improved in recent years. Recent focus groups of foster parents also indicate that they perceive a wide range of services are available through DCF, although they have concerns regarding service accessibility (see Item 36).

Factors Affecting Performance

The Department has continued to expand its service array across all its mandates since the 2002 CFSR. This has included both contracting for new services as well as the expansion of our own internal capacity. For example, domestic violence consultants are now available at every one of the fourteen Area Offices to provide social work staff with appropriate consultation on cases where this is a presenting issue. The Department has added regional medical teams comprised of child psychiatrists and pediatricians to provide consultation to staff on issues of medication and medical needs for children.

Contracted services have also been expanded to meet the needs of children and families. These include:

Early Childhood Programs: The purpose of these programs is to promote positive parenting skills, healthy development and school readiness of children ages birth to 6, who may be identified as at risk for abuse and/or neglect and/or having behavioral problems or mild developmental delays, to enable them to function optimally in future social and learning environments. There are four programs serving the Norwich, Hartford, Waterbury, and Willimantic DCF Area Offices.

Parent Education and Assessment Service (PEAS): Provides strength-based parent and child assessments, parenting education, and referrals to community services for parents and families referred by DCF for children 8 or younger. This program currently serves the Manchester, Torrington, Bridgeport, Waterbury, Norwich, Meriden, Willimantic, New Britain, Middletown and Hartford Area Offices.

Therapeutic Child Care: The therapeutic childcare program category is comprised of seven (7) childcare programs with a range of attached support services, including parent-child programs and an after school program. The target population is children ages birth to 8. The purpose is to provide specialized services to address the needs of children at risk of being in the child welfare system or who are already in the child welfare system.

Drug and Alcohol Prevention Programs: Eighteen (18) prevention programs serve youth ages 6 to 18 years through social skill training, wellness promotion, family involvement, peer interaction and community activities.

Parent Aide Programs: Parent aide programs provide in-home services for up to six months to families under stress. The goals are to reduce risk of abuse and neglect of children, improve family functioning and parenting skills and reduce the family's social isolation while improving self-sufficiency. Twenty-six (26) programs serve families statewide.

Intensive Family Preservation (IFP): IFP programs provide short-term, intensive, in-home services to strengthen families and reduce the risk of further abuse and neglect for families with children at imminent risk of out of home placement. Twenty-three (23) programs serve families statewide.

Project SAFE: Project SAFE provides priority access to substance abuse evaluations, drug testing, and substance abuse treatment services for DCF-involved primary caregivers. One program serves all Area Offices statewide.

Family Based Recovery (FBR): Family Based Recovery is an evidence-based model focusing on infants (ages 0-24 months) exposed to prenatal or environmental substance abuse and their families. Services including a range of clinical interventions, family supports, crisis intervention, case management and aftercare, substance abuse screening and access to psychiatric consultation are provided through a team model. Services are provided for up to 18 months. The Department currently funds five (5) FBR teams serving up to 60 families.

Supportive Housing for Families (SHF): Supportive housing for families provides permanent housing and intensive case management services to DCF families. Through our contracted agency, Connections, Inc., in conjunction with the family and the Department of Social Services, we provide intensive case management services to assist families to develop and utilize a network of services in the following areas: economic (financial support, employment assistance), social (housing, transportation, family support, parenting education, child care) and health (medical/mental health care for adult and child, relapse prevention, and domestic/child/substance abuse issues).

Respite: Six (6) programs offer temporary care in the home or community to children and adolescents with emotional and/or behavioral special needs in order to provide relief to their caregivers. Respite care is intended for children involved with DCF and non-DCF children involved in the local system of care. It is intended to assist these children and youth to be maintained in their homes and communities. Services are available statewide.

Family Violence Programs: These programs provide specialized counseling services, outreach, consultation and related support services. Counseling includes crisis intervention, individual, group and family counseling. Programs have flexible schedules with 24-hour coverage.

Community Emergency Services: Three (3) programs serving Willimantic, Waterbury and Norwich Area Offices provide home-based, crisis intervention and emergency host home placement.

Care Coordination: Eleven (11) programs statewide use the intensive wraparound process with families to coordinate community-based services for children that have complex behavioral health needs. Children ages 0-18 receive a child and family team meeting in order to meet their individualized needs in the home, school and community. These programs follow the Kid Care philosophy of family-driven interventions.

Emergency Mobile Services: Eleven (11) programs statewide provide crisis intervention and assessments for children in the community including homes, schools, and other locations in the community. Services include: 24-hour phone intervention to do triage; mobile assessment 10-7 daily and 1-7 on the weekend; 6-week crisis stabilization services, including referrals to longer-term treatment if necessary; and, medication evaluation.

Intensive In-Home: Intensive In-Home includes a variety of evidence-based and promising practices through out the state. Intensive in-home services are provided for 3-6 months for the child and their family. They are intended for children (and their families) who are at risk of out-of-home placement or returning from a hospital or detention or a residential treatment center. Intensive In-Home programs follow one of five intensive in-home program models: Multidimensional Family Therapy (MDFT); Intensive In-home Child and Adolescent Psychiatric Services (IICAPS); Family Functional Therapy (FFT); Family Based Recovery (FBR) and Multi-Systemic Therapy (MST). MST targets the families of juvenile males and females up to the age of 17 with substance abuse and/or conduct disorder problems. All of the intensive in-home programs combined have the capacity to serve over 2200 families annually.

Outpatient Adolescent Substance Abuse Treatment Programs: Outpatient adolescent substance abuse treatment and evaluation services are for adolescents who are at risk for substance abuse or are substance abusers, inclusive of nicotine. Services include comprehensive assessment, individual group and family therapy, and drug screening at an outpatient or intensive outpatient level of care. Six (6) programs provide services to youth in their local DCF Area Office and those communities.

Child Guidance Clinics/Out Patient Psychiatric Clinics for Children: These providers deliver a range of outpatient behavioral health services to children, adolescents and their families. Services are designed to promote mental health and improve functioning in children, youth and their families and decrease the prevalence and incidence of mental illness, emotional disturbance and social dysfunction. The target population is all children, youth and families in need of outpatient mental health services. However, priority access is given to DCF-involved children and families. The Department and the child guidance clinics work together to emphasize a family, school and community focus in the evaluation and treatment of children. There are twenty-five (25) clinics statewide serving all Area Offices.

Extended Day Treatment: There are twenty-two (22) programs located throughout the state providing an array of integrated behavioral health treatment and rehabilitative support services for children and adolescents who have psychiatric disorders and their families in partnership with the system of care. The services are delivered through a structured, intensive, therapeutic milieu and through the broader ecosystem. Services are provided year-round during non-school hours. A team of multi-disciplinary staff including psychiatrists, masters and doctoral level clinicians and paraprofessionals provide a broad array of treatment and psychosocial interventions. The program serves as a critical resource for maintaining children and adolescents in their communities. The program is intended to divert youth at risk of requiring more restrictive levels of care and to serve as a resource for children returning to the community from more restrictive levels of care. This service is available to foster, adoptive and biological families and their children, with priority access afforded to DCF-involved clients.

Crisis Stabilization: There are two (2) Crisis Stabilization programs: One serving Manchester, New Britain and Hartford; the second servicing New Haven, Middletown, and Meriden. Each program has 8 short-term, 15-day crisis stabilization beds designed to provide evaluation and assessment, medication management, short-term residential treatment and clinical support to the child and their family, with the goal to transition the child back to the care-giving family with in fifteen days.

Permanency Diagnostic Centers: Two (2) permanency diagnostic centers provide immediate, overnight care and services to children based upon a 24-hour, 365-day admission capacity. Services are directed toward children who have experienced multiple placement disruptions. Children receive intensive clinical assessments, significant levels of structure and supervision, and care coordination related to family reunification, matching with an appropriate surrogate family or other permanent placement. Services are available to all DCF Area Offices.

Safe Homes: Safe Homes are congregate care programs that provide short-term care, evaluation, permanency planning and a range of clinical and nursing services to children being removed for the first time from their homes due to abuse, neglect or other high-risk circumstances. Sixteen (16) programs serve all DCF Area Offices statewide.

Family Centers: Although varied throughout the state, these programs provide core services to support family reunification efforts. The services may include: assessment; orientation for children, biological and foster parents; supervised, therapeutic visitation; support groups; reunification; and aftercare. Many family centers also provide foster family and post-adoption support, including: social/recreational activities; parent education workshops; informal respite; support groups; and information and referral services. Eleven (11) programs serve all Area Offices statewide.

Foster and Adoptive Support Team (FAST): These programs, designed to assist in the retention of foster parents, provide assessment, behavioral management, support, respite and other therapeutic services to foster and adoptive children, their caretakers and/or parents in order to stabilize a child's living situation and avoid disruption. Services are provided in-home, at the provider agency and in the community. Five (5) programs serve all DCF Area Offices.

Foster Care Clinics: This program provides clinical services for children placed in DCF care for the first time. Their purpose is to provide a comprehensive multidisciplinary evaluation including comprehensive mental health, medical and dental evaluations. All DCF Area Offices are served.

Medically Complex Therapeutic Foster Care: This program is a family-based, service delivery approach providing individualized treatment for children, youth and their families. Treatment focuses on both medical and emotional/behavioral issues preventing the child/youth from participating fully in family and community life. Treatment is delivered through an integrated constellation of services with key

interventions and supports provided by linkages to medical professionals outside of the program and treatment foster parents who are trained, supervised and supported by qualified contractor staff. Six (6) programs serve all DCF Area Offices statewide.

Specialized Foster Care/Therapeutic Foster Care: Specialized foster care is a family-based, service delivery approach, providing individualized treatment for children, youth and their families. Treatment is delivered through an integrated constellation of services with key interventions and supports provided by foster parents who are trained, supervised, and supported by qualified program staff. Twelve (12) programs serve all DCF Area Offices statewide.

Specialized Foster Care: The Department continues to support a system of specialized foster care through contract agreements or other arrangements with private child placing agencies. The newest specialized foster care model in use in Connecticut is that of Multi-Dimensional treatment Foster Care. The target population is youth who have been released from detention and who are identified by the court or by our Department as requiring treatment at a residential level of care.

Supportive Work, Education and Transition (SWET) Programs: DCF has contracted with 3 programs statewide to provide services within a youth's particular community. These programs typically serve 8 youth and house older youth ready for greater independence. They provide the youth with the ability to apply the life skills they are living to their daily living situation. Additionally, the SWET programs will employ a full time Educational/Vocational Specialist who will work individually and in groups with the youth and partner with the local educational program to ensure each youth's individual educational outcomes are maximized.

CHAP Program: Community Housing Assistance Program (CHAP) is a scattered site apartment program with over 100 youth living in their own apartment in the community. Youth in these programs must have graduated from high school or received their GED and have enrolled in a full-time post-secondary or vocational program. Youth may receive 12 to 18 months of case management services from a community service provider, which range from financial literacy to employment readiness to educational success, while enhancing basic life skills.

Life Skills Program: The goal of the "Community Based Life Skills" program is to provide youth age 15 and older who are residing in foster care with the life skills necessary to successfully transition to adulthood. The Department currently contracts with 13 community service providers to provide community life skills to DCF-committed youth placed in community settings. During the State Fiscal Year of 2006-2007 approximately 248 youth were served by these community service providers, with almost 100 youth being placed on a waiting list.

Mentoring: Mentoring provides youth with a contact to their community other than the Department of Children and Families (DCF) Social Worker. Mentors and youth work together on a one-to-one basis to resolve issues identified by the youth. There are currently fifteen mentoring programs across the state.

Preparing Adolescent for Self Sufficiency (PASS): PASS Group Homes provide an environment that fosters the maximization of individual outcomes in areas of education, vocation, employability, independent living skills, health, mental health, community connections and permanent connections.

Re-Entry Program: A youth who is between the ages of eighteen and twenty one and who has left the care of the Department may be eligible to re-enter the Adolescent Services Program on a case-by-case basis in order to continue their education.

Post Secondary Education: The Department offers all our youth turning 18 the opportunity to continue with services on a voluntary basis. This allows for youth to participate in educational and training programs (e.g. college, vocational/trade schools, Job Corps, AmeriCorps) and receive continued support from The Department.

Jim Casey Initiative: This initiative is designed to ensure that youth aging out of foster care have increased opportunities for a successful transition to adulthood in the following areas: youth leadership, youth engagement, employment, housing and physical and mental health.

Wilderness School: The Wilderness School offers high impact wilderness programs in order to foster positive youth development. The school is designed as a journey experience, which is based on experiential and therapeutic learning models.

Job Corps Program: A no cost educational and vocational training program administered by the U.S. Department of Labor that helps youth ages sixteen through twenty-three by providing comprehensive job training and job placement. The Department presently has twenty-five slots between the two Connecticut sites for DCF-involved youth. There are other locations in the New England area that can be accessed for youth who are interested in training not offered at the Connecticut sites.

On an ongoing basis, the Department uses its own utilization data and data from the Connecticut Behavioral Health Partnership (CT BHP) to evaluate the state's service array and identify gaps. On a yearly basis, the Department submits budget options to the state Office of Policy and Management (OPM) and the Governor's Office which detail proposals for service expansion or modification based on the needs and gaps identified through the utilization data.

Item 36: Service Accessibility. Are the services in item 35 accessible to families and children in all political jurisdictions covered in the State's CFSP?

Policy Description

Since the inception of the Juan F. Consent Decree, the Department has focused on ensuring that DCF practice and service delivery are uniform and consistent across the state. To this end, the Department of Children and Families and the Department of Social Services (DSS), Connecticut's Medicaid agent, formed the Connecticut Behavioral Health Partnership (CT BHP) with ValueOptions serving as the Administrative Service Organization (ASO). The Partnership was initiated January 1, 2006 and serves as a redesign of the behavioral health service delivery system for low-income parents and children. The Partnership regularly analyzes issues of service accessibility and customer satisfaction as a method of continuous quality improvement in this area.

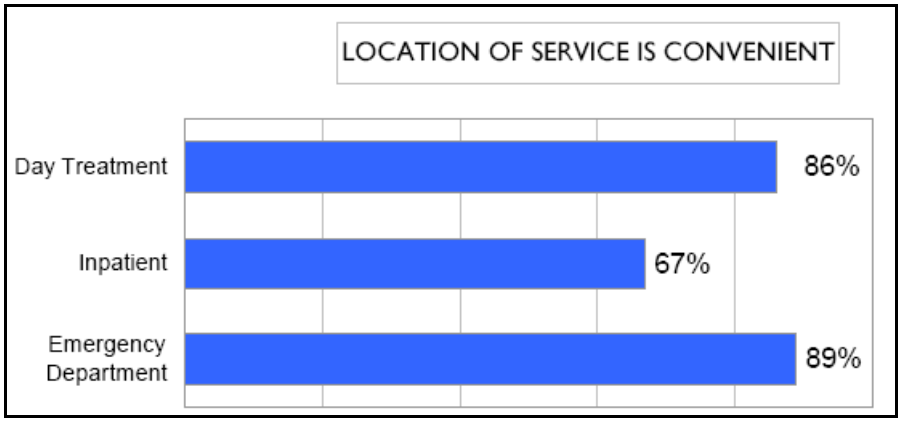
Additionally, individual DCF Area Offices regularly evaluate service utilization in their areas and make recommendations for program expansion or program modifications. This includes all services provided across the Department's mandates.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 36 was rated as an Area Needing Improvement because the accessibility of services varied considerable across the State and because there were long waiting lists for services in many of the Regions. Although the service array was praised by many stakeholders, there was general consensus that there are long waiting lists for services.

Measures of Effectiveness

In April 2008, the Connecticut Behavioral Health Partnership (BHP) issued results of a series of interviews conducted with 200 clients who received services in 2007. Overall, the majority of clients reported the location of service was convenient for them:



The BHP study also found that 94.4% of respondents reported that appointments for counseling services were at times that were convenient for them, up from 90.8% in 2006. Frequency of services was also rated highly by respondents, with 87.7% reporting they are able to get an appointment with their counselor as often as desired. Finally, 83.3% of respondents reported that their travel time to access services was 30 minutes or less.

In a recent focus group of DCF staff, many continue to be concerned that lack of transportation may continue to be a challenge for clients in order to access services. The BHP study confirms this is also a concern for clients themselves, with 23.5% reporting they have problems getting to appointments.

Factors Affecting Performance

There are several factors impacting the Department's improved performance in this area. The development of the Behavioral Health Partnership, in particular, has helped expand service availability and reduce wait lists for behavioral health services. In March 2008, the Department, in partnership with Connecticut's 211 Infoline, launched an online resource directory for staff to search for appropriate services for children and families. Search options allow social workers to search for services across the various regions of the state and in a language that is appropriate for the client. To date, the search function has been used over 2,600 times by staff to identify services for families.

When appropriate services are not available through contracted providers or through the network operated by the Behavioral Health Partnership, staff have the ability to access flexible funding dollars to purchase non-traditional and community-based services. The pool of dollars available for flexible funding has grown from $6,640,476 in state fiscal year 2003 to $29,567,439 in state fiscal year 2007.

Since the Department reorganized from three regions to fourteen local Area Offices, ensuring an equitable distribution of resources has been a major focus of the Department. In 2006, the Department's Division of Grants and Contracts produced an analysis of the distribution of service dollars and other resources across the Area Offices. This analysis helped inform the distribution of new funding in subsequent state budget cycles.

Item 37: Individualizing Services. Can the services in item 35 be individualized to meet the unique needs of children and families served by the agency?

Policy Description

DCF Policy 36-5 through 36-10, *Treatment Planning*, outlines the legal basis for treatment planning, the preparation for and development of treatment plans, as well as the frequency required for updating plans. The function of the treatment plan is described as the opportunity to identify in a time-limited and goal-oriented manner the problems, needs and services for all involved participants; the description of reasonable efforts to prevent placement or reunify children; the mutual responsibilities of the parties to achieve the identified goal; the evaluation of case progress towards; developed in compliance with federal and state requirements. Education, health and mental care are included in the assessment. Services offered and service provision, availability, utilization and results are assessed in the treatment plan, as is the appropriateness of the placement, visitation issues, and the permanency plan. Family plans include an assessment of initial reasons for DCF involvement, the present situation, a discussion of strengths and weaknesses and services offered, utilized and results. Service availability is also noted.

Since 2007, the Department has implemented Structured Decision Making (SDM) assessments at various critical points in the life of a case. One of the SDM assessments, The Family Strengths and Needs Assessment (FSNA), is used to evaluate the presenting strengths and needs of each family. This tool is used to systematically identify critical child/family issues and help plan effective service interventions. It assesses families (child/caregiver) on specific life domains. The FSNA assesses information about the entire family, not just the identified victim. The tool helps to focus case planning, monitors service provision, identifies resource needs in the state and assesses change in family functioning. The information obtained is used to inform the treatment plan.

The Department is committed to providing services which will meet the needs of children and youth. There will be times when traditional services are not sufficient to meet those needs. In those cases the child or youth may benefit from an Individualized Service Plan as described in DCF Policy 26-5.

The development and management of Individualized Service Plans shall is overseen by an Individualized Service Plan Oversight Committee. This Committee is comprised of the following individuals or their designees:

- Bureau Chief of Child Welfare
- Bureau Chief of Behavioral Health and Medicine
- Bureau Chief of Juvenile Services
- Bureau Chief of Continuous Quality Improvement
- Bureau Chief of Adolescent Services
- Bureau Chief of Juvenile Services
- Assistant Chief Financial Officer
- Office of Legal Affairs
- Director of Foster Care
- Director of Contracts
- Consultant retained in connection with WR vs. State of Connecticut settlement

This Committee meets monthly to review requests for services and to monitor the effectiveness of this approach to service delivery.

Summary of Performance in Round One of the CFSR

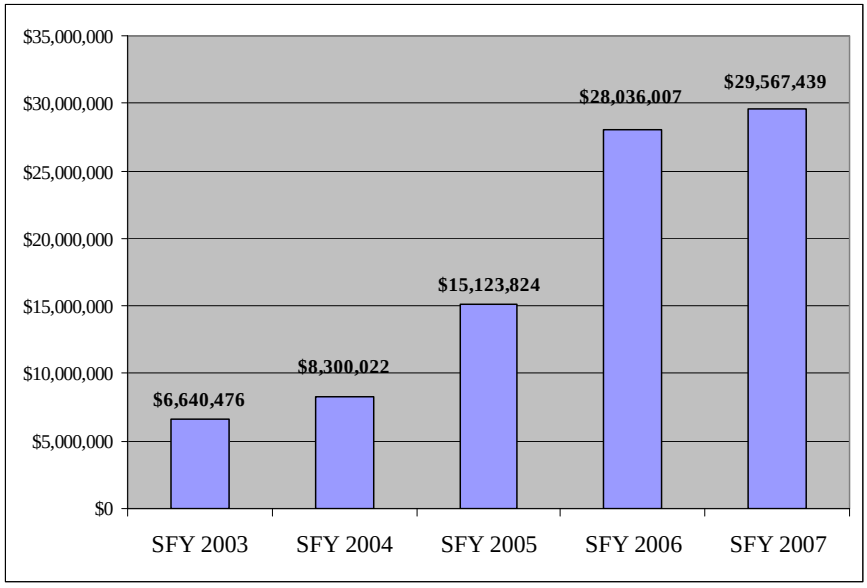
In Round One of the CFSR, Item 37 was rated as a Strength because of the availability of flexible funds to access services supports agency efforts to individualize services. Flexible funding was seen as a mechanism for enhancing DCF's ability to tailor services to meet the unique needs of children and families.

Measures of Effectiveness

In focus groups with both staff and foster parents, participants identify the use of flexible funds as an effective DCF practice for facilitating individualized service delivery. Similarly, service providers who participated in focus groups during the Connecticut Comprehensive Outcomes Review (CCOR) of the Bridgeport, Manchester and New Britain Area Offices report that flexible funds are viewed as an effective practice and that they promote efficient community-based service delivery.

Factors Affecting Performance

The Department has continued to increase its use of flexible funds to improve our ability to individualize services to meet the unique needs of children and families. Over the last five complete state fiscal years, the Department's investment in flexible funds has grown from $6.6 million to nearly $30 million:



Flexible Funding Expenditures, State Fiscal Year 2003 - State Fiscal Year 2007

An additional intervention intended to facilitate individualizing services for children is the Individualized Service Plan. Prior to any decision to initiate a person-specific Individualized Service Plan (i.e., any plan that involves paying for a setting that includes a living arrangement for a child in a not currently licensed setting) a case conference is scheduled that includes the Bureau Chief of Behavioral Health and Medicine. Such a conference may only be requested after the Area Office or facility has concluded that an Individualized Service Plan is essential to meet the needs of the child or youth and that no other reasonable alternatives are available. Similarly, the Bureau of Juvenile Services or a CT-BHP Intensive Care Manager may request a conference. In such cases the requesting Bureau or case manager coordinates the request with the Area Office as appropriate.

A summary of the Area Office's prior placement and treatment efforts, a synopsis of previous case conferences, and a current case conference clinical protocol are provided to the Bureau Chief of Behavioral Health and Medicine in advance of the Central Office conference. To be eligible for consideration for an Individual Service Plan, the child/youth will have had a significant history of multiple failed placement attempts, and will have a constellation of complex treatment and support needs which cannot be met safely and effectively by utilizing traditional services. In addition, the child may also be in discharge delay status for greater than 90 days.

As indicated above, the Individualized Service Plan Oversight Committee is responsible only for overseeing a process. Any individualized plan which results from this process will be approved only if costs fall within available appropriations and will be operationalized only upon receipt of approval by the Commissioner.

An individualized service plan proposed for a specific client is not included in the child's treatment plan or permanency plan until final approval has been received from the Commissioner.

F. Agency Responsiveness to the Community

Item 38: State Engagement in Consultation With Stakeholders. In implementing the provisions of the CFSP, does the State engage in ongoing consultation with tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies, and include the major concerns of these representatives in the goals and objectives of the CFSP?

Policy Description

There are a number of advisory councils established in statute that promote the Department's ongoing consultation with stakeholders. The State Advisory Council (SAC), established under Section 17a-4 of the Connecticut General Statutes, has the following duties:

- Make recommendations to the commissioner regarding programs, legislation or other matters which will improve services for children and youth;
- Review and advise the commissioner regarding the proposed budget on an annual basis;
- Educate the community at large on the policies, duties and programs of the department; and
- Issue any reports it deems necessary to the Governor and the Commissioner of Children and Families.

The SAC consists of seventeen members appointed by the Governor, including at least five persons who are child care professionals, one child psychiatrist licensed to practice medicine in this state and at least one attorney. The balance of the advisory council is representative of young persons, parents and others interested in the delivery of services to children and youth.

In addition to the SAC, each DCF Area Office has an Area Advisory Council that assists the local DCF Area Director in planning and implementing appropriate and effective services for children, youth and families. These councils meet the requirements for Regional Advisory Councils, established in CT General Statute, Section 17a-30 (Formerly Sec. 17-434). This statute states that the Commissioner shall create "… in each such region a regional advisory council to advise the commissioner on the development

and delivery of services of the department in that region and to facilitate the coordination of services for children, youth and their families in the region.

Originally a committee of the State Advisory Council to DCF that addressed system of care issues, the Children's Behavioral Health Advisory Committee (CBHAC) was formally established by the state legislature through Public Act No. 00-188. State statutes and CBHAC by-laws outline the following duties for this advisory group: submit a status report on local systems of care and practice standards for state-funded behavioral health programs to the State Advisory Council; submit recommendations concerning the provision of behavioral health services for all children in the state to the State Advisory Council; review federal Mental Health Services Block Grant plan for the State of Connecticut and make recommendations concerning said plan; serve as an advocate for children with serious emotional disturbance; and monitor, review and evaluate the allocation and adequacy of mental health services within the State.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 38 was rated as an Area Needing Improvement because the State did not consistently engage in ongoing consultation with all relevant community representatives. Specific concerns were noted by stakeholders with regard to the DCF's relationship with the court system. Stakeholders also noted that DCF did not sufficiently engage its various advisory committees in policy and program development.

Measures of Effectiveness

As part of the recent Connecticut Comprehensive Outcomes Review (CCOR), the Department conducted focus groups with service providers and members of the Area Advisory Councils in three of the DCF Area Offices. Service providers consistently reported that their partnerships with the DCF Area Offices have improved in recent years.

Factors Affecting Performance

The Department has been working at all levels to improve its partnerships with stakeholders and involve them in planning at both a systemic and case-specific level. The State Advisory Council continues to meet with the Commissioner or her designee on a monthly basis to provide feedback and make recommendations on the Department's services and policies. Feedback from the SAC and the other advisory councils is incorporated into the Department's CFSP and helps inform policy initiatives and budget option development.

In addition to seeking input from the various advisory councils, the Department also engages in ongoing partnerships with other state agencies that impact services for children and families. Ongoing meetings with the state Department of Developmental Disabilities (DDS) and the Department of Mental Health and Addiction Services (DMHAS) happen at the statewide and local Area Office levels in order to coordinate planning and transitioning of clients from the DCF system to the adult service system. Collaboration with the state Judicial Branch has also continued to improve since the 2002 CFSR, with regular ongoing meetings between the DCF Commissioner and Judicial administrators. These meetings have led to improved communication between DCF and the courts and have resulted in improved case processing and the identification of issues for further improvement.

There are currently two federally recognized tribes in Connecticut, the Mashantucket Pequot Tribal Nation and the Mohegan Tribe of Indians of Connecticut. Additionally, the Historical Eastern Pequot

Tribe and the Schaghticoke Tribal Nation were given preliminary recognition, but that was recently reversed and remanded for further proceedings. There are two other Native American tribes, recognized by the state, including the Golden Hill Paugussett Tribe in Colchester and the Nipmuc Indians of Southeastern Connecticut. Both are also seeking federal recognition.

The Department maintains close working relationships with the Mashantucket Pequot Tribal Nation and the Mohegan Tribe of Indians of Connecticut. The Department has memoranda of understanding with the tribes outlining responsibilities of the Department and the tribes regarding allegations of abuse and neglect involving tribal members. The Norwich Area Office, which oversees the catchment area that includes the two tribes' reservations, has liaisons to the tribes responsible for ongoing communication and facilitation of work related to specific cases.

The Department also receives ongoing feedback from its three citizen review panels, two of which are overseen by FAVOR, a statewide family advocacy organization for children's mental health. Their mission is to enhance mental health services for children with serious emotional disorders by increasing the availability, accessibility, cultural competence and quality of mental health services for children through family advocacy. Their annual reports include recommendations for improving DCF's services. These recommendations are incorporated into the Department's ongoing planning efforts, including the CFSP and action plans associated with specific departmental initiatives.

Item 39: Agency Annual Reports Pursuant to the CFSP. Does the agency develop, in consultation with these representatives, annual reports of progress and services delivered pursuant to the CFSP?

Policy Description

Connecticut develops an Annual Progress and Services Report (APSR) to describe accomplishments and new developments in the programs delivered pursuant to the Child and Family Services Plan (CFSP). Responsibility for the development of the APSR rests with the Bureau of Continuous Quality Improvement. Staff from the Bureau collaborate with internal and external stakeholders to develop the APSR. The most recent APSR was submitted to ACF on June 30, 2008.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 39 was rated as an Area Needing Improvement because of the need to engage in more consultation from both the tribes and the broader community in developing the CFSP and APSR.

Factors Affecting Performance

As noted in Item 38, the Department has a number of statutorily-created advisory bodies that are consulted for the purposes of getting feedback for the APSR. The State Advisory Council, in particular, provides ongoing feedback to the Department regarding the services delivered pursuant to the CFSP. In 2006 and 2007, the SAC's focus has been on reviewing and making recommendations regarding the Department's foster care services. Information from their reports was used to develop the APSR.

Parents and foster parents also provide ongoing input to the Department through the Connecticut Association of Foster and Adoptive Parents (CAFAP) and FAVOR, the state's children's mental health advocacy agency. Through their monthly meetings and annual conferences, these two organizations

provide a forum for parents and advocates to provide feedback to the Department about its services. While these two organizations are very effective in eliciting input from their constituents, the Department does not currently have a structured mechanism for getting feedback and input from parents whose primary reason for involvement with us is child protective services.

Since 2002, the Department has maintained formal agreements with the state's two federally recognized Native American tribes. In addition to governing the direct work of collaborating on child protective services with the tribes, the agreements also serve as the foundation for dialogue regarding services. Input from the tribes is used in developing the APSR.

Although the Department has many advisory committees and mechanisms for receiving input from stakeholders, an ongoing challenge for DCF is integrating all the input from the various bodies. In its 2007 study of the Department's quality improvement work, the Connecticut legislature's Program Review and Investigations Committee noted this as an area needing improvement at the Department. In response, the Commissioner has agreed to implement several measures aimed at improving communication between the Department and its advisory committees, as well as among the advisory committees.

Item 40: Coordination of CFSP Services With Other Federal Programs. Are the State's services under the CFSP coordinated with the services or benefits of other Federal or federally assisted programs serving the same population?

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 40 was rated as a Strength because DCF engaged in extensive coordination with other agencies in developing and implementing the KidCare initiative. According to the 2002 Statewide Assessment, DCF maintained Memoranda of Agreement with public agencies such as the Judicial Branch, the Departments of Social Services, Mental Health and Addiction Services and Mental Retardation (now the Department of Development Services).

Factors Affecting Performance

In order to facilitate interagency collaboration, the Department continues to maintain Memorandums of Understanding (MOU) with several public agencies including the Judicial Branch, Department of Social Services, Department of Developmental Services and Department of Mental Health and Addition Services. The purpose of the MOUs is to facilitate interagency programming and allow for smooth transition between the mandates of a number of state agencies. The Department also maintains numerous contracts with private providers, including but not limited to:

- Child Guidance Clinics
- Residential Treatment Facilities
- Day Treatment Programs
- Partial Hospitalization Programs
- Extended Day Treatment Programs
- Sub-acute and Intensive Residential Treatment
- Home-Based Clinical Services
- Respite Providers

DCF has a variety of interagency agreements with other state agencies that also provide services to children. Examples include but are not limited to:

Department of Public Health (DPH)
DCF and DPH coordinate the investigation of abuse/neglect allegations in day care home and day care centers (licensed by DPH). This agreement has significantly increased the effectiveness of these investigations.

Department of Social Services (DSS)
DCF and DSS have a variety of contracts related to the provision of and funding for behavioral health services. The two agencies jointly oversee the Connecticut Behavioral Health Partnership. DCF can electronically access the DSS database for information regarding eligibility and utilization of medical services. DCF and DSS also contract for the screening of daycare providers exempt from licensing, and for the funding of daycare for foster care providers who are employed and require daycare services for foster children.

Department of Mental Health and Addiction Services (DMHAS)
Quarterly meetings are held with DMHAS at the statewide and local levels in order to coordinate service delivery and facilitate transitions from DCF to the adult DMHAS system. Ongoing coordination of the transitions of children is a primary focus of the partnership between the two agencies.

Department of Developmental Services (DDS)
DCF and DDS contract for the joint planning and provision of services to children who have mental retardation and diagnosed SED. The contract also requires joint planning for children who are committed to DCF and have mental retardation. Additionally, the two agencies have a memorandum of agreement to help facilitate the transition of youth from the DCF system to the DDS service system.

Judicial Branch
The Judicial Branch is responsible for the juvenile justice youth who are delinquent but not committed. There are approximately 14,000 juvenile justice cases referred to Juvenile Court each year. Approximately 500 of those are committed as delinquent to DCF annually for out-of-home care.

The Judicial Branch operates Juvenile Probation, detention services and a wide array of community services designed to serve delinquents. Some of the services are designed to divert youth from commitment to DCF and more restrictive out-of-home settings. DCF supports this effort by providing the Judicial Branch with Multi-Systemic Treatment slots and other services.

Additionally, through an MOA with the Judicial Branch, DCF maintains 20 beds at Riverview Hospital in order to provide comprehensive psychiatric services to youth in the juvenile justice system. In addition to acute hospital evaluation and treatment, a community based aftercare program utilizing MST and other similar models is in place. Both of these approaches are designed to maintain adolescents from parole and probation in community settings while providing needed mental health services.

Department of Education (DOE)
DCF and the Department of Education jointly share responsibility for the provision of educational services to children in care. While the United School District II (USD II) remains statutorily responsible for children and youth without educational nexus, Local Education Agencies (LEA) assume fiscal responsibility and educational oversight. DCF and DOE jointly review educational programming in residential facilities.

G. Foster and Adoptive Home Licensing, Approval, and Recruitment

Item 41: Standards for Foster Homes and Institutions. Has the State implemented standards for foster family homes and child care institutions that are reasonably in accord with recommended national standards?

Policy Description

Chapter 41 of the DCF policy manual outlines the process for assessing and licensing foster homes. The statutes and regulations of the State of Connecticut give the Department of Children and Families the legal authority and responsibility to provide safeguards for those children who must be removed from their own homes and placed in another family home or child care facility to protect or provide them with specialized care.

Connecticut General Statutes § 17a-114 (a), as amended by Public Act 01-70, states in part, "No child in the custody of the Commissioner of Children and Families shall be placed with any person, unless such person is licensed by the Department for that purpose. Any person licensed by the Department to accept placement of a child is deemed to be licensed to accept placement as a foster family or prospective adoptive family."

Connecticut General Statutes §17a-114(b) as amended by Public Act 01-70 provides an exception for placing a child with a relative who is not licensed for up to 90 days pending completion of the licensing process.

The four (4) types of family care licenses are:

- Foster or Pre-Adoptive Care (General Use)
- Relative Care (Child Specific)
- Special Study Care (Child Specific)
- Independent Interstate Care (Child Specific)

The Connecticut General Statutes also empower the Department to license child-caring facilities, extended-day treatment programs and child-placing agencies.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 41 was rated as a Strength because the State had implemented standards for foster family homes and child care institutions that are in accord with recommended national standards. Stakeholders commenting on this issue indicated that standards are in place and applied to all homes.

Factors Affecting Performance

Connecticut's standards for its foster and adoptive homes are governed by both State Regulation and departmental policy and are in accord with nationally recognized guidelines such as:

- Child Welfare League of America Standards of Excellence for Family Foster Care Services
- Council on Accreditation (COA) Standards for Family foster Care
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- Program Standards for Treatment Foster Care (from the Foster Family-based Treatment Association)

The Department's Licensing Unit and foster care units ensure standards are being met through ongoing review of licenses. Foster care providers are relicensed every two years. The review includes new criminal and CPS background checks as well as additional assessments. The Licensing Unit conducts quarterly reviews of all 263 licensed child care facilities and group homes.

Item 42: Standards Applied Equally. Are the standards applied to all licensed or approved foster family homes or child care institutions receiving title IV-E or IV-B funds?

Policy Description

In accordance with the ASFA Final Rule, all individuals who wish to be licensed or approved must meet the same standards. DCF licensing standards and policy are available on the Department's public internet page and any changes are posted on an ongoing basis.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 42 was rated as a Strength because the standards were applied equally to all licensed or approved foster family homes or child care institutions receiving title IV-B or IV-E funds.

Factors Affecting Performance

In accordance with the intent and spirit of the ASFA Final Rule, all individuals who wish to be licensed or approved must meet the same standards. DCF moved to one licensing standard for all caregivers in September 2000**,** with legislation supporting that practice implemented on July 1, 2001. In order to ensure uniformity of licensing standards and approval processes, the Department's licensing functions are centrally-managed and standards are promulgated on a state-wide basis.

As described in Item 30, the Department is responsible for licensing all child-caring facilities and foster homes. The Licensing Unit, which is part of the Bureau of Continuous Quality Improvement, is responsible for licensing child-caring facilities in Connecticut. The unit is staffed by 9 regulatory consultants who are responsible for licensing new facilities and for the quarterly licensing reviews of 263 in-state residential facilities and group homes. The centralization of this function under one manager at the central office facilitates the consistent application of licensing regulations and streamlines the process of licensing new facilities.

Foster parent licensing is managed by foster care staff in the 14 Area Offices and is overseen by the Office of Foster Care Services in DCF's central office. In 2006, OFCS developed a strategic plan to improve foster care services in Connecticut. An area of focus for the first year of the plan was to standardize procedures across all 14 Area Offices to ensure consistency of licensing and service delivery in all area of the state.

Item 43: Requirements for Criminal Background Checks. Does the State comply with Federal requirements for criminal background clearances related to licensing or approving foster care and adoptive placements, and does the State have in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children?

Policy Description

Per DCF Policy 41-16-3.1, as a requirement of the pre-licensing assessment process, a search of protective service and criminal history records must be completed for the following persons:

- each candidate for licensure (includes foster care, relative, special study, pre-adoptive, or independent licenses); and
- each household member age sixteen (16) years and older who resides in the candidate's home.

In order for a license to be granted, the candidates and all household members must be in compliance with the Regulations of Connecticut State Agencies §17a-145-152(a) - (d) regarding criminal history, pending criminal actions and history of child abuse or neglect. No waiver of these requirements may be granted.

The foster care worker is required to request a criminal record search:

- at the time of initial inquiry, prior to inviting the family to a group assessment or giving them an application for licensure;
- prior to relicensure, and
- whenever circumstances indicate the need for a criminal background search.

For relative or special study placements, the child's worker must complete a criminal record search as well as a CPS history search prior to placing a child with a relative or prior to accepting a special study application.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 43 was rated as a Strength because the State complied with Federal requirements for criminal background checks.

Factors Affecting Performance

DCF contracts with the Department of Public Safety (DPS) which conducts criminal background checks on foster and adoptive care applicants. The checks include local, state and FBI background checks, with fingerprints, as well as sex offender checks and other checks that DCF would not be able to access without this contract. The background checks take some time, so the process begins when the applicant attends the PRIDE training. The foster care units in the DCF Area Offices, which are responsible for licensing activities, also conduct a motor vehicle check. Access to the Department of Motor Vehicles (DMV) licensing and violations files are, by Memorandum of Agreement, available to foster care staff from DCF offices. The Memorandum of Agreement includes the capacity to perform checks on foster parents approved by private agencies with which DCF contracts.

Anytime DPS processes fingerprints on a prospective foster parent/household member, that individual is flagged in its system. DPS staff receive a "hit" if one of these individuals has an arrest in the future. DPS notifies the Office of Foster Care Services of these hits. FASU and probate foster care staff must conduct

an assessment regarding any hit to determine whether or not foster children should remain in the home, the household member should leave, or the home should be closed. Although this does not happen often, there have been some situations in which there have been serious arrests that were not reported to FASU or the private agency.

Offering fingerprinting on-site to foster and adoptive applicants has improved the quality of the fingerprints, decreasing the FBI rejection rate and increasing the convenience to families. Anecdotally, there are few background checks with positive histories, and this is usually not the sole reason a license is denied.

Another division of the Department of Public Safety, the State Police Bureau of Information, conducts background name & date of birth checks on foster parents and adults over 16 years of age at time of re-approval for the private foster care agencies. The private foster care agencies also conduct local police department, DMV and DCF abuse and neglect Central Registry checks at the time of re-approval. DCF foster care units have access to the DPS and DMV databases and can, therefore, conduct criminal background checks directly at the time of re-licensure. Foster care staff also conduct a local police check at the point of re-licensure. Re-licensure/re-approval of foster parents occurs every two years.

The Department is in the process of purchasing LiveScan equipment/software for each Area Office to ensure timely fingerprint results on relatives, as well as timely placements of children into relative homes. So far, six of the fourteen Area Offices have LiveScan equipment.

Item 44: Diligent Recruitment of Foster and Adoptive Homes. Does the State have in place a process for ensuring the diligent recruitment of potential foster and adoptive families that reflect the ethnic and racial diversity of children for whom foster and adoptive homes are needed in the State?

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 44 was rated as an Area Needing Improvement because stakeholders noted that although there are procedures in place to promote recruitment, it was not clear that they are being implemented on a consistent basis. According to the 2002 Statewide Assessment, data gathered between 1998 and 2001 indicated that Connecticut mirrored the nation in diminishing foster family resources. Both recruitment and retention of foster families were noted as issues of concern in the data and by stakeholders.

Factors Affecting Performance

In early 2006, the Department centralized foster care management into the Office for Foster Care Services (OFCS) in order to improve recruitment and retention efforts and standardize procedures across the fourteen DCF Area Offices. The Department continues to work aggressively to increase the number of family resources available for children in care. In an effort to improve Connecticut's recruitment and retention, the Department collaborated with the University of Connecticut (UCONN) Department of Public Policy to carry out a comprehensive survey of the Connecticut public regarding their perceptions of and motivations towards becoming foster care or adoptive parents. UCONN generated a profile based on their findings of the person most likely to become a foster parent. This information, along with the other findings and recommendations in the report, will enable our recruiters to target their efforts more effectively.

UCONN also conducted a survey of existing foster and adoptive families to conduct a customer satisfaction survey revealing that "an overwhelming majority of current foster parents are satisfied with being a foster parent." The detailed data accompanying the final report will be used to educate staff about the feelings and needs of our foster parents.

All of the Area Office Foster and Adoption Services Units prepare local recruitment and retention plans. Activities center around each individual community, and are designed to attract a diverse audience which reflects the racial and ethnic backgrounds of the children we serve. Data reports on the children entering foster care in each community and age cohort are used to determine the racial and ethnic diversity of the foster care population and help inform the development of recruitment targets for foster homes. All activities and events are designed to encourage and support greater collaboration with our community members, community providers, private foster care programs, public service entities and government officials, and to recognize and show appreciation to foster families who care for our children and youth.

OFCS is also collaborating with the Bureau of Adoption and Interstate Compact and the Bureau of Adolescent and Transitional Services on a statewide media campaign with the Connecticut Radio Network (CRN). CRN developed a radio campaign as well as print materials and a website (www.Helpachildshine.com) based on the UCONN recommendations.

The Department continues to recruit adoptive families for waiting children by featuring a child or sibling group on a "Wednesday's Child" television segment. WTNH, Channel 8 in New Haven CT continues to provide this service, funded by Casey Family Services in New Haven. WTNH airs the Wednesday's Child segments during their noon and evening news programs each Wednesday. The Adoption Resource Exchange continues to manage this segment under the assignment of one Adoption Resource Specialist. This staff member works with the Area Office social worker assigned to specific children, in collaboration with Channel 8, to assure the taping experience is desired by the individual child and is a positive life experience for him or her.

Between April 30, 2006 and May 15, 2008, Ninety-Eight (98) child segments have been aired. Incorporated in the waiting child episodes are segments with regard to adoption related successes or general areas of adoption interest. Features have continued to include a family talking about their successful adoption experience, a walk through a child's adoption day and other adoption awareness issues. Fifteen success stories, or adoption-related informational segments, have been aired during this time. As a result of the many inquiries received after the segments' air-date, thirteen children have been matched with pre-adoptive families. The success stories and other features assist in generating an increase in inquiries pertaining to adoption, foster care and mentoring in Connecticut.

Since November 2003, the Department has been sponsoring the Heart Gallery, which is a travelling exhibit of photos of children waiting for adoption. The Heart Gallery has been featured in venues such as museums, theaters, art galleries, libraries, malls, churches, hospitals, and commercial spaces throughout Connecticut. Of the one hundred and forty four (144) children featured thus far, thirty five (35) have been adopted and twenty five (25) are placed in pre adoptive families.

The Bureau of Adoption and Interstate Compact services purchases a Google ad. Key words entered into a Google Search including "adoption" and other related phrases connect one directly to the Department's website. This recruitment strategy brings a monthly average of 10 families to the CT Foster and Adoptive Parent Kid Hero who express and interest in becoming licensed for adoption.

Item 45: State Use of Cross-Jurisdictional Resources for Permanent Placements. Does the State have in place a process for the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children?

Policy Description

Chapter 47 of the DCF policy manual describes the systems the Department has in place for the use of cross-jurisdictional resources for the placement of children. In particular, it states that in all instances in which children are placed into and out of Connecticut and are subject to the Interstate Compact provisions, the Department shall

- cooperate with other states;
- protect the rights of children and youth and Connecticut citizens; and,
- adhere to the requirements of the four (4) distinct Interstate Compacts.

The Bureau of Adoption and Interstate Compact Services is responsible for facilitating Connecticut's cross-jurisdictional placements.

Summary of Performance in Round One of the CFSR

In Round One of the CFSR, Item 45 was rated as a Strength because the State had in place a process for the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children.

Factors Affecting Performance

Connecticut's centralized Adoption Resource Exchange remains a component of the Bureau of Adoption and Interstate Compact Services. The Exchange serves as the single point of entry for licensed adoptive families both in and out of Connecticut for registration and matching for available children.

The Department remains committed to improving the use of multi-media sites for the purposes of securing permanent adoptive resources for children in Connecticut and throughout the United States. The Department continues to work on a contractual basis with the nationally recognized AdoptUsKids Website. Adoption Resource Specialists maintain the children for whom they are responsible for on this Web Site. The Department's current website features children and youth who are legally free for adoption and are also featured in the Department's Heart Gallery which is featured at venues throughout the state. The Department has also partnered with the state of Rhode Island and featured children from both states in their respective Heart Galleries.

The Department features one child or sibling group in the North American Council for Adoptable Children's (NACAC) national recruitment poster. The Department works with the Adoption Community of New England (ACONE) to place pictures of children within their quarterly newsletter. Monthly, the exchange submits a picture of a waiting child(ren) to this agency's employee newsletter. The Department works with other community based organizations including the Spina Bifida Association to feature a waiting child who is challenged with medical issues. The exchange provides specialized recruitment efforts for the harder to place child in the form of photo-listing and child specific recruitment plans and actualizing their recruitment plans.

The Bureau of Adoption and Interstate Compact Services in conjunction with the Office of Foster Care Services and the Bureau of Adolescent and Transition services sponsored a $200,000 media campaign to

recruit additional adoptive and foster care parents as well as more mentors through CRN for several months in 2007 CRN participated in recruitment events, developed the "Help A Child Shine" radio advertising campaign and also developed a website. A more limited campaign has continued throughout 2008. These radio ads can be heard by Connecticut's neighboring states.

The Bureau of Adoption and Interstate Compact has expanded recruitment services by purchasing via the web by the use of Google. Key words entered into a Google Search including "adoption" and other related phrases connect one directly to the Department's website. This recruitment strategy brings a monthly average of 10-12 families to the CT Foster and Adoptive Parent Kid Hero central intake telephone line who express interest in adoption.

The Department continues to recruit adoptive families for waiting children by featuring a child or sibling group on a “Wednesday’s Child” television segment. WTNH, Channel 8 in New Haven CT continues to provide this service, funded by Casey Family Services in New Haven. WTNH airs the Wednesday’s Child segments during their noon and evening news programs each Wednesday.

As a result of the many inquiries received after the segments’ air-date, thirteen children have been matched with pre-adoptive families. The success stories and other features assist in generating an increase in inquiries pertaining to adoption, foster care and mentoring in Connecticut.

SECTION V:

State Assessment of Strengths and Needs

On the basis of an examination of the data in section II and the narrative responses in sections III and IV, the Statewide Assessment Team should respond to the following questions in completing this section:

1. Determine and document which of the seven outcomes and systemic factors examined during the Statewide Assessment are primarily strengths, citing the basis for the determination.

Safety 2: Children are safely maintained in their homes whenever possible & appropriate.

Connecticut did not achieve substantial conformity with Safety Outcome 2 in the 2002 CFSR because the outcome was substantially achieved in 87 percent of the cases reviewed, which is less than the 90 percent required for a rating of substantial conformity. However, both underlying items were assigned an overall rating of Strength at that time. DCF has continued to build on that strong practice to safely maintain children in their homes whenever possible and appropriate. Since the 2002 CFSR, DCF has expanded the in-home service array and implemented Structured Decision Making (SDM). The Department's overall case trends reflect improving performance in this area, with the average in-home caseload increasing while the average out-of-home caseload is decreasing.

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

Connecticut achieved substantial conformity with Well-Being Outcome 2 in the 2002 CFSR. This determination was based on the finding that 90 percent of the cases reviewed were found to have substantially achieved this outcome, which meets the requirement for substantial conformity. Since that time, the Department has expanded its use of educational consultants in the Area Offices and continued to focus on ensuring children on our caseload have appropriate educational assessments and services to meet their needs. In the recent CCOR review using the CFSR OSRI, 24 of 33 applicable cases were rated as Substantially Achieved and 5 were rated as Partially Achieved for this outcome.

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

Connecticut did not achieve substantial conformity with Well-Being Outcome 3 in Round One of the CFSR because the outcome was rated as substantially achieved in only 71.5 percent of the applicable cases, which is less than the 90 percent required for a determination of substantial conformity. Both Items 22 and 23 were rated as Areas Needing Improvement. Since that time, however, DCF has significantly improved its capacity to appropriately assess and address children's physical and mental health needs. Each child that comes into care for the first time receives a Multi-Disciplinary Exam (MDE) that serves as the basis for identifying needed services. In the recent CCOR review, 36 cases were rated as Substantially Achieved and 8 were rated as Partially Achieved for Well-Being Outcome 3. The service array and the availability of flexible funds to meet children's needs were noted as contributing factors to our improved performance in this area. Also, the addition of pediatricians and psychiatrists to help consult to the Area Offices and the centralized medication permission process now in effect are effective contributing factors to DCF's improved performance in meeting children's medical and mental health needs.

Statewide Information System

Connecticut was not substantial conformity with this systemic factor in 2002 because functional improvements to ensure the State information system’s capacity to identify and report goals for the placement of every child who is in foster care in accordance with State Plan requirements were not fully

implemented at the time of the review. Since that time, however, significant improvements have been made to LINK, Connecticut's SACWIS. In addition to improved functionality and ease of use, a number of management reports are now available to ensure social workers, supervisors and managers are able to have relevant information to inform decision making at both the case and systemic levels. The use of SACWIS data to help inform system change has also improved greatly since 2002, with the implementation of the Results Oriented Management (ROM) system and the standardization of reporting for the Juan F. Exit Plan Outcome Measures.

Quality Assurance System

Connecticut was in substantial conformity with this systemic factor in the 2002 CFSR. DCF has continued to build on what was in place at that time to further develop our quality assurance functions. The DCF local Area Offices each have a manager assigned to overseeing quality improvement work and, as a group, they come together on a regular basis to share best practices and identify system-wide quality issues. The Bureau of Continuous Quality Improvement has continued to monitor service providers and programs to ensure they are adhering to appropriate standards of care.

Staff and Provider Training

Connecticut was in substantial conformity with this systemic factor in Round One of the CFSR. The Training Academy continues to train all newly-hired social workers as well as provide ongoing training to existing staff. Since the 2002 review, the Training Academy has also developed mentoring programs for social work staff and clerical staff to expand opportunities for professional development and growth. Supervisory and management training has also been expanded since 2002, with focus on preparing staff for further career advancement.

Service Array and Resource Development

In 2002, Connecticut was in substantial conformity with this systemic factor. The findings of the CFSR suggested that the state had an effective service array and that services could be individualized to meet family's needs. However, Item 36 was given an overall rating of Area Needing Improvement because the accessibility of services varied across the state. Since 2002, the Department has considerably expanded its service system to provide more community-based evidence-based treatments. The Department has also added 54 new group homes and tripled the flexible funding budget in order to facilitate individualizing services for children and families. The development of the Behavioral Health Partnership has helped streamline access to services and families now report that services are available close to their homes at times that are convenient for them. Improvements to intensive case management and Extended Day Treatment services have also added to the state's service delivery system.

Foster and Adoptive Home Licensing, Approval, and Recruitment

Connecticut was in substantial conformity with this systemic factor in the 2002 CFSR. All items for this outcome were rated as Strengths, except for Item 44 - diligent recruitment of foster parents. Stakeholders at the time noted that although there are procedures in place to promote recruitment, it is not clear that they are being implemented on a consistent basis. Since 2002, DCF centralized the management of foster care operations under one management team at the Central Office. A foster care strategic plan has been developed which was informed by market research analysis to develop a comprehensive recruitment

strategy. Based on that framework, each Area Office has a recruitment plan to ensure the diligent recruitment of foster parents that reflect the racial and ethnic diversity of children in care.

2. Determine and document which of the seven outcomes and systemic factors examined during the Statewide Assessment are primarily areas needing improvement, citing the basis for the determination. Identify those areas needing improvement that the State would like to examine more closely during the onsite review, for example, to explore possible causal factors. Prioritize the list of areas needing improvement under the safety, permanency, and well-being outcomes.

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

In 2002, Connecticut did not achieve substantial conformity with Safety Outcome 1. Although in 91.1 percent of the cases, reviewers determined that this outcome had been substantially achieved, the State did not meet the national standard for either repeat maltreatment or maltreatment of children in foster care. In spite of steady progress in improving the recurrence of maltreatment and the focus on this area due to the Juan F. Exit Plan, Connecticut has not met the national standards for the safety composites.

Areas to explore during the on-site review include:

- What impact is Structured Decision-Making having on child safety?
- Are child victims being seen face-to-face in a timely manner?

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

Connecticut did not achieve substantial conformity with Permanency Outcome 1 in 2002. This determination was based on the following:

- Although the State met the national standards for foster care re-entries and stability of foster care placements, the State did not meet the national standards for reunifications within 12 months of entry into foster care and adoptions within 24 months of entry into foster care.
- Only 50 percent of the cases reviewed were rated as having substantially achieved Permanency Outcome 1, which is less than the 90 percent required for substantial conformity.

In spite of performance near the national median for foster care re-entries, Connecticut has not met the national standards for any of the permanency composites. Our recent CCOR showed that, while DCF staff overall establish appropriate permanency goals in a timely manner, concurrent planning and the use of APPLA goals are a challenge for the Department. In particular, reviewers found instances of concurrent goals being identified without both goals being pursued.

Areas to explore during the on-site review include:

- What services are helping to promote placement stability for children in foster care?
- What are the barriers to the timely establishment of appropriate permanency goals?
- In what circumstances is concurrent planning working well?

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

In the 2002 CFSR, Connecticut did not achieve substantial conformity with Permanency Outcome 2. This determination was based on the finding that the outcome was rated as substantially achieved in only

80.8 percent of the cases, which is less than the 90 percent required for substantial conformity. In the June 2007 Data Profile, Connecticut did not meet the national standards for any of the permanency composites. While DCF did not meet the standards, there are many strengths present in the system related to this outcome. In the recent internally conducted qualitative review of child welfare practices (Connecticut Comprehensive Outcome Review: CCOR), proximity of foster care placement, preserving connections and relative placement all received overall ratings of Strength from our review teams. While Connecticut did not meet the national standards in the permanency composites, DCF did exceed the 75th percentile with 86.8% of children in care for 12 or fewer months experiencing two or fewer placement settings. However, visitation of children in foster care with their parents and siblings was seen as variable.

Areas to explore during the on-site review include:

- What is the frequency and quality of visitation between children in foster care and their parents and siblings?
- What services or practices help promote the continuity of relationships and family connections for children?

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

Connecticut did not achieve substantial conformity with Well-Being Outcome 1 in the 202 CFSR. This determination was based on the finding that the outcome was rated as substantially achieved in only 66 percent of the cases reviewed, which is less than the 90 percent required for a determination of substantial conformity. A general finding of the CFSR process with regard to this outcome was that DCF practice was inconsistent with regard to the involvement of fathers in terms of services, case planning, and visitation.

DCF continues to struggle with the involvement of fathers in terms of services, case planning and visitation. Additionally, services to meet the needs of foster parents are variable across the state. In recent focus groups, foster parents reported that appropriate services are available to them but that the Department does not do an adequate job of marketing and making the services known to foster parents. Finally, while social worker visits with children are happening as dictated by policy, social worker visits with parents are variable.

Areas to explore during the on-site review include:

- What barriers exist to DCF's engagement of fathers?
- What service gaps exist for foster parents?
- Are parents and children being meaningfully involved in their treatment planning?

Case Review System

Connecticut was not in substantial conformity with this systemic factor in 2002. Stakeholders at the time noted that neither Treatment Planning Conferences nor Administrative Case Reviews functioned as a means to engage families in the case planning process and parents are not routinely perceived as partners with the agency in the development of the case plan. The items for permanency hearings, filing TPR and providing foster parents, pre-adoptive parents and relative caregivers an opportunity to be heard at hearings were all found to be Areas Needing Improvement. Consistently attending to these issues continues to be a challenge for the system. Additionally, while the Department has made significant

improvements to the treatment planning and ACR processes, the meaningful involvement of clients in these processes remains variable.

Areas to explore during the on-site review include:

- How have enhancements to ACR improved the case review system?
- How is the partnership between DCF and the Judicial Branch impacting permanency hearings, filing TPR and providing foster parents, pre-adoptive parents and relative caregivers an opportunity to be heard at hearings?

Agency Responsiveness to the Community

In 2002, Connecticut was not in substantial conformity with systemic the factor of Agency Responsiveness to the Community. The findings of the review were that DCF did not consistently engage in ongoing consultation with all relevant community representatives. Specific concerns were noted by stakeholders with regard to DCF's relationship with the court system. Also, DCF needed to engage in more consultation from both the tribes and the broader community in developing the CFSP and APSR. Since that time, the relationship between DCF and the court system has improved as evidenced by ongoing collaboration between Judicial administration and DCF at the statewide and local levels. While the Department has made strides in involving external stakeholders in consulting with us on a number of issues, we still face many challenges in incorporating external input into our CFSP and APSR.

Areas to explore during the on-site review include:

- Do our stakeholders feel they are involved in meaningful ways in helping the Department develop ongoing strategic plans?

3. Recommend two additional sites for the onsite review activities, using the strengths and areas needing improvement noted in 1 and 2 (the State's largest metropolitan area is a required location). Attempt to select sites in which the issues identified through the Statewide Assessment will be present and observable. Note the rationale for selecting these sites; if there are no issues that require further examination during the onsite review, explain which factors the State considered in site selection (for example, the need for a mix of rural and urban areas or for areas with typical practices). When making recommendations, the State should include all available data, including comparative data for the suggested sites in relation to statewide data, if available.

On March 12, 2008, members of DCF senior management participated in a conference call with ACF to discuss the Department's recommendations for review sites. The major metropolitan site in Connecticut is Bridgeport. The two other sites selected for review are New Britain and Norwich.

In considering options for site selection for the CFSR, the Connecticut Department of Children and Families reviewed our available data and weighed the relative strengths and weaknesses of our 14 Area Offices. In recommending these sites, the leadership of the Department hoped to better understand case practice in our medium-sized offices, which often cover large geographic areas with diverse populations and varying service needs.

The data used as the basis for the recommendations are from our Results Oriented Management (ROM) system, into which we have built the CFSR permanency composites and underlying measures. We also used the offices' most recent performance on our federal Exit Plan outcome measures at the time of the site selection discussion, as 16 of the 22 outcomes are automated into our reporting system. Finally, we

presented the measure "no recurrence of maltreatment" as a close approximation for the CFSR Safety Composite, which we have not built into our reporting system as of this writing.

Connecticut's Department of Children and Families operates 14 Area Offices, each covering a geographic area that may or may not coincide with county lines or with the judicial districts of our Superior Court. In addition to the available data and consideration for the relative size of the various offices in terms of caseload and staffing, we also take into consideration the geographic location of each Area Offices and the number of judicial districts with which it works as factors in our site selection recommendations.

The selected review sites, the Norwich and New Britain Area Offices, represent the central and southeastern portions of the state of Connecticut. Together with Bridgeport, our largest metropolitan site, these three offices give an adequate representation of the urban, suburban and rural communities in the state. These sites are also representative of the racial and ethnic diversity of the state, including areas with African American, Latino, Asian and Native American populations.

Below are the data and information presented to ACF at the time of the site selection discussion:

Norwich Are Office	
Consideration	**County Specific Information**
Data Summary	• *State Exit Plan Outcome Measures* – Met 13 of 16 outcome measures in most recent quarter • *Exit Plan Investigation Measures*: 95.2% of investigations commenced on time and 88.8% completed on time in most recent quarter (Area Office has met both safety measures for 12 consecutive quarters) • *Child Safety Maintained (No Recurrence - 6 Months) ROM measure* - 91.8% • *CFSR Permanency Composite 1* – Did well on timeliness and permanency of reunification; Did better than state on 2 of 4 measures (Median Time for Reunification & Maintain Permanency 12 Months); Did not do as well as the state on Reunification for 1st Time Removals • *CFSR Permanency Composite 2* – Did well on timeliness of adoptions; Did better than State on 4 of 5 measures; Did not do as well as the state on Achieving Adoption within 12 Months of TPR • *CFSR Permanency Composite 3* – Did better than the state on all 3 measures • *CFSR Permanency Composite 4* – Did not perform as well as the state on any of the 3 measures
Number of In-Home Cases	348 in-home cases as of March 5, 2008 (according to internal LINK caseload report)
Number of Children in Out of Home Care	445 children in out of home care as of March 5, 2008 (according to internal LINK placement report)
Geographic Description & Population Diversity	• South-eastern Connecticut, near the border with Rhode Island • Medium size Area Office serving 19 towns, including some rural areas • 40 miles from Hartford • Population Diversity: 86.03% White, 5.40% African American/Black, 0.95% Native American, 2.07% Asian, 5.55% Latino; 3 federally-recognized tribes are located in this area

New Britain Area Office	
Consideration	**County Specific Information**
Data Summary	• *State Exit Plan Outcome Measures* – Met 11 of 16 outcome measures in most recent quarter • *Exit Plan Investigation Measures*: 96.1% of investigations commenced on time and 94.1% completed on time in most recent quarter (Area Office has met commencement measure for 12 consecutive quarters and completion measure for 11 of the last 12 quarters) • *Child Safety Maintained (No Recurrence - 6 Months) ROM measure* - 92% • *CFSR Permanency Composite 1* – Did well on timeliness and permanency of reunification; Did better than state on 3 of 4 measures; Did not do as well as the state on Reunification for 1st Time Removals • *CFSR Permanency Composite 2* – Did not do well on timeliness of adoptions; Did not do as well as the state on Adoptions in 24 Months at Exit, Median Time to Adoption at Exit and Achieving Adoption within 12 Months of TPR • *CFSR Permanency Composite 3* – Did better than the state on Achieving Permanency Within One Year After Removed for 24 Months; Did not do as well as the state on the other 2 measures • *CFSR Permanency Composite 4* – Performed better than the state on Placement Stability for Removals 12-24 months and on Placement Stability for Removals of More than 24 Months; Did not do as well as the state on Placement Stability for Removals Less Than 24 Months
Number of In-Home Cases	575 in-home cases as of March 5, 2008 (according to internal LINK caseload report)
Number of Children in Out of Home Care	600 children in out of home care as of March 5, 2008 (according to internal LINK placement report)
Geographic Description & Population Diversity	• Central part of the state • Medium Size Office serving an urban/suburban region of 14 towns • 12 miles from Hartford • Population Diversity: 86.14% White, 3.43% African American/Black, 0.12% Native American, 1.99% Asian, 8.32% Latino

4. Provide comments about the State's experience with the Statewide Assessment Instrument and process. This information will assist the Children's Bureau in continually enhancing the Child and Family Services Review (CFSR) procedures and instruments.

The process for preparing the Statewide Assessment provided DCF with many opportunities to reflect on the progress made since the 2002 CFSR. The use of data to evaluate our system and the input from service providers and clients was very valuable.

The timeframe to integrate all the input from various providers and write the Statewide Assessment presented some challenges. The timing of Connecticut's CFSR is such that our Statewide Assessment and APSR for this year are due within weeks of each other. This presented some challenges in terms of staffing and coordinating the flow of information for both projects.

The Department appreciated the opportunity to engage in the site selection discussion with ACF prior to the time specified in the CFSR Procedures Manual. Because we were able to identify the two additional review sites in March, managers and staff from those two offices were able to fully participate in the development of the Statewide Assessment and begin the process of arranging site logistics in a timely manner.

Finally, the process overall as managed by ACF and JBS were very helpful to DCF in organizing our preparation for the CFSR. We made use of technical assistance from the NRCs in planning our kick-off event and training staff to use the OSRI to conduct reviews in our Area Offices. The planning calls, also, were a helpful tool to aid out preparation.

5. Participants in the Statewide Assessment Included:

In preparation for the CFSR, DCF engaged staff from the department's various bureaus and external stakeholders from partner agencies and advisory councils. Our CFSR kick-off, which was planned with technical assistance from the National Resource Center for Organizational Improvement and the National Resource Center for Child Welfare Data and Technology, was held on the evening of March 18, 2008. Nearly 80 participants were in attendance. It was held in the evening to ensure the attendance of parents and representatives from parent advocacy groups.

Following the kick-off, committees were organized to develop the Statewide Assessment. There was one committee for each area: Safety, Permanency and Well-Being. The Statewide Assessment was developed with the guidance and input of these committees and with input from other DCF staff and clients with direct knowledge of our work. In addition to the information in the Data Profile and our own existing management reports, data for measuring the Department's effectiveness was provided by the Judicial Branch and Value Options. The framework for the state's responses on the Systemic Factors was developed by a subcommittee of the DCF Area Directors. The overall coordination of the development of the Statewide Assessment and logistics for the CFSR is overseen by a Steering Committee comprised of the CFSR Coordinator and the Local Site Coordinators and State Local Site Leaders for the three review sites.

CFSR Steering Committee:

Mark L. Dumais Program Supervisor, Middletown Area Office	Kurt Fuchs, LCSW Quality Improvement Program Supervisor, New Britain Area Office	Jayne Guckert, MSW Quality Improvement Program Supervisor, Bridgeport Area Office
Margaret Hartman, MSW Program Supervisor, Policy & Accreditation Unit	Jodi Hill-Lilly, MSW Director, Training Academy	Allon Kalisher, MSW Program Supervisor, Training Academy
Stan Kasanowski, MSW Program Director, Division of Outcome Measure Oversight	Tracy P. Lovell, MSW Quality Improvement Program Supervisor, Norwich Area Office	Treena Mazzotta, MSW Program Supervisor, Risk Management Unit
Fernando J. Muñiz, MPA Program Director, Division of Planning & Program Development (CFSR Coordinator)	Siobhan Trotman, MSW Program Supervisor, Waterbury Area Office	

Safety, Permanency & Well-Being Subcommittee Participants:

Sandra Carroll Children Services Consultant, Bureau of Adolescent and Transitional Services	Molly Cole Associate Director- Community Outreach, UConn Health Center- A.J. Pappanikou Center for Excellence in Developmental Disabilities	Marilyn E. Cloud, LCSW Behavioral Health Clinical Manager, Bureau of Behavioral Health and Medicine
Orlando Cuadrado, MSW Child Welfare Trainer, Training Academy	Virginia DelMonaco Co-Chairperson, State Advisory Council; Family & Children's Aid	Mark L. Dumais Program Supervisor, Middletown Area Office
Jean Fiorito Executive Director, Connecticut Association of Foster and Adoptive Parents (CAFAP)	Suzanne Gaither, MSW Program Supervisor, Manchester Area Office	Tammy Garris Children's Services Coordinator, Department of Developmental Services
Marilou Giovanucci Manager, Judicial Branch Court Operations (CIP Coordinator)	Irvin Girard Manchester Area Office	Janet Gonzalez, MSW Social Work Supervisor, Division of Outcome Measure Oversight

Llonia Gordon Director of Program Services, FAVOR (Family Advocacy Organization)	Frank Gregory, PhD Behavioral Health Clinical Manager, Bureau of Behavioral Health & Medicine	Gustavo Guevara, M.Ed. CPS Ombudsman, Bureau of Prevention and External Affairs
Heather M. Hicinbothem, MFT Children Services Consultant, Bureau of Adolescent and Transitional Services	Douglas Howard Children's Services Consultant, Policy & Accreditation Unit	Josh Howroyd Legislative Program Manager, Bureau of Prevention and External Affairs
Jonathan J. Jacaruso, MSW Program Director, Norwich Area Office	Merva Jackson Executive Director, African-Caribbean-American Parents of Children with Disabilities (AFCAMP)	Tina L. Jefferson, MSW Program Supervisor - Investigations, Hartford Area Office
Irvin Jennings, MD Co-Chairperson, State Advisory Council; Executive Director, Family & Children's Aid	Susan King Project Manager, Casey Center for Effective Child Welfare Practice- Casey Family Services	Wanda Ladson, MSW Administrative Case Review Supervisor, Quality Improvement Division
Pat Lorens Co-Chairperson, Bridgeport Area Advisory Council	Robin McHallen Executive Director, True Colors	Judith Meyers, PhD President & CEO, Child Health & Development Institute of Connecticut
Catherine M. Rae Children Services Consultant, Policy & Accreditation Unit	Sherry Rautenberg Quality Improvement Program Supervisor, Manchester Area Office	Gail Reyes-Walton, MSW Program Supervisor Hartford Area Office
Joni Beth Roderick, MSW Monitoring Specialist, DCF Court Monitor's Office	Nicole C. Roy, MSW Quality Improvement Program Supervisor, Greater New Haven Area Office	Lisa Sedlock-Reider, LCSW Program Supervisor, New Britain Area Office
Paul Shanley, LCSW, ACSW Program Director, Manchester Area Office	Jenny Vesco, MSW Quality Improvement Program Supervisor, Hartford Area Office	Beresford Wilson African-Caribbean-American Parents of Children with Disabilities (AFCAMP)

Focus Groups

In addition to the committees that provided the framework and data for the Statewide Assessment, significant input and feedback was gathered through a number of focus groups conducted with key constituents:

- Foster Parent Focus Group held at the Connecticut Association of Foster and Adoptive Parents (CAFAP) Annual Conference
- Foster parent focus groups held during the therapeutic foster care re-procurement process
- Service Provider focus groups held in Bridgeport, Manchester, New Britain and Norwich as part of the Connecticut Comprehensive Outcomes Review (CCOR)
- Youth Focus Group coordinated through the Bureau of Adolescent and Transitional Services
- Staff Focus Group facilitated by staff from the Bureau of Continuous Quality Improvement

In total, over 250 people participated in committees and focus groups to provide feedback to DCF on its services for children and families.

CCOR Review Team

As part of the preparation for the CFSR, DCF conducted a review of 47 cases in 4 Area Offices using the On-Site Review Instrument and CFSR methodology. The Connecticut Comprehensive Outcomes Review (CCOR) was conducted in partnership with the DCF Court Monitor's Office and will be used as part of the Department's ongoing quality improvement efforts. The following CCOR reviewers and team leaders were an invaluable part of the team that helped the Department prepare for the CFSR and develop the statewide assessment:

Team Leaders		
Jodi Hill-Lilly, MSW Director, Training Academy	Allon Kalisher, MSW Program Supervisor, Training Academy	Ray Mancuso DCF Court Monitor
Fernando J. Muñiz, MPA Program Director, Division of Planning & Program Development	Joni Beth Roderick, MSW Monitoring Specialist DCF Court Monitor's Office	
Reviewers & Logistics Team Members		
Mary Corcoran Consultant, DCF Court Monitor's Office	Orlando Cuadrado, MSW Child Welfare Trainer, Training Academy	Liz Rosado Cyr, MSW Children Services Consultant, Quality Improvement Division
Yadira Durán, MSW Social Work Supervisor, Office for Research & Evaluation	Thomas R. Gallese Consultant, DCF Court Monitor's Office	Janet González, MSW Social Work Supervisor, Division of Outcome Measure Oversight
Stefania M. Hanna, MSW Child Welfare Trainer, Training Academy	Margaret Hartman, MSW Program Supervisor, Policy & Accreditation Unit	Mary Ann Hartmann, MCW Consultant, DCF Court Monitor's Office

Douglas Howard Children Services Consultant, Policy & Accreditation Unit	Stan Kasanowski, MSW Program Director, Division of Outcome Measure Oversight	Pamela Kelly Program Supervisor, Office of Foster Care Services
Tracy Lovell, MSW Quality Improvement Program Supervisor, Norwich Area Office	Susan Marks-Roberts Consultant, Court Monitor's Office	Treena Mazzotta, MSW Program Supervisor, Risk Management Unit
Gary Minetti Program Director, Bureau of Child Welfare	Catherine M. Rae Children Services Consultant, Policy & Accreditation Unit	Eileen Rothfarb, MSPA Social Work Supervisor, Division of Outcome Measure Oversight
Nicole C. Roy, MSW Quality Improvement Program Supervisor, Greater New Haven Area Office	Renée Serafino Administrative Assistant, Division of Planning & Program Development	Sandra Tapia-Arcos, MSW Division of Outcome Measure Oversight; DCF Court Monitor's Office
Michelle Turco Consultant, DCF Court Monitor's Office	Jenny Vesco, MSW Quality Improvement Program Supervisor, Hartford Area Office	JoAnn Vizziello Child Welfare Program Specialist, ACF Region I, Boston, MA
Jon Zane Social Work Supervisor, Willimantic Area Office		

Collaborative Partners

The Department of Children and Families is deeply appreciative of the following collaborative partners who contributed time, expertise and data to assist with the development of the Statewide Assessment:

- Connecticut Judicial Branch
- Department of Developmental Services
- Department of Mental Health and Addiction Services
- State Advisory Council
- Value Options