



DEPARTMENT OF CHILDREN AND FAMILIES

Results Based Accountability Report

2009

Introduction:

In an effort to expand the use of Results Based Accountability (RBA) techniques, the Legislature's Appropriations Committee recently announced that several DCF programs will be reviewed through an RBA lens via a set of pre-established questions. Follow-up inquiries can be expected on these, and other program areas, at the Appropriations Subcommittee level. The six DCF program areas include the following:

1. Intensive In-Home Behavioral Health Services
2. Family Preservation Services
3. Flex Funds
4. Substance Abuse Treatment (youth)
5. Project SAFE
6. Foster Home Development

In addition to the above, DCF has produced this year its third annual RBA report on two more in-depth RBA reviews of two program areas which include early childhood programming and child protection/foster care. These two program areas are incorporated as part of the work of the Early Childhood Education Cabinet. As such, these components will be represented together with contributions from many other agencies and will be done at a later time.

Attached are the responses across the six program areas outlined above and provided for the committee in the appendix is a summary of agency progress across key indicators of agency performance. DCF embraces RBA and looks forward to ongoing dialogue with the Legislature on this important aspect of government work.

I. Intensive In-home Behavioral Health Services

Program name:

Intensive In-Home Behavioral Health Services is a term that describes an array of clinical interventions, as opposed to a specific clinical program. Intensive In-Home Behavioral Health Services are provided to children/adolescents, and their families, who are at risk of requiring out-of-home care (e.g., hospitalization, residential treatment) or who have received out-of-home care and are transitioning back to the community. The following are specific clinical models of Intensive In-Home Behavioral Health Services funded and overseen by DCF:

- Family-Based Recovery (FBR)
- Family Substance Abuse Treatment Services (FSATS)
- Family Support Teams (FST)
- Functional Family Therapy (FFT)
- Intensive In-Home Child and Adolescent Psychiatric Service (IICAPS)
- Multidimensional Family Therapy (MDFT)
- Multisystemic Therapy (MST)
- Multisystemic Therapy for Problem Sexual Behavior (MST-PSB)
- Multisystemic Therapy - Building Stronger Families (MST-BSF)

1. What is the quality of life result to which the program makes the most important contribution?

In-Home Behavioral Health Services are intended to contribute to the safety, permanency and well-being of Connecticut's children and families.

2. What is the program's purpose?

Intensive In-Home Behavioral Health Services are intended to enable children and adolescents with serious emotional disturbance and/or substance abuse disorders to live successfully in the community with their families. These services have a dual focus in reducing the child's symptoms and problems while improving the family's ability to effectively parent their child with serious emotional disturbance.

3. Who are the programs major customers?

The major customers of Intensive In-Home Behavioral Health Services are children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families. Intensive In-Home Behavioral Health Services are intended particularly for children and adolescents whose serious emotional disturbance and/or substance abuse disorders place them at risk of requiring out-of-home care (e.g., hospitalization, residential treatment) or who have received out-of-home care and are transitioning back to the community.

4. What measures do you use to tell if the program is delivering its services well?

How are you doing on the most important of those measures?

One measure of how well Intensive In-Home Behavioral Health Services are delivered is the service utilization rate, calculated as the number of children/adolescents who received services as a proportion of DCF-funded capacity for these services.

During the 2008 State Fiscal Year, 2,807 children/adolescents and their families received Intensive In-Home Behavioral Health Services. The total DCF-funded capacity of these Intensive In-Home Behavioral Health Services was [2,728]. This resulted in a service utilization rate of 102% percent (some additional capacity was available due to Medicaid and other 3rd party reimbursement).

An important index of how well an evidence-based service is delivered is to measure how well the service delivery follows the specific program model. This is often referred to as a measure of model adherence or program fidelity. For example, within healthcare, it is known that a particular anti-biotic is maximally effective when it is given at a specific dose for a specific number of days. A review of actual prescribing practices in comparison to optimum practice would constitute a measure of fidelity. DCF utilizes program fidelity measures to determine how well programs are being delivered.

Multisystemic Therapy (MST), for example, uses a Therapist Adherence Measure (TAM) that assesses provider adherence to MST core principles. The TAM is administered by telephone to parents/caregivers of youth receiving MST. The TAM is administered by trained objective interviewers who are not involved in providing the service to the family. The TAM is completed by each family several times during the course of their treatment.

A recent report by the Connecticut Center for Effective Practice (CCEP), a division of the Child Health and Development Institute of Connecticut (CHDI), evaluated MST TAM scores for CT providers delivering this service. In the CCEP analysis, 155 therapists were rated by parents/caregivers in 1,365 MST cases. The average TAM rating assigned by the parents/caregivers was 4.23 (on a scale of 1 to 5). The CCEP report stated that this was an indication that "caregivers generally viewed [MST] therapists as quite adherent to the program," and that, "in Connecticut, MST is being implemented with high fidelity to the treatment model."

The Department also measures entry into care rates, re-entry into care, repeat maltreatment, reducing placements and length of placements in congregate settings, and recidivism within our juvenile justice work. As we have experienced positive and/or stable trends in these areas, we correlate our performance with the sizable investments that have been made in in-home behavioral health services.

**5. What measures do you use to tell if the program's customers are better off?
How are you doing on the most important of those measures?**

Within the Intensive In-Home Behavioral Health Services, the assessment of client outcomes includes a comparison of measures completed at admission and measures completed at discharge from the service. For example, the DCF programs and services database, currently in development and scheduled to "go live" in July 2009, will require providers to submit admission and discharge case-specific indicators of child functioning, problem severity, psychiatric hospitalization, school attendance, legal involvement, and substance abuse. These indicators provide one framework for assessing the benefits of the course of treatment.

This type of outcome assessment data has not been uniformly available for all in-home service program types but will be available going forward once the implementation of the programs and services data system is completed in July of 2009. Data for IICAPS shows improvements in rates of psychiatric hospitalization, for FST there is a 50% reduction in rates of out-of-home care, and similar outcomes are documented for other in-home service types.

6. Who are the partners with a major role to play in doing better?

Families

Community Behavioral Health Service Providers

Hospitals

Residential Behavioral Health Service providers

Probation/Legal System

Schools

Department of Social Services

Value Options (CTBHP Administrative Services Organization)

CT Legislature

7. What works, what could work, to do better, or to do the least harm in a difficult financial climate?

Training and ongoing Quality Assurance mechanisms are critical to the successful implementation of these services. While these activities are seen in some arenas as "extra," or "non-essential," their central role in the effective delivery of Intensive In-Home Behavioral Health Services cannot be overstated.

Workforce development is an area that has significant impact on the delivery of Intensive In-Home Behavioral Health Services. A common reason for lack of service capacity is staff vacancy and turnover. Moreover, there is the perception that many clinicians are entering the workforce without the requisite skills to effectively respond to children and families who present with the most challenging needs. Continued attention to workforce development will be a necessary component of a successful service delivery system. Through the Mental Health Transformation Grant, the CT Workforce Collaborative on Behavioral Health is intended to provide a forum for bringing together multiple stakeholders (e.g., private providers, state agencies, universities, consumers and families) to strategize and implement initiatives in this area. One initiative now underway is a specialized course regarding Intensive In-Home Behavioral Health Services that is being delivered in several university graduate training programs (e.g., MSW, MFT) throughout the state.

8. What do you propose to do over the next two years? Focus on 1) no-cost and low-cost actions, 2) actions to reduce the harm of budget reductions, and 3) reallocation of existing resources to obtain best results.

One model of Intensive In-Home Behavioral Health Services, Family Support Teams (FST), does not include a model-specific formalized training and quality assurance protocol. It is not expected that new resources will be available to fund these activities. In the re-procurement schedule for DCF programs and services, FST was slated to be re-bid during SFY10. Although

the overall re-procurement plan has been put on hold, there is still a desire to re-bid this particular service. It would be our intention to use the re-procurement as an opportunity to improve the statewide FST clinical program model and implement enhanced training and quality assurance.

Family-Based Recovery (FBR) is a relatively newer addition to the array of Intensive In-Home Behavioral Health Services. Providers delivering this intervention, which serves families with infants who have been exposed to parental substance abuse, have, to date, not been eligible to pursue Medicaid reimbursement through the CTBHP. DCF staff will continue to work in collaboration with DSS and providers to remove barriers to the ability of programs to maximize federal reimbursement.

II. Family Preservation Services

1. What is the quality of life result to which the program makes the most important contribution?

Family Preservation Services helps children grow up in their own homes, with their own families in an environment free from abuse and/or neglect.

2. What is the program's purpose?

The key purpose of Family Preservation Services is to mitigate safety factors and to avoid the need to remove children from their homes due to abuse and/or neglect concerns.

3. Who are the program's major customers?

The major customers for Family Preservation Services are children and their parents who are involved in our Child Protection System.

4. What measures do you use to tell if the program is delivering its services well? How are you doing on the most important of those measures?

To measure if a program's activities are carried out, we utilize a client specific Data Collection Tool completed by Family Preservation providers at the conclusion of the intervention. In addition to family demographics and characteristics, this tool tracks the actual unit of service delivered to the family (frequency and intensity), how the service was delivered (individual, team), and factors associated with completion of the Family Preservation intervention.

One of the important measures to consider related to service delivery is actual number of hours each week spent in each client's home. The Family Preservation baseline identifies a caseload of 5 families for each direct service Full-time Equivalent position and a minimum of 5 hours per week of in-home face-to face service intervention per family.

In calendar year 2007, 72% of clients received 5 or more hours per week of in-home face-to face service intervention. Of that 72%, 28% received more than the 5 hour per week standard.

We would like to see the 72% increase. However, there are intervening factors such as travel time getting to clients, transportation needs of clients and local AO decision making when, for example, a decision is made to increase the intensity of the service to one family due to their specific needs and thus impacting the hours spent with other clients. A decision like this will impact the number of families that receive 5 hours of direct service each week.

5. What measures do you use to tell if the program's customers are better off? How are you doing on the most important of those measures?

Children are better off when they remain free from repeat maltreatment and when they do not need to be removed from their homes because of abuse and/or neglect. In calendar year 2007, safety factors were mitigated in 84% of cases served, averting the removal of children from those families.

6. Who are the partners with a major role to play in doing better?

DCF open cases receiving Family Preservation Services are some of our highest risk cases. Family circumstances and parental risk factors include substance abuse, mental health issues, cognitive limitations, domestic violence, parenting skill deficits as well as significant concrete needs for housing, employment and medical care. It would be fair to say that the community at large has a role in helping create safety nets for families who struggle.

7. What works, what could work, or do better, or to do the least harm in a difficult financial climate?

Continue important data development, collection and analysis and work with the provider community and client base on improving quality of care, workforce competencies, and program development.

8. What do you propose to do over the next two years? Focus on 1) no-cost and low cost actions, 2) actions to reduce the harm of budget reductions, and 3) reallocation of existing resources to obtain best results.

Same as 7 above.

III. Flex Funds

1. What is the quality of life result to which the program makes the most important contribution?

The program is intended to improve the well being of children by increasing the likelihood that they can remain in their homes or live in the most home-like setting possible.

2. What is the program's purpose?

Flexible funding refers to an administrative procedure whereby the Department's Social Workers can purchase individualized services on a case by case basis under a streamlined administrative process. By providing those closest to the case with these tools, they can provide services that are more customized and more immediate than could be provided under a traditional service development model. Thus reducing the number of children who require out-of-home services.

3. Who are the programs major customers?

The program's major customers are the children (and families) who are either being served in out-of-home care or are at risk of an out-of-home placement.

4. What measures do you use to tell if the program is delivering its services well?

Although the program is intended to provide access to individualized services, a considerable portion of costs have been concentrated in the purchase of a small number of services which were previously not available, or not available in any organized way. As a result, the Department developed standardized definitions, expectations, provider credentialing standards and reimbursement standards for six of the most commonly used services. As a result the amount of services classified as "other", "miscellaneous", or "non-categorical" fell from \$20 million in FY 2006 to \$7 million in FY 2008.

Through service definition and the establishment of necessary provider credentials, the Department has been able to ensure that services are being delivered by individuals who meet certain experience and background standards. Establishing this pool of qualified providers has allowed area office staff to have an immediate means of identifying potential providers for the families who need them. In addition, identification of the provider pool allows the Department to collect individual-specific information on the quality of service delivered.

The Department continues to develop service definitions and standards for additional services as analysis of our expenditure trends highlights additional service gaps being met through flexible funding.

5. What measures do you use to tell if the program's customers are better off?

The Department measures entry into care rates, re-entry into care, repeat maltreatment, reducing placements and length of placements in congregate settings, and recidivism within our juvenile justice work. As we have experienced positive and/or stable trends in these areas, we correlate

our performance with the ability to offer supports and services in an immediate, flexible and individualized manner through Flex Funds.

6. Who are the partners with a major role to play in doing better?

The services purchased through flexible funds are all provided by privately operated businesses and individuals. As befits the individualized nature of flexible funding, these services are provided by a wide range of providers, both large and small. The Department is committed to working with its providers to maximize the quality of service that the Department is purchasing.

7. What works, what could work, to do better, or to do the least harm in a difficult financial climate?

Balancing flexibility with accountability requires the Department to standardize those services which can address common needs while preserving the ability of Social Workers to customize services when necessary. Through the development of provider agreements, credentialing requirements, standardized rates, and increased attention to budgeting for these services at the area office level, the Department was able to reduce flexible funds spending by approximately \$3 million between FY 2007 and FY 2008.

The Department anticipates that continuing these efforts and bringing additional frequently used services under provider agreements will allow additional savings to be realized without the need to ration services.

IV. Substance Abuse Treatment for Adolescents

1. What is the quality of life result to which the program makes the most important contribution?

To support the healthy trajectory of adolescent development and recovery from substance abuse.

2. What is the program's purpose?

The program purpose is to intervene and reduce adolescent substance abuse. The early onset of adolescent substance use is intertwined with a wide range of quality of life issues. Early intervention in adolescent substance abuse has been shown to prevent/reduce the development of the associated conditions listed below;

Psychological and Behavioral Conditions (e.g. Conduct Disorder, ADHD, Depression, Anxiety, etc.), Health Conditions (Sexually Transmitted Diseases, Teen Pregnancy), Legal Issues (Juvenile Crime, Intimate Partner Violence), and Family Issues (Conflict, Child Abuse and Neglect). Recent studies have shown over 75% of the adolescents entering the treatment system have one or more of these conditions.

3. Who are the programs major customers?

Substance abusing adolescents and their families, ages 11-17, including those adolescents with co-occurring mental health problems. There is priority given to DCF involved adolescents from child welfare, family with services needs and juvenile justice systems and families with no insurance.

36% of all referrals are from juvenile or adult courts, 18% are DCF referrals, 19% come from parents/youth, and 6% are from schools. The remaining 21% are referred by behavioral health professionals.

4. What measures do you use to tell if the program is delivering its services well? How are you doing on the most important of those measures?

Utilization of existing capacity is one measure of quality service management and delivery. DCF contracted adolescent treatment capacity is 420 and 640 youth received services during the past SFY.

Engagement and retention in treatment are two process measures that are often cited in relation to the quality of adolescent substance abuse treatment. Nationally, less than 50% of youth stay in treatment for six weeks and less than 25% remain in treatment for at least 3 months as recommended by the National Institute of Drug Abuse (NIDA). DCF's performance is better than the national average with close to 50% of the adolescents receiving more than 90 days of treatment, a benchmark associated with improved treatment outcomes.

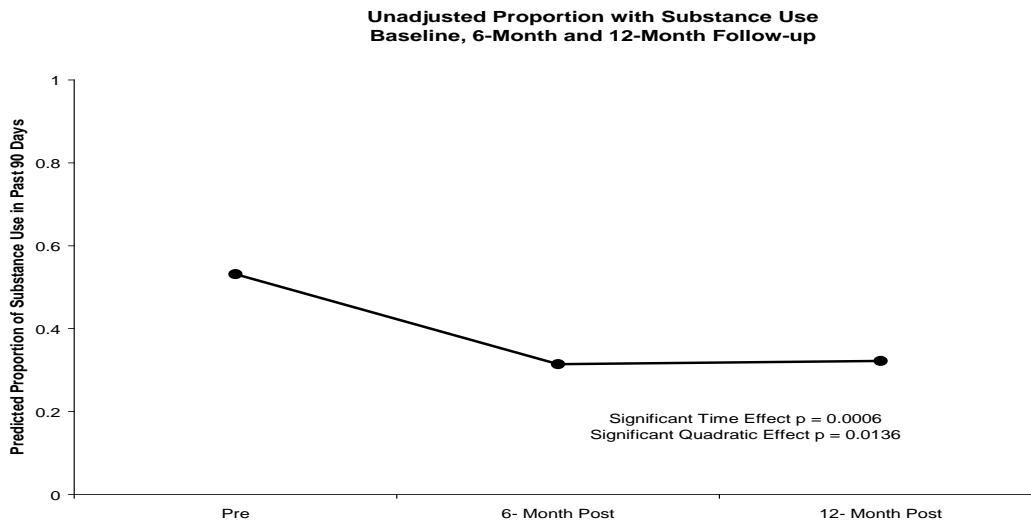
Another key service component is the quality of the initial assessment done at intake. DCF has implemented the standardized screening and assessment system called the Global Appraisal for Individual Needs (GAIN). This measure is designed to assess substance abuse and behavioral health issues and problem severity as well as track a number of treatment variables known to

impact the success of treatment such as client's perception and expectations of treatment, client self-efficacy, and client motivation.

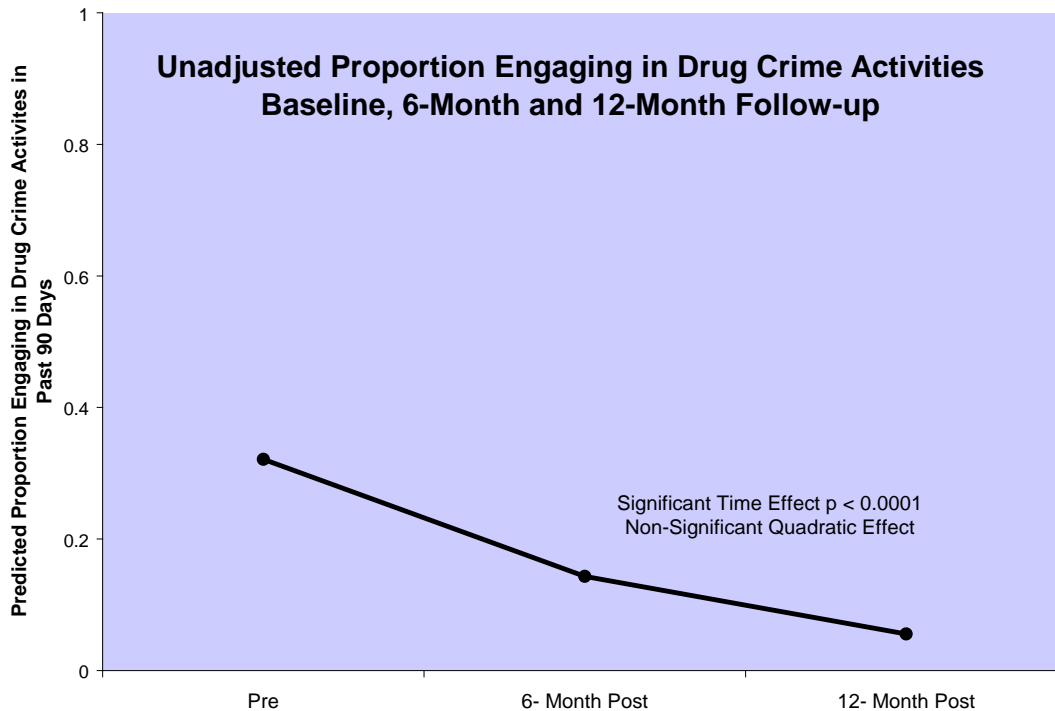
Following initial implementation of the GAIN within the adolescent outpatient treatment service system, 100% of GAIN service providers are trained, proficient at GAIN implementation, and actively administering the GAIN or the GAIN-I to clients entering service.

**5. What measures do you use to tell if the program's customers are better off?
How are you doing on the most important of those measures?**

DCF is developing baseline data and has been able to use GAIN data to compare the federally funded Hartford Youth Project with other similar populations and programs across the country. Days of drug use and reduction in criminal behavior are areas of focus. This data is currently available at intake and discharge for all out patient substance abuse service providers.



Outcomes trending in right direction for substance use and criminal activity. With the use of GAIN data, DCF will be able to track these measures plus problem severity at intake vs. discharge for treated youth.



6. Who are the partners with a major role to play in doing better?

DCF Contracted Adolescent Substance Abuse Providers of Service

DCF Child Welfare and Juvenile Justice Staff

Youth

Family Members

New England Adolescent Consortium on GAIN Implementation (share resources/expertise in GAIN implementation).

DSS (Medicaid Billing)

Connecticut Behavioral Health Partnership (CTBHP)

Judicial - Court Support Services Division

7. What works, what could work, to do better, or to do the least harm in a difficult financial climate?

Research has indicated the adolescent substance abuse tends to be a chronic relapsing condition that requires sustained intervention to be maximally effective and to avoid associated negative behavioral, health, legal, and family outcomes.

There are two areas of best practice that hold the promise for improving outcomes:

1. Implement chronic disease management technology such as recovery management or recovery support that is specifically designed for adolescents and families after formal treatment has needed. There is a growing number of studies that show superior clinical outcomes and improved cost effectiveness for a recovery support approach for very high

risk groups (child abuse, juvenile justice, mental health and early onset users). The department is exploring reallocation options and federal funding sources to support the development of a recovery management component.

2. Screening and Brief interventions for adolescents. This approach using opportunistic screening to identify early involvement in substance use paired with low-cost brief interventions to head problems off before they become entrenched. This approach has proven to be very cost effective for adults. In states where Medicaid has allowed for billing of recovery management, financial studies have found that the additional costs of recovery management are offset by savings in reimbursement at higher levels of care, resulting in cost neutrality. DCF intends to explore this option with DSS as a component of a Medicaid Waiver.

8. What do you propose to do over the next two years? Focus on 1) no-cost and low-cost actions, 2) actions to reduce the harm of budget reductions, and 3) reallocation of existing resources to obtain best results.

Continue to maximize federal revenues by exploring Medicaid reimbursement for Family Based Recovery and recovery management approaches, use of regional collaboration and other discretionary federal grant funding to continue to build the necessary treatment infrastructure, improve quality assurance, and implement a recovery management component.

V. Project Safe

1. What is the quality of life result to which the program makes the most important contribution?

Safety, permanency and well being of children involved in child welfare

2. What is the program's purpose?

In compliance with Connecticut State Statute Section 17a-101j, the department is required to refer parents or guardians involved with the child protective services to substance abuse treatment. The Project SAFE program purpose is to screen, identify and refer parents with substance abuse disorders who are involved with child protective services to substance abuse evaluation and treatment. A secondary goal is to reduce child abuse risk factors associated with parental substance abuse.

3. Who are the programs major customers?

Parents and guardians involved with child protective services and where substance abuse is a factor in their parenting. 70% to 80% of all DCF cases involved some level of substance abuse involvement.

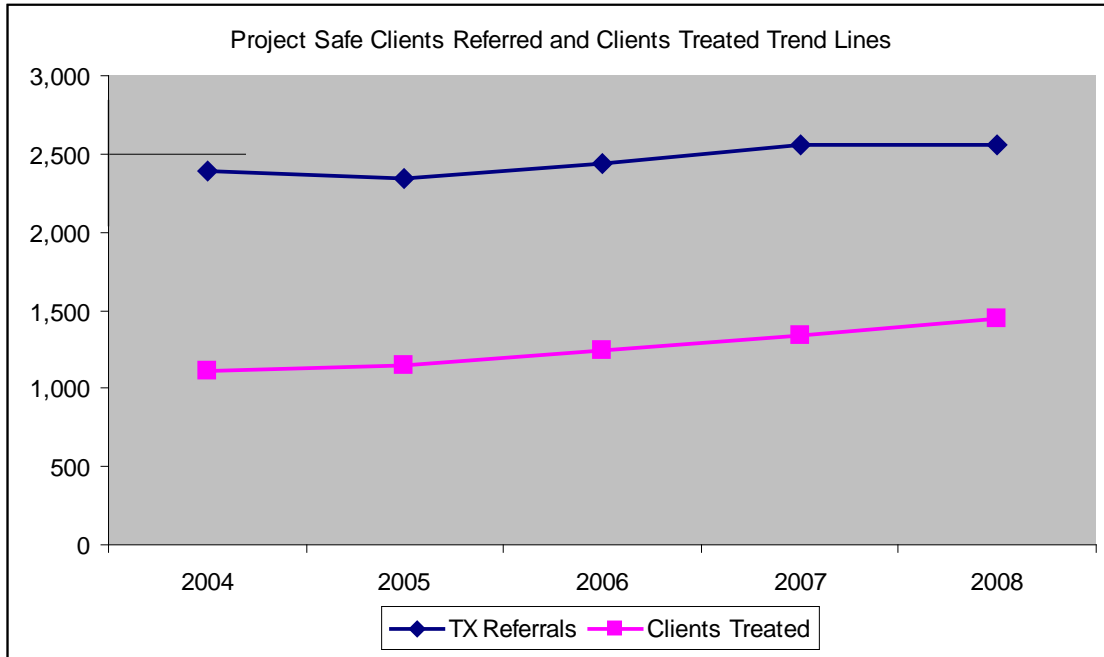
4. What measures do you use to tell if the program is delivering its services well? How are you doing on the most important of those measures?

DCF tracks urine drug tests, hair tests, and substance abuse evaluations on a per service unit basis and utilization has been steadily increasing. During the past two years DCF has implemented a standardized clinical tool for the field social workers called the Global Appraisal for Individual Needs (GAIN) Short Screen. This measure provides self-reported substance abuse symptoms and determines treatment need at low, moderate, and high levels. The measure also includes indicators of behavioral health disturbance often associated with substance abuse.

The most recent GAIN data indicate that between 80% to 85% of clients referred for substance abuse services were administered the GAIN Short Screen, indicating that the newly introduced measure is being widely implemented. Besides improvements in clinical referral data, and inclusion of standardized measures, the implementation of the GAIN SS may also provide an opportunity for further cost savings. DCF has found that referral for a further substance abuse drug screening and evaluation is not necessary for individuals who self report high levels of substance use and high levels of treatment need. DCF is negotiating with DMHAS to accept individuals in the high range of the GAIN SS directly into treatment, eliminating the need for an additional DCF funded drug test or evaluation. The department hopes to use these saving to expand the recovery management approach.

5. What measures do you use to tell if the program's customers are better off? How are you doing on the most important of those measures?

The relationship between child welfare and parental substance abuse is complex and measuring if the customer is better off depends on the definition of success. DCF is responsible for the screening and referral and not the effectiveness of the treatment (DMHAS oversees the adult SA treatment system utilized in project SAFE). It is DCF's job to get the parents to evaluation and treatment and the trend lines in this area show movement in the proper direction. As indicated in the graph below, there has been a steady increase (from 3% to 8 % each year) in treatment referrals to clients treated in Project SAFE. Project SAFE is a voluntary program and in comparison to other states and for voluntary referrals, show rates in Connecticut are above average.



Once clients reach treatment, data suggests that treatment dose and intensity is not high enough to meet clinical benchmarks and significantly impact substance abuse for many of the treatment participants. The department will continue to work with DMHAS to improve service utilization patterns and utilize pilots to explore methods of improving treatment dose, intensity, and specificity to recovering families.

6. Who are the partners with a major role to play in doing better?

The primary partners are DMHAS and DCF as outlined in State Statute Section 17a-453c ("There shall be an interagency collaboration, to be known as "Project Safe", between the Department of Mental Health and Addiction Services and the Department of Children and Families"). Other partners include the child welfare court, treatment providers, family members, and consultants funded through federal initiatives.

7. What works, what could work, to do better, or to do the least harm in a difficult financial climate?

Pilot projects have shown in-home and recovery management services promise to increase show rates, engagement in treatment and retention in treatment for clients who have a history of not engaging. The state average is below a 50% show rate for referrals. Pilots with recovery management have show rates above 80% and higher.

In Depth Technical Assistance (IDTA) is a recovery management pilot project being launched in three courts and DCF Area offices based on successful projects in Sacramento, Ca., and Illinois. Both models used in other states found substantial cost savings and improved outcomes across systems. The model calls for a recovery coach to work with the family from the moment of referral through treatment completion and includes active partnership with the legal system including the courts, attorney generals office and public defenders. The targeted population for the IDTA/CT Recovery Specialist Model is parents whose children have been removed pursuant to an Order of Temporary Custody (emergency removal order) and for whom substance abuse is identified as one of the factors in the removal. Client entry into the program is voluntary.

8. What do you propose to do over the next two years? Focus on 1) no-cost and low-cost actions, 2) actions to reduce the harm of budget reductions, and 3) reallocation of existing resources to obtain best results.

Implement IDTA in three sites and evaluate outcomes. This involves a re-allocation of existing DCF and DMHAS resources to begin this project.

An evaluation plan for IDTA is in development and will be submitted to the federal government for consideration of federal funding. A resource management group is being formed with DCF and DMHAS to look at various potential federal entitlements and revenue streams for recovery management.

DCF will continue to implement the GAIN-SS and work with DMHAS so that individuals that score high on the GAIN can directly access treatment without incurring additional costs associated with drug screening and further evaluation. The plan would be to use these savings to fund additional implementation of the recovery management model being piloted through IDTA.

VI. Foster Home Development

1. What is the quality of life result to which the program makes the most important contribution?

Foster family care is the first line of defense for children in Connecticut who must be removed from their own home due to abuse or neglect. This service provides an alternative home with all of the supports and nurturance that can only be provided by a family. In the absence of a foster family, children being removed from their home would have to be placed in an institutional or congregate care setting.

2. What is the program's purpose?

The purpose of the program is to provide a stable and nurturing family environment for children who have been removed from their home.

3. Who are the programs major customers?

The program's major customers are the children (and families) who need a stable living environment when they cannot remain in their own home.

4. What measures do you use to tell if the program is delivering its services well?

The Department utilizes the following measures from the *Juan F.* Exit Agreement:

No more than 2% of children in out-of-home care shall be the victims of substantiated maltreatment by a substitute caregiver while in out-of-home care.

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.

At least 96% of all children placed in foster homes shall be in foster homes operating within their licensed bed capacity, except when necessary to accommodate siblings.

5. What measures do you use to tell if the program's customers are better off?

The following measures and outcomes to support whether children are better off are as follows:

Measure	2004	2005	2006	2007	2008
Maltreatment OOH Care	0.5% - 0.9%	0.6% - 0.8%	0.2% - 0.7%	0.0% - 0.3%	0.2% - 0.3%
Multiple Placements (experience no more than 3 placements)	95.2% - 95.8%	95.7% - 96.2%	95% - 96.6%	92.7% - 96.3%	91.2% - 96.3%
Placement within Licensed Capacity	88.3% - 95.7%	94.8% - 97%	94.5% - 96.7%	96.8% - 97.1%	96.4 - 97.8%

6. Who are the partners with a major role to play in doing better?

Foster care relies upon critical alliances in order to ensure the timely placement of children into safe and supportive homes. Connecticut's dedicated foster parents are an obvious major partner.

In addition, the Department partners with a variety of entities to facilitate the recruitment and retention of quality foster families and to provide them ongoing support. DCF's partners also include private child placing agencies, faith-based organizations, children's relative families, local businesses and community-based service agencies. These entities are essential to the successful provision of foster care.

7. What works, what could work, to do better, or to do the least harm in a difficult financial climate?

Placing children in a family setting is essential to support their growth into happy, well-adjusted and productive adults. Best practice demonstrates that when children are unable to be cared for within their own relative homes, foster care is a normative, cost effective option. As the Judge David L. Bazelon Center for Mental Health Law states regarding therapeutic foster care (TFC):

"TFC is less restrictive than other types of out-of-home placement, and studies of children in this type of foster care show behavioral improvements and more successful transitions to less restrictive environments. It is also less expensive.¹"

Critical to the provision of foster care is rigorous oversight, quality assurance and management. Key to determining service efficacy is accurate data collection, more sophisticated analysis and timely reporting. This is predicated upon the establishment of clear service expectations and standards. Ensuring frequent home visits, ongoing foster parent support, comprehensive training and thorough home inspections are some of the means by which sound foster care provision can be effected. Enhancing and building upon existing contract and quality assurance activities are strategies that can and are being implemented to improve the quality of foster care in Connecticut.

8. What do you propose to do over the next two years? Focus on 1) no-cost and low-cost actions, 2) actions to reduce the harm of budget reductions, and 3) reallocation of existing resources to obtain best results.

DCF will be focusing on the increased recruitment and retention of a diverse and qualified pool of foster homes. Consonant with the Department's efforts to divert and return children from higher, more restrictive congregate levels of care (e.g., residential treatment), DCF is renegotiating its TFC contracts so that they are better able to provide intensive care for children with complex needs. Both regular and therapeutic level foster homes reflect not only a normative, family placement setting, but are also cost effective.

¹ Judge David L. Bazelon Center for Mental Health Law - *Wraparound and Therapeutic Foster Care and Their Implications for Taxpayers*: <http://www.bazelon.org/issues/children/wraparoundTFC.htm>

**APPENDIX
SUMMARY AGENCY PROGRESS REPORT**

Keeping Families Together and Preventing Placements

- 1,175 more families (41%) receive services in cases where the children are living in the home
 - Sept. 2008 --- 4,010
 - Jan. 2002 --- 2,835
- 1,026 fewer children (15.97%) are in out of home care as the result of abuse or neglect
 - Sept. 2008 --- 5,396
 - Sept. 2004 ---6,422
- *\$44 million in contracted services will be expended in SFY08 to help keep families intact (not including DCF personal services).*

Better Interventions Bring Lower Levels of Repeat Victimization

- A critical indicator of the quality of services is the measure of children suffering repeat maltreatment (abuse or neglect). The percent of children who are victims of repeat maltreatment has fallen from 9.4 percent in the 3rd quarter of 2004 to 5.9 percent in the 2nd quarter of 2008. The Department met the Exit Plan goal in the last five quarters and kept repeat maltreatment below 6 percent in the last three quarters.

More Family Care

- Children entering care are more likely to be placed in a family setting (foster care, relative care or special study home). Children placed with a family increased by 15 percentage points since 2002.
 - CY2002 -- 57 percent of children placed in a family setting
 - CY2005 -- 70 percent of children placed in a family setting
 - CY2006 -- 72 percent of children placed in a family setting
 - CY2007 -- 72 percent of children placed in a family setting

Timely Permanence and More Permanent Homes

- Over the eight quarters ending April 2008, the three measures of timely permanency (adoption, subsidized guardianship, and reunification) have met the goal in 20 of the 24 possible occasions.
- Compared to the 1st quarter of 2004, the percentage of children adopted within 24 months has more than tripled for each of the last eight quarters.
 - 2004 1st Quarter -- 10.7 percent
 - 2006 4th Quarter through 2008 1st Quarter -- 33 percent to 41.5 percent

- During state fiscal years 1997 to 2005, an average of 615 permanent homes (both adoptions and subsidized guardianships) were found annually for children in foster care -- more than four times the number in 1996. In FY2008, 634 adoptions were finalized and 234 subsidized guardianships granted for a total of 868 new permanent homes.

A More Fluid System For Meeting Behavioral Health Needs In The Least Restrictive Treatment Setting

- There are 340 fewer children (38.2%) in a residential program:
 - 889 in April 2004 compared to 549 in September 2008.
- There are 160 fewer children (32.6%) in an out of state residential program:
 - 491 in Sept. 2004 compared to 331 in September 2008. Of those out of state, 74% are in New England.
- Community based behavioral health funding totaled \$69 million in SFY08 or more than double the amount spent in SFY02 (\$32M).
- Therapeutic Group Homes: Since 2005, DCF has established 54 therapeutic group homes for children with behavioral health treatment needs. Approximately 273 children receive intensive clinical services in the community as a result of this initiative.
- Intensive in-home clinical services and family support services are available to approximately 2,300 children and their families. Current in-home services, which were virtually non-existent prior to 2004, include:
 - Multi-Systemic Therapy
 - Multidimensional Family Therapy
 - Intensive In-home Child and Adolescent Psychiatric Services
 - Family Support Teams
 - Intensive Community Family Support Services
 - Functional Family Therapy; and
 - Family Based Recovery and Building Stronger Families (See above under Keeping Families Together)

Reasonable Caseloads Support More Intensive Work With Families

- DCF social worker caseloads are range from 15 to 20 cases, which is in line with CWLA national standards. Prior to the Consent Decree, according to anecdotal information, workers typically had caseloads of 40 to 60 cases.

More Individualized Services For Families

- Resources for flexible, timely and individualized assistance have increased more than 400 percent since SFY04 when DCF's flexible fund expenditure was approximately \$5 million. In SFY08, DCF provided approximately \$27 million in various forms of individualized assistance, which is helping to keep families together, reduce the number of children entering care and provide stability and permanency for children.