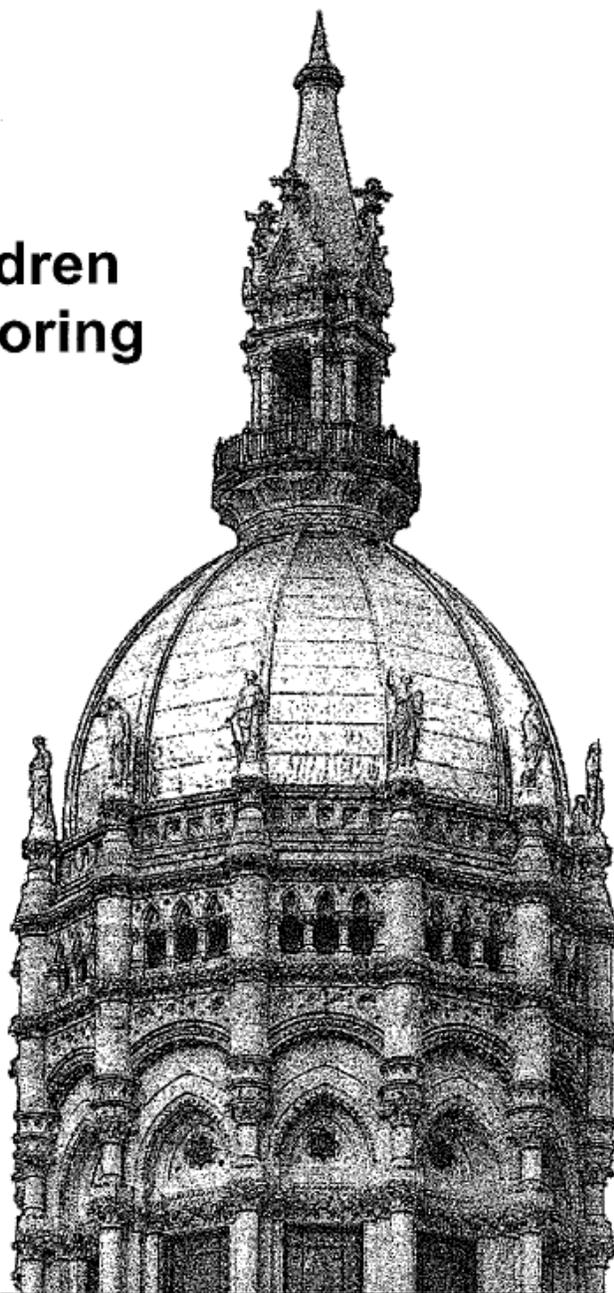


Department of Children and Families Monitoring and Evaluation

DECEMBER 2007



**Legislative Program Review and
Investigations Committee**

Connecticut General Assembly

**CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE**

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

The program review committee is composed of 12 members. The president pro tempore of the Senate, the Senate minority leader, the speaker of the house, and the House minority leader each appoint three members.

2007-2008 Committee Member

Senate

Edward Meyer
Co-Chair
David J. Cappiello
John W. Fonfara
Anthony Guglielmo
John A. Kissel
Andrew M. Maynard

House

Julia B. Wasserman
Co-Chair
Mary Ann Carson
Marilyn Giuliano
Michael P. Lawlor
Mary M. Mushinsky
J. Brendan Sharkey

Committee Staff

Carrie Vibert, Director
Catherine M. Conlin, Chief Analyst
Jill E. Jensen, Chief Analyst
Brian R. Beisel, Principal Analyst
Michelle Castillo, Principal Analyst
Maryellen Duffy, Principal Analyst
Miriam P. Kluger, Principal Analyst
Anne E. McAloon, Principal Analyst
Scott M. Simoneau, Principal Analyst
Michelle Riordan, Legislative Analyst II
Janelle Sagness, Legislative Analyst II
Bonnine T. Labbadia, Executive Secretary

Project Staff

Jill E. Jensen
Miriam P. Kluger
Michelle Riordan

STATE CAPITOL ROOM 506

HARTFORD, CT 06106

(860) 240-0300

Email: pri@cga.ct.gov

www.cga.ct.gov/pri/index.htm

LEGISLATIVE PROGRAM REVIEW
& INVESTIGATIONS COMMITTEE

Department of Children and Families
Monitoring and Evaluation

DECEMBER 2007

Table of Contents

DEPARTMENT OF CHILDREN AND FAMILIES MONITORING AND EVALUATION

Executive Summary	i
Introduction	1
Purpose	1
Study Approach	2
Methodology	6
Report Organization	8
I. Background: Overview of DCF	9
Mission, Guiding Principles, and Goals	9
Major Duties and Responsibilities	13
State Mandate Areas and Programs	15
Organization and Budget	22
II. DCF Internal Monitoring and Evaluation Activities	29
Bureau of Continuous Quality Improvement	29
Other Internal Monitoring and Evaluation Efforts	41
Contracted Monitoring and Evaluation	43
DCF Information Systems	48
III. DCF External Monitoring and Evaluation Activities	51
U.S. Department of Health and Human Services	51
Federally-Required Child Abuse Prevention and Treatment Plan	65
DCF Federal Grant Funding	68
Judicial Oversight	70
Legislative Oversight	83
Accrediting Body Oversight	88
Other Regulatory Monitoring and Evaluation Reporting	94
IV. Outside Investigations and Reviews	97
Office of the Child Advocate	97
Child Fatality Review Panel	102
State Attorney General	105
V. Advisory Group Monitoring and Evaluation Activities	107
Overview	107

Table of Contents

Agencywide and Area Advisory Groups	109
DCF Facility Advisory Groups	109
Federally Mandated Advisory Groups	111
Issue-Specific Advisory Groups	111
Inactive Advisory Groups	113
Advisory Groups Requiring DCF Participation.....	113
VI. Results from Monitoring and Evaluation Efforts	117
Overview	117
Detailed Monitoring and Evaluation Results Within Child Protective Services	119
Detailed Monitoring and Evaluation Results Within Behavioral Health Services	132
Detailed Monitoring and Evaluation Results Within Juvenile Services	138
Detailed Monitoring and Evaluation Results Within Prevention Services	139
Detailed Agencywide Results	141
Summary of Results from Key Monitoring and Evaluation Efforts	142
VII. Findings and Recommendations.....	145
Agency Goals.....	146
Overall System Assessment.....	150
Internal Efforts.....	159
External Efforts.....	171
Outside Investigations and Reviews	178
Advisory Group Efforts	181
 APPENDICES	
A. Agency Response	
B. PRI Approach to the DCF Study	
C. DCF: Developments Since 1999	
D. History of DCF	
E. Mission and Guiding Principles	
F. Summary of DCF Major Goals	
G. Child Welfare Quality Assurance Framework Components	

Executive Summary

Department of Children and Families Monitoring and Evaluation

Formed in 1974 as a consolidated children's agency, the Connecticut Department of Children and Families (DCF) has broad authority and primary responsibility for state mandates concerning child protection, children's behavioral health, juvenile delinquency, and prevention services related to children and families. The department has been studied, audited, reviewed, and subject to legal action almost continuously since it was created due to ongoing concerns about its ability to carry out its challenging mission.

Numerous internal quality improvement efforts, as well as oversight by multiple outside entities including federal and other state agencies, various advisory groups, the courts, and the legislature, have focused on how to achieve better outcomes for the children and families DCF serves. The Legislative Program Review and Investigations Committee (PRI) alone had completed seven different reports on the department prior to undertaking a review of the overall DCF accountability system in April 2007. Unlike previous PRI reviews, this study evaluated a critical function -- monitoring and evaluation of agency results -- rather than a particular mandate.

An effective results-based monitoring and evaluating system is important for three main reasons: 1) it provides an agency with productive feedback on actual outcomes and progress toward goals; 2) it allows agency staff, policymakers, and stakeholders to know where the agency is successful, where it is not, and how to make improvements; and 3) ultimately, it helps the agency provide services that meet clients' needs and make cost-effective use of taxpayer resources. The purpose of the 2007 program review committee study was to determine areas of strength and weakness, as well as gaps and redundancies, in the existing DCF accountability system, and to identify needed improvements.

Study approach and methods. The committee study employed two primary research methods: interviews with key stakeholders; and analysis of monitoring and evaluation reports and other documents produced through DCF quality assurance, performance evaluation, and oversight efforts. There were four main sources of efforts:

- 1) internal monitoring and evaluation efforts such as: provider licensing, performance-based contracting, ombudsman activities, and various department self-reviews and contracted evaluation studies;
- 2) external oversight efforts by federal agencies, federal and state courts, legislative committees, and independent entities like national accreditation organizations;
- 3) outside investigations and reviews, such as those carried out by the state Office of the Child Advocate (OCA) and the state attorney general; and
- 4) monitoring and evaluation activities by advisory groups established under federal or state law.

Executive Summary

To put into context all the information gathered about the process, sources, and results of DCF monitoring and evaluation, the core components of the current system were also compared with a national model for child welfare agency quality improvement.

The program review committee's final report contains an assessment of the overall DCF monitoring and evaluation system, details the system's positive features as well as deficiencies, and recommends nearly 40 administrative and legislative changes to improve its effectiveness. The report also summarizes data on agency accomplishments that were compiled by program review staff from more than 100 different monitoring and evaluation documents analyzed during the study.

Main findings. The program review committee found little attention has been given to examining DCF as a whole or assessing how well the agency is achieving its broad goals of safety, permanency, and well-being for all children and families. Further, while the department is responsible for carrying out four major mandates, monitoring and evaluation is focused primarily on the child protective services mandate, due largely to the ongoing impact of the federal *Juan F.* lawsuit consent decree and requirements of federal agencies.

The PRI study showed there is greater emphasis on tracking how services for children and families are delivered rather than on assessing their end results. While high quality service delivery is important, the crucial indicator of effectiveness is whether programs are making a difference and achieving stated goals. In general, more attention to outcome information is needed throughout the DCF accountability system.

The committee's review also identified pockets of strength within the system, such as the *Juan F.* exit plan process and related DCF area office quality improvement processes, the department's licensing procedures, the agency's recently revised special review process, and the activities of on-site facility monitors.

Some major weaknesses were revealed as well. In particular, the agency's contracting process provides little accountability, consequences for poor performance are rare, and working relationships with private providers need improvement. The committee also found ineffective use of some important sources of feedback on services and programs, such as child fatality reviews, OCA investigations, and even the department's own program review reports and contracted evaluations.

In part, these deficiencies are due to both fragmentation of quality improvement efforts within the agency and the fact that results data are not regularly integrated and analyzed. Both problems are related to the department's information systems, which are themselves fragmented and in some cases inadequate. Another challenge is a lack of department staff with the analytic skills and research experience needed to use results data and information. Further, there is no centralized place – like an agencywide strategic plan – where all DCF goals and information about service delivery and outcomes are brought together.

Duplication of external monitoring efforts also was revealed by the program review committee's examination of statutorily required DCF plans and reports. The committee determined several mandates could be eliminated without a loss of accountability, as certain

Executive Summary

documents have become obsolete or been replaced by newer sources of similar information. In addition, reducing the number and clarifying the purpose of reporting mandates could improve the quality of information on department results available to the legislature and the public.

Committee recommendations. Ultimately, the point of all monitoring and evaluation efforts, whether internal, external, investigatory, or advisory, is to ensure programs and services are having desired results. Taken together, the PRI committee recommendations listed below are aimed at making the current DCF accountability system more effective by:

- making agency goals explicit;
- integrating quality improvement activities and incorporating best practices throughout the agency;
- improving the quality and quantity of available data; and
- promoting the use of results information to better meet the needs of children and families.

RECOMMENDATIONS

- 1. The current statutory provision for a Department of Children and Families biennial five-year master plan shall be repealed and replaced with a mandate for ongoing strategic planning. Specifically:**
 - a) Beginning July 1, 2008, the department shall start the process of developing a vision, mission, and strategic goals with the advice and assistance of representatives of the children and families served by the agency, public and private providers, advocates, and other stakeholders.**
 - b) The department should dedicate staff, under the direction of the commissioner or a deputy commissioner, to: 1) prepare a strategic planning document that includes action steps and time frame for implementation to fulfill the vision, mission, and goals developed with stakeholders; 2) track and report on progress in achieving the plan's goals at least annually; and regularly review, revise, and update the department's strategic plan as needed.**
 - c) The first plan shall be completed and submitted to the legislature and the governor by July 1, 2009.**
 - d) The department's strategic plan shall be submitted to the agency's State Advisory Council for Children and Families for review and comment prior to submission to the legislature and governor. Progress in carrying out the plan shall be reported to the council by the DCF commissioner at least quarterly and to the legislature and governor annually.**

Executive Summary

2. The department should reinforce and expand the role of the Service Evaluation and Enhancement Committee (SEEC) in integrating monitoring and evaluation efforts across the agency and initiating proactive intervention on agencywide issues.
3. DCF performance-based contracts should specify the data required from providers. Performance standards or expected outcomes should be stated in the contract. DCF should monitor data submissions for accuracy.
4. DCF should review currently required data elements from providers and determine whether they are necessary or analyzed in any way. Data elements that are unnecessary should be eliminated and additional data elements that pertain to outcomes should be added to performance-based contract requirements.
5. DCF shall compile necessary required data elements to compare actual and expected outcomes based on the performance-based contract. Failure to meet contract expectations should result in discussion and joint plans for progress in meeting expectations.

Until automated systems are deemed reliable, DCF should monitor contract expectations manually. Summary reports should be shared with providers so that they may monitor their performance against the aggregated data. Reports should be distributed to providers and DCF staff made more aware of the existence of these reports.

6. A central repository should be created by DCF of contracted research and evaluation reports and internally produced research and evaluation reports. This repository should be accessible and searchable by all DCF staff and should include the Office of Policy and Management (OPM) feedback form as applicable.
7. The DCF licensing unit should expand internal self-monitoring by inspecting High Meadows and Connecticut Children's Place, the two DCF facilities not currently under external licensure or accreditation. The licensing unit should follow the child care facilities regulations standards used to inspect external residential treatment facilities similar to High Meadows and Connecticut Children's Place.
8. The department should establish an internal written policy for responding to recommendations from the internal special reviews of child fatalities and other critical incidents. The policy should require a corrective action plan be developed, implementation of accepted recommendations be monitored, and a status report be prepared for the commissioner every 90 days. A forum to discuss results and lessons learned should be scheduled with managers and key staff from all relevant areas of the department within 45 days of release of the report.

Executive Summary

9. DCF should be permitted to establish a long-term research partnership with the Child Health and Development Institute and its affiliate, the Connecticut Center for Effective Practice, through a multi-year, sole source contract to carry out a broadly defined research and evaluation agenda related to the agency's mission.
10. DCF should reexamine the role of its program lead position and consider the allocation of time necessary for this responsibility. DCF should also develop a team approach for working with contracted providers that will ensure contract obligations are being met, provide assistance when necessary so that programs do not reach a crisis point, and support and assist programs with quality improvement.
11. Considering contractor monitoring best practices, DCF should examine the roles of staff within the Grants Development and Contracts Division to determine whether some of the 19 positions could be reallocated from the financial/accounting function of contract management to program development and implementation support activities.
12. DCF should maintain a centralized and complete electronic grants and contracts library on the department's intranet. Grants and contracts missing should be scanned into the library. Previous years' contracts should be maintained for future reference.
13. The department should require the Grants Development and Contracts Division to receive and review feedback from area office and program lead staff on the performance of a provider before deciding to renew a contract. If concerns are raised about a provider, then discussions with the appropriate parties should occur and a performance improvement plan developed.
14. A workgroup should be convened by the department and the Offices of Policy and Management and the Attorney General to clarify the guidelines regarding contract bidding and related programming suggestions.
15. DCF should develop a protocol for providers to submit suggested programs or program enhancements. A form for submitting the idea should be developed and timelines for response from DCF publicized.
16. DCF should work with the Department of Administrative Services (DAS) to develop: 1) an appropriate job classification for staff positions within the agency responsible primarily for research and analysis; and 2) recruitment strategies for obtaining personnel with the necessary qualifications to fill them.

Furthermore, the department should increase its internal analytic capacity. The size and scope of the Risk Management Unit staff should be expanded to include the following duties in addition to compiling information to support the SEEC function: interpreting data produced by the state's behavioral health Administrative Service Organization (ASO); compiling contracted evaluation results; maintaining the research repository recommended earlier; supporting agency strategic planning activities; and sharing outcome, best practices, and results information agencywide.

Executive Summary

17. For programs exceeding \$20 million in funding, DCF should require an external evaluation be conducted to assess the outcomes of the program.
18. DCF should develop and issue guidelines for staff and consultants regarding the format for final evaluation reports.
19. The Office of the Child Advocate should undertake an investigation to assess adequacy and integrity of the internal process for reviewing and responding to allegations of staff child abuse and neglect. It should also examine compliance with C.G.S. §17a-103c.
20. Wilderness School staff should work with the Department of Public Health to develop a more appropriate licensure as a wilderness school rather than as a camp.
21. Replace the following statutory reports:
 - a) DCF biennial five-year master plan (C.G.S. §17a-3);
 - b) DCF annual report on the Connecticut Juvenile Training School (CJTS) (C.G.S. §17a-6b and C.G.S. §17a-6c); and

Repeal the statutory reports listed below:

- c) Children's Behavioral Health Advisory Committee (CBHAC) annual local systems of care status report (C.G.S. §17a-4a(e));
 - d) CBHAC biennial recommendations on behavioral health services (C.G.S. §17a-4a(f));
 - e) Quarterly hospital reports to DCF on psychiatric care (C.G.S. §17a-21);
 - f) KidCare Community Collaborative annual self-evaluations (C.G.S. §17a-22b);
 - g) DCF/DSS five-year independent longitudinal evaluation of KidCare (C.G.S. §17a-22c(c));
 - h) DCF monthly report to legislature on children in subacute care in psychiatric or general hospitals who cannot be discharged (C.G.S. §17a-91a);
 - i) Cost-benefit evaluation of juvenile offender programs (C.G.S. §46b-121m);
 - j) Licensed child care facilities annual reports (C.G.S. §17a-145);
 - k) DCF annual evaluation reports on Unified District #2 to the education commissioner (C.G.S. §17a-37(d));
 - l) DCF to conduct studies to evaluate effectiveness (C.G.S. §17a-3(a)(6)); and
 - m) Adoption Advisory Committee report (C.G.S. §17a-116b(g)(3)).
22. All DCF facilities shall be required to produce an annual report for their respective advisory groups. The report shall contain at a minimum the following:
 1. aggregate profiles of the residents;
 2. description and update on major initiatives;
 3. key outcome indicators;
 4. costs associated with operating the facility; and
 5. description of education programs and outcomes.

Executive Summary

23. Research and evaluation reports produced through federal grant requirements should be included in the report repository recommended earlier concerning contracted evaluation reports and internally produced research products.
24. DCF should adopt a written policy requiring that formal results from research and evaluation reports produced from federal grants be reviewed and considered when agency managers make decisions concerning future funding and/or continuation of programs developed with federal grants.
25. DCF should convene a workgroup including program leads, a representative from the *Juan F.* court monitor's office, and DSS to develop a treatment plan and review process that satisfies both the internal DCF and federal (e.g., Private Non-Medical Institution Initiative or PNMI) requirements.
26. A pilot program should be created to assess the feasibility of conducting one treatment plan conference to be held at court that combines: the Specific Steps identified during the initial case status conference at court and the corresponding DCF treatment plan conference currently held in the area office.
27. The statutes concerning the Office of the Child Advocate and the Child Fatality Review Panel (CFRP) shall be amended to require the Department of Children and Families, and other state entities subject to OCA and CFRP investigative activities, to provide a written response to formal recommendations made by the child advocate and the panel for improving state services provided to children.

The agency response should: include proposed corrective actions to address identified problems and a time frame for implementation of improvements; and be provided to OCA or CFRP within 45 days of receipt of the recommendations. Copies of the agency response also should be submitted to the legislative committees of cognizance and the appropriations committee.
28. The resources necessary to improve the OCA data management system should be provided during the next fiscal year, either by the Department of Information Technology (DOIT) making this project a priority or through funding for a consultant to design and implement an upgraded system for the child advocate's office.
29. DCF should establish a policy for area office advising bodies to adopt a model whereby advising body members attend DCF area office quality improvement meetings, and DCF area office representatives attend advising body meetings, furthering promotion of a partnership.
30. DCF facility advisory boards shall be required by statute and it shall be mandated that all boards respond to their facility's annual report and that they add recommendations deemed necessary.
31. The role of the State Advisory Council for Children and Families (SAC) should be strengthened to include monitoring the agency's progress in achieving its goals as well as offering assistance and an outside perspective. The board's statute shall be written to

Executive Summary

clarify this role and DCF's participation with the board concerning strategic planning as recommended above. The council's meetings should be held at locations that facilitate participation by members of the public, such as the Legislative Office Building, and its agendas and minutes should be posted on the DCF website. The department should provide the council with funding for administrative support services and to ensure members representing families from across the state can serve on the council.

32. DCF should establish an electronic mechanism, for example a blog, where members of area office advising bodies can share information with each other, the SAC, and vice versa. Additionally, minutes and agendas from all meetings should be posted on the DCF website.
33. DCF should fund all three required Citizen Review Panels equally.
34. The Children's Behavioral Health Advisory Committee (C.G.S. §17a - 4a) should be incorporated into the State Advisory Council as opposed to remaining a separate entity.
35. Repeal the statutory requirement for the Adoption Advisory Council (C.G.S. §17a-116b).
36. Repeal the statutory requirement for the Connecticut Juvenile Training School Public Safety Committee (C.G.S. §17a-27f).
37. DCF shall hire an external consultant to:
 - a) perform a gap analysis¹ and workflow analysis with the focus on integrating the functions of the department with technology modeled to support the service model;
 - b) develop a project plan; and
 - c) develop a request for proposals to procure the team needed to integrate the data systems and replace the LINK System.

¹ Refers to identifying technology requirements and assessing existing capabilities to determine where needs are not being met.

Introduction

Department of Children and Families Monitoring and Evaluation

The Connecticut Department of Children and Families (DCF) has broad authority and primary responsibility for the state's main child welfare mandates -- protecting children from abuse and neglect, providing children's behavioral health and juvenile justice services, and carrying out prevention efforts for children and families at risk of abuse, neglect, mental illness, substance abuse, and juvenile delinquency. To carry out its mission, the department has an annual budget exceeding \$800 million and a full-time staff of nearly 3,500 employees.

Since its formation as a consolidated children's agency in 1974, the department has been studied, audited, reviewed, and subject to legal action almost continuously. Multiple entities outside the agency, such as the state Office of the Child Advocate (OCA), legislative committees, the Judicial Branch, national accrediting bodies, federal agencies that provide funding for children's services, and the federal courts, track aspects of DCF performance and provide oversight of various program outcomes. Concerns continue to be raised about the efficiency, effectiveness, and advocacy capabilities of DCF through these many oversight efforts.

At the same time, there has been a number of initiatives to improve department operations and services in recent years. Many changes have been made in response to the ongoing federal *Juan F.* consent decree concerning Connecticut's child welfare system.

Reports from the federal court monitor show caseloads for the agency's social workers comply with national standards, community-based treatment and support services have been expanded, and there is more collaboration with other agencies involved with children and families such as the Departments of Social Services, Mental Health and Addiction Services, Developmental Services (DSS, DMHAS, DDS) and the Court Support Services Division (CSSD) of the Judicial Branch. The Department of Children and Families also has instituted various internal monitoring and evaluation efforts, such as those carried out by its continuous quality improvement bureau, as ways to strengthen management and policy decision making.

An effective process for tracking and assessing results is the cornerstone of accountability and improved performance of state agencies. In April 2007, the Legislative Program Review and Investigations Committee (PRI) voted to undertake a comprehensive assessment of efforts to monitor and evaluate DCF.

Purpose

The purpose of the program review committee study of DCF monitoring and evaluation was to determine areas of strength and weakness, as well as any gaps and redundancies, within the existing agency accountability system. The main goal was to identify improvements to internal and external oversight efforts that would lead to better agency performance and, ultimately, to better outcomes for children and families.

Specifically, the study centered on: 1) describing how goals set for and by the agency are measured and tracked; 2) evaluating the department's progress in attaining its goals; 3) examining the extent to which the results of monitoring and evaluation efforts are used by DCF to improve the services it provides to children and families; and 4) identifying ways to increase the overall effectiveness of the DCF accountability system. Unlike all previous PRI studies of the Department of Children and Families, the focus was on a critical function -- monitoring and evaluation -- rather than a particular agency mandate.

Previous committee DCF studies. It is not uncommon for the program review committee to conduct multiple studies of a state agency over time, especially a complex one like the Department of Children and Families. Six prior PRI studies evaluated how the agency carried out its various mandates and identified ways to make specific programs more efficient and effective.² The committee's last report on DCF, issued in December 1999, examined implementation of its overall consolidated children's services mission. PRI proposed a significant restructuring of department duties that was intended to achieve higher quality services, better coordination and integration, and stronger leadership and oversight.

While there has not been a major reorganization of child protection, behavioral health, and juvenile justice programs in Connecticut since the 1999 PRI study, a number of changes have occurred within DCF and in the general environment of children's services. Since 1999, DCF's capacity for self-evaluation and corrective action has increased and there are more external mechanisms for providing productive feedback and accountability for results. Major developments in effective oversight within and outside DCF are highlighted in Chapter I, and described more fully in Appendix C.

In reviewing these developments, it appeared to the program review committee that better monitoring and evaluation efforts might attain the improvements in agency performance sought previously through restructuring proposals. This study, therefore, centered on the effectiveness of the system for tracking, assessing, and using information on DCF outcomes to reach agency goals for children and families.

Study Approach

The committee study scope was limited to monitoring and evaluation of DCF that has occurred both within and outside of the agency over the past three to five years. For the purposes of the study, the following definitions were used:

- The term "**monitoring**" refers to the effort to systematically track program delivery.³ It can answer such questions as: has a program been delivered as planned and to the group for which it was intended? Did particular activities

²The six PRI reports are: The Department of Children and Youth Services: A Program Review (1978); Juvenile Justice in Connecticut (1977); Psychiatric Hospital Services for Children and Adolescents (1986); Juvenile Justice in Connecticut (1988); Department of Children and Youth Services: Child Protective Services (1990); and Department of Children and Families Foster Care (1995).

³ Rossi, P. H. & Freeman, H. E., *Evaluation: A Systematic Approach* 7, Newbury Park, CA: Sage Publications, Inc., 2004.

occur within a given time frame? Did the program serve the number of children it was expected to serve?

- The term “*evaluation*” means efforts to determine the extent to which programs are effective, which can answer such questions as: what impact has the program had on the people it served? Did the expected program outcomes occur? Is anyone better off?⁴ What is the program’s cost in relation to its benefits?

If the DCF monitoring and evaluation system is working well, the quality of agency programs and services should continually improve, benefiting the clients, and justifying the public’s investment. When information on actual results is produced, and then used by the agency to guide decisions on policies, operations, and resources, more efficient and effective services for children and families should result. The key research question is: do existing efforts to track agency accomplishments and assess client outcomes result in better services for children and families?

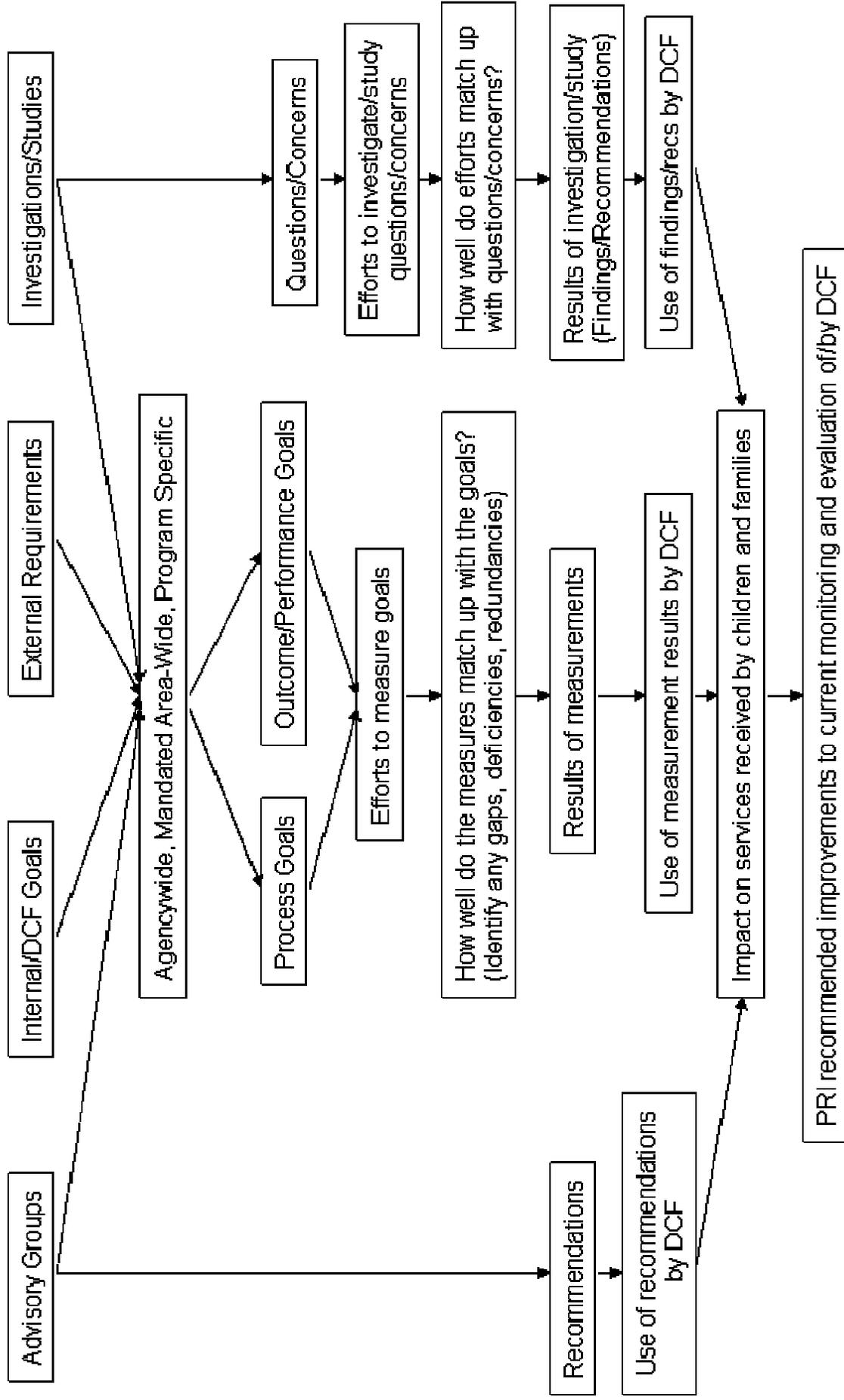
The committee’s overall approach to the study, illustrated in Figure 1, had five main components. These components, described in detail in Appendix B, were:

1. Capture and categorize, by source, efforts to monitor and evaluate DCF accomplishments and identify the goals the agency is trying to achieve;
2. Assess how well the various efforts to measure agency goals and progress made are working;
3. Summarize the outcome information produced and reported (e.g., results achieved, deficiencies noted and recommended improvements);
4. Describe the impact of the feedback information on DCF decisions about policies, resources, and services; and
5. Recommend ways to make the current monitoring and evaluation system more effective, thereby improving the quality of DCF programs and services for children and families.

As Figure 1 shows, four main sources of DCF monitoring and evaluation were identified and analyzed: internal efforts; external efforts; outside investigations and reviews; and advisory groups established under federal or state law. Each source is summarized in Table 1.

⁴ Friedman, M., *Trying Hard Is Not Good Enough: How To Produce Measurable Improvements for Customers and Communities*, Victoria, BC, Canada: Trafford Publishing, Ltd., 2005

Figure 1. Monitoring and Evaluation of DCF: PRI Study Approach



Source: PRI staff design.

Table 1. Examples of DCF Monitoring and Evaluation Efforts by Source

Internal Monitoring & Evaluation:

- DCF Bureau of Continuous Quality Improvement (BCQI)
- DCF performance-based contracting activities
- Internal child fatality and critical incident reviews
- Office of the Ombudsman activities

External Monitoring & Evaluation:

- Federal Oversight
 - U.S. Department of Health and Human Services (DHHS)
 - Children’s Bureau of Administration for Children and Families (ACF)
 - Substance Abuse and Mental Health Services Administration (SAMHSA)
 - U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention (OJJDP)
- Judicial Branch/Federal Court Monitoring (e.g., *Juan F.* Court Monitor)
- Independent Accreditation Groups
 - The Joint Commission (hospitals)
 - Council on Accreditation (child welfare agencies)
 - Commission on Accreditation for Corrections (correctional facilities)
- Legislative Oversight
 - Committees of Cognizance
 - Statutory reporting requirements
 - Results-Based Accountability

Outside Investigations and Reviews:

- Office of the Child Advocate (OCA)
- Child Fatality Review Panel (CFRP)
- Office of the Attorney General (OAG)

Advisory Groups (established under state or federal law):

- State & Area Advisory Councils to DCF
- DCF Facility Advisory Groups
- Connecticut Citizen Review Panel(s) (required by federal law)
- Connecticut Behavioral Health Partnership Oversight Council (BHPOC)

Source: PRI staff analysis.

Methodology

The committee, through its staff, employed two main research methods to study the DCF monitoring and evaluation system. The methods were: key stakeholder interviews; and analysis of monitoring and evaluation reports and related documents produced through all four sources of efforts -- internal, external, investigative, and advisory.

Stakeholder interviews. Committee staff conducted approximately 100 interviews with: division and unit personnel within the DCF bureaus; court monitor staff; Office of the Child Advocate staff; advisory group chairs; federal agency officials; external evaluators; and representatives of providers and advocacy groups. Given the time and resource constraints of the study, not every area office or DCF facility could be visited; however, efforts were made to visit or interview staff from a full range of locations and types of operations.

Document analysis. Committee staff reviewed 126 reports and materials pertaining to monitoring and evaluation of DCF. The study focused on reports and other materials documenting monitoring and evaluation efforts that occurred within the past three to five years (through September 2007). In order to assess the efforts, PRI staff evaluated each document using an internally developed standardized rating system to answer the questions shown in Table 2. Ratings required agreement between two PRI staff who had independently reviewed the documents and then met to discuss their ratings.

Study limitations. Several limitations were encountered during the committee study. First, PRI staff was unable, within the study time frame, to completely assess every effort to monitor and evaluate the Department of Children and Families. For example, while work force development and employee performance evaluation procedures have an important role in supporting quality improvement, the DCF human resources division, the department's Training Academy, and the agency's use of the Performance Assessment and Recognition System (PARS) were not examined.

Additionally, a key department program, foster care, was undergoing a major restructuring at the time of the committee review. Nearly all aspects of foster care monitoring and evaluation were being revamped, so little about efforts in that area could be assessed as it was too soon to know the impact of the new procedures.

Further, not every activity or product within a given type of monitoring and evaluation effort (e.g., licensing visit report, quality improvement plan, advisory group meeting, evaluation report, etc.) could be examined. Due in part to the fragmentation of the DCF monitoring and evaluation system, it is likely that other documents that could have been included in the analysis were not identified. However, the committee believes that the statistical reports, studies, and other documented information about major programs within the department reviewed by PRI staff are a representative sample of monitoring and evaluation currently underway.

There were also situations where multiple monitoring and evaluation efforts were overlapping or occurring simultaneously. This made it difficult to discern which effort led to changes in programs or facilities, particularly when recommendations were similar. Another

challenge was attributing outcomes to particular programs, especially when children and families were receiving a variety of services and supports at the same time.

Table 2. Areas Assessed in Each Monitoring and Evaluation Document

Question Areas*	Description
Is the focus of the monitoring and evaluation on DCF agencywide goals, mandate areas, or specific programs?	PRI staff identified the purpose of each monitoring and evaluation effort.
What is tracked: process (service delivery), outcome (end result) or both?	PRI staff classified monitoring and evaluation as: 1. “process only” for those efforts that pertained to the way in which service is delivered; 2. “outcome only” for those efforts that addressed expected end results or outcomes of the service; or 3. “both process and outcome” for efforts that addressed both aspects of monitoring and evaluation.
Are the goals and issues studied S.M.A.R.T.?	The stated goal(s) or issue(s) subject to the specific monitoring and evaluation effort was rated on whether it was: specific, measurable, attainable, relevant, and trackable (“S.M.A.R.T.”). On a scale from 1 to 5, where 5=very positive.
How well do the measures used match up with the goals?	The measures selected to assess progress on reaching the goal were rated on their logical relationship to the goal (versus chosen for convenience/ready availability). On a scale from 1 to 5, where 5=very well.
How good a job was done in collecting information to answer the question or ascertain progress in attaining the goal?	Examining the mechanical efforts to obtain information to address the goal or issue, PRI staff rated monitoring and evaluation efforts on the extent to which measures were consistent, with good quality data and little or no missing information. On a scale from 1 to 5, where 5=the <i>goal</i> is measured consistently, with good quality data and little or no missing information, or the <i>issue</i> or question is clearly addressed, with good quality data or sources of information.
Were the monitoring and evaluation findings used to make changes?	Step 1: PRI staff assessed whether the findings addressed organizational barriers, communication barriers and/or resource barriers. Step 2: Through interviews, PRI staff determined if the monitoring and evaluation findings were used by DCF to make changes to policy, training, or services, or if legislative changes were made. On a scale from 1 to 7, where 1=no findings were used, to 7= findings were fully used to identify organizational and resource barriers and to make changes to policies, training, and services, and used to seek legislative changes.
Were the recommendations stated clearly, did they flow logically from the findings, and did they contain actions?	Based on the reviewed documents recommendations were rated on a scale from 1 to 5, where 5=very positive.
Were the recommendations adopted?	Based on interviews and available documents, PRI staff estimated the percent of recommendations that were adopted. On a scale from 1 to 5, where 1=not at all, to 5=completely.

* In addition to these questions, PRI staff looked at how the data were collected and then analyzed.

Source: PRI staff.

Lastly, it is important to note the rating system employed for the study does not capture the magnitude of a particular monitoring and evaluation activity. The committee staff did not try to assess the significance of each effort or any resulting recommendation. Staff calculated only the percent of recommendations implemented, and did not attempt to rate their impact or importance.

Report Organization

This report consists of seven chapters and a number of appendices. Chapter I provides background information on the Department of Children and Families including descriptions of its mission, goals, major mandates and activities, current organization, and operating budget. The agency's internal efforts to monitor and evaluate its programs and services through various quality assurance and improvement functions such as licensing, case reviews, performance-based contracting, program reviews, risk management analysis, and contracted evaluations are described in Chapter II.

External monitoring and evaluation of DCF activities that are carried out by federal agencies, the courts, the legislature, other state agencies, and national accrediting organizations are described in Chapter III. Outside investigations and reviews, which are conducted by the Office of the Child Advocate, the Child Fatality Review Panel, and the state attorney general's office are discussed in Chapter IV. The many advisory groups responsible under state or federal law for assisting the department in carrying out its mission and assessing its performance are highlighted in Chapter V.

Information about the results of DCF programs and services that was compiled from the monitoring and evaluation reports reviewed for this study is provided in Chapter VI. The program review committee's findings concerning the strengths and deficiencies of current internal, external, investigatory, and advisory monitoring and evaluation efforts are presented in Chapter VII, along with recommendations for improving the DCF accountability system through administrative and legislative changes.

Agency response. It is the policy of the Legislative Program Review and Investigations Committee to provide agencies subject to a study with an opportunity to review and comment formally on committee recommendations prior to publication of the final report. A written response to this study was submitted by the Department of Children and Families and is presented in Appendix A.

Background: Overview of DCF

Connecticut established its consolidated children's agency, the Department of Children and Families, in the 1970s. The legislature combined the state's primary child welfare programs in one organization with the intent of achieving a comprehensive, coordinated statewide system of services for children and families who are at risk because of abuse or neglect, delinquency, mental illness, emotional disturbance, or substance abuse problems.

Since its formation, the department has undergone numerous internal reorganizations, shifts in policy and practice, and almost continuous critical review as it seeks to carry out its complex mission. Background information on DCF is presented in this chapter and includes: an overview of the agency's mission and operating principles; descriptions of its major mandates and associated programs and activities; and a summary of the department's current organization and budget. A brief history of the agency and children's services in Connecticut is provided in Appendix D.

Mission, Guiding Principles and Goals

The purpose and goals of the Department of Children and Families are implied in many of its legislative mandates, although there is no single statutory policy statement about the agency's role. Over time, the department has adopted various mission statements that reflect its broad scope as well as the general evolution of child welfare policy and practice. The current mission of DCF, as stated on the agency's website, is: *to protect children, improve child and family well-being and support and preserve families.*

DCF management officially adopted six guiding principles for all agency activities based on its mission statement. They include the following overarching principle encompassing the core agency mission and five specific principles intended to guide department practice:

- Overarching Principle: Safety, Permanency, and Well-Being
- Principle One: Families as Allies
- Principle Two: Cultural Competence
- Principle Three: Partnerships
- Principle Four: Organizational Commitment
- Principle Five: Work Force Development

Descriptions of each principle were developed by the department and are provided to all employees and contracted providers, and made available to the general public. A copy of the agency's mission and guiding principles document is presented in Appendix E.

Many goals have been established internally and externally for the Department of Children and Families. At this time, the department does not have a single document containing all goals for the overall agency, its mandate areas, or its specific programs. The information about DCF goals presented below was compiled from a variety of sources, including state

statutes, agency plans and budget documents, mission and goal statements included on the agency's webpage, and interviews with agency staff. A summary is in Appendix F.

Agencywide goals. As its overarching principle indicates, the Department of Children and Families has three main goals for children: 1) safety; 2) permanency; and 3) well-being. These goals, like the agency mission statement and its guiding principles, are not specified in state statute. However, they are implied in many of the laws directing DCF operations.

Safety and permanency as goals for children in the department's care and custody do have a statutory basis. Since 1998, DCF is required by law to prepare a written plan for each child and youth under agency supervision that includes, but is not limited to: "... a goal for permanent placement ... which may include reunification with the parent, long-term foster care, independent living, transfer of guardianship or adoption. The child's or youth's health and safety shall be the paramount concern in formulating the plan." Under another state statute, it is the policy of Connecticut to protect children from abuse, strengthen the family and make homes safe for children, and provide a temporary or permanent nurturing and safe environment for children when necessary.

Other agencywide goals are the department's Positive Outcomes for Children. These 22 positive outcomes mirror the exit plan outcome measure established under the federal *Juan F.* child welfare consent decree, which are described in detail in Chapter III and summarized in Appendix F. All of the positive outcomes/exit plan outcome measures are focused on safety, permanency, and the well-being of children and families. The agency mission, guiding principles, and positive outcomes are posted throughout the agency and the department has developed and revised an action plan for meeting the performance goals set under the *Juan F.* consent decree exit plan.

Child protection mandate goals. The department's goals related to its children's protective services mandate are based on state statutory policy directives to protect children from abuse and neglect, plan for permanent placement, and provide comprehensive services to meet the needs of at risk children and their families. They parallel the child welfare goals set for states under federal legislation. Like its agencywide goals, DCF's main child protection goals are: safety; permanency; and well-being.

Specific child protection goals include the 22 outcome measures for the *Juan F.* exit plan and the closely-related federal outcomes standards for state child welfare agencies. These standards are summarized, with all other major agency goals, in Appendix F.

As noted above, the department has an action plan, with specific strategies and time frames, for achieving compliance with the *Juan F.* consent decree goals. Progress in implementing the plan is regularly assessed by department management as well as the court monitor. The *Juan F.* action plan also is incorporated in DCF's Child and Family Services Plan, developed in accordance with federal requirements to outline the agency's child welfare goals and strategies for achieving them. Another document containing department child protection goals is its Performance Improvement Plan that must be prepared and implemented in response to federal Child and Family Services Review (CFSR) findings. (CFSR and other federal requirements are discussed in more detail in Chapter III.)

Behavioral health mandate goals. The goals of the DCF's behavioral health mandate, as defined in the agency's FY2008-2009 biennium governor's budget document, are:

- to address children's behavioral health needs, serve children in their homes and communities to the greatest extent possible, and use the most effective, evidence-based practices in all behavioral health services.

Goals for the department's overall behavioral health system are not clearly set out in statute. However, expected outcomes for the state's major behavioral health reform initiative, the Connecticut Behavioral Health Partnership, and for KidCare, the children's services component overseen by DCF, are described in state law. The statutory goals for KidCare are included in Appendix F.

DCF participates in the statewide mental health planning process the Department of Mental Health and Addiction Services carries out to meet federal mental health block grant funding requirements. DCF prepares the section of the federal plan on children's services, which must describe how the state will implement an organized, community-based system for improving mental health services for children with serious emotional disturbances.

In addition to describing the current state service system, the federal mental health plan must: identify and analyze system strengths, needs, and priorities; and discuss performance goals and action plans for improvement. Although goals and measures are outlined in the children's services section, the document does not appear to be used by DCF or its behavioral health bureau as a strategic guide for providing services.

A two-year strategic plan that sets goals for Riverview, the children's psychiatric hospital operated by DCF, was developed by facility staff with the help of the DCF Bureau of Continuous Quality Improvement in the spring of 2007. A multidisciplinary hospital staff workgroup is responsible for implementation, and progress is reviewed quarterly by facility management, a BCQI representative, and an on-site monitor from the Office of the Child Advocate.

Juvenile justice mandate goals. DCF's juvenile justice goals, as outlined on the agency's Juvenile Services Bureau website, are:

- to serve children in the juvenile justice system and their families; protect public safety; collaborate with the courts, communities, and partners; and provide a continuum of effective prevention, treatment, and transitional services children need to succeed in their families and communities.

Further, there are specific statutory goals for the state juvenile justice system, which apply to the courts as well as DCF. These are also listed in Appendix F and are generally reflected in the juvenile services bureau goal statement.

A statewide juvenile justice strategic plan was prepared by the DCF Juvenile Services Bureau and the Court Support Services Division of the Judicial Branch with input from many

public and private stakeholders.⁵ Issued in August 2006, it sets a vision, mission, 10 guiding principles, and 12 broad system goals in four areas (resource development; coordination, collaboration, and information sharing; data analysis; and work force development).

A workgroup of staff from the DCF Juvenile Services Bureau and the Court Support Services Division, advocates, and parents, with the help of a consultant, operationalized the statewide plan into a results-based accountability format. In addition, DCF and CSSD have jointly developed a plan that both carries out the goals and meets the required service outcomes under the final settlement agreement for the *Emily J.* juvenile justice class action lawsuit.

Staff at the DCF Connecticut Juvenile Training School (CJTS) developed a strategic action plan for that secure juvenile justice facility in the summer of 2005. In addition to setting six main goals for improving programming and accountability, the plan: defined objectives and outcomes for each goal; included specific action steps for each one; and outlined implementation time frames and responsibilities. Progress was monitored and strategies were revised as needed on a monthly basis until the end of 2006. Strategic planning for CJTS has been put on hold pending a final decision about the facility's future.

Prevention mandate goals. State statute specifically includes prevention services as a DCF responsibility in providing comprehensive services to children and families at risk for abuse, neglect, delinquency, and behavioral health problems. The department's goals for its prevention mandate are set out in detail on the agency webpage and budget document. In brief, they are to:

- promote a range of services that enable children and their families to thrive independently in their communities; and
- apply evidence-based or best practice prevention approaches to ensure successful transition from DCF involvement, or to prevent DCF involvement at all, by children and their families.

The DCF prevention office also has adopted seven guiding principles that reflect and expand on the agencywide guiding principles (see Appendix E). Further, the department developed a five-year child welfare prevention plan in 2006 that outlines four goals related to primary prevention and early intervention efforts carried out by the agency. Progress is monitored by the prevention office director, who provides status reports as needed or on request to agency top management.

Major programs. Goals of each of the major department programs within each of the four mandate areas are also listed in Appendix F. The main source for program-specific goals is the agency's budget document. All of the more than 70 specific budgeted programs reviewed have stated goals, although they do vary in specificity, measurability, and relevance.

Many of the program goals are related to outcomes for children and families, usually in very broad terms (e.g., "foster positive youth development"), but a significant number primarily

⁵ DCF Bureau of Juvenile Services and Connecticut Judicial Branch Court Support Services Division, *The Connecticut Juvenile Justice Strategic Plan: Building Toward a Better Future*, August 2006.

relate to how services are to be delivered (e.g., “receive appropriate services in the least restrictive setting”). Few of the program goals identified by PRI staff incorporate the agency’s guiding principles concerning family-centered practice, partnerships, and cultural competence. For the most part, however, they are consistent with the agency’s overall and mandate area goals.

Major Duties and Responsibilities

The Department of Children and Families has broad authority and responsibility for protecting and supporting children and families by carrying out state and federal child welfare, juvenile justice, and children’s mental health and substance abuse programs. Current state statutes require the department to:

- “...plan, create, develop, operate or arrange for, administer and evaluate a comprehensive and integrated state-wide program of services including preventive services for children and youths...” who are abused, neglected or uncared for, mentally ill or emotionally disturbed, substance abusers, delinquent, or whose behavior does not conform to the law or acceptable community standards;⁶
- provide a “flexible, innovative, and effective program for placement, care, and treatment” of committed, transferred, and voluntarily admitted children and youth, as well as provide appropriate services as needed to the families of children and youth in its care;
- work in cooperation with other agencies and organizations to provide or arrange for preventive programs, including but not limited to teenage pregnancy and youth suicide prevention;
- establish or contract for services for the “identification, evaluation, discipline, rehabilitation, aftercare, treatment, and care of children and youth served by the agency....”; and
- “... undertake or contract for or otherwise stimulate research concerning children and youth....”

At present, the agency contracts with nearly 200 different private providers for more than 100 types of services for its clients. The Department of Children and Families, as specified in state statute, also operates the state’s only public psychiatric hospital for children and youth, two residential treatment facilities, and a secure correctional facility for delinquent boys. The department runs a therapeutic program for troubled youth through its Wilderness School, another facility named in statute. Table I-1 provides a brief description of each DCF facility.

⁶ For the purposes of DCF statutory provisions, child means a person under the age of 16 and youth means a person at least age 16 and under age 19.

Monitoring and evaluation. The agency has a number of specific statutory charges to monitor, assess, and evaluate its activities. It is required to:

- collect, interpret, and publish statistics related to children and youth in the department;
- conduct studies of any program, service, or facility developed, operated, contracted for, or supported by the department to evaluate its effectiveness; and
- prepare and submit biennially to the General Assembly a five-year master plan that includes but is not limited to:
 - the department’s long-range goals and their current level of attainment; and
 - an overall assessment of the adequacy of children’s services in Connecticut.

Name/Location	Scope
<i>Riverview Hospital for Children and Youth</i> Middletown	98-bed psychiatric hospital for children and adolescents ages 5 through 17. Patients admitted when intensive 24-hour care and treatment is necessary in a protected environment.
<i>High Meadows</i> Hamden	42-bed residential treatment facility for severely emotionally disturbed adolescents (ages 12 to 17) who require intensive and comprehensive 24-hour services but not a closed setting.
<i>Connecticut Children’s Place (CCP)</i> East Windsor	Formerly the State Receiving Home, now a 54-bed residential diagnostic center for children and youth ages 10 to 18, who are in need of protection due to abuse, neglect, abandonment, unmanageable behavior, or sudden disruption in their current placement or residence. Diagnostic and evaluation services and brief treatment are available while permanent placement is pending.
<i>Connecticut Juvenile Training School (CJTS)</i> Middletown	Secure facility for approximately 100 boys who are committed delinquents; intended to prepare residents for successful community re-entry through educational, treatment, and rehabilitative services. (Opened in 2001 to replace Long Lane School)
<i>The Wilderness School</i> East Hartland	Therapeutic camp/outdoor expedition program for troubled youth age 13 and over intended to foster positive development; 20-day, 5-day, 1-day and alumni follow-up programs are provided.
Source: Connecticut General Statutes and DCF agency website.	

DCF is also required by law to award funding to community service programs in proportion to their effectiveness. Furthermore, it must: evaluate the programs based on analysis of their outcomes and an assessment of service needs; and collect, maintain, and analyze data used for evaluation on an ongoing basis. As noted below in the discussion of the current agency organization, a grants development and contracts division within the Bureau of Finance has responsibility for the DCF performance-based contracting process. The agency’s contract monitoring procedures, including how contractor performance information is used for decision making, is described in Chapter II.

Under state statute, DCF must report each year to the governor and legislature on the status of all children committed to the department. It also must establish and maintain a central registry of all children with permanency plans that recommend adoption and, under legislation enacted in 1999, have a system in place to monitor progress in implementing such plans. Information on the status of the various reports, plans, and reviews the department is required by state or federal law to produce, or to receive from service providers and advisory groups, is provided in more detail in Chapter III.

Legislation enacted in 2005 requires the department to seek accreditation from the national accrediting body for public child welfare agencies, the Council on Accreditation (COA). The COA accreditation process and standards and DCF efforts to comply with this requirement are also discussed in Chapter III.

Federal mandates. DCF is the state agency responsible for carrying out a number of federal mandates in areas of child welfare, children's behavioral health, and juvenile delinquency. Currently, the department is subject to oversight by: the U.S. Department of Health and Human Services, Administration for Children and Families; the Substance Abuse and Mental Health Services Administration of HHS; and the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. It must prepare any required state plans, grant applications, and reports for these federal agencies.

Federal monitoring and evaluation activities related to DCF, such as the Child and Family Services Reviews carried out for all state child welfare agencies, were examined in depth by committee staff. Major federal oversight activities on DCF services and programs for children and families are described in Chapter III.

Advisory groups. More than a dozen councils, committees, commissions, and boards established in accordance with state and federal law have responsibility for advising and assisting DCF or generally providing input to the governor and/or legislature on matters within the department's purview. These groups include:

- general agency advisory groups, such as the state and area advisory councils and the advisory groups for DCF facilities; and
- program or issue-specific advisory groups, such as the Behavioral Health Partnership Oversight Council and the Youth Suicide Advisory Board.

Program review staff reviewed the roles of these advisory groups in tracking program outcomes, assessing performance, and making recommendations to DCF for service improvements. Descriptive information on the advisory groups is presented in Chapter V.

State Mandate Areas and Programs

The department's many programs and activities are generally organized by its four main statutory mandate areas: child protective services; children and youth behavioral health services; juvenile justice services for adjudicated delinquents; and prevention services. DCF also categorizes its treatment services within each area on a continuum ranging from community-based and in-home services to increasingly intensive out-of-home placements. Like federal and

other state children's agencies, providing appropriate care in the least restrictive, most family-like environment possible is the underlying goal of most of the department's efforts.

Each DCF mandate area and the main programs and activities it includes are described briefly below. Figure I-1 summarizes, by area, the many types of services carried out or funded by the department at the time of the committee's review. (The most recent annual data available for DCF activities were for FY 06 while funding information reflects FY 07 appropriations).

Child protection. Efforts to protect children from abuse or injury are the core work of DCF in its role as the state's primary child welfare agency. If children cannot remain safely at home, the department must arrange temporary placements with relatives, in foster homes, or in other residential settings. When reunification with their families is not possible, DCF is required to seek permanent homes for children through other means, such as adoption and subsidized relative care.

Services in the child protection area usually start with the Child Abuse and Neglect Hotline, which is the state's single point of contact for reporting suspected child abuse and neglect. It is operated 24 hours a day, seven days a week by DCF. Reports accepted for investigation are forwarded to trained professional social work staff in the department's area offices. If abuse or neglect is substantiated, the case is assigned to an area office treatment social worker for ongoing services to help ensure the child is safe and the family is supported. DCF received 43,500 abuse and neglect reports, investigated 28,790, and substantiated 7,568 during FY 06.

The treatment social worker is responsible for providing appropriate services to the child and family. If the child's safety can be assured without removal, services may include in-home supports, such as a parent aide or substance abuse screening. If removal is required, out-of-home care is provided. In accordance with federal and state requirements, DCF must develop an initial written treatment plan for every child under its supervision within a specific time frame and treatment plans must be reviewed every six months.

In most cases, children who are removed from their homes are placed in foster homes, all of which are licensed by the department. On average during FY 06, about 3,200 children were living in foster care. If the department determines reunification with the child's own family is not possible, the social worker will try to achieve permanency through other options such as adoption, a subsidized guardianship with a relative, or sometimes, in the case of older children, independent living arrangements. In FY 06, over 1,200 children were living with licensed relative caregivers and over 700 youths were in independent living situations. Also that year, the department finalized 498 adoptions and granted 308 subsidized guardianships.

Behavioral health. DCF is responsible for addressing the behavioral health needs of Connecticut's children by planning, developing, and providing appropriate mental health and substance abuse assessment, treatment, and aftercare services. The agency provides behavioral health services to: children committed to DCF because of abuse and/or neglect; delinquents committed to its custody; and to children and youth with behavioral health needs and no involvement with DCF. State law allows families to apply on a voluntary basis to the department for state funded mental health and substance abuse services for children under 18.

FIGURE I-1. DCF AGENCY SERVICES AND PROGRAMS BY MANDATE AREA (AS OF FY 07)

CHILD PROTECTION (CP)	BEHAVIORAL HEALTH (BH)	JUVENILE JUSTICE (JJ)	PREVENTION
<p><u>CP Community-Based Services</u></p> <ul style="list-style-type: none"> ▪ Hotline ▪ Social Work (Area Offices) ▪ In-Home (family preservation, parent aide, substance abuse screening) 	<p><u>BH Community-Based Services</u></p> <ul style="list-style-type: none"> ▪ KidCare ▪ Emergency mobile psych ▪ Care coordination ▪ Parent advocacy ▪ Child guidance clinics ▪ Extended day treatment ▪ Substance abuse treatment including family-focused and supportive housing programs ▪ Flexible Funding ▪ Intensive in-home treatment <ul style="list-style-type: none"> • MST (multi-systemic therapy) • MDFT (multi-dimensional family therapy) • FFT (functional family therapy) • IICAPS (intensive in-home child and adolescent psychiatric services) • FST (family support team) 	<p><u>JJ Community-Based Services</u></p> <ul style="list-style-type: none"> ▪ Parole Services ▪ Aftercare for Delinquent Youth <ul style="list-style-type: none"> • MST(multi-systemic therapy) • Outreach, Tracking and Reunification and Choice • STEP (Success Teams for Educational Progress) 	<p>Fund and directly provide:</p> <ul style="list-style-type: none"> ▪ Parent Education and Assessment Services ▪ Positive Youth Development Initiative ▪ Suicide Prevention ▪ Youth Suicide Prevention Project ▪ Early Childhood Mentoring ▪ Parents with Cognitive Limitations Workgroup ▪ Regional Homelessness Prevention Training ▪ Family Day ▪ Child Abuse Prevention Month ▪ The Wilderness School
<p><u>CP Out-of-Home Services</u></p> <ul style="list-style-type: none"> ▪ Adoption ▪ Subsidized Guardianship ▪ Relative Caregivers ▪ Foster Care ▪ Independent Living ▪ SAFE Homes 	<p><u>BH Out-of-Home Services</u></p> <ul style="list-style-type: none"> ▪ Residential treatment ▪ Group homes ▪ Therapeutic group homes (new model starting 2005) ▪ Specialized foster care ▪ Treatment foster care ▪ Professional parent ▪ Transitional (to DMHAS) ▪ Residential drug treatment ▪ Short-term residential substance abuse treatment ▪ Short-term assessment resource homes (replaced shelters) ▪ Respite services 	<p><u>JJ Out-of-Home Placements</u></p> <ul style="list-style-type: none"> ▪ Residential treatment ▪ Group homes ▪ Specialized foster care ▪ Treatment foster care ▪ Professional parent ▪ Inpatient drug treatment ▪ Short-term residential substance abuse treatment 	

Source: PRI staff analysis.

The department operates three behavioral health facilities for persons under age 18 -- Riverview Hospital, High Meadows Center, and Connecticut Children's Place, which were described earlier in Table I-1. It also contracts for residential treatment services as well as a variety of behavioral health treatment programs of lesser intensity, such as partial hospitalization, extended day treatment, child guidance (outpatient) clinics, and emergency mobile psychiatric services.

In FY 06, DCF had 874 children in behavioral health residential placements and the capacity to serve about 2,000 children per year with intensive in-home programs. Riverview Hospital had an average daily census of about 80 children and the department's two other residential behavioral health facilities together served about 260 children during the year.

It is DCF's objective to develop a system of community-based services that allows children with mental health and substance abuse problems to be served in their homes and communities to the greatest extent possible. In collaboration with the Department of Social Services, DCF is implementing the Connecticut Behavioral Health Partnership (BHP), a system for coordinating, financing, and delivering family-focused, community-based behavioral health services and supports mandated by the legislature in 2005 (P.A. 05-280). The children's services component of this effort is called Connecticut Community KidCare.

KidCare. During the 1980s, through federal research projects and pilot programs, states began developing "system of care" models intended to eliminate gaps and barriers in mental health and related services for children with emotional disturbances. Connecticut Community KidCare grew out of efforts made over the past two decades by children's advocacy groups and parents to establish local systems of care in the state.

Under the model, state agencies, local entities including schools, community-based organizations, public and private service providers, and families collaborate at the local level to deliver an array of services to meet children's needs through a coordinated network. The principles underlying the system of care concept are:

- Children with behavioral health needs should receive services in their communities whenever possible;
- Parents and families are an integral part of the planning and decision making process; and
- Services need to be provided in a linguistically and culturally competent fashion.

Legislation enacted in 1997 mandated a system of care planning process for certain mentally ill or emotionally disturbed children, but required DCF to develop and implement services within available appropriations. Limited resources prevented development of comprehensive local systems of care statewide. However, collaborative service networks did begin to operate in some areas of the state in the late 1990s.

In 2000, DCF, in consultation with DSS, was mandated to develop, jointly fund, and evaluate the integrated, community-based behavioral health service delivery system called KidCare for children who: are in DCF custody; receive DCF voluntary services; or are eligible

for the state HUSKY medical care program. The subsequent Behavioral Health Partnership enabling legislation incorporated the KidCare program. The BHP law also established an oversight council responsible for monitoring and evaluating implementation and administration of the new partnership, including its KidCare services.

At present, 25 KidCare community collaboratives have been established with DCF assistance and cover all communities in the state. The collaboratives are local systems of care networks composed of behavioral health and community service providers, parents, and advocates. Available services and operations vary, but the following services are in place statewide: inpatient; outpatient; home-based and emergency mobile psychiatric services; partial hospitalization; and crisis stabilization beds. Children with complex behavioral health needs are eligible for enhanced services that may include: care coordination; comprehensive assessment; intensive home-based services; respite services; extended day treatment; residential treatment; individualized support services; and behavioral management and consultation services.

DCF currently funds about 60 care coordinator positions. These employees work with the community collaboratives to provide assistance to families who need help identifying and procuring appropriate services. In partnership with the families, the care coordinators, who largely act as “service brokers,” are responsible for ensuring individual service plans are developed and implemented to meet children’s needs.

In accordance with statutory provisions, the Behavioral Health Partnership contracts with an Administrative Services Organization (ASO) for utilization management services that include clinical oversight, authorizing the correct level of care, and monitoring the types of services used. The current ASO contractor, Value Options, which began operating in January 2006, manages and supports a number of services provided through KidCare. It also generates data for DCF on child-specific service outcomes and service needs by type and area of the state.

Juvenile justice. Primary responsibility for carrying out the state’s juvenile justice policies rests with the Judicial Branch. The Juvenile Court and the Court Support Services Division conduct intake and assessment of all juveniles charged with a crime and operate the state’s juvenile probation and detention programs. The Judicial Branch also contracts for a variety of community-based services for delinquent youths.

DCF’s juvenile justice mandate is limited to the system’s most challenging children -- adjudicated delinquents committed by the courts to the agency for care and treatment. Of the approximately 14,000 youths under age 16 referred to the Juvenile Court each year, about 1,200 adjudicated delinquents are committed to DCF for secure out-of-home care.

By law, the department runs the state’s only secure residential facility for committed delinquents, the Connecticut Juvenile Training School. DCF also contracts with licensed, private providers for various types of residential treatment needed by juveniles committed to its care. In addition, the agency is responsible for:

- Parole: services and supervision for its juvenile justice clients who have completed out-of-home treatment and are living in the community; and

- Aftercare: services to help delinquents successfully re-integrate back into their communities after discharge from CJTS or a residential program.

The Connecticut Juvenile Training School, which opened in 2001 with a 240-bed capacity, now serves an average daily census of about 100 boys. It replaced the Long Lane School, the department's co-educational facility for delinquent boys and girls. Although planned to be a "state of the art" secure juvenile correction facility, CJTS has been the subject of much criticism since it opened.

Citing serious operating problems, the governor announced in August 2005 a plan to close the facility during 2008 and replace it with several small, regional treatment facilities developed specifically for the CJTS population. That plan is currently under review, in part because no funding has been provided for any of the proposed residential facilities for delinquent boys. Another consideration is what facilities and services will be needed when the new law that raises the age of juvenile jurisdiction to under 18 years old goes into effect in three years (P.A. 07-4, June SS).

The agency does not operate any secure facility for delinquent girls at this time. Instead, DCF sends most of the adjudicated females in its care to private residential treatment programs or Riverview Hospital. In some cases, they are placed at the adult prison for women in Niantic.

A study conducted by an outside consultant for DCF in 2005 outlined a plan for new services for girls in the Connecticut juvenile justice system.⁷ The department currently is working on implementation of that proposed service system for girls as well as initiatives to address the strategic plan for juvenile justice services developed in August 2006. As noted earlier, the plan was prepared by DCF, CSSD, and a group of stakeholders convened by DCF, through a process facilitated by the Child Welfare League of America (CWLA).

DCF also is working with the Court Support Services Division, in response to the settlement agreement for the *Emily J.* lawsuit, to develop and implement the previously mentioned corrective action plan for services that can divert children involved with juvenile court from CJTS and other congregate care placements to community-based services. At present, these services include but are not limited to, special foster care, therapeutic group homes, mentoring, and family-based substance abuse treatment.

Families with Service Needs (FWSN). Connecticut, like many states, enacted legislation a number of years ago to remove status offenses from the definition of delinquency. Status offenses are behaviors considered unlawful only when committed by individuals under a certain age (usually 16), such as failing to go to school, running away from home, and being beyond parental control. The intent of the law was to remove children who have not committed crimes from the juvenile justice system and provide an alternative, treatment-oriented approach for handling status offenses that can promote positive development and reduce recidivism.

⁷ Marty Beyer, Ph.D., *A System of Services for Girls in Connecticut*, December 2005.

Under P.A. 79-567, which was later amended and went into effect in 1981, the state established separate law enforcement and judicial procedures, and a Families with Service Needs program, for juveniles through age 15 committing status offenses. A parallel program called Youth In Crisis (YIC) that extends a similar process and court services to 16 and 17 year olds acting out in non-criminal ways was established under legislation enacted in 2000.

The FSWN and YIC programs allow families and certain other parties to request and receive services from the juvenile court, ranging from counseling and community-based supervision to evaluations and residential treatment, without going through delinquency proceedings. Children found eligible for the programs are subject to court order and can be held in custody for violating such orders at this time.

However, legislation enacted in 2005, which became effective on October 1, 2007, prohibits children adjudicated as FWSNs from being held in a juvenile detention facility or being found delinquent solely for violating a FWSN court order. In addition, before ordering an out-of-home placement or commitment to DCF for a FWSN child, a judge must find there is no less restrictive alternative appropriate to the child's and the community's needs.

In 2006, an advisory group was created by statute (P.A. 06-188) to monitor and make recommendations concerning implementation of the requirements of the FSWN program amendments by DCF and the Judicial Department. Legislation requiring the state to establish a network of family support centers to meet the service needs of juvenile status offenders, a key recommendation from the FSWN advisory group, was passed during the June 2007 special session (P.A. 07-4, June SS).

Prevention. The department's broad prevention mandate is to promote positive development in children, youth, families, and communities. To achieve this mandate, the department funds or directly provides: child abuse prevention services; parent education and support; positive youth development programs; early childhood services; juvenile criminal diversion projects and juvenile review boards; mentoring programs; and public awareness campaigns. Specific DCF prevention programs operating in FY 07 are listed in Figure I-1.

Children's Trust Fund. Preventing child abuse and neglect is the sole mission of the Connecticut Children's Trust Fund, which provides more direct resources for primary prevention efforts related to children and families than the department. The Children's Trust Fund was established by statute in 1983 in response to a national movement to create mechanisms in every state to coordinate and fund community-based child abuse and neglect prevention efforts (P.A. 83-20, June SS).

The fund was administered originally by DCF with input from the Children's Trust Fund Council. In 1997, the legislature made the council an independent agency with the authority to use the resources of the Children's Trust Fund to develop, operate, and fund services and initiatives to strengthen families and prevent child abuse and neglect. The council also administers the Parent Trust Fund, which was created in 2001 to fund programs aimed at improving the health, safety, and education of children by teaching parents leadership skills. Each year, the council must report to the legislative committees on human services, public

health, and education concerning the sources and amounts of funds received by both trust funds and how they were administered and disbursed.

The Children's Trust Fund Council is composed of 16 members, including the commissioners of the Departments of Children and Families, Education, Public Health, and Social Services, or their designees and various community representatives appointed by the legislative leadership. Its total estimated budget for FY 07 was nearly \$12.1 million, about 94 percent of which was state General Fund money appropriated to the Children's Trust Fund. Other sources were federal grant monies and private donations. Including the executive director, the Children's Trust Fund Council is presently staffed by 18 full-time employees.

Among the prevention programs currently funded by the Children's Trust Fund are: The Nurturing Families Network; Family Empowerment Initiatives; The Help Me Grow Program; Kinship and Grandparents Respite grants; and three initiatives supported by federal child abuse prevention grant funding -- shaken baby syndrome prevention, childhood sexual abuse prevention, and family development skill training for human services agency staff. Responsibility for the Nurturing Families Network, a statewide system of preventive services aimed at high-risk infants originally known as Healthy Families, was transferred from DCF to the Children's Trust Fund Council in 2005.

By law, the council must: develop training, standards, and protocols for Nurturing Families Network providers; develop and implement a request for proposal process to procure required services; establish a data system that provides a variety of standardized provider information; and report to the legislature every six months on progress made by the network. The network is also monitored by a 13-member statutory commission that is, among other duties, responsible for advising the legislature on program outcomes and recommending necessary modifications.

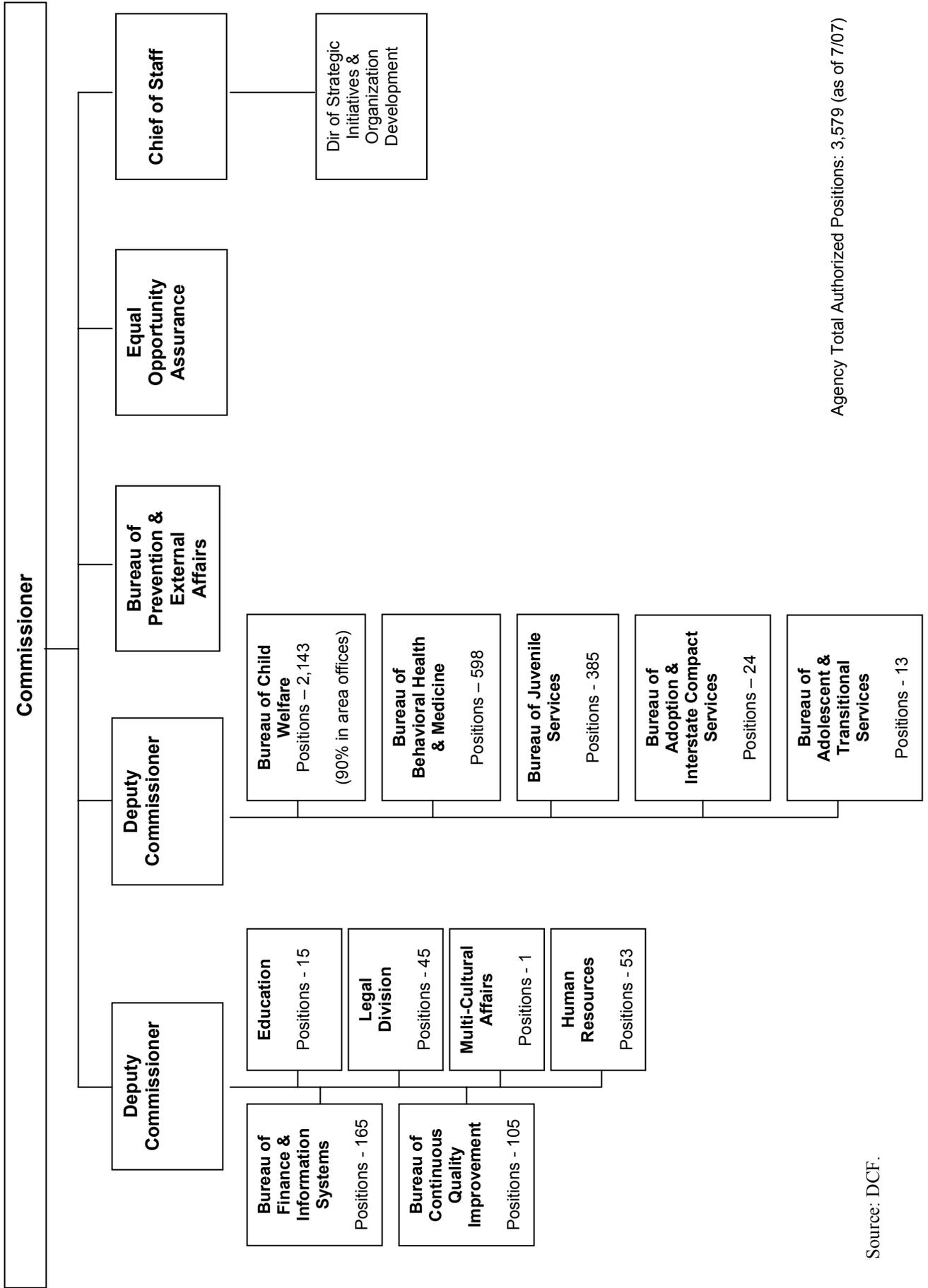
Organization and Budget

At present, the Department of Children and Families organization is made up of a central office with eight main bureaus and 14 service areas statewide. Figure I-2 shows the structure of the agency as of July 2007.

The department is staffed by approximately 3,500 permanent full-time employees. As the figure indicates, the department's Bureau of Child Welfare Services employs the largest number of staff (over 2,100), with almost 90 percent of those positions assigned to the DCF area offices.

The agency's eight functional bureaus are shown in detail in Figure I-3. That figure also shows the four facilities (Riverview Hospital, High Meadows, Connecticut Children's Place, and the Connecticut Juvenile Training School) and the therapeutic camp (The Wilderness School) operated by the department.

Figure I-2. Department of Children and Families Organization: July 2007



Agency Total Authorized Positions: 3,579 (as of 7/07)

Source: DCF.

Five of the eight DCF bureaus have responsibility for carrying out programs and services related to the agency's mandate areas. The ***Child Welfare Bureau*** carries out all child protection functions of the agency from intake through the DCF Hotline to investigation of reports of abuse or neglect, to in-home services and out-of-home placements. Substantiated cases are assigned to treatment social workers in one of the department's 14 area offices. They provide on-going services to support children and families.

The ***Bureau of Behavioral Health and Medicine*** has jurisdiction over the department's mental health and substance abuse services, both community-based and those provided at DCF behavioral health facilities – Riverview Hospital, High Meadows, and Connecticut Children's Place. Similarly, the ***Juvenile Services Bureau*** oversees the Connecticut Juvenile Training School and all community-based services the department provides for adjudicated delinquents committed to its care.

Two other bureaus, ***Adoption*** and ***Adolescent and Transitional Services***, as their names imply, are focused on those particular aspects of the department's broader child welfare, behavioral health, and juvenile services mandate areas. Programs of the adolescent services bureau, which include the Wilderness School program, are aimed at providing DCF youth with the skills, supports, and resources they need to succeed as adults.

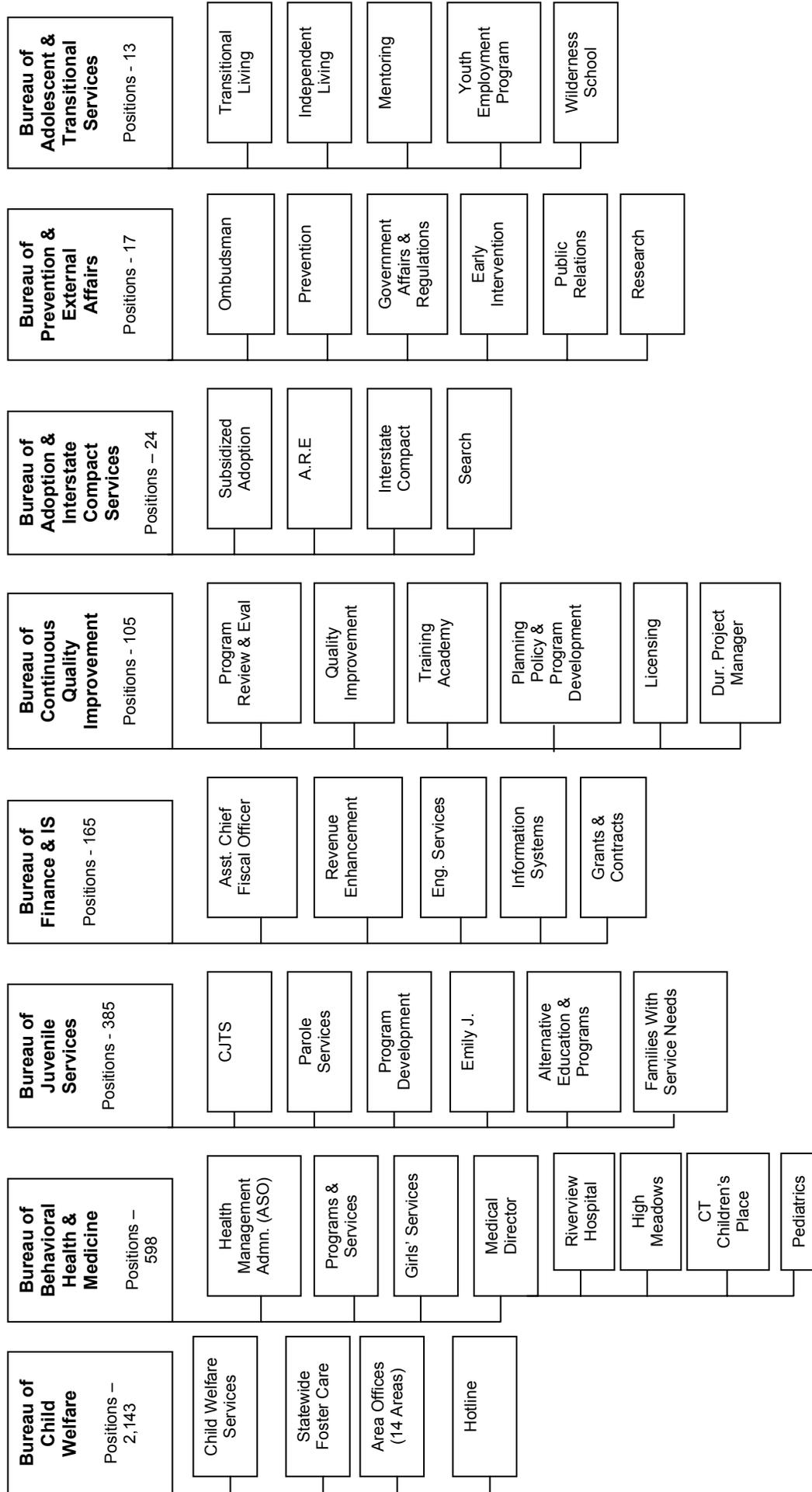
Responsibility for the fourth DCF mandate area is centered in the ***Prevention Division*** of the agency's Prevention and External Affairs Bureau. There are three central office prevention staff, and prevention liaisons have been appointed within each DCF area office and facility. The prevention staff in the community assist in shaping area prevention plans through monthly meetings.

In addition to the Prevention Division, the department's ***External Affairs Bureau*** includes the recently reorganized Office of Ombudsman that is responsible for receiving and investigating inquiries and complaints about DCF services and facilitating a resolution that is in the best interests of children. The bureau's research unit primarily focuses on conducting independent reviews of all critical incidents and child fatalities, and developing findings and recommendations to improve agency practice, policy, and management based on those reviews.

The ***Bureau of Continuous Quality Improvement*** encompasses all agency divisions and units involved in monitoring, evaluating, and correcting and improving department performance. Much of the program outcome and management information currently available for the department is produced by BCQI. The bureau's licensing and other compliance functions as well as its review and reporting efforts, all of which are central to this study's focus, are described in detail in Chapter II.

The bureau also encompasses the department's ***Training Academy***. In accordance with the *Juan F.* consent decree, the department established a training academy to identify and provide training needs for DCF staff in 1997. The academy, which is operated by the agency, has 19 full-time staff including a training director. A 22-member advisory group consisting of representatives of the agency, educational institutions, service providers, and foster and adoptive parents consults with the DCF training director and reviews the department's annual statewide training plan and reports.

Figure I-3. DCF Bureaus (July 2007)



Source: DCF.

The **Finance Bureau** of the department handles all accounting, auditing, central business operations, and other fiscal functions and has responsibility for DCF's automated statewide child welfare information system (LINK) and all other agency computerized databases and information systems. The bureau's Grants Development and Contracts Division oversees all external contracting for services and is responsible for the agency's performance-based contracting process.

Operating budget. For FY 07, the DCF budget totaled more than \$820 million, most of which came from the state General Fund. Federal funding accounted for less than 3 percent of the total budget, about \$22.3 million. The agency also received an estimated \$999,000 in private funds for the current fiscal year.

The allocation of funding among the department's four mandate areas and for overall agency management for the current fiscal year is shown in Table I-2. Child protective services, which include the 14 area office operations and the majority of DCF staff, account for about half of the agency budget. About one-third of DCF funding is allocated to the behavioral health area, which encompasses three of the department's residential facilities. Another 8 percent is spent on the juvenile justice area including CJTS operations, and less than 1 percent goes for the department's prevention programs and services.

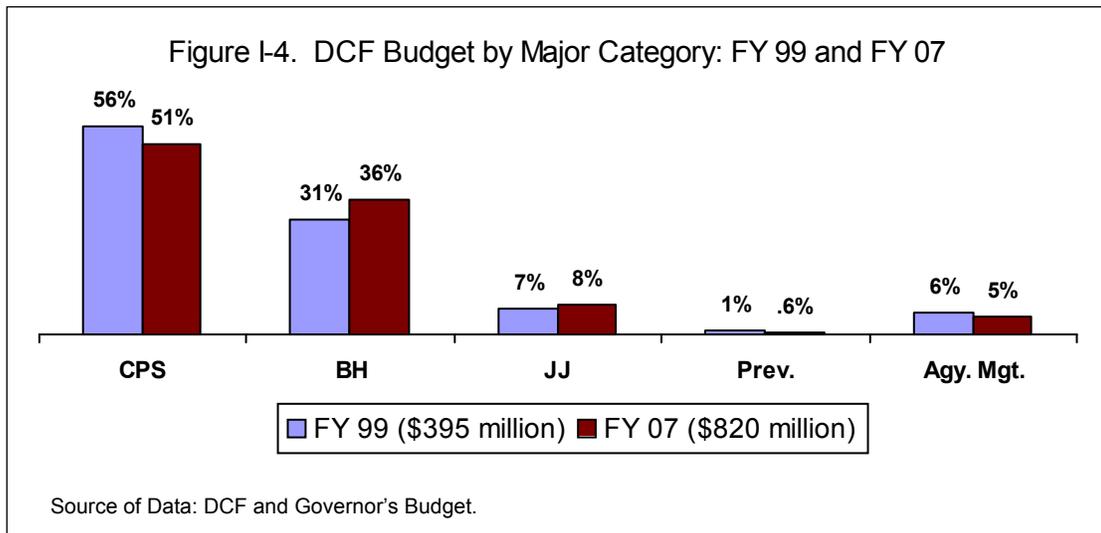
Management services, which account for less than 5 percent of the total DCF budget, include all the administrative infrastructure functions that support the agency's programs and facilities for children and families. In addition to all fiscal, human resources, legal, and contracting activities, agency management consists of policy setting, ombudsman, and other external affairs functions, as well as the planning, evaluation, and quality assurance efforts that were the focus of the program review committee study.

Figure I-4 compares the portion of the department budget expended on each major category -- child protective services (CPS), behavioral health (BH), juvenile justice (JJ), prevention, and agency management -- in FY 07 with those for FY 99, the time of the committee's last program review of the agency. The information provided in the figure is only an initial look at agency spending patterns since the items included in the various categories may not be completely comparable. For example, in some years, certain funding for the agency's automated information systems was included as an agency management cost while at other times it was included with child protective services expenditures. Consistent definitions of the spending categories in the DCF budget have not been developed.

However, based on available data, shifts in the overall allocation of DCF resources have occurred during this time period. Funding for the CPS mandate still makes up the largest portion of the agency budget, and prevention spending remains 1 percent or less of total expenditures. The percentage of the DCF budget allocated to the behavioral health and, to a lesser extent, the juvenile justice mandates, has increased while the percentage of spending on agency management has dropped.

Agency Programs	Total Est. Expend. (\$ in millions)	% of Total
Child Protective Services (CPS)	\$417.095	50.9%
CPS Community-Based Services	\$24.993	3.0%
CPS Out-of-Home Services	\$223.183	27.2%
CPS Administration	\$168.917	20.6%
Children & Families Behavioral Health (BH)	\$293.654	35.8%
BH Community-Based Services	\$78.606	9.6%
BH Out-of-Home Services	\$152.880	18.6%
BH State-Operated Facility	\$54.964	6.7%
BH Administration	\$7.202	0.9%
Juvenile Justice (JJ)	\$65.901	8.0%
JJ Community-Based Services	\$18.775	2.3%
JJ Out-of-Home Placement	\$17.593	2.1%
JJ State-Operated Facility	\$25.055	3.1%
JJ Administration	\$4.477	0.5%
Prevention for Children & Families	\$4.904	0.6%
Agency Management Services	\$38.449	4.7%
TOTAL	\$820.005	100.0 %

Source of Data: Governor's Budget FY 2008 - FY 2009 Biennium (February 2007).



Chapter II

DCF Internal Monitoring and Evaluation Activities

Internal efforts by the Department of Children and Families to monitor and evaluate progress in achieving the goals of its programs, mandate areas, and agency overall occur primarily within its Bureau of Continuous Quality Improvement. Monitoring and evaluation activities also are carried out by the Bureaus of Prevention and External Affairs, Finance, and Child Welfare, as indicated in Figure II-1. Especially within the Bureau of Child Welfare, DCF's 14 area offices play a key role in the agency's efforts. Additionally, the department contracts with outside organizations to supplement its internal analytical and evaluation resources. This chapter describes major components of the department's internal monitoring and evaluation activities.

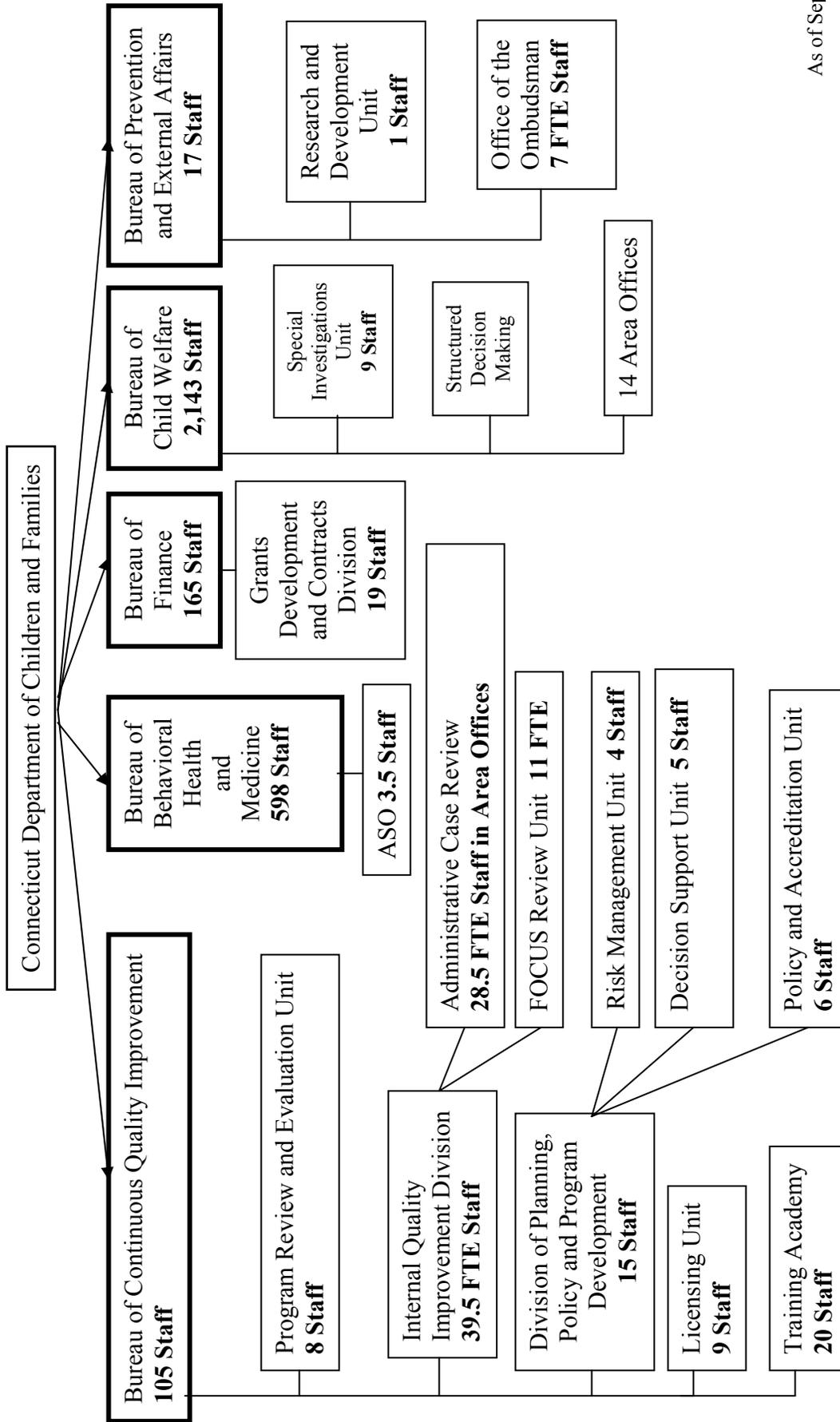
Bureau of Continuous Quality Improvement

Key monitoring and evaluation responsibilities for DCF are carried out by the Bureau of Continuous Quality Improvement (BCQI). The previous Bureau of Quality Management, first created in the late 1980s, had similar responsibilities. The current BCQI, established in 2003, is staffed by a bureau chief and 104 staff, some of whom are assigned to the 14 area offices to conduct Administrative Case Reviews.

The bureau is in charge of various department initiatives to assess and improve performance and the services received by children and families. Efforts range from specific case reviews to analysis of multiple cases. The bureau includes five units and divisions: 1) Program Review and Evaluation; 2) Internal Quality Improvement; 3) Training Academy; 4) Planning, Policy and Program Development; and 5) Licensing (see Figure II-2).

Program Review and Evaluation Unit. By law, the Department of Children and Families has been required since 1975 to "conduct studies of any program, service or facility developed, operated, contracted for, or supported by the department in order to evaluate its effectiveness." (C.G.S. Sec. 17a-3(a)(6)). The Program Review and Evaluation Unit (PREU) carries out this mandate with eight staff. Until 1995, there was a focus primarily on paper reviews (i.e., checking that policies were in place). Since then, the emphasis has shifted to outcomes, and the quality and effectiveness of programs. The following are highlights of some of the PREU activities shown in Figure II-2.

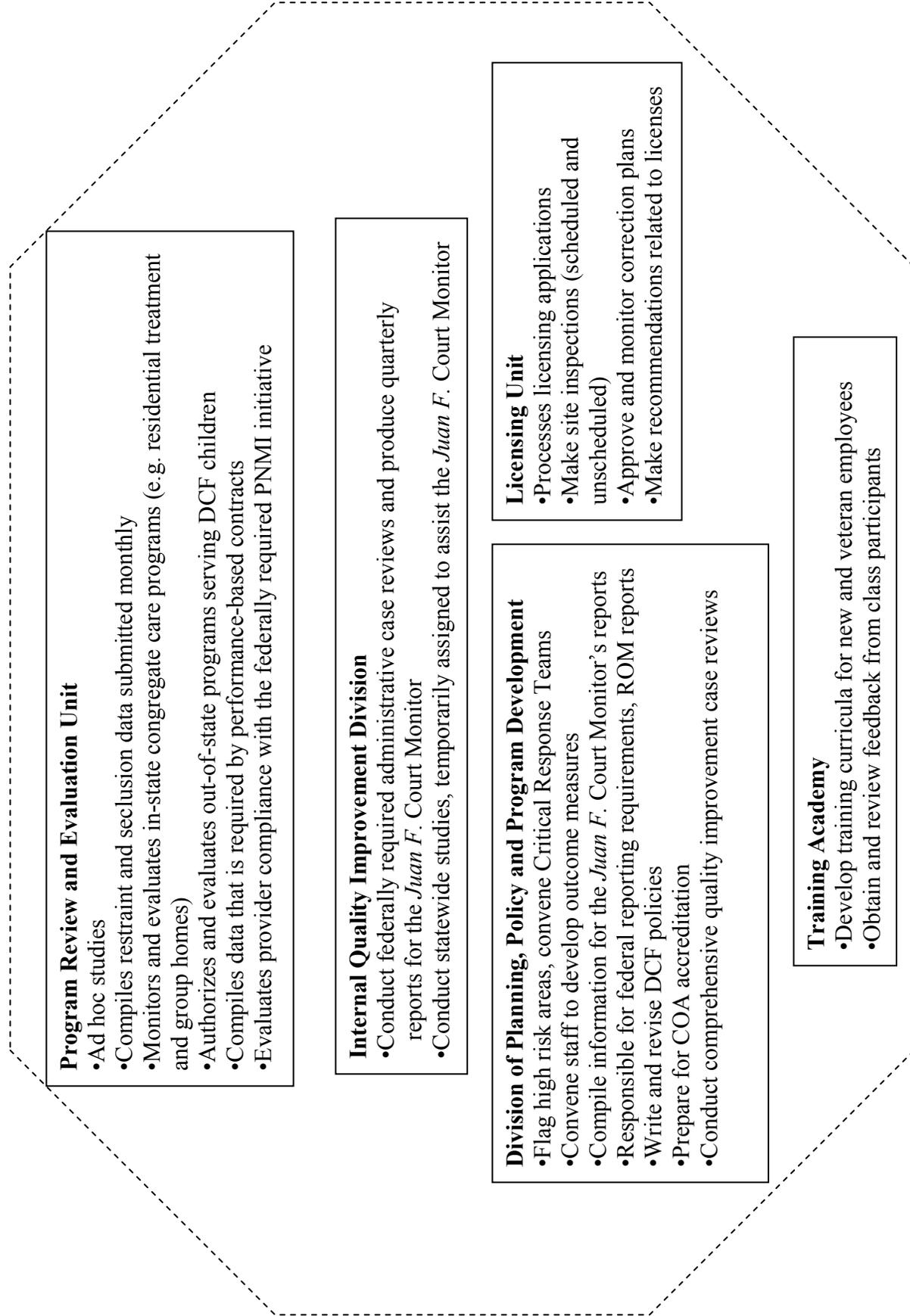
Figure II-1. DCF Areas With Monitoring and Evaluation Responsibilities



As of Sept. 07

Note: Additional monitoring and evaluation occurs through Quality Assurance Program Supervisors and Quality Improvement Teams in the area offices and facilities, and through the agencywide Service Evaluation and Enhancement Committee, a group of DCF managers that examines aggregate information on critical incidents and determines whether program improvements are needed.

Figure II-2. Responsibilities of Units Within the Bureau of Continuous Quality



Source: DCF management and PRI staff analysis.

Ad hoc studies. The Program Review and Evaluation Unit conducts ad hoc studies of any program, service, or facility to evaluate its effectiveness. Ad hoc studies may originate from: problems indicated by patterns found among agency data (e.g., Hotline reports); or concerns raised by DCF workers, the Office of the Child Advocate, the Court Monitor, or parents. Recent ad hoc study topics have included Riverview Hospital, therapeutic group homes, and residential programs.

Restraint and seclusion data. Restraint and seclusion data are submitted on a monthly basis to PREU by all programs, agencies, or institutions currently licensed, contracted, funded, or operated by the department. The unit aggregates the data by program type and reports on the number and duration of physical restraints, non-serious and serious injuries, and other relevant information.

Extensive in-state facility monitoring. On occasion, a program within Connecticut is found to have significant issues that require extensive monitoring. One program, for example, is currently slated for closure and, until the program closes, PREU staff will visit the facility on a daily basis. Children and staff are observed, formal monitoring procedures followed, and levels of responsibility and actions for PREU monitoring staff outlined.

Private Non-Medical Institution Initiative (PNMI). Non-medical facilities that are licensed by DCF to provide behavioral health services for children, such as therapeutic group homes and residential treatment centers, participate in the Connecticut Medicaid Private Non-Medical Institution program (PNMI). Enrollment as a PNMI provider occurs through the execution of a Medicaid Provider and Billing Agreement by the Connecticut Department of Social Services, DCF, and the performing provider of PNMI services for children. This enrollment allows reimbursement from the federal government of 25 percent of the allowable cost of therapeutic group homes and residential treatment centers.

Three staff from PREU monitor and evaluate the PNMI requirements of the therapeutic group homes and residential treatment centers. The PNMI review is a paper review, examining such areas as whether the appropriate person signed the proper documents and whether an activity occurred within a given time frame. The Program Review and Evaluation Unit expanded these PNMI reviews to include qualitative areas. Program Review and Evaluation Unit staff also conduct site visits to residential and therapeutic group homes for PNMI compliance.

Recent focus has been on the therapeutic group homes. There are 33 items that reviewers examine in the case records that fall into the categories of: general; need for services; treatment planning; clinical service delivery; residential service delivery; and DCF reporting. PNMI requirements, for example, include facility development of an individualized treatment plan within 30 days of admission; treatment plans that are developed in conjunction with DCF, the child, and the child's family if possible; and specific behavioral health goals and objectives within every treatment plan.

After the record review, PREU staff provides the group home or treatment center with verbal feedback as well as a form documenting any corrections required. The intent of the review is to ensure that required structures and procedures are in place. In the instance of therapeutic

group homes, every record is examined during visits that occur every 1-2 months until corrections have been completed.

Out-of-state facility evaluations. The Program Review and Evaluation Unit also authorizes and evaluates out-of-state programs. In spring 2007, there were approximately 280 children in out-of-state programs. A priority of DCF several years ago was to reduce the more than 500 children in out-of-state programs at that time. The steps that typically occur during the out-of-state facility evaluation process are:

- PREU is notified that a child has been referred to an out-of-state program;
- various quality checks, such as child protective services, licensing, and abuse and neglect allegations are conducted;
- if quality checks are satisfactory, PREU sends the out-of-state facility a memorandum of agreement listing all service conditions;
- if the memorandum of agreement is acceptable to the out-of-state program, PREU will do a site visit that involves PREU teaming up with experts within DCF in that particular program area;
- PREU will approve or not approve the facility;
- if approved, DCF rate setting staff will set the facility payment rate;
- the program will come on line and be available to DCF children; and
- in 2-3 years, PREU will re-evaluate the program.

During the PREU site visit, more than 70 items are reviewed, covering such areas as:

- treatment plan;
- staff oversight/collaboration;
- milieu interactions;
- child behavior management;
- educational programming;
- medical services; and
- physical plant.

Internal Quality Improvement Division. The Internal Quality Improvement Division is staffed by 39.5 FTE positions. Some staff are located in the DCF central office, and others are in the 14 area offices. The role of the division is to encourage and support area office and facility quality improvement efforts. The functions of the Internal Quality Improvement Division are carried out by two units: Administrative Case Review, and FOCUS Review. Each is now described.

Administrative Case Review Unit. The Administrative Case Review unit, or ACR unit, has 28.5 FTE staff located in area offices. Federal regulations require that independent case reviews occur every six months, assessing such areas as the appropriateness of placement, safety, permanence, and well-being. Specifically, their responsibilities include a review of treatment plans, examining such areas as the way in which treatment goals are defined, determining who is

responsible for implementing the treatment plan within a given time frame, and producing quarterly reports for the Office of the Court Monitor. Case reviews may occur more frequently when circumstances require a new treatment plan to be prepared.

Each ACR takes approximately 1.5 hours. They are conducted in the area offices and mandatory participants include the administrative case reviewer, the DCF social worker whose case is being reviewed, and his/her supervisor. Any member of the Area Resource Group, a community consultant, support-staff worker, and/or community service provider who has participated in any aspect of the case in the seven months prior to the review are also required to participate in the ACR, as well as an adoption specialist as needed. The parents of children without terminated parental rights, foster parents, and foster children themselves who are age 12 or older are also invited to the ACR.

At least two weeks prior to the ACR, a written case summary and copy of the current and previous treatment plans are submitted to the reviewer by the DCF social worker. This information is then shared with the remainder of the review participants at least one week prior to the review. The case record is also reviewed prior to the ACR and available at the ACR itself.

Specifically, the **process goals** of the Administrative Case Review are to:

- assure that each child in the physical and/or legal custody of the department and associated family has a treatment plan and that the plan is efficacious, or has a reasonable chance of addressing the child's and family's needs and moving the child expeditiously out of the foster care system;
- examine whether case plans are being developed appropriately and implemented properly;
- allow families, child welfare staff, and others the ability to reexamine the case situation before significant decision making points;
- provide an opportunity for all parties involved in the case to assess the effectiveness of case planning and service delivery and to strengthen or revise planning if needed;
- prompt and support the people who do and supervise the work;
- review actual case practice against expectations, policy, procedures, protocols, and other requirements; identify strengths and challenges; identify what is working and what is not, for whom it is or is not working, and the reasons;
- provide recommendations and solutions for case and system improvements;
- manage, monitor, and improve practice and outcomes;
- inform child welfare staff and administrators how policy is being implemented in the field;
- encourage the participation of the parents of the child; conduct the review with the appropriate persons—at least one of whom is not responsible for the case management or delivery of services to the child or parents who are the subject of the review; and
- serve as an external check to the operational line of authority responsible for direct supervision and case practice for the children and families being served.

The **outcome goals** of the Administrative Case Review are:

- safety of the child;
- determination of the continuing necessity for and the appropriateness of the placement;
- extent of compliance with the case plan;
- extent of progress in alleviating or mitigating the causes necessitating placement in foster care;
- projection of a likely date by which the child may be returned to and safely maintained in the home or placed for adoption or legal guardianship;
- verification of whether the family:
 - participated in the development of the treatment plan;
 - understands what they must do to achieve the goals;
 - understands and agrees with the services provided; and
 - monitor child welfare staff's compliance with the policies and practice about family participation in case planning, goal setting and case reviews.

At the ACR, each case plan component is discussed fully. Any obstacles to achieving treatment plan goals, and recommendations for eliminating obstacles are identified and formally contained in a written report called an "FYI." An FYI, or "For Your Information," is an email that is sent to all that are involved in the case, including the social worker, social worker's supervisor, and area office manager. The FYI identifies areas of strength as well as areas for improvement related to safety, permanency, child and family well-being, placement, treatment planning, case work practice, and/or child welfare system performance. Common examples of reasons to send FYIs include safety issues, inappropriate placement, or no discharge plan.

A member of the ACR staff will then review the child's case record within 45-60 days of the ACR to assess whether the issues contained in the FYI were resolved. If not resolved, the program supervisor is notified and must respond within 30 days to the Director of the Division of Internal Quality Improvement and appropriate Division program director.

In addition to the case-specific ACR process, there is also a systemic review process. Systemic problems may relate to a particular program or facility. All reports related to significant events, sentinel events, critical incidents, Hotline, etc., are reviewed bi-weekly by the Service Evaluation and Enhancement Committee (SEEC), a cross-section of agency staff from the Bureau of Child Welfare, Division of Internal Quality Improvement, Risk Management, and others. Sentinel events are one-time occurrences that can be either critical (i.e., related to child abuse or neglect) or significant (a non-child abuse or neglect related concern). For example, treatment planning was identified as a systemic problem. It was found that there was difficulty obtaining consistency on the treatment goals and objectives. The solution was to conduct relevant training and increase time devoted to reviewing automated data, reading hard copy material on cases, developing more qualitative information, and promoting strengths-based language in the treatment plan.

FOCUS Review Unit. The Focus Review Unit has 9 full-time and 2 part-time staff, and a durational program director assigned to area offices to assist with quality improvement plans and initiatives, setting priorities, and developing strategies. The unit also conducts statewide studies, such as a recent study of exit planning for youth 18 years and older transitioning from DCF to DMHAS and DDS. During 2007, there were three FOCUS staff temporarily assigned to assist the *Juan F.* court monitor with the monitor's comprehensive case review (see Chapter III).

Area Office Quality Improvement Teams. Each area office has an Area Office Quality Improvement (QI) Team, formed in 2004 in response to the *Juan F.* consent decree exit plan requirements. The makeup of the QI teams varies by DCF area office, with some including the area office director. There is no department policy on the membership of QI Teams.

A QI team's main duty is to develop and implement a Quality Improvement (QI) plan for its area office. Plan goals and activities may focus directly on the *Juan F.* exit plan outcome measures or indirectly, through topics such as safety, adolescent issues, social worker support, case practice improvements, and diversity sensitivity. It is up to the QI team, the Bureau of Child Welfare (under which the area offices operate), and other program bureau chiefs to look at why goals are not being reached, and the changes needed to address deficiencies.

When the Internal Quality Improvement Division staff identifies a problem at an area office, they work with the office to develop corrective actions. For example, the Internal Quality Improvement Division helps with *Juan F.* exit plan measures that may be especially challenging for a particular area office, such as repeat maltreatment or re-entry. Area offices differ on performance, having different needs and resources.

Training Academy. The Training Academy has 20 staff and conducts all major statewide training initiatives, but may hire consultants to provide additional training. The Academy anticipates as well as responds to skill and knowledge needs identified during monitoring and evaluation activities. For example, the QI Teams, discussed earlier, may identify staff training needs based on the results of their monitoring of the 22 *Juan F.* exit plan outcome measures.

The Training Academy is currently working with the Child Welfare League of America⁸ to help identify what areas are needed for child case worker training based on the National Child Welfare Competencies, a nationally recognized curriculum.⁹

The department requires newly hired social workers, about 300-400 annually, to participate in training that takes approximately one year to complete. Pre-test and post-test measures on participants are collected and changes to the training offerings modified accordingly.

⁸ CWLA is an association of nearly 800 public and private nonprofit agencies that assist more than 3.5 million abused and neglected children and their families each year with a range of services.

⁹ The curriculum includes: 1) core competencies, such as legal issues, case planning, and family centered casework; 2) specialized competencies, such as adoption, foster care, and working with adolescents; and 3) related competencies, such as casework with children, and writing skills for case documentation.

Division of Planning, Policy and Program Development (PPPD). This newly formed division was created from a combination of several previously existing functions in Spring 2007. Approximately 15 staff work within the division's three units: Risk Management; Decision Support Unit; and Policy and Accreditation Unit. The idea behind the division is that through analytically monitoring and evaluating risk, and making decisions with the best possible data, services to children and families can be improved. According to the division director, staffing for the analytical requirements of the new division is a challenge to meet given the limitations of the relevant current job classifications.

Risk Management Unit. The Risk Management Unit has four full-time staff. The unit acts as an agencywide conduit for information including critical incidents, flagging areas of concern, notifying the appropriate DCF unit for action, and subsequently monitoring the department's response. Upon request, the unit compiles ad hoc reports (e.g., 9-1-1 calls made by providers).

Critical incidents are those occurrences related to suspected abuse and/or neglect involving:

- the death of a child;
- a life-threatening condition resulting from abuse and/or neglect;
- serious injury (e.g., broken bones) in a child under six years of age, where the injury is suspected to have been caused by abuse or neglect;
- serious injury including sexual assault (by an adult or child) of a child at a DCF-operated facility or an in-state or out-of-state facility licensed or used by DCF;
- serious injury, including sexual assault, suffered by a child, caused by a person whom the department has permitted to gain access, including a DCF employee, licensed foster/adoptive parent, or an employee of a licensed or contracted private provider; or
- a runaway who presents an imminent danger to himself/herself or the community, or all runaways under the age of 13.

All critical incidents are contained in a Critical Incident Database with information obtained from the Incident Report, most often completed by DCF Hotline staff. There is additional information included in the Critical Incident Database that is taken from the Critical Incident Update and the department's statewide automated child welfare system. Critical incident reports are distributed within DCF and externally to the Office of the Child Advocate and Office of the Court Monitor for the purpose of information sharing and possible subsequent changes in department policies and procedures.

Critical Response Teams. In some instances, a Critical Response Team may be formed to respond to an issue, and the Risk Management Unit is responsible for convening the team. The Critical Response Team, composed of different DCF staff relevant to the issue at hand, takes an in-depth look at the reasons behind an event and, working with the provider or facility, develops recommendations.

Trend analyses. The Risk Management Unit also conducts trend analyses on topics such as type of incident and area of concern. The unit identifies incidents that rise above an acceptable threshold (e.g., number of restraints in a particular program). These “rate-based incidents” may be shared with the department’s Service Evaluation and Enhancement Committee and/or another area of DCF for further action.

Service Evaluation and Enhancement Committee. The SEEC comprises staff from Policy, Licensing, Program Review and Evaluation, Risk Management, all bureau chiefs, representatives from the commissioner’s office, ombudsman, contracts, fiscal, and Hotline. It is the central mechanism for tracking available results information to “red flag” patterns of poor performance or undesirable outcomes. Another SEEC role is to identify issues that require proactive intervention from areas throughout the agency.

SEEC meets every two weeks to look at aggregated critical incident data, significant events, and other program information (e.g., ombudsman complaints, staff turnover rates, or providers with financial trouble) compiled by Risk Management Unit staff. With the help of that staff, it looks at trends, identifies problem programs or providers, and develops ways to take corrective actions as early as possible.

Decision Support Unit. The purpose of the Decision Support Unit is to bring together DCF staff with an interest and expertise in outcome measurement and performance data. The unit consists of five full-time staff and is currently led by the Division Director of Planning, Policy and Program Development. Responsibilities of the Decision Support Unit include:

- overseeing the *Juan F.* Exit Plan activities, outcome measurements, and reporting;
- developing a plan to transition to the Quality Service Reviews (QSR) process;
- assuming responsibility for the development and maintenance of various databases (e.g., Administrative Service Organization database, DSS Data Warehouse, Results Oriented Management (ROM), CT Health Information Network, LINK Reports, *Emily J.* Database, and Chapin Hall)
- developing and submitting the annual federal Child and Family Services Plan (CFSP) and Program Improvement Plan (PIP);
- planning and implementing a needs assessment process;
- assuming responsibility for federal reporting as required by the Child Abuse Prevention and Treatment Act (CAPTA), Adoption and Safe Families Act (ASFA), and other federal formula grant programs;
- supporting the work of the Resource Management Authority, including identifying and implementing an agency program data collection model (the Resource Management Authority is a committee made up of senior managers who collectively decide how DCF’s resources can best be used, allocated, and distributed);
- assuming responsibility for the research consortium including coordinating efforts of the Connecticut Center for Effective Practice and various other research initiatives; and

- compiling ad hoc reports based on data from various automated sources including LINK and the Provider Support Data System, an information system for behavioral health providers.

A key responsibility of the Decision Support Unit is to identify and develop requests for data needed to make management and quality control/improvement decisions. The work includes shaping inquiries, determining report specifications, understanding data concepts, and assuring consistency. The unit works with Information Systems staff, Division of Grants and Contracts Management staff, and other CQI staff.

Finally, the unit oversees the Results-Oriented Management system (ROM). Managed by the University of Kansas, the system takes some of the LINK data and “scrubs” it for subsequent use in outcome reports. DCF ROM reports have been available since FY 06. Managers are able to look at office-specific information, monitoring frequency of supervision, number of children in unlicensed foster homes, etc. The ROM is also used to track performance goals and *Juan F.* exit plan outcomes. The data for the majority of *Juan F.* exit plan outcomes are now produced by ROM.

Policy and Accreditation Unit. The Policy and Accreditation Unit, with six staff, is responsible for all DCF policy manual revisions and additions. The unit also has duties related to accreditation, ROM, the *Juan F.* exit plan, and several federal requirements such as the Adoption and Foster Care Analysis and Reporting System (AFCARS) and the Child and Family Services Reviews (CFSRs).

Other responsibilities of the policy unit include: playing a key role in the Council on Accreditation accrediting process; and managing the Closed Records Unit, the unit responsible for physically getting files to area offices when a closed case is reopened (has one full-time and three part-time staff).

Licensing Unit. The Licensing Unit has nine licensing inspectors and is responsible for assessing compliance with federal, state, and local regulations, laws, and ordinances. The Licensing Unit processes licensing applications (new and renewal), makes site inspections (scheduled and unscheduled), approves and monitors correction plans, and makes recommendations related to licenses, including temporarily closing admissions, reducing capacity, suspension of license, and revocation of license. The licensing function is considered a quality assurance effort as it is an assessment of regulatory compliance. There are five types of in-state licenses for which the unit is responsible. These are:

- child care facilities (e.g., residential treatment, residential education, temporary shelters, group homes, and safe homes);
- child placing agencies (e.g., private adoption and foster care);
- extended day treatment programs;
- out-patient psychiatric clinics for children; and
- permanent family residences.

Out-of-state agencies. Through the Interstate Compact Unit, the Licensing Unit approves out-of-state agencies that place children with Connecticut families. Approval of out-of-state child placing agencies requires receipt of current license, program description, and contact with DCF's Licensing Unit. Two-year approvals are received; no site visits are required. There are more than 100 out-of-state agencies that are currently approved.

New in-state provider. When a provider is selected from a pool of applicants responding to a request for proposals (RFP), the Licensing Unit will send the new program requesting licensure an application packet with all the requirements. The licensing requirements are based on the regulations.

When the application packet is returned to the Licensing Unit, it is assigned to a licensing inspector. The unit examines each specific requirement and reviews the facility to ensure compliance with the requirement. Requirements pertain to staff, physical plant, and policies such as the use of restraints. A program cannot become licensed until all of the requirements are in place, usually taking a program three to six months to complete.

A provisional license, good for 60 days, is then granted for a new program. Up to six consecutive provisional licenses can be received. During the provisional licensing period, the Licensing Unit is monitoring the program, assessing, for example, whether the program is fully staffed, treatment plans are being written for all children in the program's care, fire drills are taking place, and administration of medication is being done according to regulation.

Site visit schedule. Once all systems are fully operational in a new program, then a regular license is issued. The regular license is good for two years from the date of the first provisional license and must be renewed every two years thereafter (except for permanent family residences). The license renewal involves two to three licensing inspectors visiting the program for two to three days. Permanent family residences, which are being phased out by DCF, receive licenses for one year. There are currently four permanent family residences, which are a hybrid between a foster home and group home, with as many as 13-16 children in a single home. Two of the permanent family residences serve significantly handicapped children, one is a respite shelter, and one is for temporary shelter.

Additionally, child care facilities receive site visits from the Licensing Unit every three months, usually one licensing inspector for a half-day visit. During the brief site visits, the inspector typically focuses on one or two regulation areas. By the end of the two-year cycle, the quarterly visits will have reviewed all of the regulation areas.

Non-compliance. Any time a site visit occurs and a program is found to be out of compliance with a regulation, the facility is required to submit a corrective action plan to the Licensing Unit within 30 days. Corrective action plans are monitored with the assistance of an ACCESS database that tracks license expiration dates and site visits. A license will not be issued until the areas of noncompliance covered by the corrective action plan have been addressed. Adherence to the corrective action plan is monitored through quarterly site visits.

Site visits may also be triggered by a complaint coming into the hotline. While the hotline team will investigate initially, the Licensing Unit will also make a site visit if there is a problem with regulation compliance.

Licensure requirement differences. There are specific requirements in regulation regarding DCF licensure of particular programs or facilities. For example, outpatient psychiatric clinics for children are required by regulation to have a comprehensive and well-designed plan for measuring and improving performance (R.C.S.A. 17a-20-59).

Other Internal Monitoring and Evaluation Efforts

Performance-based contracts. Within the Bureau of Finance is the Grants Development and Contracts Division, responsible for approximately 300 contracts DCF has with outside program providers. There are 19 staff in this division, who manage over 100 different types of services procured through these 300 contracts. It is possible for one provider to have just one contract, with that one contract covering multiple types of services.

Within the standard contract template is a section pertaining to expected performance from the provider. Periodically, the providers are required to report progress on meeting these service expectation goals. Fiscal performance is monitored by the Grants Development and Contracts Division, and program implementation is monitored by program leads within each of the bureaus. The Program Review and Evaluation Unit, with the assistance of a vendor (Advanced Behavioral Health), aggregates provider-supplied information about the clients served, including demographics, length of service, and reasons for service discontinuation, into various quarterly reports. Use of performance-based contracting can be both a means to monitor purchased services as well as to evaluate overall provider performance, and serve as a consideration in future contract awards.

Special Investigations Unit. The Special Investigations Unit (SIU), within the Bureau of Child Welfare Services, is staffed by a Program Supervisor and eight social workers. The SIU is responsible for investigating child abuse or neglect allegations regarding a child in congregate care, foster care, or of a DCF employee.

Structured decision making. Another endeavor of the Bureau of Child Welfare Services is called structured decision making. This initiative is intended to provide the tools and reports necessary to help guide the decision making of child protective services workers relative to assessing risk and safety. Structured decision making is also intended to reduce the variability in decision making during the child protective services process.

Best Practice Unit. Approximately two years ago, a Best Practice Unit was planned but never got off the ground. According to the Chief of the Bureau of Behavioral Health and Medicine, the unit's intent was to focus on residential care. One aspect of that focus was to address fragmentation between the Bureau of Behavioral Health and Medicine and the Bureau of Continuous Quality Improvement, a problem because staff from both bureaus needed to come together quickly to respond to critical incidents at congregate care facilities. However, the behavioral health bureau chief reported that there were challenges hiring staff for the unit as well as clearly defining the purpose of the unit.

There is now a new Residential Treatment Unit that will provide services to the approximately 20 contracted residential treatment centers that will include some of the original ideas behind the Best Practice Unit. Each Residential Treatment Unit staff member is expected to have two residential facilities for which to act as a best practice “guru.” Half their time will be spent in the field at residential facilities, getting to know the staff, children, and programs.

Administrative Service Organization (ASO). The KidCare ASO, Value Options, has the capability to track services received by children in the KidCare system of care. There are 3.5 staff within the Behavioral Health Bureau assigned to manage the ASO function. Examples of the more than 200 reports produced include: length of time to answer the telephone; length of time for providers to get questions answered; list of children residing in a residential facility; hospital discharge delays; daily census reports; and aggregate reports to identify trends.

CJTS performance-based standards. For the past two years, the Connecticut Juvenile Training School has monitored and evaluated its stability through the performance-based standards (PbS), a self-improvement and accountability system for youth correction and detention facilities that is used by more than half the states in the U.S.

The PbS sets national standards for the safety, education, health/mental health services, security, justice, and order within facilities. No more than four facility improvement plans can be developed at one time based on the results of PbS.

Riverview Hospital. Internally, Riverview Hospital has established multiple committees that monitor and evaluate the hospital’s services, which are overseen by a Quality Assurance manager. Established committees include: Environment of Care Committee, Staff Development Committee, Infection Control Committee, Medical Records Committee, Pharmacy and Therapeutic Committee, and Patient and Family Education Committee. Each year the committees set goals for the coming year and then monitor progress throughout the year. Additionally, each committee issues quarterly reports that track progress in reaching the goals. These reports are presented to the central office as well as the facility advisory committee for feedback.

As a result of the joint ad hoc program review conducted in 2006, Riverview Hospital developed a strategic plan containing both long and short term goals. An Implementation Committee made up of 25 members of the Riverview staff representing all disciplines and units of the hospital was established to help meet the goals in the plan. In addition, an independent monitor who reports to the Office of the Child Advocate, and the Director of the BCQI Division of Planning, Policy and Program Development review activities related to the Riverview Hospital Strategic Plan.

Research and Development Unit. The Research and Development Unit within the Bureau of Prevention and External Affairs consists of one full-time director. Due to the small staff size, the Child Welfare League of America (CWLA) is used extensively to assist with its efforts.

Internal child fatality reviews are a way to evaluate the causes of such tragedies. Under the Research and Development Unit, they are conducted with up to three key CWLA team

members and include a case analysis of the facts (who, what, when, where, and how). The Research and Development Unit also examines what happened as it relates to practice, whether, for example, staff worked together as a team. In recent years, the Office of the Child Advocate has also been invited to participate in this internal child fatality review.

In addition to individual child fatality reviews, the Research and Development Unit also aggregates information from several reviews, identifying patterns and making recommendations. In 2005, such an aggregate review was done for 13 child fatalities.

Office of the Ombudsman. Approximately three years ago, the consolidated Office of the Ombudsman was formed to serve children, foster and adoptive parents, providers, and citizens. Protocols were established, staff size expanded, and an information system developed to track inquiries. There are currently eight staff, some of whom are part-time and assigned to various facilities.

The office receives and investigates inquiries and complaints relating to DCF, including those submitted through grievance boxes located at each of the DCF facilities. The office monitors and evaluates these complaints and tries to resolve issues in the best interest of the children involved. The Ombudsman's Office received 3,788 inquiries in 2006, with 1,000 of the inquiries coming from York Correctional Institution and Manson Youth Institution, both correctional facilities.

The Ombudsman also makes site visits to residential treatment centers and group homes when time permits. The Ombudsman also solicits feedback via letters to residential treatment centers and group homes.

Contracted Monitoring and Evaluation

The Department of Children and Families periodically uses outside organizations to supplement its internal evaluation resources and to obtain special expertise that cannot be found within the agency. Contracting out for evaluation services also can lend credibility to the results by providing an independent assessment of a program's strengths and weaknesses.

Some of the outside evaluations commissioned by DCF have been required as a condition of federal funding or as part of the agreement for using a proprietary service model. Independent reviews of agency programs also have been directed by the legislature. For example, an outside evaluation of the agency's implementation of the KidCare program, which was carried out by the Child Health and Development Institute of Connecticut (CHDI), was a statutory mandate.

In addition to program-specific evaluation projects, the department also contracts for a variety of ongoing monitoring and evaluation services. These services range from conducting child fatality reviews to managing parts of the agency's child welfare data. With the Department of Social Services, DCF also has contracted with a private firm (Value Options) to serve as the ASO for the state's Behavioral Health Partnership. Monitoring and reporting on utilization of, and need for, mental health and substance abuse services by children and families are among the duties of the ASO.

Both types of contracted monitoring and evaluation services are described in more detail below. Information on project-specific contracts for the past five years was developed by the department at the request of the program review committee staff. Efforts by some of the commissioner's staff to start tracking contracted studies began around FY 03. However, as there is no central control over the products resulting from outside monitoring and evaluation efforts, the list provided for this study is not considered exhaustive.

Through interviews with agency managers, advisory groups, and private providers, program review committee staff became aware of several external reviews of DCF programs that were not included on the department's list of contracted evaluations. In addition, some monitoring and evaluation efforts may be carried out as part of other, broader contracts that bureau chiefs, facility heads, or other agency managers develop for the programs they administer.

One example is the foster care division's contract with the Connecticut Association of Foster and Adoptive Parents (CAFAP) for foster parent training and support services. That contract includes a provision for CAFAP to carry out exit interviews with caregivers leaving the system to obtain their feedback about the agency's administration of the program. The foster care division also has an agreement with the University of Connecticut to conduct opinion surveys of the general public and providers regarding strengths and weaknesses of state foster care.

At this time, decisions about contracted evaluations are not coordinated throughout the agency and there are no standard criteria for determining when outside services are needed. Like all agency contracted services, however, authorization of an external evaluation or monitoring project is subject to the approval of top management and procurement is overseen by the central office contract, fiscal, and legal staff.

Recent contracted evaluations. Over the past five years, DCF has contracted for at least 15 different evaluation projects. Information about each one is summarized in Table II-1. On average, the department contracted for three to four external evaluations per year during this period. The cost of the evaluations included in the table ranged from \$8,000 to over \$1 million each, depending on the scope and time frame of services. Overall, the total value of the external evaluation services provided through these contracts was more than \$2 million.

The majority of the contracted services were for studies related to behavioral health issues. This is due to two main factors. First, as part of its ongoing KidCare initiative, and through its participation in implementing the Connecticut Behavioral Health Partnership, the department has developed and expanded a number of new community-based mental health and substance abuse programs for children and families. Second, many of the new behavioral health intensive in-home services mandate provisions for outside evaluations of their effectiveness.

Most of the evaluations shown in Table II-1 extend over a period of several years, although a few short-term reviews (about one year) have been conducted. A variety of entities are involved in performing evaluations for the department including: non profit providers, such as the Village for Families and Children; academic institutions and research centers, like Yale University and the Connecticut Center for Effective Practice (CCEP) of the Child Health and

Development Institute of Connecticut (CHDI); and national consultants and research organizations like Matrix and the Casey Foundation.

In three cases, a report was not produced as part of the contract. Instead, training and other workforce development or technical assistance was provided to department staff as a result of the evaluation. Also, copies of reports regarding two other evaluations (regarding flex funds and mentoring) could not be provided by the department. At the time of the committee's study, several evaluations were still in progress or had just released final reports.

The department's arrangement with CHDI and its affiliated research entity, CCEP, differs from the other contracted evaluation services. In many ways, CHDI and the Center serve as an independent research resource for the department on children's health and mental health care matters.

Under a competitively awarded, five-year personal service agreement, the institute provides DCF with broadly defined evaluation and training services related to the state's KidCare behavioral health reform initiative. The institute designed the multi-year evaluation to be done in phases, focusing first on implementation and baseline measures, then system capacity and responsiveness issues, and finally on changes in children's outcomes.

From June 2003 through January 2007, CHDI issued six evaluation reports related to KidCare as part of this agreement and two subsequent amendments made to it. These studies examined the Emergency Mobile Psychiatric Services and Care Coordination components of the KidCare system and measured family satisfaction with services received. Currently, the institute is completing a first-year evaluation of the Behavioral Health Partnership, which will include a set of performance indicators to be used as the system "report card." CHDI also has organized and funded on-going training in wraparound service delivery for KidCare local providers and care coordinators.

CHDI. The Child Health and Development Institute is the operating arm of the Children's Fund of Connecticut, a public charitable foundation established in 1992 to improve the healthy development of Connecticut's children. CHDI carries out the fund's mission by combining direct funding for research, policy analysis, advocacy, and technical assistance that emphasizes family-centered, comprehensive physical and mental health care.

The institute works in partnership with Connecticut hospitals, universities, state agencies including DCF, and other organizations on a variety of initiatives intended to improve the quality of care for all children in the state. These range from strategic planning for early childhood programs, to evaluations of the effectiveness of juvenile offender treatment therapies and various DCF KidCare services.

Table II-1. DCF Contracted Evaluation Services: FY 03 - FY 07				
Project	Organization	Start Date	End Date	Amount
Community KidCare Multi-Year Evaluation and Training	Connecticut Center for Effective Practice / Child Health and Development Institute of CT	03/01/05	02/28/09	\$1,127,000
MultiSystemic Therapy (MST) - Consultation and Evaluation	Advanced Behavioral Health, Inc	05/01/07	06/30/09	\$166,780
Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) - Consultation and Evaluation	Yale University	01/01/06	06/30/08	\$125,000
Develop Evaluation Design Methodology for Differential Response System (DRS)	OMG Center for Collaborative Learning	7/1/2003	9/30/2004	\$75,000
Evaluation Adoption Services	Casey Family Services	09/15/02	08/01/03	\$50,000
Multi-Dimensional Family Therapy (MDT) Evaluation	Village for Families & Children	01/01/06	12/31/07	\$30,000
Evaluation of Positive Youth Development Initiatives (PYDI)	Matrix Public Health Consultants	10/01/05	06/30/08	\$220,000
Establish Evaluation System for Early Childhood Consultation Partnership - ECCP	Yale University	07/01/07	06/30/10	\$420,000
Assessment of Implementation of Trauma-Informed Treatment at Girls Residential Program	CORE Associates LLC	11/20/06	09/15/07	\$8,000
Evaluation of the CT Behavioral Health Partnership	Connecticut Center for Effective Practice / Child Health and Development Institute of CT	03/01/07	06/30/07	\$15,000
Evaluation of Flex Funds/ Non DCF Children	Village for Families and Children	10/15/02	08/30/04	\$30,000
Evaluate Mentoring & Other Adolescent Services	Kraimer-Rickaby, Lisa M.A.	04/15/03	12/31/03	\$29,722
Evaluation of Community Collaboratives (training and workforce dev.)	Mika Research and Training	07/01/03	02/28/04	\$15,000
Behavioral Health Services Administrative Review (training/tech. asst.)	Fr. Flanagans Boys Town, Inc.	07/01/07	04/30/08	\$32,262
Behavioral Health Services Administrative Review: Mt St. John's (training/tech. asst.)	Fr. Flanagans Boys Town, Inc.	10/01/06	06/30/07	\$31,094
Source: DCF.				

In 2002, the institute created CCEP, a partnership of two state agencies, DCF and the Court Support Services Division of the Judicial Branch, and two higher education institutions, the Psychiatry Department of the University of Connecticut Health Center and the Yale University Child Study Center. The center's overall mission is focused on developing, training, disseminating, evaluating, and expanding effective practice models for children with serious emotional, behavioral, and addictive disorders. Core funding for CCEP's work comes from the Connecticut Health Foundation. Additional support has been provided from the Children's Fund of Connecticut, the Tow Foundation, and DCF.

One of CCEP's primary activities is working with DCF to identify and implement cost-effective, evidence-based, behavioral health treatment services for children and youth. Most recently, the center just completed a study with recommendations for the redesign of children's Emergency Mobile Psychiatric Services as a way of addressing the inappropriate use of hospital emergency departments.

Other contracted services. DCF also contracts with outside organizations for ongoing monitoring and evaluation services in several areas. Examples of these types of contracted services are summarized in Table II-2.

Organization	Service	Contract Period	Contract Value
Chapin Hall	Data sharing agreement/child welfare database (longitudinal data on foster care) and technical assistance with analysis	n/a	\$50,000 (One-time set up and service fee)
Univ. of Kansas, School of Social Welfare	Child welfare electronic, web-based management reporting system (ROM)	4/04 - 6/08	\$511,827
Center for the Study of Social Policy (CSSP)	<i>Juan F.</i> Court Monitor Technical Advisory Committee	11/05 - 12/07	\$175,000
Child Welfare League of America (CWLA)	Child fatality reviews; technical assistance and case-specific reports	7/07 - 1/10	\$480,000
Value Options, Inc.	Administrative Services Organization for CT Behavioral Health Partnership	8/05 - 12/08	\$30,487,811

Source: PRI staff analysis.

Two of the five contracts shown in the table, the Chapin Hall longitudinal foster care data analysis project and the ROM services provided by the University of Kansas, are indirectly related to monitoring and evaluation efforts. They primarily provide DCF with data management services, technical assistance, and advice regarding analysis and performance measurement.

Both, however, are critical to the department's ability to assess compliance with *Juan F.* exit plan outcome measures and federal child welfare performance indicators, as well as to develop related corrective actions and program improvements plans.

The Center for the Study of Social Policy carries out the Technical Advisory Committee (TAC) function required as part of the *Juan F.* consent decree exit plan. The committee's responsibilities include providing expert advice and technical assistance on methodologies for outcome measures, best practices, and the latest child welfare research. In addition, the TAC occasionally evaluates agency operations. Only one written TAC evaluation report, a 2002 assessment of DCF's quality assurance system, has been issued. Feedback is more often given informally, through memos or meetings. Most recently, the committee arranged for a consultant to help DCF staff develop an agencywide practice model and work on the results-based management system the department calls its Accountability framework.¹⁰

About three years ago, the Child Welfare League of America was hired to assist the department with its internal child fatality review process. Fatality reviews can be viewed as case-specific evaluations of agency policies and practices. To date, CWLA has conducted over 30 in-depth reviews of deaths and other critical incidents involving children and youth in DCF care.

Value Options was awarded the contract to serve as the ASO for the state's Behavioral Health Partnership in January 2006. Its main roles are authorization and utilization review. However, the ASO also has responsibilities for evaluating the existing behavioral health service network and identifying need for new or expanded programs as well as for assessing the efficiency and effectiveness of clinical work.

DCF Information Systems

Currently DCF has multiple automated data systems that serve its different bureaus, programs, and facilities. The system that supports social workers' case management practice, LINK, became operational in 1996. LINK serves as the federal statewide automated child welfare information system (SACWIS). By law, LINK is required to support the reporting of data to the Adoption and Foster Care Analysis Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS). LINK also serves as the primary source of data for the *Juan F.* outcome measures. It does not, however, provide useable data to supervisors or the necessary analytic capability to improve outcomes. Instead, DCF uses the ROM system from the University of Kansas for reporting capabilities using LINK data. ROM extracts data from LINK and provides management reports on outcome measures with the capability to generate reports by office, unit, and worker.

¹⁰ The Accountability Framework project is intended to bring together agency values and goals, data on results, and strategies to improve the agency's ability to reach its goals. It is anticipated that a department-wide practice model based on this framework will be developed with the help of a national consultant and a stakeholder group. At present, the department is finalizing a written guide to its goals (the results it seeks to achieve) and indicators (data that demonstrate progress toward goals) to serve as both an accountability document and a management tool. Revised procedures for monitoring and evaluating agency performance in terms of this framework are being designed with the assistance of the National Child Welfare Resource Center for Organizational Improvement.

In addition, there are multiple systems throughout the agency that support day-to-day operations as well as multiple data collection systems. Since LINK only serves as a child protection case management system, each DCF run facility has developed its own database to provide automated client information and support daily operations.

The Bureau of Behavioral Health and Medicine has various data collection systems. For example, the ASO has a database that tracks the services received by children in the KidCare system of care and produces approximately 200 reports. The reports include such information as: length of time to answer the telephone; list of children residing in a residential facility; hospital discharge delays; and trend analyses. In addition, behavioral health providers submit data that is contained in the Behavioral Health Data System. However, there are concerns over the quality of the data, the quantity of required data elements, and the department's intended purpose for collecting all the information.

Risk Management, Licensure, and the Bureau of Adoption each have standalone access databases for their respective areas. In addition, the Office of the Ombudsmen has an ACT system for tracking complaints and the hotline utilizes ACD Navigator for entering and recording calls. Finally, Juvenile Services bureau has CONDOIT for keeping records on their client population. All of these systems and databases act independently and are not connected under one single technology infrastructure.

Chapter III

DCF External Monitoring and Evaluation Activities

External monitoring and evaluation activities of the Department of Children and Families are carried out by a number of entities -- federal agencies that fund and review various state children's services and programs, such as the Children's Bureau of the U.S. Department of Health and Human Services, state and federal courts, and the state legislature. Certain department facilities and functions are also assessed periodically through independent, national accrediting processes and federal or state regulatory activities. This chapter describes the major external efforts to monitor and evaluate DCF during the past three to five years. Chapter VI contains the results of these efforts.

U.S. Department of Health and Human Services Children's Bureau

The U.S. Department of Health and Human Services Administration for Children and Families has a Children's Bureau that monitors state child welfare services in part to assist Connecticut and other states in achieving positive outcomes for children and families. Figure III-1 on page 69 shows the relationships between the reporting systems, reviews, and annual federal reports described in this section.

Children's Bureau Reporting Systems. There are three federal and state reporting systems administered by the Children's Bureau:

- Adoption and Foster Care Analysis and Reporting System (AFCARS);
- National Child Abuse and Neglect Data System (NCANDS); and
- Statewide Automated Child Welfare Information System (SACWIS).

The Adoption and Foster Care Analysis and Reporting System. AFCARS is a federally mandated system that collects case level information on every child in foster care for whom state child welfare agencies have responsibility for placement, care, or supervision and on every child adopted under the auspices of the state's public child welfare agency. AFCARS also contains information about foster and adoptive parents. Descriptive foster care information, for example, includes:

- number and percent of children entering foster care in the fiscal year who were in care for seven days or less before being discharged from foster care;
- number and percent of children exiting foster care in the fiscal year who were in foster care for seven days or less;
- number of children in foster care on the first and last day of the fiscal year and number of children entering and exiting foster care in the fiscal year;
- placement settings for children in foster care;
- case plan goals for children in foster care;
- number of placement settings in the current foster care episode;

- number of foster care episodes of children in foster care at the end of the fiscal year;
- number and percentage of children in foster care for 17 of the most recent 22 months, calculated from the number of all children in foster care on the last day of the fiscal year;
- median length of stay (in months) in foster care of children in care on the last day of the year; and
- number of children who discharged to each type of permanency goal and the length of stay in foster care (in months) for those children who discharged to each permanency goal.

The AFCARS data are used in a number of federally required child welfare service assessments and reports, discussed later. During each federal fiscal year, states are required to submit adoption and foster care data twice, once for the period October 1 through March 31, and again for the period April 1 through September 30. The AFCARS reporting requirement is over a decade old.

AFCARS Assessment Review. The purpose of the AFCARS assessment review, which is a case file review conducted by the federal Children’s Bureau, is to verify that the electronic data submitted to AFCARS matches the data that is in the state child welfare agency’s paper files. Connecticut’s most recent review occurred in July 2001.

Because adoption records are sealed in Connecticut, only foster care case files were included in the review. (The federal review team did not require Connecticut to unseal the adoption records due to time constraints in scheduling the review.)

The reporting period reviewed in July 2001 covered April 1, 2000 through September 30, 2000. As would happen in any other state, the minimum tasks required to correct deficiencies found in Connecticut’s AFCARS data were included in an AFCARS Improvement Plan. Once DCF makes all of the required changes to the information system, the system will be tested again. The AFCARS Improvement Plan is considered to be completed once the federal government and the state agree that the quality of the data is acceptable. No additional on-site reviews will occur unless DHHS hears of concerns about the quality of Connecticut’s data.

The National Child Abuse and Neglect Data System. NCANDS is a voluntary national data collection and analysis system developed to meet the requirements of the federal Child Abuse Prevention and Treatment Act (CAPTA) (P.L. 93-247) as amended by the Keeping Children and Families Safe Act of 2003. CAPTA directed the DHHS secretary to establish a national data collection and analysis program for available state child abuse and neglect reporting information. The information is gathered once a year, with the first system report based on 1990 data. For FFY 2005, a total of 49 states submitted case-level data to NCANDS. Specifically, CAPTA requires each state to report¹¹:

¹¹ The most recent reauthorization of CAPTA, The Keeping Children and Families Safe Act of 2003, Public Law 108-36, (42-U.S.C. 5106), retained these provisions.

- 1) the number of children who were reported to the state during the year as abused or neglected;
- 2) of the number of children, described in (1), the number for whom such reports were substantiated, unsubstantiated, or determined to be false;
- 3) of the number of children described in (2), the number that did not receive services during the year under the state program funded under this section or an equivalent state program, the number that received services during the year under the state program funded under this section or an equivalent state program, and the number that were removed from their families during the year by disposition of the case;
- 4) the number of families that received preventive services from the state during the year;
- 5) the number of deaths in the state during the year resulting from child abuse or neglect;
- 6) of the number of children described in (5), the number of such children who were in foster care;
- 7) the number of child protective services workers responsible for the intake and screening of reports filed in the previous year;
- 8) the agency response time with respect to the provision of services to families and children where an allegation of abuse or neglect has been made;
- 9) the number of child protective services workers responsible for intake, assessment, and investigation of child abuse and neglect reports relative to the number of reports investigated in the previous year;
- 10) the number of children reunited with their families or receiving family preservation services that, within five years, result in subsequent substantiated reports of child abuse and neglect, including the death of the child; and
- 11) the number of children for whom individuals were appointed by the court to represent the best interests of such children and the average number of out of court contacts between such individuals and children.

NCANDS data are also used in a number of other federal reports, discussed later. In addition, the data are used for an annual report on child maltreatment, which is published each spring, and for the Program Assessment Rating Tool (PART), which is “a systematic method of assessing the performance of program activities across the Federal government”¹²

Additionally, Children’s Bureau programs funded from the CAPTA Basic State Grant use NCANDS data for two program assessment ratings: improve states’ average response time between maltreatment report and investigation; and reduce the percentage of children who are repeat victims of maltreatment within six months. Children’s Bureau programs provided by funds from the Community-Based Child Abuse Prevention (CBCAP) State Grants use NCANDS data for one measurement for their program assessment rating: decrease the rate of first-time victims per 1,000 children.

¹² Office of Management and Budget. Guidance for Completing the Program Assessment Rating Tool (PART). March 2005.

NCANDS data consist of aggregated data and more detailed case-level data. The aggregated data include information on:

- screened investigations;
- maltreatment fatalities not reported in the more detailed child level data;
- CPS staffing;
- provision of preventive services; and
- response time to investigation.

The more detailed, case-level data contains the following categories of information:

- demographic characteristics (e.g., age, gender, race);
- details of the alleged maltreatment incident (e.g., report date, maltreatment type, maltreatment disposition);
- description of services received as related to the maltreatment report (including foster care placement); and
- information regarding the alleged perpetrator (e.g., demographic characteristics, relationship to the victim).

NCANDS also includes the:

- *median* time from receipt of an allegation of child maltreatment to the initiation of an investigation;
- *mean* time from receipt of an allegation of child maltreatment to the initiation of an investigation;
- average time to investigation;
- percent of children in foster care who are the subject of a substantiated or indicated maltreatment where the perpetrator is a parent;
- number of reports alleging maltreatment of children that reached a disposition within the reporting year; the total numbers of reports, and the number of unique children associated with reports alleging maltreatment;
- numbers and percentages of reports that were given a disposition of “Substantiated and Indicated”, “Unsubstantiated”, and “Other”;
- numbers and percentages of child cases opened for services, which is based on the number of victims during the reporting period under review;
- numbers and percentages of children entering foster care in response to a child abuse/neglect report; and
- number of child fatalities.

The Statewide Automated Child Welfare Information System. SACWIS refers to any of a variety of electronic case management systems designed for adoption and foster care social workers to process child protective services and child welfare information on a statewide basis. As a federally supported project, the primary goals of SACWIS are:

- facilitating more efficient child welfare program administration and case management;
- integrating and coordinating other federal programs such as Title IV-A, Title IV-D (child support enforcement, Title XIX (Medicaid), and NCANDS; and
- facilitating the collection and reporting of AFCARS data.

Although information in SACWIS is used to produce AFCARS reports, not all states have fully operational automated information systems. Federal funding may be available to develop a SACWIS, and those states with SACWIS are required to use the system to collect the data required by AFCARS. All but seven states are participating in SACWIS and approximately 30 are fully operational. Connecticut has an operational system called LINK, which is not yet SACWIS-compliant.

The Department of Children and Families and the state's Department of Information Technology (DOIT) have shared responsibility for the LINK system, which became operational more than a decade ago in July 1996. The LINK system replaced the earlier Case Management System (CMS) that had been in use since the early 1980s.

LINK contains several core elements:

- case management, including participant relationships and demographics, contact/collateral demographics and case closure;
- intake, including CPS reports, voluntary services referrals, and investigations;
- legal, including legal actions and court dispositions, and termination of parental rights status;
- placement, including document placements and visitation plans, and bed requests;
- provider management, including arrangement and maintenance of services, training and support for provider families, contracting with providers and provider information, requests and reservations for beds;
- financial management, including processing payments, collections and determination of eligibility;
- reimbursement management, including maintaining budgets and audits;
- common application functions, including internal messaging, office automation, search function, ticklers, and checklists;
- meeting and document management;
- narrative;
- risk assessment;
- education;
- criminal/background checks;
- treatment planning for the family, children in placement, independent living, and adolescent discharge;
- system and policy help functions;

- worker assignments;
- supervisory approvals;
- behavioral health information;
- multi-level appeal process; and
- expungement and archive process.

LINK has four primary functional areas: service management; provider management; financial management; and common application functions.

Service management. This function gives workers and supervisors the tools to better manage service delivery including child protective services reporting, investigations, risk assessment, voluntary services referrals, case maintenance, and case closing. The management of legal actions, placement, case participant information, medical information and adoption are also included within service management.

Provider management. This function has tools to manage service providers, licensing, contract, and foster homes. Support of the licensing and certification processes, and documentation of home providers is included within provider management.

Financial management. This function contains the business aspects of the department including the processing of payments and voucher requests. The function also supports the “Random Moment Time Study” (RMTS), which documents and gathers costs associated with administering and operating child welfare programs. The information gives the department information about the amount of effort workers spend on various activities associated with child welfare case maintenance. The RMTS study includes observing employees activities on an individual basis during random time intervals.

Common application functions. These functions are required by more than one of the LINK subsystems and cover areas such as person management, worker assignment, approvals, checklists, ticklers, and security. LINK system help is also contained within the common application functions.

Additionally, LINK enables DCF to produce key management reports, including the number of children in different types of placement at a particular point in time, caseload trends, and performance statistics that are submitted to the *Juan F.* court monitor.

The LINK system does not include information about participants in programs of the Bureaus of Behavioral Health and Medicine as well as Juvenile Services, unless the participants are dually committed. (i.e., children involved both with Child Protective Services or Child Welfare Services as well as Behavioral Health and Medicine and/or Juvenile Services.)

SACWIS Assessment Review (SAR). The federal Children’s Bureau conducts an assessment of how well a state’s SACWIS is functioning approximately one year after it becomes operational. This assessment review includes a one-week, on-site review. Approximately six weeks prior to the review, states provide the Children’s Bureau with

background information through completion of a SACWIS Assessment Review Guide. The on-site review includes a system walk-through and interviews with users of the system.

Following the SAR site-visit, a detailed exception report is generated that gives the state a comprehensive description of the review team's findings. Only after the state has either modified its version of SACWIS, or developed an acceptable corrective action plan, is the review process considered finalized.

The first SAR for Connecticut occurred in 1998, and the most recent occurred in September 2006, with the purpose to evaluate progress toward completing the LINK system (the Connecticut version of SACWIS). As part of the visit, the team assessed areas covered in the Connecticut SACWIS Assessment Review Report (SARR). Specifically, the monitoring visit was intended to:

- assess the progress of Connecticut in addressing issues that remained open in the SACWIS Assessment Review Report (SARR);
- verify continued executive sponsorship, project leadership, and project funding; and
- observe use and efficiency of LINK by interviewing some of the system users.

Federal monitoring systems. In addition to the reporting systems just described, the federal government also has two monitoring systems: 1) Child and Family Services Reviews; and 2) Title IV-E Foster Care Eligibility Review. DHHS is also required to annually report to Congress on child welfare outcomes based on national standards.

Child and Family Services Reviews. The CFSR is a results-oriented, comprehensive monitoring system that was first implemented in fiscal year 2001. DHHS developed this review to fulfill a mandate in the Social Security Amendments of 1994 (see section 1123A of the Social Security Act) to promulgate regulations for reviews of state child and family services programs that operate under Titles IV-B and IV-E of the Social Security Act.

The Child and Family Services Reviews assess state performance in the areas of safety, permanency, and child and family well-being. Performance is compared against national standards developed from state adoption/foster care data (AFCARS) and abuse and neglect data (NCANDS). The Child and Family Services Reviews also assess seven systemic factors that affect the agency's ability to achieve the national standards.

The CFSRs are based on six central principles and concepts:

- 1) collaborative effort between the state and the federal government;
- 2) use of multiple sources to assess state performance;
- 3) covers outcomes and systemic factors;
- 4) addresses both strengths and needs;
- 5) promotes best practice principles; and
- 6) emphasizes accountability through potential for financial penalties.

CFSR Statewide Assessment. The CFSR process occurs in two phases. The first phase is the statewide assessment, during which the state analyzes its child welfare data and practice. It involves external partners or stakeholders and the Children’s Bureau staff. The process is guided by completion of the Statewide Assessment Instrument. The Statewide Assessment Instrument has five sections:

- general information about the department (i.e., DCF);
- narrative assessment of seven outcome areas;
- data profiles for the outcome areas related to safety and permanency;
- department characteristics and narrative responses for each of the seven operational system factors; and
- department assessment of its strengths and challenges, as well as the identification of issues and geographic locations requiring further examination during the onsite review.

Data to complete the Statewide Assessment Instrument come from information from state adoption/foster care data (AFCARS) and state abuse and neglect data (NCANDS).

The CFSR Statewide Assessment information is used to:

- guide site selection by the Children’s Bureau and the state for the onsite review;
- provide an overview of the state child welfare agency’s organization, capacity, and performance for the Onsite Review Team;
- facilitate identification of issues that need additional clarification before or during the onsite review;
- serve as a key source of information for rating the CFSR systemic factors;
- provide context for the outcome ratings;
- enable states and their stakeholders to identify early in the CFSR process the areas potentially needing improvement and to begin developing their PIP approach;
- inform the Child and Family Services Plan and the Annual Progress and Services Report (APSR) processes;
- educate stakeholders about state strengths and needs and enlist their support in developing and making program improvements;
- inform stakeholders and the public about the improvements/progress the state has made since the previous Statewide Assessment; and
- openly share with stakeholders and the public the areas that the state child welfare agency has identified as continuing to need improvement.

CFSR On-Site Reviews. After the CFSR Statewide Assessment, the second phase of the CFSR is an on-site review, during which federal and state teams examine outcomes for children and families by assessing child welfare practices, and assessing systemic issues through stakeholder interviews.

The CFSR On-Site Review includes: 1) a random review of foster care and in-home case records; 2) interviews with children and families receiving services; and 3) interviews with community stakeholders (e.g., courts, community agencies, foster families, caseworkers, service providers). The purpose of the on-site review is to evaluate progress in achieving the qualitative CFSR outcomes. The site visit lasts for one week.

The CFSR on-site review is conducted by a team of federal and state representatives (including external partners). Connecticut's team included court personnel, youth, parents, and staff from provider agencies. Members may serve as reviewers of case records or assist in the development of a possible subsequent Program Improvement Plan.

CFSR Outcomes. There are seven CFSR outcomes used to assess state performance, covering the areas of safety, permanency, and child and family well-being. (Two of the seven CFSR outcomes (Safety Outcome #1 and Permanency Outcome #1) are derived from aggregated AFCARS and NCANDS data, and have national standards associated with them.) The seven CFSR outcomes are:

- 1) Children are, first and foremost, protected from abuse and neglect (Safety Outcome 1);
- 2) Children are safely maintained in their homes whenever possible and appropriate (Safety Outcome 2);
- 3) Children have permanency and stability in their living situations (Permanency Outcome 1);
- 4) The continuity of family relationships and connections is preserved for children (Permanency Outcome 2);
- 5) Families have enhanced capacity to provide for their children's needs (Well-Being Outcome 1);
- 6) Children receive appropriate services to meet their educational needs (Well-Being Outcome 2); and
- 7) Children receive adequate services to meet their physical and mental health needs (Well-Being Outcome 3).

In addition to these seven CFSR outcomes, there are seven operational, systemic factors identified that may affect an agency's ability to achieve the outcomes. The seven systemic factors examined are:

- 1) Statewide Information System;
- 2) Case Review System;
- 3) Quality Assurance System;
- 4) Training;
- 5) Service Array;
- 6) Agency Responsiveness to the Community; and
- 7) Foster and Adoptive Parent Licensing, Recruitment, and Retention.

States are rated on a scale from 1 to 4 for each of these systemic factors, with criteria for rating each factor found in the CFSR Procedures Manual. Ratings of "3" or "4" indicate "substantial conformity" and ratings of "1" or "2" indicate "not in substantial conformity" with

the factor. The assessment on these seven systemic factors is based on ratings on 22 indicators. The state is rated on each indicator as having either a “strength” or an “area needing improvement.” According to the Children’s Bureau website, states are rated on:

- the extent to which they have met these seven requirements through systems, policies, procedures, or training;
- how these systems are operating in day-to-day practice in the field, as demonstrated through data or stakeholder input; and
- the effectiveness of the state with regard to the systemic factors in achieving positive outcomes for children and families.

National standards. The first round of CFSR reviews of every state, the District of Columbia, and Puerto Rico was conducted between FY 2001 and FY 2004. The national standards for the first round of state reviews were based on relative, rather than absolute, performance across states for each of the six CFSR data measures related to safety and permanency goals. The standard was set at the 75th percentile based on state NCANDS and AFCARS data from earlier reporting periods (see Table III-1 CFSR Round One column for those national standards).

The second round of reviews is scheduled to occur between FFY 2007 and FFY 2010. The national standards for the second round are higher than those for the first round, and are based on 2004 state performance levels. Connecticut is scheduled for its second review in FFY 2008, on September 22-26, 2008.

In regard to all states, the Children’s Bureau reported¹³ that:

- of the seven outcomes measured by the state child and family services reviews, Well-Being Outcome 2 (“children receive services to meet their educational needs”) was met by the highest number of states (16). No states achieved substantial conformity to Well-Being Outcome 1 (“families have enhanced capacity to provide for children’s needs”) or to Permanency Outcome 1 (“children have permanency and stability in their living situations”); and
- states performed better on systemic factors, with more than half of the states showing substantial conformity with each of five of the seven factors: (1) Training, (2) Quality Assurance, (3) Statewide Information Systems, (4) Agency Responsiveness to the Community, and (5) Foster and Adoptive Parent Licensing, Recruitment, and Retention.

Child Welfare Outcomes Annual Report to Congress. The DHHS is required by federal law to produce an annual Report to Congress on child welfare outcomes. (The DHHS is behind in producing these reports; as of October 25, 2007, the 2004 report information still had not been published). These reports provide information about state performance on the seven national

¹³ Children’s Bureau Express, October 2004.

child welfare outcomes as well as population characteristics to provide a context for the information. The population characteristics include:

- number and race/ethnicity of children in the state's population (from U.S. Census Bureau, Current Population Survey);
- number and characteristics (age, race/ethnicity, and type of maltreatment) of child maltreatment victims;
- number and characteristics of children in foster care at the start of the fiscal year and of children who entered and exited foster care during the fiscal year;
- median length of stay of children in foster care;
- number and characteristics of children "waiting for adoption"; and
- number and characteristics of children for whom an adoption was finalized during the fiscal year.

While both the Report to Congress and CFSR contain information on the national child welfare outcomes, CFSR is considered more of a monitoring system, providing more comprehensive information about state performance. The Report to Congress is limited to automated data contained in AFCARS and NCANDS.

Both the Report to Congress and CFSR, however, share similar goals of informing Congress, DHHS, the states, and the public about performance in achieving desired outcomes for children in the public child welfare systems, and identifying areas needing improvement. The DHHS, therefore, connected the Report to Congress and CFSR by establishing national performance standards for six of the measures contained in the Report to Congress:

- 1) recurrence of maltreatment;
- 2) incidence of child abuse and/or neglect in foster care;
- 3) foster care re-entries;
- 4) stability of foster care placements;
- 5) length of time to achieve reunification; and
- 6) length of time to achieve adoption.

These national performance standards have been modified somewhat, and the changes to the CFSR highlight the differences.

Changes to CFSR. Following the first round of CFSR reviews, DHHS contracted with a consultant to study the process and make recommendations. One adopted recommendation describes all data performance measures from a positive perspective. Another adopted recommendation replaced the six existing CFSR single data measures (used to set national standards) with four data composites and two single measures. The composite scores were scaled from 50 to 150, with higher scores indicating better performance.

The composite scores combine related measures of permanency already contained in AFCARS, and have the following advantages:

- provide a more effective assessment of state performance because combined, weighted measures are more reliable and valid than the individual measures on which the composite is based;
- provide a more holistic view of state performance in a particular domain than a single data measure can achieve;
- ensure that the data component of a state's performance with regard to a particular domain will not depend on one measure; and
- promote consistency in approach, as data composites are being used by the federal government to assess other programs.

In order to be considered in substantial compliance during the first round of CFSR, states were required to substantially achieve the outcome standard in 90 percent of reviewed cases. For the second round, the percent that must substantially achieve the outcome increased to 95 percent.

Table III-1 shows the changes in the two national child welfare standards and outcomes that occurred between round one and round two. Note that the two national standards are based on state performance in FY 2003 and FY 2004.

Title IV-E Foster Care Eligibility Review. Federally, the Foster Care Program was authorized in 1980 under Title IV-E of the Social Security Act, with the intent of assuring proper care for children requiring placement outside their homes, in a foster family home or institution. The Foster Care Program provides funds to states to help them with foster care maintenance for eligible children, administrative costs, training for staff, foster parents, and staff of child care institutions providing foster care services. In SFY 2007, Connecticut received \$106 million for reimbursement for foster care and adoption expenses.

A child is eligible for this financial benefit based on a federal requirement that the child was removed from a family that qualified for, or would have qualified for, cash assistance. The Title IV-E Foster Care Eligibility Reviews also determine whether the state had a valid basis for ensuring that appropriate payments were made on behalf of eligible children, homes and institutions, as specified in regulations to the Social Security Act (45 CFR §1356.71 and §472).

As with the Child and Family Services Reviews, the Title IV-E Foster Care Eligibility Review team consists of federal and state representatives. A minimum size sample of 80 cases is randomly drawn from a state's AFCARS data submission. Using the Title IV-E Onsite Review Instrument, the cases are examined for specific federal eligibility requirements, such as:

- a court order confirming the need to remove the child from the home;
- a court order confirming the state agency's reasonable efforts to preserve the family, when it is safe to do so, and to finalize a permanency plan;
- completed criminal background checks on foster and adoptive parents;
- licensed foster care providers;
- an income test to confirm the child's eligibility; and
- state responsibility for placement and care of the child.

Table III-1. Changes to National Child Welfare Standards and Outcome Measures	
CFSR Round One (Performance Measure-- national standard)	CFSR Round Two (Performance Measure-- national standard)
National Child Welfare Outcome: Children are, first and foremost, protected from abuse and neglect (CFSR Safety Outcome 1)	
<p>Performance Measure 1: Repeat maltreatment—Of all children who were victims of substantiated or indicated child abuse and/or neglect during the first 6 months of the reporting period, 6.1 percent or less had another substantiated or indicated report within a 6-month period.</p> <p>Performance Measure 2: Maltreatment of children in foster care—Of all children who were in foster care during the reporting period, 0.57 percent or less were the subject of substantiated or indicated maltreatment by a foster parent or facility staff member.</p>	<p>Performance Measure 1: Recurrence of maltreatment—Of all children who were victims of a substantiated or indicated maltreatment allegation during the first 6 months FY 2004, 95.2 percent or more were not victims of another substantiated or indicated maltreatment allegation during a 6-month period.</p> <p>Performance Measure 2: Maltreatment of children in foster care—Of all children in foster care in FY 2004, 99.67 percent or more were not victims of a substantiated or indicated maltreatment by a foster parent or facility staff members.</p>
National Child Welfare Outcome: Children have permanency and stability in their living situations (Permanency Outcome 1)	
<p>Performance Measure 1: Timeliness of reunification—Of all children who were reunified with their parents or caretakers at the time of discharge from foster care, 76.2 percent or more were reunified in less than 12 months from the time of the latest removal from home.</p> <p>Performance Measure 2: Re-entry into foster care—Of all children who entered foster care during the reporting period, 8.6 percent or less were re-entering foster care in less than 12 months of a prior foster care episode.</p> <p>Performance Measure 3: Timeliness of adoption—Of all children who</p>	<p>(Four Composite Measures)</p> <p>Composite 1: Timeliness and Permanency of Reunification Composite incorporating two components and four measures (National Standard for this composite score: 106.7 or higher).</p> <p><u>Component A:</u> Timeliness of reunification (has 3 measures)</p> <ol style="list-style-type: none"> 1. Of all the children discharged from foster care to reunification in FY 2004 who had been in foster care for 8 days or longer, what percent were reunified in less than 12 months from the time of the latest removal from home? 2. Of all the children discharged from foster care to reunification in FY 2004 who had been in foster care for 8 days or longer, what was the median length of stay from the time of the most recent entry into foster care until discharge to reunification (in months)? 3. Of all children entering foster care for the first time in the first 6 months of FY 2004 who had remained in foster care for

<p><i>exited foster care to a finalized adoption, 32 percent or more exited foster care in less than 24 months from the time of the latest removal from home.</i></p> <p>Performance Measure 4: Placement stability—<i>Of all children who have been in foster care for less than 12 months from the time of the latest removal from home, 86.7 percent or more have had no more than two placement settings.</i></p>	<p><i>8 days or longer, what percent were discharged from foster care to reunification in less than 12 months of the time of entry into foster care?</i></p> <p><u>Component B</u>: Permanency of reunification (has 1 measure)</p> <p><i>1. Of all children discharged from foster care to reunification in FY 2003, what percent re-entered foster care in less than 12 months?</i></p> <p>Composite 2: Timeliness of Adoptions Composite incorporating three components and five measures (National Standard for this composite score: 102.1 or higher)</p> <p><u>Component A</u>: Timeliness of adoptions of children discharged from foster care (has 2 measures)</p> <p><i>1. Of all children who were discharged from foster care to a finalized adoption in FY 2004, what percent were discharged in less than 24 months from the time of the latest removal from the home?</i></p> <p><i>2. Of all children who were discharged from foster care to a finalized adoption in FY 2004, what was the median length of stay in foster care (in months) from the time of removal from the home to the time of discharge from foster care?</i></p> <p><u>Component B</u>: Progress Toward Adoption for Children Who Meet ASFA Time-In-Care Requirements (has 2 measures)</p> <p><i>1. Of all children in foster care on the first day of FY 2004 who were in foster care for 17 continuous months or longer, what percent were adopted before the end of the fiscal year?</i></p> <p><i>2. Of all children in foster care on the first day of FY 2004 who were in foster care for 17 continuous months or longer, what percent became legally free for adoption (i.e., a TPR was granted for each living parent) within 6 months of the beginning of the fiscal year?</i></p> <p><u>Component C</u>: Progress Toward Adoption of Children Who Are Legally Free for Adoption (has 1 measure)</p> <p><i>1. Of all children who became legally free for adoption during FY 2004, what percent were discharged from foster care to a finalized adoption in less than 12 months?</i></p> <p>Composite 3: Achieving Permanency for Children in Foster Care Composite incorporating two components and three measures (National Standard for this composite score: 105.2 or higher)</p>
--	---

	<p>Component A: Achieving Permanency for Children in Foster Care for Extended Periods of Time (has 2 measures)</p> <ol style="list-style-type: none"> 1. <i>Of all children who were discharged from foster care and were legally free for adoption (i.e., there was a TPR for each living parent), what percent exited to a permanent home defined as adoption, guardianship, or reunification prior to their 18th birthday?</i> 2. <i>Of all children in foster care for 24 months or longer at the start of the fiscal year, what percent were discharged to permanency in less than 12 months and prior to their 18th birthday?</i> <p>Component B: Children Emancipated Who Were in Foster Care for Extended Periods of Time (has 1 measure)</p> <ol style="list-style-type: none"> 1. <i>Of all children who exited foster care with a discharge reason of emancipation or who reached their 18th birthday while in foster care, what percent were in foster care for 3 years or longer?</i> <p>Composite 4: Placement Stability Composite incorporating three measures (National Standard for this composite score: 108.2 or higher)</p> <ol style="list-style-type: none"> 1. <i>Of all children in foster care for 8 days or longer and less than 12 months, what percent had two or fewer placement settings?</i> 2. <i>Of all children in foster care for at least 12 months but less than 24 months, what percent had two or fewer placement settings?</i> 3. <i>Of all children in foster care for at least 24 months, what percent had two or fewer placement settings?</i>
<p>Source: Federal Register: June 7, 2006 (Volume 71, Number 109), pages 32969-32987.</p>	

Federally-Required Child Abuse Prevention and Treatment Plan

CAPTA State Plan. Another source of external monitoring involving the federal government is the five-year Child Abuse Prevention and Treatment Act (CAPTA) State Plan DCF is required to submit to DHHS. This plan is integrated by DCF with other required federal plans, i.e., the Child and Family Services Plan, which any state receiving federal child welfare funds must file and have approved, and the Independent Living Plan, related to adolescents in foster care.

Under CAPTA, nine potential areas through which a state's child protective services system may be improved are identified. In its last two CAPTA plans, covering 1995-2004, DCF focused on implementing four of those areas:

- 1) creating and improving the use of multidisciplinary teams and interagency protocols to enhance investigations;
- 2) developing, strengthening, and supporting child abuse and neglect prevention, treatment, and research programs in the public and private sectors;
- 3) developing, strengthening, and facilitating training opportunities and requirements for individuals overseeing and providing service to children and families through the child protective services system; and
- 4) developing, implementing, or operating information and education programs or training programs designed to improve the provision of services to disabled infants (“children with medically complex conditions”) with life threatening conditions for professionals, parents and caretakers.

For its current CAPTA plan for 2005-2009, DCF chose to focus on three of the four areas, dropping the training opportunities area of focus due to funding limitations.

Annual Progress and Services Report. State child welfare agencies are required to submit annual progress and services reports (APSRs) to DHHS for programs and efforts that receive CAPTA and other funds (i.e., Title IV-B (foster care), Chafee Foster Care Independence (CFCIP) and Education and Training Voucher (ETV) programs). Each annual progress and services report requires documentation of progress made since the last progress report, including efforts related to the Child and Family Services Reviews Program Improvement Plans.

Examples of programs/activities funded by CAPTA in 2007-2008 include:

- family-based recovery program – Waterbury;
- medically fragile foster care program;
- multidisciplinary teams in various locations including Child Guidance Clinic of Southern CT, Middletown Police Benevolent Association, and Charlotte Hungerford Hospital of Waterbury;
- domestic violence initiative;
- citizen review panel support;
- prevention activities including Family Day and public awareness/education on Healthy Early Childhood Topics; and
- statewide training on working with parents with cognitive limitations.

Examples of programs/activities funded by Chafee Foster Care Independent Living Services (for youth in secondary programs) in 2007-2008 include:

- Indian Child Welfare Act coordination of programs with the Mashantucket Pequot and Mohegan Tribes to ensure benefits and services are made available to the Indian youth in Connecticut;
- volunteer mentor program;
- aftercare to support transition to community life; and
- driver education.

Examples of programs/activities funded by the Education and Training Voucher (ETV) (for youth in post-secondary programs) in 2007-2008 include:

- group homes (Preparing Adolescents for Self-Sufficiency (PASS) Group Homes);
- Wilderness School;
- Life Skills Program; and
- employment and training (workforce development).

The following must be included for each of the programs in the Annual Progress and Services Report:

- specific accomplishments and progress achieved to date;
- steps the state agency will take to expand and strengthen the range of existing services and develop and implement services to improve child outcomes;
- explanation of revisions to existing goals and objectives;
- update of goals and objectives to incorporate areas needing improvement that were identified in a CFSR, Title IV-E, AFCARS, or other improvement plan;
- description of services to be provided, highlighting any changes or additions in services or program design and how the services will achieve program purposes; and
- population(s) served.

Other aspects described include collaboration, program support, tribal consultation, monthly caseworker visit data, state plan requirements, and financial and statistical information reporting.

The Annual Progress and Services Report is reviewed by DHHS, and the department responds to any clarifying questions. Examples of recent clarifications required by DCF were to:

- provide more information on how the department is reaching out to collaborate with the courts;
- include information regarding the cost allocation of training expenses in the training plan;
- clarify the information provided on caseworker visits with the child and match with new federal requirements;
- break out the number of new and ongoing Education and Training Vouchers by year; and
- provide the actual amount of FFY 2005 Chaffee funds used to pay for room and board for 18-21 year olds.

DCF Federal Grant Funding

Children’s Bureau Funded Specific Programs. Another source of external monitoring are the requirements of specific DHHS Children’s Bureau federal grants to submit progress and data on a quarterly/annual/periodic basis. One DCF program funded by a grant from the Children’s Bureau under the Adoption Opportunities category is the “Helping to Achieve Permanent Placements for Youth (HAPPY) Program.” As with other grants funded by the Children’s Bureau, DCF is required to submit progress reports every six months to the Children’s Bureau.

SAMHSA Funded Programs and Block Grants. The Substance Abuse and Mental Health Services Administration, also part of the U.S. Department of Health and Human Services, funds four DCF programs in part or fully by SAMHSA. They are:

Building Blocks for Bright Beginnings (Willimantic);
Partnership for Kids Project – PARK (Bridgeport);
State Adolescent Substance Abuse Treatment Coordination; and
Hartford Youth Project.

There are annual reporting requirements for each of these SAMHSA grants that include plans and accomplishments. Additionally, progress reports and fiscal reports are due every six months. The progress reports require an update on project goals, barriers, and evaluation efforts. SAMHSA site visits occur every two years. As an example, a description of the Building Blocks for Bright Beginnings grant and its monitoring requirements is provided.

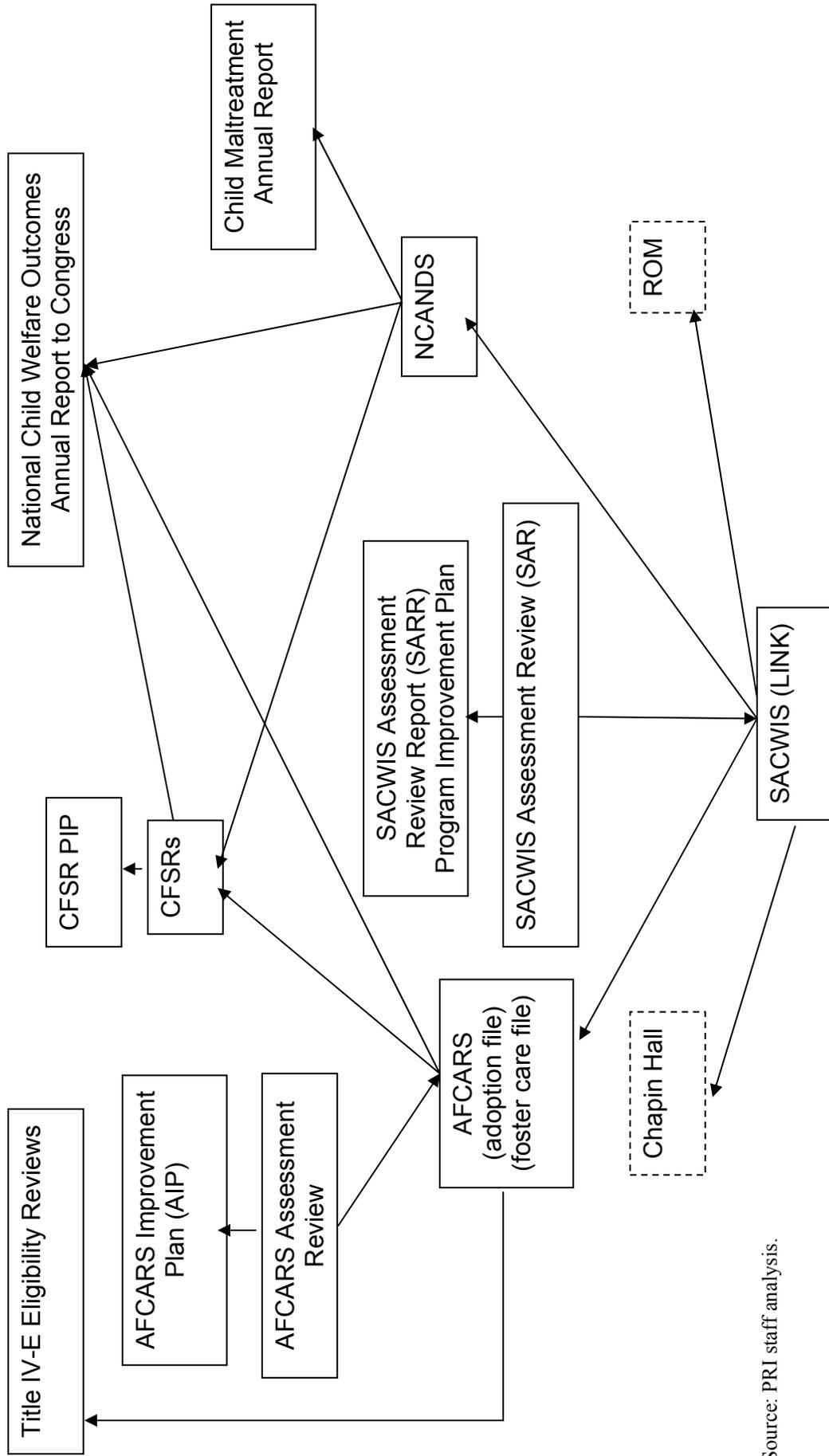
Building Blocks for Bright Beginnings. The Building Blocks for Bright Beginnings SAMHSA grant is entering its third year of funding and progress is evaluated by the Yale Consultation Center. The Building Blocks program was established in cooperation with DCF and the Southeast Mental Health System of Care in partnership with Families United for Children’s Mental Health.

The purpose of the grant is to enhance the existing coordinated network of mental health and human service providers, community members, and families by providing comprehensive mental health and other services for children birth through five with social emotional challenges and their families from Southeast Connecticut, supported by evidence-based practices. Building Blocks is also expected to expand the existing system of care in an effort to increase the capacity and expertise around early childhood mental health with science-based information on screening, assessment, referral, and early intervention.

SAMHSA provides program funding through the Community Mental Health Services Block Grant Program. This funding has the goal of improving mental health services through the support of existing public services and encourages the development of community-based care for individuals with serious mental disorders. The funding supports grassroots initiatives that are creative and cost-effective.

Progress reports and fiscal reports are required every six months, and reapplication for

Figure III-1. Federally Required Reviews, Reports and Automated Systems



Source: PRI staff analysis.

the award occurs every March. Additionally, Building Blocks team members are required to attend two national meetings/conferences per year, and site visits occur every two years.

Mental Health Block Grant. Additionally, there is the Mental Health Block Grant from SAMHSA to DMHAS. Approximately \$1.3 million of the block grant goes to DCF to supplement respite, FAVOR training, suicide prevention, and maintenance and expansion of the mental health system of care.

There are data reporting requirements for the Mental Health Block Grant, including an annual Youth Services Survey for Families. This 10-15 minute telephone survey conducted by the University of Connecticut Department of Public Policy is given to caregivers of children who have received services from the behavioral health system. The survey collects information in the following seven areas: cultural sensitivity; access to care; participation in treatment planning; outcomes; functioning; social connectedness; and general satisfaction.

Juvenile Justice Grant Programs. Several DCF programs are funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) within the U.S. Department of Justice Office of Justice Programs. Funding for the programs comes from the Juvenile Accountability Block Grants (JABG), which are administered by the State Relations and Assistance Division of OJJDP. The goal of the JABG program is to reduce juvenile offending through the use of accountability-based programs that focus on both the offender and the juvenile justice system. Connecticut's JABG grant focuses on programs that have the goal of reducing drug-related and violent crime, and also improving the functioning of the criminal justice system.

Judicial Oversight

The state Judicial Branch, through its various child protection and juvenile delinquency responsibilities, has a broad role in overseeing children in the care and custody of the Department of Children and Families. The federal courts also have been given a direct role in monitoring and evaluating various aspects of DCF performance under agreements resulting from settlements of class action lawsuits brought against the state concerning children's services.

Three recent federal class action lawsuits that have influenced the department and the services it provides are: *Juan F.*, *Emily J.*, and *W.R.*¹⁴ Federal court monitoring efforts related to each are discussed below.

Juan F.

The federal class action lawsuit filed in 1989 on behalf of nine children in DCF care, including a 10-year boy named Juan F., has had a major impact on DCF policies, programs, and resources. Settlement of the lawsuit was reached by the parties and approved by the federal district court for Connecticut in January 1991.¹⁵ It resulted in a 120-page consent decree and an accompanying set of 12 policy manuals. Together, these documents contained approximately

¹⁴ Citations for these three U.S. District Court (District of Connecticut) cases are: *Juan F. v. O'Neill* (now Rell), Civ. No-H-89-859 (D. Conn., Dec. 19, 1989); *Emily J. v. Weicker* (now Rell), 3:93CV1944 (D. Conn., Oct. 25, 1993); and *W.R. v. Connecticut Department of Children and Families*, 3:02-CV-00429 (D. Conn., Mar. 8, 2002).

¹⁵ The parties are the attorneys for the plaintiffs, currently Children's Rights, Inc. of New York, and DCF as defendant (technically the governor is named as defendant in the lawsuit and consent decree documents).

1,200 mandates for the agency to meet in order to be found in compliance and to end court supervision.

The majority of the original consent decree provisions were process-oriented requirements related to key agency functions carried out for the *Juan F.* population of children, such as intake, treatment, health management, family training and support, staff training, contracting, and quality assurance. The *Juan F.* class includes: a) all children in the care, custody, or supervision of DCF as a result of being abused, neglected, or abandoned or being found at risk of such maltreatment; and b) all children about whom the department should know are or will be abused, neglected, or abandoned, or are or will be at serious risk of such maltreatment.

The focus of the *Juan F.* consent decree and related compliance monitoring, therefore, is on children and families involved in DCF's protective services system and the programs and child welfare services they need (i.e., investigations and assessment, case management, family preservation and support, foster care, and adoption, as well as related therapy and behavioral health treatment, medical care, and education). Requirements of the *Juan F.* settlement do not apply to children committed to DCF solely for delinquency reasons, or children and families receiving services voluntarily from the agency.

Monitoring history. At first, agency compliance with the *Juan F.* consent decree was monitored by the same three-judge panel that mediated the settlement. In December 1992, an independent, full-time court monitor was appointed to replace the mediation panel as overseer of consent decree implementation.

The *Juan F.* court monitor, who reports directly to the trial judge, must "... work actively with the parties to ensure timely and effective compliance of the provisions of the Consent Decree...."¹⁶ Major responsibilities include: submitting periodic compliance reports to the court and the parties, hearing requests from the parties for modifications of the settlement agreement, and trying to resolve disputes without the need for court intervention. Under the court monitoring order and its subsequent revisions, the *Juan F.* monitor must have timely access to DCF data, documents, staff, and other information, and may retain staff and consultants necessary to perform all duties required under the consent decree.

Between 1995 and 2001, a number of revisions to both the consent decree content and the monitoring process were negotiated. By 1999, the monitor and the parties began discussions concerning an exit plan that would: a) shift the focus of consent decree compliance from procedural requirements to positive outcomes for children and families; and b) lead to termination of court oversight of DCF. In February 2002, the court approved a transition and exit plan that contained an 18-month time frame and 38 areas, including 28 outcomes with specific performance standards, for measuring agency compliance with the provisions of the *Juan F.* consent decree.¹⁷

A year later, the court found noncompliance in fundamental exit plan areas of caseload reduction and staffing improvements and only modest progress in improving other performance outcomes. The court monitor was ordered by the trial judge in October 2003 to prepare a revised

¹⁶ Civil No. H-89-859 (AHN) Monitoring Order (#166) dated December 1, 1992.

¹⁷ Performance and Outcome Measures, Transition, and Exit Plan Order (#413) dated February 19, 2002.

exit plan.¹⁸ The order also established a three-member task force, comprising the *Juan F.* court monitor, the secretary of the state Office of Policy and Management, and the DCF commissioner, which was given management authority over the entire department.

Initially, the parties identified over 100 possible goals and measures for a new exit plan process. Over about a nine month period, through discussions conducted under the direction of the court monitor, the parties reached agreement on 22 required areas of compliance, as well as definitions of outcomes and methods for measuring them. A group of experts (e.g., judges, child welfare professionals, and foster parents) assembled by the court monitor served as an advisory group during this process.

As with all court monitoring matters, final approval over the plan's outcome measures and methodologies, which are described in more detail below, rested with the monitor and, ultimately, the trial judge. A revised exit plan containing the 22 outcome measures currently used for determining *Juan F.* compliance was drafted by the court monitor in December 2003 and approved by the court in July 2004.¹⁹ Table III-2 lists each measure with its full definition.

The revised *Juan F.* exit plan measures are aimed at improving child welfare practice and the quality of department decision making to ensure better outcomes for children. Many parallel the federal Child and Family Services Reviews and related child welfare outcome goals used to assess state child protection agencies, discussed earlier in the chapter. They were intentionally selected by the parties and the court to promote consistency among the dual monitoring efforts and avoid duplicative reporting.

In response to the revised exit plan, DCF prepared an agency action plan called Positive Outcomes for Children (POC) that was finalized in May 2004.²⁰ The POC plan identified: the key steps DCF needed to take to reach the goal set for each of the 22 outcome measures; the agency staff person responsible for coordinating implementation of each step; and the expected time frame for implementation.

In October 2005, a revised monitoring order for the *Juan F.* consent decree was approved, which incorporated the appointment of a new court monitor and formation of an expert Technical Advisory Committee (TAC) to assist the monitor's office.²¹ About the same time, the plaintiffs, asserting noncompliance with the July 2004 plan, initiated negotiations through the new court monitor concerning what they considered to be the two fundamental indicators of how well children and families are being served by DCF -- effective treatment planning and meeting service needs.

Based on the parties' discussions, with advice from the TAC and the court monitor, changes to the exit plan case review methodology were proposed to assess better agency compliance with the *Juan F.* goals related to treatment plans and needs met (Outcome Measures 3 and 15). A modification of the exit plan containing a new methodology for reporting on these two measures was approved by the court in July 2006.²² The department and the court monitor

¹⁸ Civil No. H-89-859 (AHN) Stipulation Order (#447) dated October 7, 2003.

¹⁹ *Juan F. v. Rell* Revised Exit Plan, July 1, 2004.

²⁰ Department of Children and Families, *Positive Outcomes for Children Plan*, May 2004.

²¹ Civil No. H-89-859 (AHN), Revised Monitoring Order, dated October 12, 2005.

²² *Juan F. v. Rell* Revised Exit Plan modified as of July 1, 2006.

Table III-2. Summary of Juan F. Consent Decree Exit Plan Outcome Measures

No.	Measure	Description
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	ReEntry 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	<u>All</u> 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)	<u>All</u> 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.

Source: DCF Positive Outcomes for Children (Exit Plan), Summary of Outcomes 1-22.

first implemented the revised case review method for the exit plan quarterly report for the third quarter (July 1 - September 30, 2006) results.

The 2006 revised *Juan F.* Exit Plan also reflects an agreement reached by the parties concerning: 1) a department action plan to address key components of case practice related to meeting children's needs (Outcome Measure 15); and 2) new monthly reporting of point-in-time and longitudinal data on placement and permanency issues. On March 12, 2007, the department submitted the required plan for improving Outcome Measure 15 performance, with action steps, strategies, and implementation time frames.

The department's first monthly "point-in-time" report was issued on March 21, 2007. It covered all *Juan F.* children in out-of-home placement as of that date (almost 3,400) and included a number of statistics on their characteristics (e.g., age when they entered and when they exited care, or permanency goal) and their permanency status (e.g., legally free, termination of parental rights not filed and why, in care for more than 15 months, no permanency goal after 2, 6, or 15 months in care). As required, the April 2007 monthly report contained a variety of new information on foster family recruitment and retention, such as data on inquiries made, applications filed, licenses issued and revoked, and children on waiting lists.

Under the revised exit plan, sustained compliance -- defined as compliance for at least two consecutive quarters (a six-month period) -- with all 22 outcome measures is required before the court will consider asserting the state to be in compliance. In addition, total compliance must be maintained throughout the decision making process concerning termination of court jurisdiction over DCF. The court monitor must present findings and recommendations about ending supervision to the federal district court, based on a review of a statistically significant sample of case files and other necessary measurements. The parties must have an opportunity to be heard by the monitor before those findings and recommendations are presented.

Court monitor activities. The main activities carried out by the Court Monitor's Office to track DCF compliance with the *Juan F.* consent decree include:

- data analysis and reporting on the 22 exit plan outcome measures on a quarterly basis;
- conducting and reporting on targeted, comprehensive case reviews performed jointly with DCF Internal Quality Improvement Division staff;
- monitoring and intervention concerning specific problem areas; and
- regular and special meetings with various stakeholders, such as DCF staff, attorneys for the parties, families and youth, foster and adoptive parents, private providers, community advocates, and legislators.

Additional monitoring procedures for the March 2007 *Juan F.* Action Plan were developed recently by the court monitor with the assistance of the TAC. They were finalized after review by the parties in June 2007. The new process incorporates provisions for: analysis and presentation of data extracted from the new monthly reports; monitoring implementation of the strategies and initiatives contained in the plan; and targeted case reviews of specific issues related to certain populations of children, for example, those age 12 and under who are living in congregate care, or children with long-term foster care as their permanency goal.

Data analysis. An appendix to the department's May 2004 Positive Outcomes for Children corrective action plan specifies the sources and methods for collecting data related to the 22 *Juan F.* exit plan outcome measures. Approval by the court monitor is required before the department can make any changes to the methodologies or information systems used to report on *Juan F.* outcome measures.

The court monitor currently measures compliance with all but two exit plan outcomes based on an analysis of quantitative data submitted in quarterly reports prepared by the DCF exit planning staff within the Bureau of Continuous Quality Improvement. Initially, automated data were available for only a few measures and accuracy was a serious issue. The monitor required DCF to supply quarterly outcome information compiled both from its central computerized child welfare case management system (LINK) and from original paper records until data reliability could be verified for each measure. Furthermore, modifications of the LINK system by an outside consultant have been required in order to produce data in an automated report format (called Results Oriented Management or ROM reporting) for more than half of the exit plan measures.

At present, the department reports on four measures using information produced directly by LINK and on 12 more through the supplemental ROM reports that are based on LINK system data. The DCF exit planning staff develops the quarterly data necessary for Exit Plan Outcome Measures 20 and 21 by reviewing the case records for all youth discharged from agency care each quarter. Automated reporting for these measures is planned for the future. Data related to foster parent training, Outcome Measure 13, also are manually compiled from the department contractor responsible for providing that training (the Connecticut Association for Foster and Adoptive Parents).

The court monitor's office conducts its own case reviews to develop the information necessary for assessing compliance with two outcome measures that require a qualitative approach -- treatment plans (#3) and needs met (#15). The data gathered through these case reviews related to other outcome measures is also compared with the quarterly outcome data submitted by the department as another check on the reliability and validity of the agency's automated information.

Case review process. As noted earlier, revisions to the methodology for conducting case reviews for these measures were adopted in July 2006. The modifications added additional review elements and a provision for the reviewers to attend DCF meetings concerning treatment planning (e.g., Administrative Case Reviews, Treatment Planning Conferences, or Family Case Conferences) held for each case reviewed.

Under the revised methodology, which went into effect for the third quarter of 2006, a random sample of approximately 70 DCF child welfare cases, stratified to reflect the caseload distribution across area offices, is selected each quarter for in-depth review. The reviews are conducted by 10 to 12 experienced social work professionals assigned to two-person teams. Individuals from the court monitor's review staff are paired with current DCF case workers as review teams. Each team member separately completes an individual assessment of treatment planning and needs met for their assigned cases, according to an agreed upon protocol. Teammates meet to jointly arrive at a final score for the case.

When agreement cannot be reached, teams request review by a supervisor and assistance in developing an overall score. If consensus still cannot be reached, the case is submitted to the court monitor for review and final determination of the scoring.

Each case review involves examination of all automated case record (LINK) documentation, concentrating on the most recent six-month period. Narratives prepared by DCF case managers, treatment planning documentation, investigations information, and any narratives prepared by foster care providers are reviewed and scored based on set criteria. Reviewers are trained and provided with definitions and standards for evaluating treatment plans to help ensure consistency and validity. The full process, including attendance at any DCF meetings on the case, typically takes between seven to 12 hours to complete.

Quarterly reporting and follow up. Information developed from the analysis of data submitted by the department and gathered through the case review process is compiled in a quarterly reporting document by the court monitor and assistant court monitor. The report submitted by DCF is attached and both are provided to the judge prior to public distribution. The court monitor meets with the judge to discuss the report, noting progress made during the quarter and any areas of concern, but the judge does not edit or make changes to the report contents. The monitor also will informally let the parties know the overall findings before the official release of the final report for the quarter.

Following the report's release, the court monitor meets with both DCF staff and the plaintiffs to discuss the results in detail. At present, attention is focused on issues underlying outcomes related to treatment planning and needs met but there is always feedback between the parties and the monitor on all areas covered by the exit plan. The court monitor notes one of his key responsibilities is ensuring information is shared among all the parties and everyone involved has an opportunity to provide input.

Based on the findings presented in the quarterly report, the department will make adjustments to policies and procedures and develop action steps to improve compliance with the exit plan outcomes. Although the court monitor is not required to approve corrective actions planned by DCF, he generally is involved in agency meetings and staff discussions related to exit plan activities, and sometimes brings along TAC members to provide advice and assistance.

The department's exit planning staff oversees efforts to improve compliance with all outcome measures, under the direction of the agency's former chief of staff, now the commissioner's director of strategic initiatives and organizational development. In the past, various staff throughout the agency have been assigned lead responsibility for action steps on particular outcomes and progress has been tracked through a "status of work" section of the DCF quarterly report to the court monitor. This process began with the department's POC plan and has been further developed and refined over time. Beginning with the quarterly report for the first quarter of 2007, the department is focusing its status reporting on implementation of the *Juan F.* Action Plan strategies concerning treatment planning.

However, the agency's website currently has up-to-date information on the compliance status of each measure and performance reports also can be accessed for each area office. The exit planning staff maintain a variety of quality improvement information on-line for agency

staff and the public (quarterly reports, forms, guides, practice standards, policy updates, contacts for assistance, etc.).

Also, the court monitor's recently implemented *Juan F.* Action Plan includes: regular meetings with DCF staff, the plaintiffs, provider groups, and other stakeholders to examine the impact of the plan's action steps; selected site visits; targeted reviews of critical elements in the plan; ongoing analysis of monthly point-in-time and other selected data reports; and attendance at a variety of meetings on specific initiatives outlined in the plan.

According to the court monitor, targeted reviews will look at specific populations of children with permanency and placement issues to develop information to promote better practice and better inform the parties about the results of agency programs and services. The revised case review methodology developed for Outcome Measure 15 will be applied to these targeted reviews and several additional qualitative methods (interviews with children and families, for example) will also be incorporated.

Other activities. In addition to regular data analysis and case reviews related to quarterly progress reporting, the Office of the Court Monitor periodically carries out studies on topics of particular importance to agency compliance with the *Juan F.* consent decree. In the past, the court monitor has done program reviews of the DCF quality assurance function, adoption practices, investigations functions, and use of flexible funding.

Most recently, the court monitor participated with the Office of the Child Advocate and the department's continuous quality improvement bureau in the ad hoc study of Riverview Hospital. Ongoing activities related to this project include review and monitoring of the hospital's new strategic plan, updates with DCF staff, facility visits, analysis of facility data, attendance at advisory group meetings, and meetings with the unions representing the hospital staff.

The court monitor also undertakes occasional comprehensive case reviews of large samples to develop qualitative and quantitative information on overall compliance progress and on each exit plan measure. For example, the court monitor's office conducted a comprehensive targeted review of approximately 2,500 cases and issued a report in September 2007 with the final results, in addition to the regular quarterly exit plan report. The monitor's basic case review methodology of pairing DCF and its own staff in review teams is employed for comprehensive reviews. The larger random sample size makes the findings more generalizable and allows analysis by area office or program.

The monitor has access to any and all meetings held at DCF and regularly attends:

- commissioner's meetings;
- other executive staff meetings;
- area office directors' meetings; and
- various continuous quality improvement bureau meetings, such as the monthly meetings of area office Quality Improvement Program Supervisors.

By observing and sometimes participating in agency meetings, the monitor believes he has a better understanding of where the department is placing its efforts and can give the plaintiffs a more accurate picture of the work that is being done in the field as well as in the DCF central office.

Organization and resources. The monitor for the *Juan F.* consent decree is appointed by and solely responsible to the U.S. district court trial judge for the case. All expenses of the court monitor, including staff, consultants, equipment, supplies, and space, upon approval by the trial judge, must be paid by the state. For FY 07, the proposed budget of the *Juan F.* Court Monitor's Office totaled approximately \$665,000.

During the committee study, the office was staffed by three full-time and 14 part-time employees. The full-time staff included the court monitor, a monitoring specialist, and an office manager. Six part-time positions were case reviewers who worked under contract to the court monitor's office as needed. In most cases, the contracted case reviewers were retired DCF social workers. The other part-time personnel were current Department of Children and Families staff who were assigned as liaisons to the monitor's office to carry out case review activities as needed.

Technical Advisory Committee. As noted above, provisions of the October 2005 Revised Monitoring Order created a Technical Advisory Committee of national experts to assist the court monitor with the methodologies and data collection used to report on DCF performance under the *Juan F.* consent decree. In collaboration with the court monitor, the TAC is also responsible for advising the department on practice, infrastructure, or other functions concerning members of the *Juan F.* class that need improvement. Specific issues subject to this advisory function include: ensuring children's needs are met; ensuring an appropriate treatment planning process; and permanency needs of children in foster care.

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, the director of detention services, the chief court administrator, and the supervisors of the Bridgeport, Hartford, and New Haven Juvenile Detention Centers) 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 incarceration 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.

Monitoring history. 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 (i.e., children involved with the juvenile court as delinquent or FWSN and for whom the judge ordered an inpatient evaluation).

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.

During the committee study, 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.

***Emily J.* services.** Overall, DCF spent approximately \$15 million since FY 03 to meet its *Emily J.* obligations.²³ The department recently reported the *Emily J.* settlement resulted in the development and implementation of \$6.9 million in new or expanded community-based services for the targeted class of children (i.e., children who are in detention or who have recently been in detention, and who are determined to be at imminent risk for residential placement). The services began as a pilot program in Hartford in October 2005 and during FY 07 were expanded statewide.

The new services included: multidimensional treatment foster care; a gender-specific therapeutic group home for girls; family-based substance abuse treatment; flex funding; and therapeutic mentoring (which is paid for with flex funding). Flex funding provisions allow DCF caseworkers to allocate discretionary funds for a variety of purposes based on a child's particular needs. As established under the *Emily J.* settlement, flex funds may be used to pay for after school care, music instruction, Boys Club memberships, or other services that address factors related to delinquency.

For identified *Emily J.* class members, DCF and CSSD convene a meeting to identify and develop an appropriate placement diversion plan. For all DCF-involved children (who are those committed to the department or part of an open case), a "triage" meeting is convened within three days of their being detained in the judicial system. The intention of the meeting is to develop service plans for the court's consideration, with a goal of reducing the number of days the children are held in detention.

Children found by the triage team to be at risk for residential treatment typically receive a bundle of services that may include: recreational services (e.g., dance, basketball, art, or music lessons); individual therapy; vocational services; after school programs; treatment services from

²³ Connecticut General Assembly, Office of Legislative Research Report, "State Obligations Under *Emily J.* Decision," January 8, 2007.

private providers, such as medication management through the HomeCare Program; and other community-based treatment services such as Multi-Systemic Therapy and family advocacy.

Monitoring and evaluation activities. As required by the court, an independent monitor oversaw and reported on implementation of the *Emily J.* settlement agreement provisions since 1997. The monitor's main activities included: holding status conferences with the judge; reviewing reports from DCF; talking with the plaintiffs; meeting with children from the *Emily J.* class; conducting site visits; meeting with department staff; and publishing quarterly compliance reports. Over time, the monitor became less directly involved in agency operations as the departments (both DCF and the Judicial Branch CSSD) succeeded in developing a comprehensive internal monitoring and evaluation process for activities covered by the *Emily J.* service system.

Internal process. In an effort to plan and implement services and to develop outcome measures as defined in the settlement agreement, an *Emily J.* implementation team was formed in June 2005. DCF convened the team as a way of managing the compliance process going forward. The team consisted of representatives from the two state agencies involved, DCF and the Judicial Branch Court Support Services Division, as well as staff from the Connecticut Center for Effective Practice and the University of Connecticut Health Center.

The health center staff collected assessment data from CSSD, DCF, and direct service providers, including retrospective data on the children who were served in the first year of services, to provide a comprehensive look at outcomes. In accordance with the settlement agreement, quarterly reports based on data gathered by the implementation team were submitted to the court monitor and the state attorney general's office.

DCF also assigned responsibility for internally managing progress and monitoring compliance with the *Emily J.* settlement to a team of agency staff that included: a program director, full-time social work supervisor, three part-time detention liaisons, and one clerical worker. Results were tracked by the DCF team on a weekly, monthly, and quarterly basis through reports provided by providers, CSSD, and the agency's own automated systems. Examples include: monthly utilization, outreach, and program development reports that all *Emily J.* providers are required to prepare; reports on triage and diversion efforts; and weekly client outcome reports. These reports were reviewed and analyzed with DCF management and then summarized and submitted to the court monitor and the plaintiffs.

In preparation for the expiration of the current settlement, the *Emily J.* implementation team developed a plan for sustaining progress in the spring of 2007. This sustainability plan formed the basis of a subsequent memorandum of agreement between the Judicial Branch and DCF aimed at ensuring: a) continuous improvement of services; and b) continued success in diverting children from residential treatment and helping them remain in the community.

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;
- who are in need of community-based placements; and/or
- who 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 Office of the Child Advocate. They claimed 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.

Frustrated by the lack of progress in resolving the case, 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, which 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, was approved by the legislature, effective July 2007. 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. No comments in opposition to the agreement were received and the settlement agreement went into effect for a three-year period that concludes June 30, 2010. The lawsuit is considered ended and no independent, on-going monitoring, beyond the consultant activities called for in the approved agreement, is required.

Settlement provisions. Under the settlement agreement, DCF agreed to take the following steps to increase its ability to serve all members of the *W.R.* class:

- expand Emergency Mobile Psychiatric Services (EMPS);
- create an Individual Community Based Options (ICBO) program to help the class members obtain and remain in appropriate community-based placements;
- provide regular and structured guidance to DCF staff and contracted individuals and organizations that provide services to *W.R.* class members; and
- hire a third-party consultant, agreed upon by DCF and the plaintiffs, to implement the settlement agreement, at an annual salary of up to \$175,000.

The settlement requires the department to increase EMPS funding by \$1 million per year for three years, using the additional money to increase staffing during peak and expanded hours to "allow maximum mobility and faster response times to crisis calls."²⁴ It also outlines the

²⁴ *W.R. v DCF* Civil Action No. 3:02cv 429(RNC), United States District Court, District of Connecticut: Summary of Notice to Potential *W.R.* Class Members, 2007.

allocation of the additional resources across geographic areas and requires the consultant to periodically review the allocation of EMPS services, and if the parties agree, DCF may reallocate funding to areas where need is greatest.

The consultant is also required to help DCF develop and implement the new ICBO program, establish the program's eligibility criteria, and institute an appropriate transition process for participation in the program. DCF must commit \$1,312,500 in the first year of the settlement to provide *W.R.* class members with certain services including: therapeutically supported living; crisis supports; and related services to help maintain them in the community. In the second and third years of the agreement, the department must commit \$2 million annually for such ICBO services.

Guidance on *W.R.* services, which is to be provided by DCF in consultation with the consultant, must address: transition planning beginning at age 14; unconventional or "out-of-the-box" planning options, understanding there is a "no eject/no reject" policy for services for all DCF clients; and the availability of increased EMPS, group home, and ICBO services under the agreement. The consultant additionally must help DCF develop transition planning and policy to help older adolescent class members prepare for adulthood, and, if appropriate, transition to DDS or DMHAS services.

For four of the plaintiffs, the department is required to fund small (\$5,000) special needs trust funds. For two plaintiffs who have already aged-out of the DCF system, the department is required to cover the cost of a case manager, educational and vocational mentors, living expenses, and educational, health care, and other related expenses up to a total of \$199,953 per year for three years. Another plaintiff currently receiving voluntary services for serious mental illness will remain eligible for services and receive the same priority as a committed DCF youth until age 23. The department also will pay \$150,000 for the plaintiffs' attorney fees and costs.

Monitoring. Other duties of the *W.R.* consultant include reviewing and reporting on implementation of the settlement agreement. Quarterly reports on EMPS and ICBO services, services provided in group home settings related to the *W.R.* class, and the nature and extent of guidance provided to DCF by the consultant must be submitted to the agency and the plaintiffs' counsel during each of the three years of the agreement. The consultant is also responsible for identifying best and promising practices for clinical and supportive services provided in group homes and for EMPS and ICBO services, and making recommendations for improvements. Overall, the guidance provided to DCF by the consultant is intended to improve department staff and contractor practice, particularly in the way they deal with and plan for *W.R.* class members.

Legislative Oversight

Legislative oversight of state agencies is the primary function of the General Assembly's Program Review and Investigations Committee. In that role, PRI has conducted a number of evaluations of the Department of Children and Families and its mandates and major programs. The General Assembly's committees of cognizance over the department, which include the legislature's human services and judiciary committees, as well as the Select Committee on Children, have ongoing authority for monitoring and evaluating the department's performance and compliance with legislative intent.

A key way the legislature oversees and assesses DCF and other state agencies is through the appropriations process. The appropriations committee's recently established Results-Based Accountability (RBA) project, in particular, is focused on monitoring and evaluating the progress agencies are making in achieving their policy and program goals. DCF's participation in the RBA process as well as recent DCF monitoring and evaluation activities of the children's committee are highlighted in this section.

As another mechanism for tracking agency progress in meeting its goals, DCF is required by law to provide a number of reports and plans to the legislature. Current statutory reporting requirements for the department are also presented in this section.

Children's committee activities. In regard to DCF, the children's committee over the past five years has held a number of informational forums on areas of concern including the *Juan F.* exit plan, the Connecticut Juvenile Training School, and Riverview Hospital. The forums have provided committee members and other legislators with opportunities to discuss issues related to children's services in detail with officials and key program staff from DCF and other state agencies, as well as representatives of various stakeholder groups (e.g., private service providers, advocates, and parent organizations). The committee has also used the forums to monitor agency progress in meeting the exit plan goals and to address performance problems at CJTS and Riverview Hospital identified through various internal and external evaluations and investigations.

One significant resource for the children's committee oversight efforts is the Commission on Children, a legislative entity established in 1985 with 25 members representing all three branches of government, advocates for children, and private service providers and professionals who work with children. By law, the commission is responsible for: studying and providing information on the status of children and children's programs in Connecticut; and identifying programs and policies needed to improve the development of children and strengthen families.

The children's commission has focused its research and policy development efforts on prevention, particularly in the areas of early childhood and positive youth development. It views its role as advising the legislature and working in partnership with DCF and other state agencies and interest groups to improve services and policies for children.

The Commission on Children has no oversight authority over DCF; its monitoring activities are limited to looking at data and general trends related to outcomes for children and providing that information to policymakers. For example, the commission supported the development of the state's annual social health index, a tool that looks at long-term trends in 11 indicators of social well-being including child abuse, youth suicide, and high school dropout rates.

Results-Based Accountability. Results-Based Accountability is an approach for planning, implementing, and managing programs and policies in terms of desired outcomes and performance measures. It was developed by Mark Friedman of the Fiscal Policies Studies Institute; at present, the RBA process is used, to some extent, in over 40 states, predominantly at the county and municipal levels.

In 2005, the General Assembly's appropriations committee co-chairs established a work group to carry out a pilot project to try to apply the RBA framework to the state's budget process. Two program areas (early childhood education and Long Island Sound water quality) were selected for the initial test of the process during the 2006 legislative session. A consultant, The Charter Oak Group, was retained to help the work group adapt RBA principles to the legislature's appropriations process and implement the pilot project.

The main steps in the first RBA budget process included: identifying overall population goals (i.e., "quality of life results"); developing a standard template for providing data on results achievement (indicators), as well as key budget information, for use during the appropriations subcommittee hearings; and subcommittee presentations by the budgeted agencies that discussed the results data and plans for improving performance (i.e., "turning the curve" to meet the program goal). After evaluating the programs according to measurable goals, committee members then could make funding decisions (either increases or cuts in appropriations) based on the results data.

Positive feedback from all participants in the pilot project led the appropriations committee to continue its Results-Based Accountability approach, and expand it to include more programs and agencies during the 2007 budget process. As one of the added agencies, the Department of Children and Families applied the committee's RBA framework to four of its programs. DCF prepared templates for two programs related to early childhood, an area targeted for inclusion by the appropriations committee work group, and for two key agency functions, foster care services and general child protection services activities.

The department noted in its budget hearing testimony to the appropriations committee that participating in the RBA process was very similar to its experience with the *Juan F. consent decree exit plan*. In fact, the program results information DCF submitted in its RBA templates for foster care and child protection includes performance measures similar to several of the 22 exit plan outcome measures, as Table III-3 indicates.

Statutory reporting requirements. DCF is required by law to report on matters that cover all mandate areas of the agency as well as on agencywide activities. Overall, there are more than a dozen different state plans and reports the department must prepare and submit periodically to the legislature. Each of these statutory reports is summarized now briefly summarized.

Agencywide activities. Public Act 79-165 required DCF to prepare and submit to the legislature a five-year master plan on an annual basis; a 1986 amendment changed the plan to a biennial requirement. By law, the master plan must include: long range goals and the current level of attainment of the goals; a detailed description of the types and amount of services provided; a forecast of future service needs; a written plan for the prevention of child abuse and neglect; a comprehensive mental health plan for children and adolescents; and an overall assessment of the adequacy of children's services.

Biennial master plans including this information have never been prepared by the department. Periodically, DCF has created multi-year strategic plans that have partially addressed this requirement; the last five-year plan was produced in 2000. Now, however, the

Table III-3. RBA Information for Selected DCF Programs, Feb. 2007

Program	Foster Care	Child Protective Services
Program Purpose	To provide for the health, safety, permanency and development of children who cannot remain in the care of their birth parents	To provide for the health and safety of children at risk of abuse, neglect, and/or maltreatment
Performance Measures	<ol style="list-style-type: none"> 1. Percentage of children birth to 5 experiencing a single foster care placement from first entry 2. Percentage of children birth to 5 entering DCF custody who have a Multi-Disciplinary Exam (MDE) completed within 30 days of entry 3. Percentage of foster parents accessing 45 hours of training or more 	<ol style="list-style-type: none"> 1. Percent of investigations commenced in a timely manner 2. Percent of families receiving two protective services visits per month while residing at home 3. Percent of children in protective services who remain safe for 6 months 4. Number of allegations substantiated
Results	<p>Data indicate:</p> <ul style="list-style-type: none"> • Placement stability for children 0-5 varies with length of time in foster care; those in care 30 days or less experience greatest stability • Since Jan. 2006, percentage of children 0-5 with completed MDE at or above 90% (increase from under 30% in 2004) • All foster parents now complete 45 hours of training 	<p>Data indicate:</p> <ul style="list-style-type: none"> • DCF has developed a timely reporting system • Steady increase in percent of families receiving twice per month visits • Percentage of children maintained safely in homes for 6 months at least 90% since Jan. 2004 • Substantiated allegations increased in some categories (physical neglect) and decreased in others (emotional neglect) between 2003 and 2005
Total Current Year Funding	\$159,271, 770	\$231,666,830
Funding as % of Total Agency Budget	21.1%	30.7%
Source of Data: PRI staff analysis.		

department considers its action plan for meeting the outcomes of the *Juan F.* consent decree exit plan as the agencywide strategic planning document.

Behavioral health. Statutory requirements in the behavioral health mandate area date back to 1981, when quarterly hospital reports to DCF were required concerning psychiatric care. More recent legislation included reporting requirements for the KidCare program and, subsequently, a variety of evaluation and assessment reports related to the state's Behavioral Health Partnership (BHP).

To meet the 1981 mandate, DCF initially provided monthly reports to the legislature on hospital admissions, diagnosis, discharge, and demographic information. This type of reporting

is currently handled by the BHP's Administrative Services Organization, which began its behavioral health service authorization and utilization management functions for DCF and DSS in January 2006.

With the enactment of the KidCare program in 2000, the legislature required annual self-evaluations of the program's community care collaboratives and mandated a five-year independent longitudinal evaluation of the implementation of this children's behavioral health reform. Periodic status reports on the KidCare collaboratives and services, in addition to the outside, contracted longitudinal reports on the program were completed in accordance with statute. However, these reporting requirements were revised in 2003 and in effect replaced by a variety of Behavioral Health Partnership reports.

Under P.A. 05-280, an annual report is due each March 1 by the Behavioral Health Partnership Oversight Council (BHPOC). The current report, which includes subcommittee updates on annual progress and council recommendations, can be found on the partnership's website. The BHPOC may also conduct an independent external evaluation of the BHP. The RFP was recently issued for this project and a "report card" is expected in the coming year. Additionally, the BHP must report annually to legislative committees on the estimated cost savings of the BHP as well as provide an annual evaluation report. The first annual evaluation was expected to be completed by the end of 2007; the partnership is still working on the methodology for determining the cost savings.

Another advisory group, the Connecticut Behavioral Health Advisory Committee (CBHAC) must provide the DCF State Advisory Council with annual reports on the local systems of care and biennial recommendations on behavioral health services. As of August 2007, only one report, completed in 2003, had been done to meet both statutory requirements.

Protective services. State statute (C.G.S. §17a-91) requires DCF to provide an annual report to the legislature on all committed children. However, 2001 was the last year for which this was completed. Additionally, DCF must establish a central registry of all children for whom a permanency plan has been formulated and in which adoption is recommended. According to the department, the intent of this report is met by the registry of children awaiting adoption found on the DCF website.

State law also requires all licensed residential, child care facilities to submit annual reports. Standardized reports containing the following six items are provided to the department: 1) number of children currently in residence; 2) number of children in residence one-year ago; 3) number of children served during the year; 4) number of admissions during the year; 5) number of discharges during the year; and 6) number of deaths during the year. The information required in these reports is collected in a variety of other ways by the department through licensing, contracts, and the ASO; it entails duplicative work by the agencies.

Prevention. DCF must annually provide an update to OPM on its activities related to the Child Poverty and Prevention Council 10-year plan. The department's Director of Prevention submits annual updates to the council on current DCF prevention programs such as the Positive Youth Development Initiative, Suicide Prevention, and Prevention of Shaken Baby Syndrome.

The updates include long-term goals and the number of children and families served along with measurement and outcome information.

Juvenile justice. Under C.G.S. §17a-6b, the CJTS advisory group is to provide an ongoing review of the training school with recommendations for improvement or enhancement. The statute outlines nine items that must be contained in the report, including but not limited to: a review of the program and policies of the facility; the percentage of residents in need of substance abuse treatment; and demographic information on the residents. The department currently prepares the report, which is then reviewed by the advisory group.

Other reporting requirements. Under C.G.S. §17a-37, DCF must provide an annual evaluation on its school district (Unified District #2) to the commissioner of education. When PRI staff inquired about these reports, the department could not document fulfilling this specific requirement. However, similar to other school districts in the state, the DCF unified district submits annual reports concerning special education services it provides and strategic school profile information to SDE.

Under another statute, C.G.S. §17a-3 (6), DCF must "... conduct studies of any program, service or facility developed, operated, contracted for or supported by the department in order to evaluate its effectiveness." Currently, the department partially fulfills this mandate through the program review and evaluation functions of its Bureau of Continuous Quality Improvement. However, to date, much of the bureau's focus is on residential facilities and protective services, with an emphasis on process rather than outcomes.

Since 1999, the department has been required to respond to actions taken regarding recommendations put forth by the advisory committee promoting adoption and provision of services to minority and difficult to place children. The last year the department fulfilled this requirement was 2003 and this advisory group has no members and does not exist at present.

Accrediting Body Oversight

Accreditation is intended to put forth standards against which an organization is measured to assure a minimum level of care. It has been reported that accreditation has the benefit of formalizing and clarifying policies and procedures. It is also useful as a credential signifying organizational quality to consumers, funders, and other key stakeholders. Accreditation usually requires an organization to submit evidence of adherence to required standards (the "self-study") and undergo a site visit by inspectors of the accrediting body. Areas found to be out of compliance require correction before accreditation or reaccreditation is granted.

The Department of Children and Families currently receives accreditation for Riverview Hospital through the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations). Additionally, the Connecticut Juvenile Training School is pursuing accreditation by the American Correctional Association. Further, the Connecticut General Assembly passed legislation in 2005 (P.A. 05-246) requiring DCF to apply for accreditation by the Council on Accreditation within a reasonable time. Each of the accrediting bodies is now described.

The Joint Commission. The Joint Commission, until 2007 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), currently accredits Riverview Hospital, Connecticut's only state-run psychiatric hospital for children between the ages of 5 and 17. The Joint Commission is a U.S.-based nonprofit organization formed in 1951 with a mission "to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations."²⁵ The commission currently accredits approximately 80 percent of all hospitals in the country.

The Joint Commission accreditation steps include preparation of an in-depth self-study followed by a site visit. There are several hundred standards for accreditation that fall into 11 areas:

- 1) ethics, rights, and responsibilities;
- 2) provision of care, treatment, and services;
- 3) medication management;
- 4) surveillance, prevention, and control of infection;
- 5) improving organizational performance;
- 6) leadership;
- 7) management of environment of care;
- 8) management of human resources;
- 9) management of information;
- 10) medical staff; and
- 11) nursing.

During the site visit, the performance of the hospital is compared to the relevant standard for that area. Riverview Hospital was first accredited as a psychiatric hospital following a survey on December 13-15, 2003. Prior to 2003, Riverview Hospital was accredited as a behavioral health facility.

Site visits occur at least once every 39 months. Unannounced site visits may occur at any time, as was the case for Riverview Hospital in October 2004. Unannounced site visits may be prompted by at least one patient care concern received from the public. The Joint Commission does not tell the hospital what the complaint is about; however, the targeted inspections give some indication of the areas of concern.

The Joint Commission now uses a tracer methodology. Upon arrival, Joint Commission site reviewers, called "surveyors," request case records to review. Based on the records reviewed, the surveyors will trace a child's stay at Riverview Hospital. Any of the services used during the child's stay may be assessed according to Joint Commission standards. Internal services used to support the child's stay at the hospital, such as building safety issues, may also be reviewed.

In addition to the hospital accreditation process, the Joint Commission began recognizing hospitals for meeting National Patient Safety Goals in 2005. The purpose of the goals was to

²⁵ The Joint Commission website: www.jointcommission.org.

highlight problematic areas in health care and describe evidence- and expert-based solutions to these concerns. The national patient safety goals for hospitals in 2006 were:

- improve the accuracy of patient identification;
- improve the effectiveness of communication among caregivers;
- improve the safety of using medications;
- reduce the risk of health care-associated infections;
- accurately and completely reconcile medications across the continuum of care; and
- reduce the risk of patient harm resulting from falls.

Additionally, because Riverview Hospital uses a consulting pharmacy rather than an on-site pharmacy, the Joint Commission requires monthly documentation that demonstrates compliance with standards for pharmacy practice.

The cost of accreditation by the Joint Commission includes the direct fee paid annually to the Joint Commission (\$2,500) to maintain accreditation, and \$5,900 to McLean Hospital for a data comparison required by the Joint Commission. The Oryx submission of data requires five days per month from an Information Systems staff person. There is an additional on-site survey fee of \$15,000 on years when the reaccreditation site visit occurs.

The Riverview Hospital Quality Assurance Manager is primarily focused on Joint Commission activities 40 hours per week. This includes Infection Control Coordinator activities, survey readiness activities of the Quality Assurance department, submission of the annual periodic performance review, tri-annual application process, follow-up survey reports, and monitoring. In essence, efforts for Joint Commission accreditation is part of the everyday operation activities of the hospital, largely determining the committees formed, areas monitored, and policies and protocols written.

Council on Accreditation. In 2005, the Connecticut General Assembly enacted legislation requiring DCF to become accredited by the Council on Accreditation (P.A. 05-246). The act directed the commissioner to apply, within a reasonable time, for accreditation of the department by the Council on Accreditation. A failed bill (SB 334) during the 2007 regular session attempted to amend the statute to require the commissioner to apply for accreditation no later than October 1, 2007. To date, there is no statutory deadline and the department has not officially sought accreditation from the Council.

The Council on Accreditation is an international, independent, not-for-profit organization that accredits child and family serving agencies, and behavioral and healthcare organizations. The Council has been in existence since 1977 when it was co-founded by the Child Welfare League of America and Family Service America (now the Alliance for Children and Families). The standards are based on best practices in the field. The accreditation process requires a self-study (self-evaluation) followed by a site visit. The accreditation lasts for a four-year period.

There are standards for accreditation of the department overall in such areas as:

- continuous quality improvement;
- training and supervision;
- intake, assessment, and service planning;
- financial management; and
- ethical practice, rights, and responsibilities.

Beyond the generic standards, accredited public agencies must also adhere to standards specific to services such as:

- adoption;
- case management;
- extended day treatment;
- family preservation;
- foster care;
- outpatient mental health services;
- residential treatment services; and
- wilderness and adventure-based therapeutic outdoor services.

Currently, the state child welfare agencies in Arkansas, Illinois, Kentucky, Louisiana, and Maryland are accredited; the COA Public Agency Accreditation Report of June 2007 also identifies six additional state administered child welfare agencies that are currently going through the accreditation process (Maine, Missouri, Ohio, Tennessee, Washington, and West Virginia).

In preparation for DCF becoming COA-accredited, the Director of Planning, Policy and Program Development, the Director of Policy and Accreditation, and several other DCF staff attended basic accreditation training in March 2007. The training focused on how to calculate the staffing needed to complete the COA process. The department has prepared an estimate for DCF and its 14 area offices and facilities to become accredited. Unlike other states with a strong county system where each county may get accredited separately, Connecticut's 14 offices make this function quite spread out, and accreditation of one entire state a more involved process. Beyond the area offices, there are also DCF-run facilities that would need to be visited and brought into line with COA accreditation standards. DCF estimates that it will cost as much as \$909,675 to become accredited, based on 7-8 part-time positions (\$415,000-\$475,000) and accreditation fees (\$434,675). Funding would then be needed to make improvements required to meet accreditation standards, and additional funding to prepare for subsequent reaccreditation processes.

The Policy and Accreditation Unit of the Planning, Policy and Program Development division of the Bureau of Continuous Quality Improvement will be responsible for shepherding DCF through accreditation. Concern has been expressed that COA standards change frequently and the accreditation process will be very time consuming. Some believe that states with

accredited child welfare agencies are no better than other states that do not have the accreditation. Another concern is that the department is very focused on meeting the *Juan F.* exit plan outcome measures and preparing for the upcoming Child and Family Services Review; getting ready for accreditation on top of these other efforts could be overwhelming.

In an effort to identify any deficiencies, a comparison is currently being done part-time by one DCF staff person of COA standards with current department policies and procedures. The Director of Policy and Accreditation believes that human resources and LINK are two areas that will require significant change in order for DCF to meet COA standards. The department also has an opportunity to go through a mock COA review that would help DCF identify areas of weakness and help prepare for accreditation.

Commission on Accreditation for Corrections. The Commission on Accreditation for Corrections is a private, nonprofit organization that administers the only national accreditation program for all components of adult and juvenile corrections. Accreditation standards are set by the American Correctional Association (ACA). The Connecticut Juvenile Training School is considering accreditation by the commission as a juvenile correctional center (juvenile detention centers have different ACA standards). According to the American Correctional Association, organizations seek accreditation to ensure that they are in compliance with national standards, and to demonstrate to key stakeholders that they are operating at acceptable professional levels. The Commission on Accreditation for Corrections is made up of 28 corrections professionals from throughout the nation to ensure that the commission is independent and impartial. The main purpose of the commission is to conduct accreditation hearings to verify that agencies applying for accreditation meet the relevant standards.

The association's Standards and Accreditation Department develops new standards, revises existing standards, and coordinates the accreditation process including the semi-annual accreditation hearings. The Standards and Accreditation Department also provides technical assistance to agencies and training for consultants participating in the accreditation process.

The standards are a national benchmark for the effective operation of correctional systems, addressing services, programs, and operations essential to good correctional management. Operations examined pertain to:

- administrative and fiscal controls;
- staff training and development;
- physical plant;
- safety and emergency procedures;
- sanitation;
- food service; and
- rules and discipline.

The association has 21 different manuals of standards, each of which applies to a particular kind of correctional facility or program. The accreditation process usually takes up to 18 months. Accreditation lasts for a three-year period.

All programs and facilities conduct a self-assessment of operations and complete a Self-Evaluation Report that specifies the agency's level of standards compliance. The Self-Evaluation Report is submitted to the American Correctional Association for review. A standards compliance audit can only occur if all of the mandatory standards and at least 90 percent of the non-mandatory standards are met.

The compliance audit is administered by trained American Correctional Association consultants who have an average of 18 years experience in the corrections field. The audit is usually done by three consultants during a three-day period, during which time they will determine whether the policies described in the self-assessment have actually been implemented.

An accreditation decision by the American Correctional Association Board of Commissioners is then made. The DCF Bureau Chief for Juvenile Services estimates that there are over 400 standards, about 40 of which are mandatory; 80 percent of the remaining 350 standards must also be met for a facility to be accredited.

Accreditation hearings, which are conducted by a panel of three to five commissioners, are held three times per year at three different conferences sponsored by ACA. Concerns are addressed with the facility representatives that attend the accreditation hearing. Issues that could prevent accreditation would be known prior to the accreditation hearing through the unofficial report given to the facility by the auditors before they leave the facility. The facility would then have the opportunity to change the audit to a "technical visit" and request an extension and re-audit six months later. Accreditation denial almost never occurs at accreditation hearings.

The Bureau Chief of Juvenile Services noted that just 33 juvenile correctional centers in the entire country are ACA accredited, and accreditation of CJTS would be a source of pride to staff, and recognition by external stakeholders.

Annual certification statements to the American Correctional Association are required once an organization has become accredited. These statements contain the following:

- current standards compliance levels, update of plans of action, and significant events, such as a change in the agency administration, or major staffing changes;
- mission change or program revisions;
- changes in the offender population, including number of offenders or general offender profile;
- physical plant renovations, additions, or closings; and
- any major disturbances such as extended periods of lock-down, employee work stoppages, etc.

A monitoring visit may occur during the initial three-year accreditation period to ensure continued compliance with the appropriate standards. Accredited agencies then apply for reaccreditation approximately nine months prior to accreditation expiration.

The Judicial Branch Court Support Services Division (CSSD) went through the accreditation process for their juvenile detention centers. While the future of the Connecticut Juvenile Training School is up in the air, the Bureau Chief for Juvenile Services believes that preparation now for accreditation will serve as a foundation for future ACA accreditation regardless of whether there is a single training school or several smaller facilities. Policies and procedures are currently being compiled in preparation for ACA accreditation.

The cost of ACA accreditation for CJTS includes the direct fee paid to the American Correctional Association (\$10,000), which covers the costs of three auditors visiting CJTS for three days, and one CJTS staff person to attend the ACA conference to represent the facility at the hearing and to receive the accreditation. Additional costs associated with the requirements for maintaining accreditation include the assignment of one quarter to one half of the time of a manager to act as the ACA manager. The DCF bureau chief noted that after the initial accreditation, the standards become part of the facility operation and the cost would become negligible.

Other Regulatory Monitoring and Evaluation Activities

Additional monitoring and evaluation of DCF includes review and reporting requirements carried out by several other federal and state agencies. Recent activities of the federal Centers for Medicare and Medicaid Services (CMS), the U.S. Drug Enforcement Administration (DEA) and the Connecticut Department of Public Health (DPH) are now briefly described.

CMS. Riverview Hospital has to be approved by the federal Centers for Medicare and Medicaid Services. In 2000, Conditions of Participation (COPs) standards were introduced for hospitals receiving Medicaid and Medicare reimbursement.

The Centers for Medicare and Medicaid Services conduct unannounced site visits and stringent reviews. In Connecticut, the Department of Public Health performs the CMS reviews on behalf of the federal government. Riverview Hospital is also required to submit information to CMS notifying them, for example, on the purchase of a new Glucometer machine for patient testing. Riverview Hospital is also required to submit a report to CMS whenever there is an adverse reaction to medication.

DEA. Riverview Hospital is required to maintain a controlled substance license through the federal Drug Enforcement Administration. The DEA has offices in each state and inspectors conduct unannounced spot visits periodically. The visits entail a visual check of where medications are stored and secured. The last inspection occurred in May 2007 during which inspectors witnessed the destruction of controlled drugs.

DPH. In 2007, the Wilderness School was licensed as a youth camp by the Department of Public Health. The purpose of this licensure is to assure the health and safety of campers. Licensure requires adherence to 121 requirements including standards in the areas of physical plant, staff qualifications, safety, and administration of medications. Licensure site visits to the Wilderness School occur annually. Additionally, DPH requires the Wilderness School to report any positive medical diagnoses (e.g., strep or hospital admission).

Riverview Hospital is required to report information to DPH including infection control and immunizations. The Riverview Hospital Immunization Coordinator and Pediatrician, for example, submit all information regarding vaccinations to DPH on a monthly basis. Additionally, a form outlining treatment and follow-up care is sent to DPH whenever there is positive identification of a patient with tuberculosis.

Outside Investigations and Reviews

Several state entities have independent oversight roles related to children's services and the Department of Children and Families. These include the Office of the Child Advocate and the Child Fatality Review Panel, both of which have statutory investigatory powers and duties related to programs and services provided to children by DCF and other state agencies. The Office of the Attorney General (OAG), under the provisions of the state "whistleblower" law (C.G.S. § 4-61dd), also has investigatory responsibilities concerning reports of mismanagement or misconduct occurring in any public agency, including the Department of Children and Families. The DCF monitoring and evaluation functions of all three entities are described in this chapter.

Office of the Child Advocate

The Office of the Child Advocate was established in 1995 to monitor and evaluate services provided to children and families by DCF and other state agencies (P.A. 95-242). Concerns over accountability for protecting children and their rights, reinforced by the tragic death of an infant in a child abuse case, led the legislature to create OCA as an independent agency with strong oversight authority.

The OCA enabling legislation also established an advisory committee for the child advocate's office and a Child Fatality Review Panel, of which the state child advocate is a member. The oversight duties and activities of the Office of the Child Advocate are summarized below, followed by a description of the Child Fatality Review Panel.

Statutory requirements. The state child advocate is appointed by the governor from a list submitted by the OCA advisory committee and subject to legislative approval. The individual appointed to the position must have knowledge of the child welfare system and legal system, and be qualified by training and experience to perform the duties of the office. These specific statutory duties include:

- evaluate delivery of services to children by state agencies and entities funded by the state;
- periodically review the procedures of state agencies providing services to children, with a view towards children's rights, and recommend revisions;
- review complaints concerning services provided to children, make appropriate referrals, and investigate those where it is determined a child or family needs the advocate's assistance, or that raise a systemic issue in state's provision of children's services;
- periodically review the facilities and procedures of any and all public and private institutions where juveniles are placed by any agency or department;
- recommend changes in state policies concerning children, including changes in systems for providing juvenile justice, child care, foster care, and treatment;

- periodically review special needs children in foster care or a permanent care facility, and recommend changes in placement policies and procedures for such children; and
- take all possible actions to secure and ensure legal, civil, and special rights of children who reside in Connecticut.

State statute grants the child advocate broad authority to access any information, even confidential records, necessary to carry out the office's duties. According to OCA, it is the only state agency authorized to review information from all aspects of a child's life, including DCF court files, school and health care records. Information obtained or generated by OCA in the course of an investigation, as well as the identity of persons making reports to the advocate, is confidential and may be released by the advocate only if it is deemed to be in the best interest of a child or the public.

The child advocate may issue subpoenas to compel the production of books, papers, and other documents as well as the attendance and testimony of witnesses. The child advocate is also authorized to bring actions on behalf of any child before a court or state agency, provided a good faith effort has been made to resolve issues or problems through mediation. Each year, the child advocate must submit a detailed report analyzing the work of the office to the governor and legislature.

By law, the seven-member child advocate advisory committee²⁶ must meet with the advocate and OCA staff three times per year to assess:

- patterns of treatment and services for children;
- the policy implications of those patterns; and
- necessary systemic improvements.

Authorization by the advisory committee also is needed for the advocate to initiate legal actions against the state. The advisory committee is required to provide an annual evaluation of the effectiveness of the child advocate's office. To date, this has been issued in the form of a cover letter to the OCA annual report from the committee chairman, which briefly assesses the office's accomplishments over the prior year.

In practice, the OCA advisory committee meets four times a year to help set priorities for the office and to review the status of ongoing work. The child advocate considers the multidisciplinary committee a useful resource and has called on members for their expertise and technical assistance. For example, the psychologist who serves on the committee was asked to review and evaluate CJTS surveillance videos obtained during the OCA/OAG review of that facility.

²⁶ The seven members must include: a pediatrician, a public child welfare social worker, a representative of private children's agencies, and a representative of education, all appointed by various legislative leaders; a Family Division judge appointed by the chief justice; a psychologist appointed by the Connecticut Psychological Association; and an attorney appointed by the Connecticut Bar Association.

Activities. According to its annual report, the mission of the Office of the Child Advocate is to oversee the care and protection of children and advocate for their well-being. Its purpose is: to monitor public and private agencies that care for children and evaluate state agency policies and procedures to ensure they protect children’s rights and promote their best interests.

The main activities of the child advocate’s office, discussed briefly below, include: ombudsman activities; reviews and investigations of facilities and programs; and special projects. In addition, OCA conducts public education and legislative advocacy, and recommends policy changes and system reforms based on its reviews and ombudsman activities. The child advocate also serves on the Child Fatality Review Panel, which is described later in this chapter.

Ombudsman activities. A primary OCA function is to receive and review inquiries and complaints from citizens about the state’s child-serving systems and programs. One assistant advocate serves as the intake coordinator, screening initial calls, providing guidance and information about available services, programs, and policies, and making referrals to other agencies. All OCA professional staff share responsibility for follow up on calls and work on cases opened for investigation. In addition to helping children and families access services and resolve problems, OCA uses its ombudsman process to identify trends and areas of concern, and to set priorities for its oversight efforts.

The numbers of calls received and cases opened by the child advocate’s office over the past three fiscal years are shown in Table IV-1. Of the approximately 1,100 calls to the office from the public during FY 06, about 300 only needed general information while around 800 required more follow up. Most of the calls needing follow up (over 75 percent) were taken care of through referral or with additional information; OCA opened cases for investigations regarding the remainder (172).

Table IV-1. OCA Ombudsman Activities: FY 04 - FY 06			
	FY 04	FY 05	FY 06
Total Calls Received (approximate)	1,500	1,115	1,100
Cases Opened (for investigation)	over 360	over 300	172
Source: OCA Annual Reports, FY 04 - FY 06.			

The information presented in Table IV-1 is based on estimates because of limitations of the OCA call management database. While the advocate is working with the Department of Information Technology to improve the system, little progress has been made, mainly due to a lack of funding and staff resources.

As a result, it continues to be difficult for OCA to compile data routinely on the nature of complaints received. An analysis of citizen concerns was carried out on calls received in FY 04. That review found the majority of calls were made about child welfare issues, most frequently

about DCF child abuse investigations and case management. The second largest category of calls was legal, which involved concerns about the rights and representation of children and families in abuse and neglect proceedings. The legal category also included calls about child custody and visitation cases, and some about the rights of children in adult criminal proceedings.

The primary concern for the mental health category, the next largest number of calls received by OCA, was access to services. Another large category of calls was related to special education, with the majority requesting help in negotiating children's individual education plans. Other, smaller areas of concern were: regular education issues; children's medical issues; assistance for children with mental retardation/developmental disabilities; juvenile justice matters including Families with Service Needs cases; and specific facilities, such as the Connecticut Juvenile Training School.

According to the child advocate, expansion of the internal DCF Ombudsman function beginning in 2004, has greatly assisted OCA's efforts to ensure appropriate care of at-risk children and protection of their rights. In addition, the advocate's case-specific workload has gone down over the past three years (as Table IV-1 indicates), while the number of cases handled by the department's ombudsman staff has steadily grown. Furthermore, based on information OCA compiled about systems in use in other states, the DCF Ombudsman Office developed a call management system with case tracking and analysis capability.

Reviews and investigations. Since it was established, OCA has conducted five facility investigations, three of which concerned the Connecticut Juvenile Training School operated by DCF, and six general reviews. Seven of these studies have been carried out in cooperation with the Office of the Attorney General and one was a joint effort of OCA, DCF and the *Juan F.* Court Monitor. The child advocate's office also has issued a dozen in-depth reports on individual child fatalities and several follow up reviews of child fatality investigations carried out by CFRP. All publications of the child advocate's office are listed in Table IV-2.

Special projects. As part of its advocacy role, OCA carries out a wide range of special projects to protect children and promote their well-being. Recent efforts include: running a youth advisory group; conducting training and technical assistance for children's attorneys; and public education about teen dating violence. Professionals hired by, and reporting to, the child advocate also have conducted on-site monitoring at two DCF facilities -- Connecticut Juvenile Training School during 2003 and in 2005 to 2007, and Riverview Hospital, starting in June 2007.

In addition, OCA has initiated and/or participated in several lawsuits on behalf of children in need of mental health services and other appropriate care and treatment. During FY 04, the child advocate filed for, and was granted, intervener status in the recently settled *W.R.* federal court case. That case focused on ensuring that the state provides children with mental health needs with appropriate services in the least restrictive setting possible. Earlier, in December 2003, OCA filed legal proceedings against DCF for violating children's civil rights and failing to provide appropriate care and treatment in a case that became *Boy Doe, et. al. v. Department of Children and Families.*

Table IV-2. Office of the Child Advocate Publications

Facility Investigations	General Reviews	Fatality Reports	Other Publications
<p><i>Riverview Hospital Joint Program Review</i>, OCA with the <i>Juan F. Court Monitor</i> and DCF Bureau of Continuous Quality Improvement, Dec. 2006</p> <p><i>CJTS: Second Follow Up Report</i>, OCA/OAG, July 2004*</p> <p><i>CJTS: Supplemental Report</i>, OCA/OAG, Feb. 2003*</p> <p><i>CJTS</i>, OCA/OAG, Sept. 2002*</p> <p><i>DCF Oversight of Haddam Hills Academy</i>, OCA/OAG, May 2002*</p>	<p><i>Connecticut Children Losing Access to Psychiatric Care</i>, OCA/OAG, Apr. 2007*</p> <p><i>Children with Special Health Needs: A Plan of Action</i>, Feb. 2007</p> <p><i>School Mobility (Educational Access for Children in Foster Care)</i>, University of Connecticut for OCA, Dec. 2005</p> <p><i>Investigation into DCF Hotline</i>, OCA/OAG, Sept. 2003*</p> <p><i>The Cost of Failure: Consequences of Inadequate Community Services for Children</i>, OCA/OAG, March 2003*</p> <p><i>Services for Children with Special Health Needs</i>, May 2001</p>	<p><i>Child Fatality Review Panel Annual Reports</i>, 1997-98 - 2005-06</p> <p><i>Child Fatality Investigations of DCF</i>, 1996 - 2003</p> <p><i>Summary Review of 1998 Fatalities of Children</i>, 1999</p> <p><i>Child Advocate's Follow Up Report</i>, 1999</p> <p><u>Fatality Reports:</u> <i>Makayla K.</i>, 2004 <i>Joseph Daniel S.</i>, 2003 <i>Ezramicah H.</i>, 2002 <i>Emily H.</i>, 2001 <i>Alex B.</i>, 2001 <i>Falan F.</i>, 2001 <i>Aquan S.</i>, 1999 <i>Andrew M.</i>, 1998 <i>Shanice M.</i>, 1998 <i>Ryan K.</i>, 1998 <i>Tabatha B.</i>, 1998 <i>Raegan M.</i>, 1997</p>	<p><i>OCA Annual Reports</i>, 1997-98 - 2005-06</p> <p><i>Protecting Our Children: Overview of Connecticut's Child Protection System</i>, 2002</p> <p><i>Child Protection: Meeting the Challenges</i>, OCA with the Judicial Department, Oct. 1999</p> <p><i>Progress Report of the Child Advocate</i>, Feb. 1997</p>

*Joint investigation reports prepared with the Office of the Attorney General

Source: OCA.

Organization and resources. The total estimated FY 07 budget for OCA was just over \$1 million. Most child advocate office expenses (over 80 percent) are related to its personnel costs. About \$83,000 of the OCA FY 07 budget was allocated for activities of the Child Fatality Review Panel.

The Office of the Child Advocate had only 1.5 positions when it was established; at present, it is staffed by 10 professional and two support staff. It supplements its personnel resources with interns and volunteers, and has also pursued federal grants to support some special projects.

The associate child advocate oversees the office's investigations and ombudsman activities. One assistant child advocate serves as the intake coordinator for the office's ombudsman function and another staffs the Child Fatality Review Panel, in addition to representing the office on a number of prevention-related advisory groups, and participating in various child and family prevention initiatives.

Child Fatality Review Panel

Connecticut's statutorily mandated Child Fatality Review Panel is composed of 13 permanent members including the state child advocate.²⁷ The current child advocate serves as the panel's chair.

The panel was established to review the circumstances of the death of any child placed in out-of-home care, or whose death was due to unexpected or unexplained causes. The panel's scope, therefore, extends beyond children involved with DCF or other state service systems. By law, CFRP reviews have two main purposes:

1. to facilitate development of prevention strategies to address identified trends and patterns of risk; and
2. to improve coordination of services to children and families in the state.

At the request of two-thirds of the panel members, or at the child advocate's discretion, OCA must conduct an in-depth investigation and issue a report on a death or critical incident (e.g., serious injury including sexual assault, life-threatening condition, human rights violation) involving a child. OCA child fatality investigation reports must be submitted to the governor, legislature, and the commissioner of any state agency cited, and be made available to the general public.

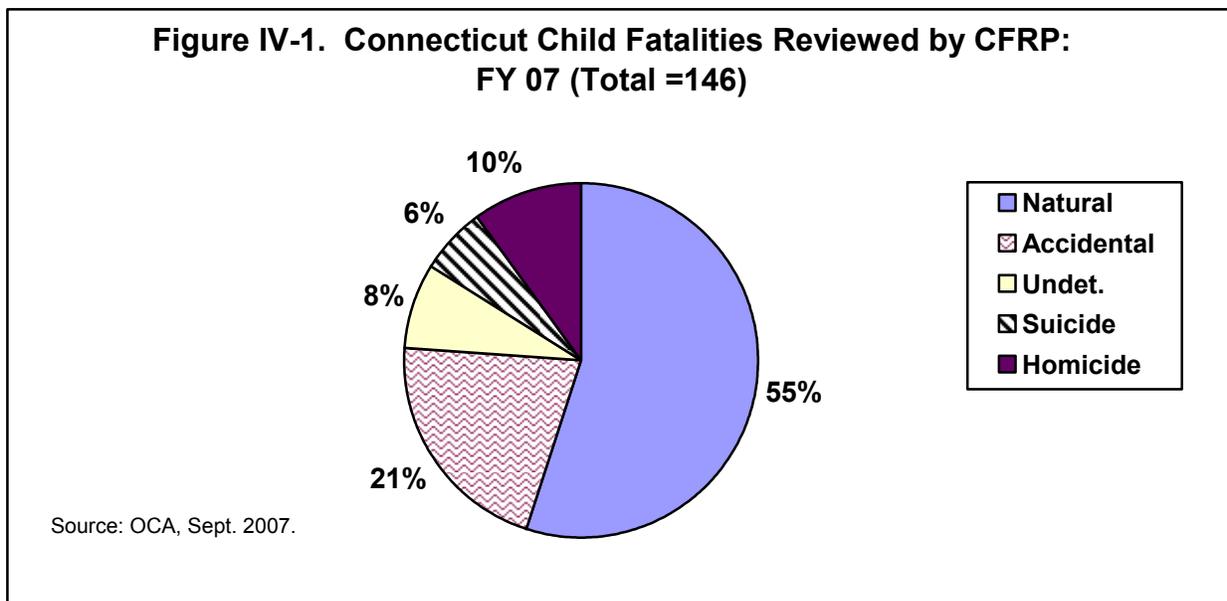
Each January 1, the panel must issue an annual report on its review of child fatalities that includes its findings, and any recommendations, to the governor and legislature. The panel, rather than producing a separate document, has included a summary of its yearly activities and proposals for change in the child advocate's annual report to the legislature.

²⁷ Panel members, who to the greatest extent possible must represent the ethnic, cultural and geographic diversity of the state, are: the child advocate; the commissioners of DCF, DPH, and the Department of Public Safety; the chief state's attorney; the chief medical examiner; a pediatrician appointed by the governor; and representatives of law enforcement, a community service group, and injury prevention, and an attorney, a social work professional, and a psychologist, each appointed by a legislative leader. A majority of panel members may select not more than three additional temporary members with particular expertise or interest to serve with the same duties and powers as permanent members.

Activities. CFRP reviews all child deaths reported to the child advocate with assistance of an OCA assistant child advocate. As noted earlier, that staff person carries out the day-to-day activities of the panel, which include: reviewing all reported deaths; leading in-depth investigations when determined necessary; preparing fatality investigation reports; and managing the panel's automated fatality database.

The panel meets on a monthly basis at least 10 times per year to review child fatalities reported to the state's chief medical examiner or fatalities that appear in the media. At the panel meetings, members are provided with a summary of facts related to each case prepared by the panel's OCA staff person. The case summary includes information on any DCF involvement with the child or family, based on OCA's review of the department's automated child welfare information.

During FY 07, the panel reviewed 146 child fatalities. As Figure IV-1 shows, in over half of the cases (55 percent), the child's death was due to natural causes. Accidental deaths accounted for 21 percent of the cases reviewed, and homicide or suicide was the cause of death in 10 and 6 percent of all cases, respectively. The cause of death was undetermined for the remaining cases (8 percent).



While all child deaths reported to the panel are reviewed, in-depth investigations generally are conducted only when it is determined there was, or should have been, involvement by state agencies. Since 2004, the panel has redirected its efforts to reviewing, and participating in, the child fatality investigations carried out internally by DCF rather than conducting separate investigations and issuing its own reports on cases with department involvement.

In addition to reducing duplication of investigatory efforts, this change reflects the panel's confidence in the quality of the department's recently revised internal special review process, which is carried out in conjunction with the Child Welfare League of America. A brief description of the current DCF process and the panel's participation is summarized below.

DCF special review process. Several years ago, in response to its own concerns and those of a former *Juan F.* court monitor, the department sought technical assistance through a competitive bid process to develop a new internal review based on current best practices. In April 2004, CWLA was selected to structure and help implement a review process for DCF child fatalities and critical incidents that focused on improving policies and practices by providing: information for professional learning; practical feedback; and staff support.

In addition to providing expertise and technical resources for specific reviews, CWLA has three staff assigned to DCF to carry out the special review process. The CWLA personnel works primarily with the department's Director of Research and Development within the Bureau of External Affairs, who, among other duties, oversees the agency's special review process.

The special review process currently is limited to child fatalities or critical incidents on open DCF cases and/or those closed within the previous six months. The process, which has been in place for three years, typically includes the components listed below:

- Determination is made by DCF senior leadership that CWLA will conduct a fatality review, usually within 48 hours of the incident; case records and a list of staff involved are forwarded to CWLA;
- A Core Review Team established by CWLA clarifies roles, time frames, and scope, as well as coordinates with the DCF field administrator and the department staff person designated as senior leader by the central office;
- An entrance meeting is held with DCF field staff which orients staff to the process, emphasizes stress reduction, and provides a debriefing opportunity;
- Individuals and small groups are interviewed; relevant documents and records are reviewed;
- The Core Review Team drafts an initial report and forwards it to staff involved with the case, the field administrator, and designated senior leader;
- An exit interview with DCF staff and the field administrator, facilitated by the Core Review Team, is held to examine the draft report for accuracy,-- discuss findings and recommendations, exchange feedback on the process, and create closure for the staff involved;
- Revisions and modifications based on the exit interview are made and the final draft is forwarded to central office senior leadership;
- Senior DCF leadership reviews the draft and may suggest modifications;
- A final report is completed within seven days, redacted for confidentiality, and forwarded to the DCF Training Academy for integration into the curriculum and is placed on the department intranet;
- Learning forums to discuss the case facts, key findings and recommendations, and implications for current cases, may be conducted with targeted audiences, as determined by the Core Review Team, local administrators, and central office senior leadership; and
- The department's Bureau of Continuous Quality Improvement is responsible for implementation of recommendations and follow-up activities, which may be coordinated with area office/facility quality improvement teams.

The OCA assistant child advocate who staffs the Child Fatality Review Panel is notified by DCF of the initiation of all special reviews and attends all entrance meetings. She is authorized to participate in interviews and meetings related to the review process and has access to all materials. She also meets periodically with the department's research director and the CWLA staff to discuss specific cases, as well as systemwide issues raised by the special review process.

Both the draft and the final reports are reviewed by the OCA staff person assigned to the Child Fatality Review Panel and findings and recommendations are shared with panel members. According to the child advocate, the panel has been satisfied with the process and content of the reviews carried out by CWLA and the department. No separate reports or findings and recommendations have been issued, although modifications have been made to drafts based on input from the panel and its staff.

As of November 2007, DCF had completed 32 special reviews. The Child Fatality Review Panel, through its OCA staff person, was involved to some extent in about half of these and was participating in another seven reviews underway at the time of the committee's study.

There is some concern among panel members and OCA staff about the department's heavy reliance on an outside organization to staff its internal review function. However, the CWLA process is well-regarded for its independence, high-quality research, and support for workers. Both CWLA and the child advocate and other CFRP members have suggested the department consider ways to expand its capacity for fatality reviews and begin to examine critical incidents on a regular basis. It has also been suggested that the threshold for targeting cases for special review be extended from active DCF cases or those closed within six months to active cases or those closed within twelve months of the fatality or critical incident. These matters were among the system issues the OCA fatality review staff was discussing with the DCF research director and the CWLA consultants during the committee study period.

State Attorney General

The Office of the Attorney General has no general oversight authority for the Department of Children and Families or any particular state agency. Its main responsibilities regarding DCF are to: a) represent the agency in state and federal court proceedings brought on behalf of abused and neglected children's; and b) provide counseling on various civil matters including the legal sufficiency of contracts and regulations. However, through its role in whistleblower investigations, the attorney general's office also has conducted several in-depth reviews of DCF operations.

The state whistleblower law allows any citizen, including state officers and employees, to provide information about fraud, corruption, waste, abuse of authority, violations of state law or regulation, unethical practices, or mismanagement in a state department or quasi-public agency, without disclosure of their identity, to the State Auditors of Public Accounts. Matters received under this statute are reviewed by the auditors and forwarded, with their findings and any recommendations, to the attorney general for appropriate investigation. At the conclusion of the investigation, the attorney general, where necessary, reports any findings to the Governor, or in the case of criminal activity, to the Chief State's Attorney.

Limited staff resources require the attorney general's staff to prioritize its investigation projects. (Only about a dozen lawyers are dedicated to the functions of the Healthcare Fraud/Whistleblower/Health Insurance Advocacy Department of OAG.) In general, only whistleblower cases with substantial public interest concerns or evidence of system-wide failures, are selected for a full investigation.

To date, the attorney general has issued investigative reports on five matters related to DCF based on whistleblower complaints. These include: the department's oversight of a private residential treatment provider (Haddam Hills Academy); operations of the Connecticut Juvenile Training School, which involved an initial investigation and two follow-up reviews; the adequacy of community-based services for children; the DCF Hotline system; and children's access to psychiatric care. All were carried out in conjunction with the Office of the Child Advocate.

The attorney general's partnership with OCA began when the child advocate requested assistance in gathering evidence for its own review of Haddam Hills Academy at the same time the OAG's whistleblower unit was reviewing allegations of mismanagement at that facility. Recognizing that each office could benefit from the other's special expertise (e.g., OAG staff had experience with the subpoena process while OCA staff were familiar with DCF computer systems), the child advocate and the attorney general decided to conduct a joint investigation. Since that 2002 investigation, both agencies continue to work together on topics related to children and families.

Chapter V

Advisory Group Monitoring and Evaluation Activities

A number of committees, commissions, councils, and boards, established in accordance with state and federal law, have responsibility for advising and assisting DCF on matters within the department's purview. Such groups can provide the agency with an important external perspective on areas needing improvement or issues of concern. Recommendations, both informal and formal, for changes intended to achieve better outcomes for children and families often result from advising group monitoring and evaluation activities.

The PRI study focused on the monitoring and evaluation roles of the formal advisory groups that provide input directly to DCF. These include the statutorily established state and area office advisory councils as well as the advisory groups the commissioner is authorized to create for department-operated facilities. The program review study also examined the activities of several statutory groups that require DCF participation in providing advice to the legislature or governor on policies and services for children at risk, such as the Child Poverty and Prevention Council, the Families with Service Needs Advisory Board, and the Governor's Task Force on Justice for Abused Children.

During the study, the committee became aware of a number of informal advisory groups that appear to be influential in different areas under DCF jurisdiction. For example, CJTS has put in place a youth advisory board composed of facility residents who make recommendations regarding day-to-day practices at the facility. Additionally, a youth advisory group composed of children from various therapeutic group homes funded by the agency convenes monthly and makes proposals about residential matters in addition to planning outings and activities for the residents of the homes. While these and other ad hoc groups can provide an important outlet for children in the DCF system, the program review committee analysis was limited to activities of the key advisory groups required by either state or federal law.

Overview

The twelve mandated DCF advisory groups examined by the program review committee are summarized in Table V-1. Most of them were created a number of years ago, although four were created in the past seven years. In general, the groups meet on a monthly basis but at the time of the study two were inactive.

Membership of the groups also varies. In addition to members appointed by the governor and/or legislative leaders that represent parents, service providers, advocates, and the community, many require representation from state agencies, often on an ex officio, nonvoting basis.

As the table indicates, some groups are intended to serve only in an advisory capacity while others also are authorized to provide written recommendations or produce reports. In a few cases, the advisory group has, by law, specific monitoring and evaluation responsibilities. A good example is the Connecticut Behavioral Health Partnership Oversight Council. The duties, membership, and activities of each group is described in this chapter.

Table V-1. DCF Advisory Groups: Statutory Duties, Membership, and Status as of 2007			
<i>Advisory group (Yr. Estb.)</i>	<i>Statutory Duties</i>	<i>Members/ Appointment</i>	<i>Status</i>
State Advisory Council on Children and Families (SAC) (1971)	<ul style="list-style-type: none"> Make recommendations Annually advise on agency budget Consult on DCF commissioner appointment 	17 members representing children's services professionals, clients, and advocates appointed by the governor	Meets quarterly
Area Advisory Councils (1975)	<ul style="list-style-type: none"> Advise on planning and coordinating services within a DCF service area 	Created by DCF commissioner for each area with no more than 21 persons representing private service providers and others within the service area	Meet monthly
Children's Behavioral Health Advisory Committee (CBHAC) (2000)	<ul style="list-style-type: none"> Make recommendations to SAC Monitor, review and evaluate the provision of state dollars for children's mental health services 	Composed of: 24 public members that fairly and adequately represent parents of children who have a serious emotional disturbance, appointed by governor, legislative, and SAC chair and 8 ex-officio state agency representatives	Meets monthly
Connecticut Behavioral Health Partnership Oversight Council (BHPOC) (2005)	<ul style="list-style-type: none"> Assess state BHP program; monitor ASO Make recommendations Review delivery of mental health services to assure maximum federal contribution 	Composed of 16 members representing providers, consumers, and experts appointed by the chairs of the Medicaid Managed Care Advisory Council; 12 legislative committee chairs and ranking members; the DMHAS commissioner; a Community Mental Health Strategy Board member; and at least 9 state agency and other ex officio members	Meets monthly
CJTS Public Safety Committee (1999)	<ul style="list-style-type: none"> Review safety and security issues re facility 	Required to be composed of school superintendent and community representatives appointed by the mayor of the host municipality	Inactive
Families With Service Needs Advisory Board (2006)	<ul style="list-style-type: none"> Monitor progress of services for girls and implementation of P.A. 05-250 Make recommendations 	20 members including certain judicial, legislative, and executive branch officials or their designees and state employees and others specializing in juvenile justice appointed by various judicial, legislative, and executive, branch officials	Meets monthly
Citizen Review Panels - Federal mandate (1996)	<ul style="list-style-type: none"> Evaluate the extent to which the state is fulfilling its child protection responsibilities in accordance with its federal CAPTA plan 	Members must be broadly representative of the community and include individuals with expertise in prevention and treatment of child abuse and neglect	Meet as needed
Governor's Task Force on Justice for Abused Children (1996)	<ul style="list-style-type: none"> Monitor and evaluate DCF multidisciplinary child abuse teams Make recommendations for modification to the system of multidisciplinary teams 	Composed of parents, advocates and professionals, and co-chaired by the Chief State's Attorney and DCF commissioner	Meets monthly
Adoption Advisory Committee (1999)	<ul style="list-style-type: none"> Evaluate child welfare reform projects Make recommendations to promote adoption of hard-to-place children 	Required to have 12 members appointed by DCF commissioner	Inactive
Youth Suicide Advisory Board (1989)	<ul style="list-style-type: none"> Make recommendations Develop strategic prevention plan 	20 members including professionals and others with expertise in children's mental health/suicide prevention, students, educators, and a parent, all appointed by DCF, and three state agency representatives	Meets every other month
Child Poverty and Prevention Council (2004)	<ul style="list-style-type: none"> Develop 10-yr plan to reduce child poverty Establish prevention goals, outcome measures to promote health and well-being of children and families 	22 legislative leaders and state agency heads	Meets monthly
DCF Institution/Facility Advisory Groups (1971)	<ul style="list-style-type: none"> Created at commissioner's discretion to advise the facility 	Not specified in statute (in practice, varies by facility)	Varies by facility

Source: PRI staff analysis.

Agencywide and Area Advisory Groups

State Advisory Council on Children and Families. The State Advisory Council on Children and Families, established in 1971, is mandated to meet quarterly. In recent years, it has met on a monthly basis. Council members are appointed by the governor. By law its membership must include: persons who are child care professionals; a child psychiatrist; and at least one attorney. The remaining members must represent young persons, parents and others interested in the delivery of services to children and youth.

The DCF commissioner according to C.G.S. § 17a-6(m), shall “submit to the state advisory council for its comment proposals for new policies or programs and the proposed budget for the department.” This was not occurring during the committee study period. State law also calls for the governor to appoint the commissioner of children and families after consultation with the council. However, the council had a minimal role in the selection process for the most recent commissioner.

State statutes are silent as to the council’s primary role. Therefore, the SAC co-chairs decided to identify a main purpose for 2008 and over the next year focus on ways to improve the foster care system. The chairs made coordination with advising activities that are being carried out by various groups throughout the state another council priority.

Area Advisory Councils. As required by state statute since 1975, the commissioner of DCF must create “...an area advisory council to advise the commissioner and the area director on the development and delivery of services of the department in that area and to facilitate the coordination of services for children, youths and their families in the area.” At the time of the committee study, there were 13 area advisory councils in place.

Each council must not consist of more than 21 people, the majority of whom must be persons who earn less than 50 percent of their salaries from the provision of services to children, youth and their families. The balance of members must be representative of private providers of human services throughout the area. State statute sets specific guidelines on term limits and requires councils to meet at least quarterly.

The 13 area advisory councils set their own agendas and, therefore, all operate somewhat differently. For example, at the time of the committee study, the Norwich and Willimantic Area Advisory Councils held periodic community and provider forums, in which recommendations were made to their area offices and changes to DCF practice occurred. On the other hand, the Waterbury Area Advisory Council, which grew out of a national child welfare initiative (i.e., the Casey Breakthrough Series), focused its activities on developing and delivering prevention services to an area elementary school.

DCF Facility Advisory Groups

Under state law, enacted in 1971, the commissioner “may appoint advisory groups” for any DCF run institution or facility. Although discretionary, advisory groups have been in place at most department facilities in recent years. At the time of the program review study, the

Connecticut Juvenile Training School, Riverview Hospital and High Meadows all had active advisory groups, which are briefly described below. While an advisory group for the Connecticut Children's Place, had been active at one time, the program review committee found it had not met since September 2005.

Connecticut Juvenile Training School. The CJTS advisory group meets monthly at the facility. Members of the group include representatives from: community providers, the public defender's office, the mayor of Middletown, and juvenile court among others.

Unlike other DCF facility advisory groups, the board that advises CJTS has specific statutory duties that were enacted in 2003. To comply with these mandates, the staff of CJTS present facility updates and distribute summary data on critical incidents at each monthly meeting. Observations by program review staff showed the advisory group members are active participants in this process, offering suggestions on different ways to look at facility data to understand trends, as well as giving input on services and programs available at the facility.

The CJTS group serves as an informal mechanism for providing feedback to the facility. In addition, the advisory group has a formal monitoring and evaluation role: it is required by statute to submit an annual report to the legislature summarizing information about the residents, services, costs, certain program outcomes, and strategies for transitioning residents back to their communities. Staff of the facility initially prepares this report for review by the group members. The advisory group then develops its recommendations for improvement or enhancement of CJTS, which are included in the final document presented to the DCF commission and the legislative committees of cognizance.

Riverview Hospital. Riverview Hospital's advisory group activity has ebbed and flowed in recent years. After many months of not meeting, the hospital's advisory group was reinstated by the facility's acting superintendent in January 2007. Prior to her appointment, the advisory group lacked clear direction and was composed mostly of DCF employees.

During the committee's review, the group designated a new chairperson and was in the process of formalizing its structure and expanding the diversity of its membership. The advisory group's plan for the upcoming year included monitoring progress with the hospital's newly developed strategic plan and working to develop relationships between the hospital and the community.

High Meadows. The citizen advisory group for High Meadows was established several years ago primarily in response to community concerns about the facility. It was meeting on a quarterly basis but hadn't met since January 2007 at the time of the committee's study.

Although not formally required by statute, High Meadows also has a youth advisory group that meets on a monthly basis. Each cottage has representatives. They meet with the Ombudsman, intake worker, and cottage supervisor. Similar to a student council at a public school, the youth advisory group focuses on issues related to activities, food, rules, and community living.

Federally Mandated Advisory Groups

Citizen Review Panel. Under the federal Child Abuse Prevention and Treatment Act, Connecticut, like all states, is required to establish a minimum of three Citizen Review Panels. Each panel must evaluate the extent to which the state is fulfilling its child protection responsibilities in accordance with its CAPTA state plan. This evaluation includes: 1) examining the policies, procedures and practices of state and local child protection agencies; and 2) reviewing specific cases where appropriate. In addition, consistent with sections 106(c) (4) (a) (iii) of CAPTA, a panel may examine other criteria that it considers important to ensure the protection of children, including the extent to which the state and local CPS system is coordinated with the Title IV-E foster care and adoption assistance programs of the Social Security Act (Section 106(c) (4) (a) and (ii)).

In order to assess the impact of current procedures and practices upon children and families in the community and fulfill the above requirements, citizen review panels must provide for public outreach and comment (Section 106(c) (4) (c) of CAPTA). Finally, each panel must prepare an annual report that summarizes the activities of the panel and makes recommendations to improve the CPS system at the state and local levels, and submit it to the state and the public (Section 106(c) (6) of CAPTA). DCF then has 6 months to respond to the panels' recommendations.

Currently, the State Advisory Council, with federal approval, fulfills the role of one of the state's panels. In 2005, DCF contracted with FAVOR, Inc., a statewide family advocacy organization for children's mental health, to establish and administer the other two panels.

Although both groups have met their obligations as required by federal law, only the panel conducted by FAVOR receives funding from DCF to carry out its panel responsibilities.

Issue-Specific Advisory Groups

Children's Behavioral Health Advisory Committee. CBHAC was originally formed as an ad hoc subcommittee of the State Advisory Council that addressed children's mental health systems of care issues. It was formally established under P.A. 00-188 to serve in an advisory capacity to the State Advisory Council in promoting and enhancing the provision of behavioral health services for all children in Connecticut.

Under current state law, CBHAC is composed of eight ex officio members who are state agency officials or their designees, eight public members appointed by legislative leaders and the governor, and 16 public members appointed by the State Advisory Council on Children and Families. By law, the majority of members must be "parents or relatives of a child who has or had a serious emotional disturbance or persons who had a serious emotional disturbance as a child." The appointed members are limited to two-year terms.

The committee is chaired by two persons elected from among its public members, at least one of whom is a parent of a child with serious emotional disturbance. The committee must meet at least bimonthly with DCF supporting the committee by providing a staff person to take minutes and publish its agendas.

CBHAC is required by statute to submit an annual status report on local systems of care and practice standards for state-funded behavioral health programs to SAC. On a biannual basis, it also must submit “recommendations concerning the provision of behavioral health services for all children in the state” to the State Advisory Council on Children and Families. The committee also reviews the state’s federal Mental Health Block Grant and submits recommendations, which then accompany the state’s grant application.

During 2007, the advisory committee spent six months revising its by-laws in an attempt to put more structure around its activities. The by-laws were approved at its September 2007 meeting. Under the new by-laws, the committee sends its monthly minutes, which contain recommendations, to the SAC to allow for more timely communication. In general, the committee is considered to provide a forum for strong parent involvement.

Youth Suicide Advisory Board. The Youth Suicide Advisory Board, created by P.A. 89-191, was established within the Department of Children and Families to serve as a coordinating source for youth suicide prevention. As outlined in statute, the board must consist of 20 members, including: a psychiatrist; a psychologist; a representative from a local or regional board of education; a high school teacher; high school student; a college or university faculty member; a college or university student; a parent; and representatives from the Departments of Public Health, Education, and Higher Education.

State statute outlines the following seven duties for the advisory board:

- increase public awareness of the existence of youth suicide and means of prevention;
- make recommendations to the DCF commissioner for the development of statewide training in the prevention of youth suicide;
- develop a strategic youth suicide prevention plan;
- recommend interagency policies and procedures for the coordination of services for youth and families in the area of suicide prevention;
- make recommendations for the establishment and implementation of suicide prevention procedures in schools and communities;
- establish a coordinated system for the utilization of data for the prevention of youth suicide; and
- make recommendations concerning the integration of suicide prevention and intervention strategies into other youth-focused prevention and intervention programs.

At present, the DCF Director of Prevention is responsible for the Youth Suicide Advisory Board. Its activities are funded through the agency budget and federal Mental Health Block Grant monies the department receives. The board has been active over time and submits recommendations to the commissioner each year. Implementation of these recommendations is tracked by the advisory board and DCF prevention staff.

Inactive Advisory Groups

Adoption Advisory Committee. Although required by statute since 1999, the 12-member Adoption Advisory Committee currently does not exist. When initially established, the committee was active and met quarterly. However, in 2002, it was merged with the department's five Community Collaboratives, that for all practical purposes meet the committee's intended purpose.

The collaboratives, which are made up of members of the community and DCF staff, are responsible for implementing strategies for recruitment and support of foster and adoptive families. Each collaborative must do outreach to specific minority groups, with recruitment efforts focusing on the need for placement of minority children. Current strategies include: increasing visibility in targeted neighborhoods; organizing presentations and advertisements on minority radio; and targeting Latino cultural events. Each DCF area office, with the assistance of the collaboratives, must develop a foster care recruitment plan with a focus on recruitment for minority and difficult to place children.

CJTS Public Safety Committee. Under a state law enacted in 1999, a public safety committee must be established to review safety and security issues that affect the host community where the Connecticut Juvenile Training School is located. The mandated membership of the CJTS Public Safety Committee includes the school's superintendent and an unspecified number of representatives appointed by the host community mayor. Although active at one time, this committee does not exist at present. Its function essentially has been assumed by the CJTS advisory group, an entity that includes the mayor of Middletown, which is where the facility is located.

Advisory Groups Requiring DCF Participation

Behavioral Health Partnership Oversight Council. In 2005, an oversight council to the state's Behavioral Health Partnership was created by state statute with clearly defined membership requirements and specific monitoring and evaluation duties. In addition to the chairpersons and ranking member of the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health, appropriations and the budgets of state agencies (or their designees), council member must include the DMHAS commissioner, and a member of the Community Mental Health Strategy Board, and 16 members appointed by the Medicaid Managed Care Advisory Council that represent certain providers, consumers, and experts. The statutes also provide for at least nine ex officio council members, seven of whom are appointed by various state agency heads and officials, two or more who are consumers appointed by the council chairperson, and others who represent the BHP administrative services organization and Medicaid managed care organizations.

The oversight council is organized into five subcommittees: Coordination of Care, Quality Management and Access, Provider Advisory, Operations, and DCF Advisory. Each of the subcommittees, as well as the oversight council, meets on a monthly basis.

In accordance with its statutory mandate, the council must also submit a report on its activities and progress to the legislature each year. Additionally the council must make specific recommendations on matters related to the planning and implementation of the Behavioral Health Partnership, which must include, but are not limited to the review of:

- any contract entered into by DCF and DSS with an administrative services organization, to assure that decisions are based solely on clinical management criteria developed by the clinical management committee;
- behavioral health services pursuant to Title XIX and Title XXI of the Social Security Act to assure that federal revenue is being maximized; and
- periodic reports on the program activities, finances and outcomes, including reports from the director of the Behavioral Health Partnership, on achievement of service delivery system goals.

Finally, the council may conduct, or cause to be conducted, an external, independent evaluation of the Connecticut Behavioral Health Partnership.

Governor’s Task Force on Justice for Abused Children. The Governor’s Task Force on Justice for Abused Children, first established in 1988, focuses on coordinating DCF multidisciplinary teams in the beginning stages of a child abuse or neglect investigation. Designees from the Department of Children and Families and the Division of Criminal Justice co-chair the committee. Other members of the task force include, but are not limited to: designees from the Office of the Public Defender, Office of the Attorney General, and Office of the Child Advocate; a parent; a health professional; a parent group representative; a disabled children’s advocate; and a private practice clinician. The task force receives federal funding to support its activities from the state’s Children’s Justice Act Grant.

In 2002, in accordance with C.G.S. § 17a.-106a(c), a permanent Multidisciplinary Team (MDT) Evaluation Committee was established as part of the Governor’s Task Force to review protocols and monitor and evaluate the performance of MDTs and make recommendations for modification to the system.

Child Poverty and Prevention Council. In June 2006, the state’s existing Child Poverty Council and the inactive Prevention Council were combined to form one statutory advisory group. The council, which is overseen by the Office of Policy and Management, now is composed of 22 legislative leaders and agency heads, including the DCF commissioner, or their designees.

At present, the Child Poverty and Prevention Council has two main purposes:

1. to develop and promote the implementation of a ten-year plan to reduce the number of children living in poverty in the state by 50 percent; and
2. to establish prevention goals and recommendations, and measure prevention service outcomes, to promote the health and well-being of children and families.

Prior to the two councils joining, the Child Poverty Council had created a ten-year plan to reduce child poverty. That plan, which contained 67 recommendations for executive and legislative branch consideration, is being monitored by the current combined council.

By law, the council must submit an annual progress report containing updates on actions taken to date to implement the plan to the legislature. Each year, DCF, like all other agencies with prevention responsibilities, submits a progress report on its programs focused solely on prevention to the council.

Families with Services Needs Board. The FWSN advisory board was established in 2006 by P.A. 06-188. Its members must include: the chief court administrator, chief child protection attorney, chief state's attorney, the child advocate, the OPM secretary, and four members of the Judiciary and the Human Services Committees (or their designees); two juvenile services DCF employees appointed by the commissioner; a juvenile court judge appointed by the chief justice; a public defender specializing in FWSN cases appointed by the chief public defender; a member appointed by the governor; and two chairs, one each appointed by the House speaker and the Senate president pro tempore.

At the time of the committee's review, the board, as required by law, was meeting monthly. Under its statute, the Families With Service Needs Advisory Board must: monitor the progress being made by the Department of Children and Families in developing services and programming for girls from families with service needs and monitor the progress being made by the Judicial Department in the implementation of the requirements of P.A. 05-250.

The FWSN board is also responsible for providing advice and, by December 31, 2007, making written recommendations to the Judicial Department or the General Assembly with respect to P.A. 05-250. A report with recommendations was submitted by the board as required. Originally, the board was scheduled to terminate on its reporting deadline but its timeframe was extended to July 2008 by legislation enacted during the June 2007 special session.

Chapter VI

Results From Monitoring and Evaluation Efforts

A major task in this study was gathering findings on the performance or results of DCF services and programs. In this report, the term “results” refers to the data or information about the department collected in any monitoring and evaluation report. For example, if the monitoring and evaluation effort related to a *Juan F.* consent decree goal of having at least 85 percent of all child abuse/neglect investigations completed within 45 calendar days of the call’s acceptance by Hotline, then the results are the data about how long it took for the hotline investigations to be completed.

Study results and other available written materials from the various entities monitoring and evaluating the agency were reviewed. Although the department produces a number of reports containing activity and outcome data, this chapter brings together DCF agencywide and specific program performance information from internal, external, investigative, and advisory group monitoring and evaluation sources.

The chapter begins with an overview of what is known about the progress made in achieving the department’s main goals within the past three to five years. A detailed summary of consent decree data as well as federal evaluation results are then presented, two key monitoring and evaluation areas. Information is then provided about the effectiveness of programs within each of the four mandate areas and agencywide. The chapter concludes with a summary of results from key monitoring and evaluation efforts.

As noted earlier, the information presented here should not be considered a complete inventory of agency results, as not every monitoring and evaluation effort occurring over the past three to five years could be reviewed within the study time frame. However, this information represents a large sample of DCF results data drawn from multiple sources and many types of outcome measurement and reporting activities.

Overview

One purpose of the PRI study was to determine what the various monitoring and evaluation reports produced within the past five years concluded about the performance of DCF. The committee found that *the monitoring and evaluation results are mixed, with some positive and some negative results*. Overall, the external monitors and evaluators are the most positive, and the investigators most negative.

In comparison to reports pertaining to one of the four mandate areas, those focusing on the entire agency were significantly more likely to have negative findings. The committee further found that investigations have the greatest proportion of efforts with an agencywide focus (40 percent), which also tend to have the most negative results.

Mandate area and agencywide results are shown in Table VI-1. More detailed results are provided in the rest of this chapter.

Table VI-1. Selected Monitoring and Evaluation Data Results (2002-2007)

Mandate Area	Data Results
Child Protective Services	<ul style="list-style-type: none"> • Targets for the majority of quantitative <i>Juan F.</i> exit plan outcome measures concerning practice standards have been reached; performance is still considerably below benchmarks for quality indicators related to treatment planning and meeting children’s needs • System gridlock (discharge delays, wait lists, lack of foster and adoption resources) exists in the current array of treatment and placement services • The number of foster homes is decreasing rather than increasing • The results are about the same for SAFE Home and Foster Care (e.g., similar average length of stay (seven months), sibling placement) but SAFE Home costs twice as much as foster care • From 2000-2005, the proportion of children put in family settings increased from 65% to 71% (found that the older the child, the less likely to be put in a family-like setting)
Behavioral Health Services	<ul style="list-style-type: none"> • The Intensive In-home Child And Adolescent Psychiatric Services (IICAPS) program found a decrease in the number of inpatient admissions and a decrease in inpatient lengths of stay for those who had to be admitted • The Hartford Youth Project found a decrease in alcohol use, marijuana use, illegal activity, and 5+ absences from school • Children impacted by the <i>Emily J.</i> settlement agreement were more likely to avoid residential placement (for 72% of children) and remain in the community for at least six months (for 2/3 of the children) • PARK project staff built a strong partnership with the school system in Bridgeport (viewed as "best practice") • The Mental Health Transformation State Incentive Grant (MHT-SIG) met 27 of 29 target goals (93%) including using Multi-Systemic Therapy, Multi-Dimensional Family Therapy, and other evidence-based treatment models to support youth with co-occurring disorders (both substance abuse and mental health disorders)
Juvenile Services	<ul style="list-style-type: none"> • Supervision of parole workers and parole supervisors was found to be inconsistent; there were no criteria or processes to guide parole decisions to discharge children from out-of-home care • The Connecticut Juvenile Training School (CJTS) showed the same or

Table VI-1. Selected Monitoring and Evaluation Data Results (2002-2007)	
Mandate Area	Data Results
	<p>better ratings on 26 of 32 critical outcome measures over a recent six-month period; two-thirds (64%) were the same or better than similar facilities in the field nationally</p> <ul style="list-style-type: none"> • Reduction in restraints and seclusion for boys at CJTS; however, there is not total compliance • The recidivism rate for 121 boys discharged from CJTS during Sept. 1, 2005-April 10, 2006, was 35 percent (22 percent returned to CJTS and 13 percent into the adult criminal system) • CJTS discharge plans and aftercare are uneven • The purpose of CJTS activities is vague • A pilot program found a high percent of boys receiving needed services while at CJTS, and the majority follow up on post-CJTS needed services
Prevention Services	<ul style="list-style-type: none"> • Some program developers of evidence-based models understate the resources needed to implement the program with fidelity to the model; different contexts have unique sets of challenges; there are also issues with translated materials (Spanish not available or incorrect) • There has been an increase in self-confidence and self-reliance for youth who participate in a Wilderness School program
Agencywide	<ul style="list-style-type: none"> • Child fatality reviews found that DCF failed to monitor or follow up to ascertain whether parents were complying with court orders • Child fatality reviews found that DCF did not coordinate or facilitate communication between DCF, service providers, medical experts, courts, and attorneys • Child fatality reviews found that DCF did not keep accurate records • Child fatality reviews found that DCF failed to follow its own policies
Source: PRI staff analysis.	

Detailed Monitoring and Evaluation Results within Child Protective Services

Information about DCF's performance derived from the *Juan F.* consent decree and *Emily J.* settlement agreement court monitoring and federal evaluations is presented here. Data from monitoring efforts related to major child protective services programs, such as the Hotline, adoption services, foster care services, and SAFE Homes, are also discussed.

***Juan F.* consent decree.** Under the current exit plan for the *Juan F.* consent decree, sustained compliance -- defined as meeting performance goals for at least two consecutive quarters (a six-month period) -- with all 22 outcome measures is required before the court will consider ending judicial oversight of DCF child welfare activities. In addition, total compliance must be maintained throughout the court's decision making process concerning termination.

Quarterly status reports prepared by the court monitor show steady progress is being made in achieving the exit plan goals (see Table VI-2). The latest report available within the study time frame was issued on September 24, 2007 (for the period April 1 to June 30, 2007) and stated the agency:

- was in compliance with 17 of the 22 required exit plan outcome measures;
- had sustained compliance with 15 measures for at least 2 consecutive quarters (6 months); and
- had not achieved compliance with 5 measures.

Figure VI-1 shows the department’s improved *Juan F.* compliance performance over the last three and a half years. 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.

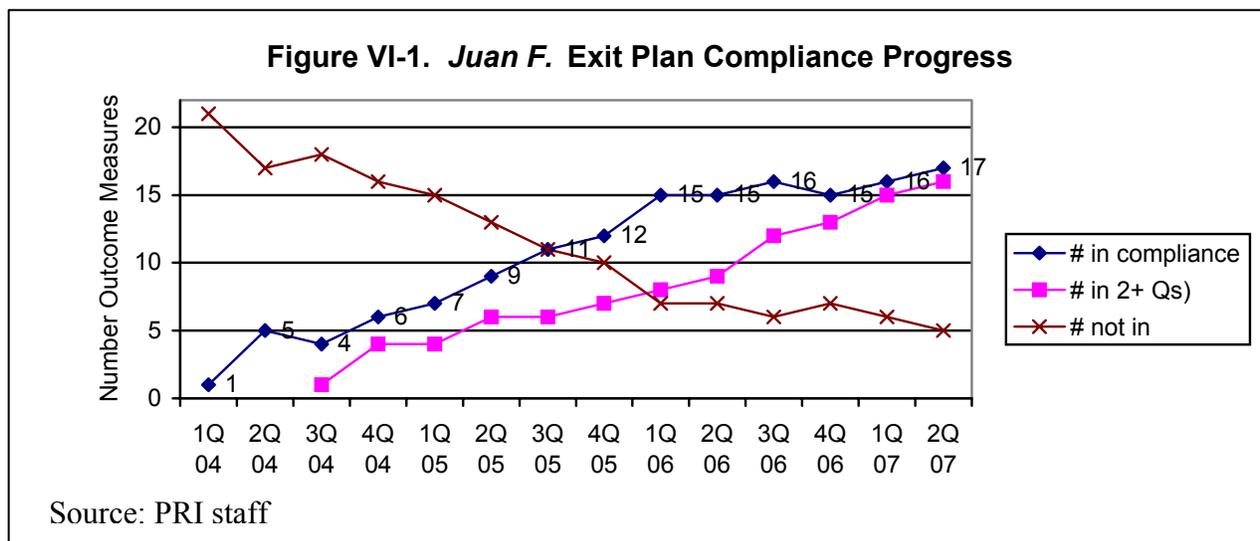


Table VI-2. Juan F. Consent Decree Outcome Measures: Compliance Status as of June 2007

No.	Measure	Target	Baseline	2Q 2007 Results	Target Met? (# Consecutive Quarters Met)
1	Investigation Commencement	>=90%	X	97.1%	YES (11)
2	Investigation Completion	>=85%	73.70%	93.7%	YES (11)
3	Treatment Plans	>=90%	X	30.3%	NO
4	Search for Relatives	>=85%	58%	93.8	YES (7)
5	Repeat Maltreatment	<=7%	9.30%	6.3%	YES
6	Maltreatment of Children in Out-of-Home Care	<=2%	1.20%	0.1%	YES (14)
7	Reunification with Parents/Guardian	>=60%	57.80%	67.9%	YES (8)
8	Adoption	>=32%	12.50%	40.6%	YES (3)
9	Transfer of Guardianship	>=70%	60.50%	88.0%	YES (4)
10	Sibling Placement	>=95%	57%	79.1%	NO
11	Re-Entry into DCF Custody	<=7%	6.90%	8.5%	NO
12	Multiple Placements (<=3 during 12 months)	>=85%	X	96.0%	YES (13)
13	Foster Parent Training	100%	X	100%	YES (13)
14	Placement Within Licensed Capacity	>=96%	94.90%	97.1%	YES (4)
15	Children's Service Needs Met	>=80%	X	51.3%	NO
16	Worker-Child Visitation (Out-of-Home)*	monthly >=85%	Monthly/Quarterly	94.61% 98.7%	YES (7)
17	Worker Child Visitation (In-Home)	>=85%	X	90.9%	YES (7)
18	Caseload Standards	100%	69.20%	100%	YES (13)
19	Residential Placement Reduction	<=11%	13.50%	11.0%	YES (5)
20	Discharge Measures	>=85%	61%	100.0%	YES (8)
21	Discharge to DMHAS and DMR	100%	X	83.0%	NO
22	Multi-Disciplinary Exam (MDE)	>=85%	5.60%	96.8%	YES (6)

* Under the provisions of the consent decree, the measure for worker-child visitation for out-of-home cases is reported on both a monthly and quarterly basis

Source of Data: Exit Plan Quarterly Report April 1, 2007 - June 30, 2007, Juan F. Court Monitor's Office, September 24, 2007.

While acknowledging the department's success in achieving a number of the exit plan goals related to compliance with time frames and other process requirements, the monitor called for the department to focus attention on improving quality of effort, particularly in the area of treatment planning. Gradual progress in some areas of the treatment plan assessment was shown by the comprehensive case review. However, in spite of increased training and resources, plans were found to be developed without full participation of active case participants on a regular basis. In addition, treatment plans often lacked: clear, focused goals; inclusive action steps for the case participants, providers, and DCF; and identification of progress.

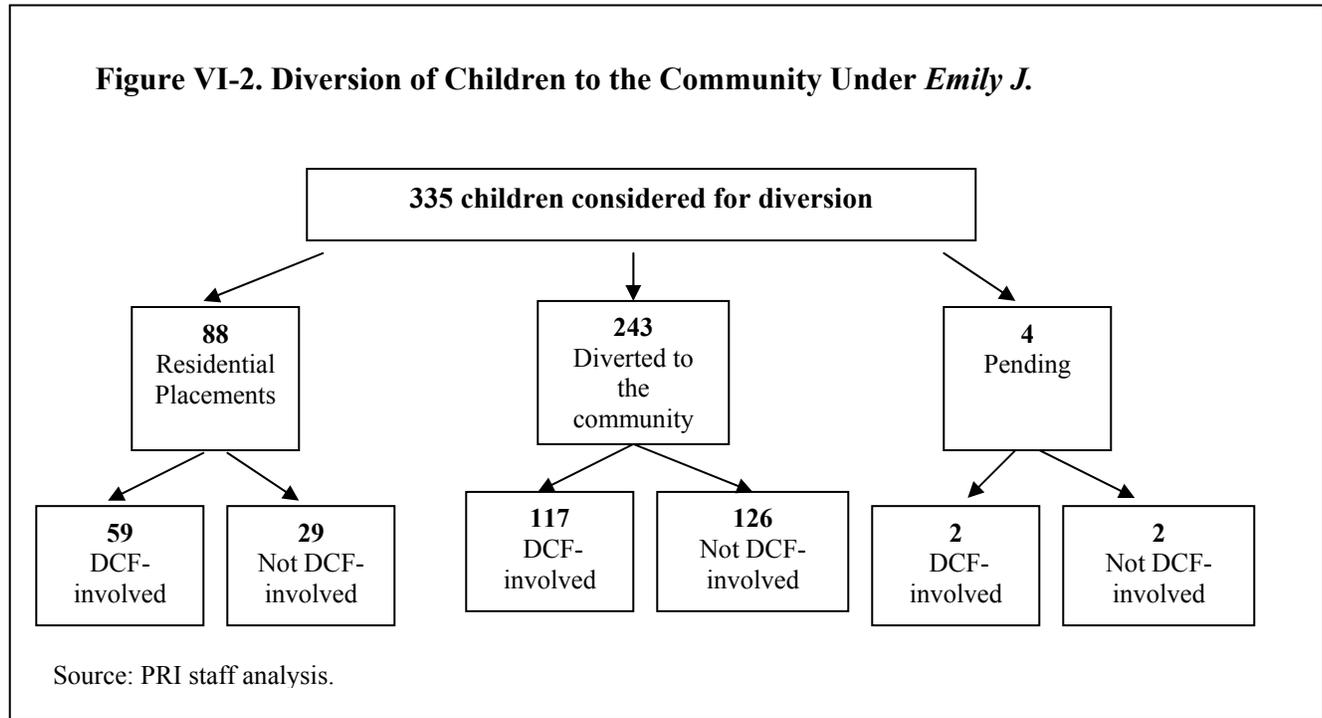
According to the monitor, a barrier to meeting the needs of children and families identified in their treatment plans is gridlock in the current array of available treatment services and placement options. Discharge delays are routine at all levels of residential behavioral health care and there are wait lists for community-based programs in most areas. Foster care and adoptive resources are also inadequate.

Summary of *Juan F.* consent decree results. To summarize, both parties and the monitor attribute the dramatic compliance progress since January 2004 to: a) the court monitor's efforts to track and report on results; and b) the agency's efforts, in response, to focus on corrective actions to improve performance. According to the monitor, due to capacity and treatment plan deficiencies, the pace of improvement has stalled over the last year as DCF remains challenged in meeting placement, permanency, and treatment needs for a number of children. Compliance for two closely related key outcomes -- Treatment Plans (#3) and Needs Met (#15) -- continues to be well below the targets established by the exit plan.

The court monitor's exit plan report for the second quarter of 2007 shows just 30.3 percent of DCF child welfare cases had appropriate treatment plans (versus the goal of at least 90 percent). Service needs of children and families were met in accordance with treatment plans in just over half (51.3 percent) of cases (compared with a target of at least 80 percent). The *Juan F.* Action Plan developed in the spring of 2007 to address the needs met and treatment planning goals is an attempt to replicate the success of the earlier Positive Outcomes for Children action plan for reaching other consent decree goals.

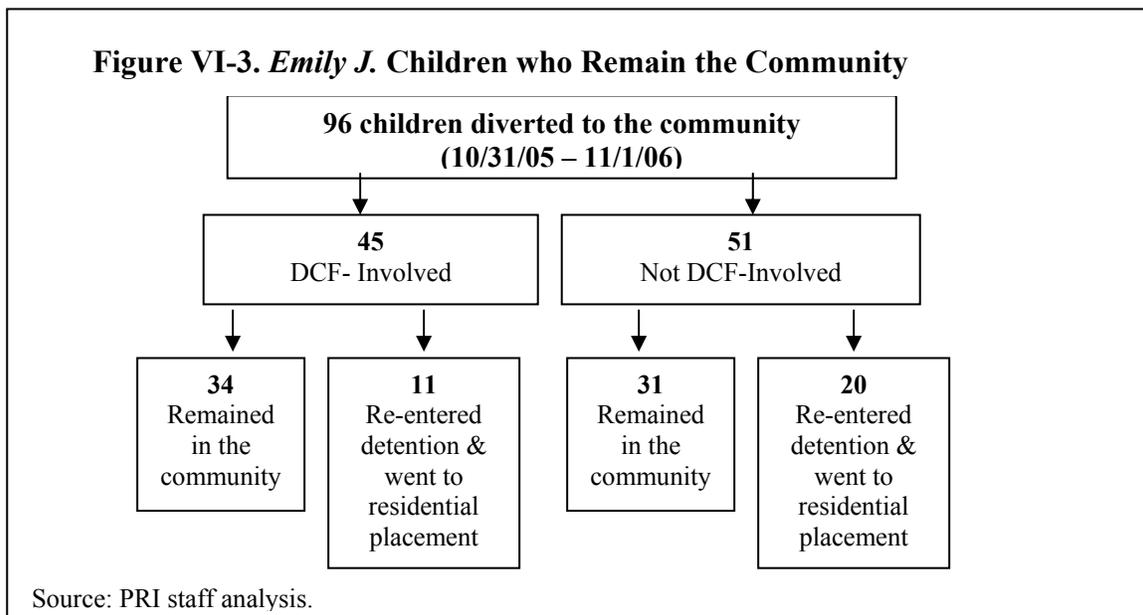
***Emily J.* settlement agreement.** Ensuring children involved in the juvenile justice system remain in the community is a key goal of the *Emily J.* settlement. Between October 31, 2005 and May 31, 2007, there were 335 children considered for diversion from residential placement (see Figure VI-2). Of those, 243 (72.5%) were diverted to the community, 88 went to residential placement, and 4 cases were still pending. Almost two thirds of the children diverted from residential placement (117) were DCF-involved.

Figure VI-2. Diversion of Children to the Community Under *Emily J.*



Ensuring children remain in the community after diversion from residential placement is another key goal of the *Emily J.* settlement. Of the 243 who were diverted to the community, 96 children were diverted between October 31, 2005 and November 1, 2006 (see Figure VI-3). To determine whether the children were able to successfully remain in the community, DCF with the technical assistance of the University of Connecticut Health Center, tracked the placement of the children. As of May 1, 2007, a total of 65 (67.7%) remained in the community after their initial diversion, while 31 re-entered detention which resulted in residential placement.

Figure VI-3. *Emily J.* Children who Remain the Community



Summary of *Emily J.* settlement results. Collaboration between local DCF and CSSD personnel to put new services in place because of the *Emily J.* settlement has helped divert youths from the juvenile justice system, especially from residential facilities, to treatment in the community. In its second year, the settlement resulted in more than \$6 million in new community-based treatment services for detention-involved children at imminent risk for residential treatment. Together, both agencies have developed plans to sustain these programs and services and expand them statewide to constituents beyond the *Emily J.* class. As a result, 72.5 percent of children were diverted from residential placement to the community. The *Emily J.* settlement was successfully completed and the case closed in October 2007.

Federal evaluation results related to AFCARS. As described in Chapter III, the Adoption and Foster Care Analysis and Reporting System (AFCARS) is a federally mandated system that contains case level information on every child in foster care for whom state child welfare agencies have responsibility for placement, care, or supervision, and on every child who was adopted under the auspices of the state's public child welfare agency. AFCARS also has general requirements that determine both the accuracy of the population being reported and the technical requirements for constructing the data file.

In 2001, the federal government assessment report of Connecticut cited significant deficiencies on both population and technical general requirements. As Table VI-3 shows, no comparison states to date received such low scores in both requirement areas.

State	Foster Care Data Elements Requiring System Modifications	Adoption Data Elements Requiring System Modifications
Connecticut	83%	89%
Maine	36%	40%
Massachusetts	30%	40%
New Hampshire	41%	51%
New Jersey	Not yet reviewed	Not yet reviewed
New York	Not yet reviewed	Not yet reviewed
Rhode Island	30%	51%
Vermont	32%	22%

Source: U.S. Department of Health & Human Services Administration for Children & Families Children's Bureau AFCARS Assessment Review Findings-General Requirements (www.acf.hhs.gov/programs/cb/stats_research/afcars/aar)

At DCF's request, an AFCARS site visit occurred in January 2007. A total of eight areas were reviewed during the 1.5 day site visit. Issues found related to removal dates, discharge dates, and treatment plans. Table VI-4 shows the general requirements and foster and adoption data elements that continue to be out of compliance. Since the first AFCARS site visit in July 2001, a total of 60 percent of the general requirements, 100 percent of the foster care data requirements, and 91 percent of the adoption data requirements that had been out of compliance in 2001, remain out of compliance in January 2007.

Summary of federal AFCARS results. Connecticut continues to struggle to meet the federal AFCARS requirements. Two consultants were recently hired to work on AFCARS. They have developed an action plan that documents, for example, every element and lays out when coding changes for particular variables will occur, in priority order. Key improvements are needed in preparation for the September 2008 Child and Family Services Review, which will rely on AFCARS information.

Federal evaluation results related to Child Welfare National Outcome Standards. Connecticut had its Child and Family Services Review onsite visit during April 8-12, 2002. The review examined records for the time period of April 1, 2001 through April 8, 2002. Table VI-5 shows Connecticut's outcomes on these measures in relation to the national standards. Connecticut met national standards on two of the six measures (33 percent). The data reflected in Table VI-5 are prior to significant changes made by the department.

Other standards reviewed involve systemic areas, and Connecticut's conformance with the national systemic factors is shown in Table VI-6. The state achieved substantial conformity with four of the seven system factors (57 percent).

Table VI-4. AFCARS Areas Out of Compliance

Continued Non-Compliance Areas under *General Requirements*

Three of the five general requirement areas continue to be out of compliance:

- Capturing population of children that remain in the state’s care, placement, or supervision while the child has been on a trial home visit
- Lack of previous removal information for cases that were open in 1993 or earlier, due to the department’s conversion from a former system (CMS) to the LINK system
- Lack of historical information related to removals and discharges for cases that were closed when the department converted from CMS to LINK, and have since re-opened

Continued Non-Compliance Areas under *Foster Care Requirements*

- All 34 Foster Care Data Elements continue to be out of compliance
- Progress was made on 22 of the Foster Care Data Elements
- Among the foster care requirements that continue to be out of compliance are:
 - Lacking dates of periodic reviews conducted on youth in the juvenile justice population that are under the care of DCF
 - Current placement setting does not capture runaways; are coded under “independent living”
 - Some Termination of Parental Rights dates were not converted from paper files to LINK

Continued Non-Compliance Areas under *Adoption Requirements*

- All 22 Adoption Data Elements continue to be out of compliance
- Progress was made on two of the Adoption Data Elements
- Among the adoption requirements that continue to be out of compliance are:
 - Setting missing information to “unable to determine” for whether child is of Hispanic origin
 - Defaults to “agency has determined the child has no special needs” when status has not been determined
 - Capturing of medical information such as visually/hearing impaired

Source: AFCARS Assessment Review Improvement Plan, Children’s Bureau, March 2007.

Table VI-5. Connecticut's Conformance with the National Standards in 2002

Data Indicator	National Standard (Percentage)	CT Percentage*	Standard Met by CT?
<i>Repeat Maltreatment</i>	6.1 percent or less	11.4 percent	No
<i>Maltreatment of Children in Foster Care</i>	.57 percent or less	3.07 percent	No
<i>Foster Care Re-Entries</i>	8.6 percent or less	6 percent	Yes
<i>Length of Time To Achieve Reunification was less than 12 months from the time of the latest removal from home</i>	76.2 percent or more	55.1 percent	No
<i>Length of Time To Achieve Adoption was less than 24 months from time of the latest removal from home</i>	32 percent or more	6.5 percent	No
<i>Stability of Foster Care Placements (of all children in foster care less than 12 months, the percent that have had no more than two placement settings)</i>	86.7 percent or more	92.8 percent	Yes

* Data prior to significant changes made by the department

Source: Children's Bureau Child and Family Services Reviews Key Findings Report, Connecticut Department of Children and Families.

Table VI-6. Connecticut's Conformance with the National Systemic Factors in 2002								
Systemic Factor	Achieved Substantial Conformity?							
	CT	ME	MA	NH	NJ	NY	RI	VT
Statewide Information System	No	Yes	Yes	Yes	Yes	No	Yes	Yes
Case Review System	No	No	No	No	No	No	No	Yes
Quality Assurance System	Yes	No	Yes	Yes	No	Yes	No	No
Training	Yes	Yes	Yes	Yes	No	Yes	No	Yes
Service Array	Yes	No	Yes	No	No	No	No	Yes
Agency Responsiveness to the Community	No	Yes	Yes	Yes	No	Yes	No	Yes
Foster and Adoptive Parent Licensing, Recruitment, and Retention	Yes	Yes	Yes	Yes	No	Yes	No	No
Source: Children's Bureau Child and Family Services Reviews Key Findings Reports Fiscal Years 2001 through 2004.								

As Table VI-5 shows, Connecticut was able to meet two of the six national outcome standards: foster care re-entries and stability of foster care placements. The federal report also examined seven national systemic factors, and cited several strengths of DCF's quality assurance system. These include the implementation of standards to ensure that children in foster care are provided with quality services, and the state's system capacity to monitor the quality of services, identify strengths and needs of the service delivery system, provide reports, and evaluate program improvement measures. The federal report also cited several concerns about the statewide information system, including an inability to determine the status, demographics, location, and goals for all children in foster care. The report also noted reviewer concerns with children in foster care not having written case plans, and children and parents not consistently involved in case planning when it does occur.

A Program Improvement Plan was developed by DCF and submitted to the Children's Bureau. In Fall 2003 the PIP plan was rejected by the federal government for lack of evaluative strategies. In recognition of a need for better use of data, Connecticut contracted with the University of Kansas the following year to develop a system to extract data from LINK, called the ROM reporting system.

Title IV-E Foster Care Eligibility Review. In state FY 07, Connecticut received \$106 million for reimbursement for foster care and adoption expenses under Title IV-E of the Social Security Act. As part of the monitoring to determine whether eligibility determination for reimbursement is conducted properly, state strengths and areas in need of improvement are

identified by the federal reviewers. In the most recent Title IV-E Foster Care Eligibility Review, it was noted under “strengths” that: “Overall, DCF and the Courts have significantly improved the content and timeliness of the court order sanctioning the removal of the child from his/her home.” Under “Areas in Need of Improvement,” the review reported that “six cases had issues with the lack of and/or untimely criminal records/safety checks.”

Table VI-7 shows the outcomes of the two most recent Title IV-E Foster Care Eligibility Reviews for Connecticut and other states in New England and the Northeast. In comparison to the other states, Connecticut is one of the few with substantial compliance for both reviews.

Table VI-7. Title IV-E Foster Care Eligibility Review Outcomes		
State/Region	Most Recent Review* Substantial Compliance?	Next Most Recent Review Substantial Compliance?
Connecticut	Yes	Yes
Maine	Yes	No
Massachusetts	Yes	No
New Hampshire	Yes	Yes
New Jersey	No	No
New York	Yes	No
Rhode Island	Yes	Yes
Vermont	Yes	No
* Reviews are conducted approximately every three years.		
Source: Source: Children’s Bureau Website – Title IV-E State Reports (http://www.acf.hhs.gov/programs/cb/cwmonitoring/final/primary/ma.htm).		

Child Protective Services Programs Specific Results

Hotline. *The goal of Hotline is to: provide professional, timely response to reports of alleged child abuse/neglect and services to ensure the best protection of children.*

Hotline services have improved greatly in the past two years with regard to timeliness of commencement and completion of investigations. A new process called Structured Decision Making, which is expected to improve substantially the agency’s risk assessment process, was implemented in the spring of 2007. Regular evaluation of its impact on child safety outcomes is planned by a workgroup of agency staff and stakeholder representatives.

Adoption Services. *The goal of Adoption Services is to: provide permanent homes for children who cannot return to their biological families.*

Connecticut was far behind most other states in having adoptions occur within 24 months of a child's entry into care. The department has made great progress, however, in improving the timeliness of adoptions. DCF has sporadically achieved the related *Juan F.* adoption outcome measure, which is the same as the federal outcome measure. A negative consequence to improving the speed with which adoptions occur is the unacceptably high disruption rate (i.e., failed adoption) found by the court monitor, and the record of DCF social worker concerns about the fit of the child with the family found by Casey Family Services.

Foster care services. *The goal of Foster Care Services is to: provide for a child's needs in a substitute family experience until return to home is possible, or, if not, until an alternate permanent home can be found.*

The shortage of foster homes makes it difficult for some children requiring out-of-home placement to have the need for a substitute family met. Despite this shortage, an increasing proportion of children in out-of-home care have been placed in foster homes (from 65 percent in 2000 to 71 percent in 2005). A federal review noted that Connecticut's courts and DCF have significantly improved the process and timeliness of necessary child removals, but can continue to improve in the timeliness of criminal record and safety checks of prospective foster parents. Relative foster care results in fewer multiple placements compared with children in non-relative foster care. The department just completed a new plan for foster family recruitment and retention.

SAFE Homes Program. *The goal of SAFE Homes is to: provide better long-term outcomes in reunification and permanency, reducing the number of placements within the first year of care, insuring that more siblings will be placed together, and attempting to allow more children to remain in their communities.*

Similar outcomes occurred for children in both SAFE Homes and foster care in that there was a reduction for both in the frequency of placements and a similar length of stay in out-of-home placement. There was also a similar rate of reunification. Though no more effective than foster care in reunification and reducing the number of placements, SAFE Homes cost twice as much. The department is in the process of redesigning the SAFE Homes model.

Table VI-8 provides specific results from the 55 monitoring and evaluation efforts reviewed within child protective services.

Table VI-8. Specific Results for Major Programs Within Child Protective Services

For DCF Hotline:

- At least 90% of all reports commenced the same calendar day, 24 hours or 27 hours depending on response time designation. Hotline has been about to exceed this *Juan F.* exit outcome measure since 4Q04, with the lowest level of compliance in 4Q04 at 91.2%.
- At least 85% of all reports had their investigation completed within 45 calendar days of acceptance by Hotline. The Hotline department has maintained above 85% for the last 10 quarters (since 4Q04) for the *Juan F.* Exit Outcome Measure, with the most recent quarter (1Q07) at 93%.
- These findings contrast with a 2003 hotline investigation by the child advocate and attorney general where they found that DCF was not following policies and procedures, resulting in a failure to respond to child abuse properly and in a timely manner. They also found instances of cases with substantiated allegations of child abuse/neglect that were closed and families referred to another agency, but no follow up ever occurred.

For Adoption Services:

- In comparison to other states, Connecticut has the third lowest percent of adoptions finalized within 24 months of a child's entry into foster care; however, from 2000 to 2003, Connecticut had the greatest improvement of any state, going from 6.5% to 12.9%, nearly a 100% improvement.
- Looking at the *Juan F.* Exit Outcome Measure on adoption, a peak was reached in 1Q06 with 40.8% achieving adoption within 24 months of removal from his/her home; however, it declined for 2 quarters to below the goal (27% in 3Q06). For the previous two quarters, it went up and in 1Q07, it was 34.5%. The department is unable to consistently sustain these adoption efforts; however, according to the Office of the Court Monitor, the small numbers of children adopted impact the outcome measure results.
- A study completed by the Office of the Court Monitor found that the overall time frame for adoption to occur remains too long, with more than 25% of the children waiting four years or more. They also found the number of adoption disruptions is unacceptably high (9.1%) and suggested that additional or more effective adoptive parent support services for a longer period of time are necessary to ensure that adoptions are permanent.
- A study by Casey Family Services found that too much time is consumed making the decision as to whether to seek termination of parental rights, and concurrent planning is more of a concept than reality. They also cited a practice of further delaying the adoption finalization process of children who have passed the 24-month benchmark in favor of processing those who have not. In many of the disruptions, it was noted in the record that the DCF social worker had concerns about the fit of the child with the family but adoptions proceeded without services.

For Foster Care Program:

- Foster parents are visited at least once every three months by a DCF social worker from the Foster and Adoptive Services Unit; this unit is also responsible for licensing and biennial re-licensing of foster parents.
- Despite many efforts to recruit and retain foster families, the number of foster homes is decreasing rather than increasing, failing to meet the department's goal of 25 new homes (net) per month. In September 2007, for example, the department licensed 9 new homes, but lost 11 homes.
- The decrease in foster homes is due in part to the increased emphasis on adoption, draining the supply of foster homes as they adopt their foster children.
- Half of foster parents leave within the first two years--many because they have adopted a child--however, there are a significant number who leave who are dissatisfied with DCF support (e.g., lack of information received about kids, not being included in decision making, and child reimbursement levels and procedures).
- There is a particular shortage of foster homes for DCF's largest populations in care (0-5, 12-18 year olds).
- In a Connecticut Association of Foster and Adoptive Parents Program study of public perception of foster parenting, those with exposure to the foster care system were twice as likely to consider fostering a child (26% vs. 14%).
- A Chapin Hall Report on performance of the DCF foster care system found that, from 2000-2005, the proportion of children in out of home care that were placed in family settings increased from 65% to 71% (also found that the older the child, the less likely to be put in a family-like setting).
- Chapin Hall also found that just 14% of children placed with relatives experience one or more placement moves in the first six months in comparison to children in non-relative foster homes (47%).

For SAFE Homes Program:

- Though no more effective than foster care in reunification and reducing the number of placements, SAFE Homes cost twice as much.
- Following the establishment of SAFE Homes, the percent of school-age children with three or more placements in their first year of out of home placement decreased from 75% to 20-25% (was a similar drop for foster children).
- By one year follow up, half of children in SAFE Homes had returned home.
- The SAFE Homes Program Evaluation conducted by DCF and the Yale University Department of Psychiatry also found that the trauma history was much more severe than anticipated, and most experienced multiple trauma; 80% of birth parents had substance abuse problems.

Source: PRI staff analysis based on 55 monitoring and evaluation efforts from 2002-2007.

Detailed Monitoring and Evaluation Results within Behavioral Health Services

This section provides information about the results from monitoring and evaluation efforts related to Riverview Hospital, Extended Day Treatment, Residential Treatment,

Therapeutic Group Homes, KidCare, and outpatient psychiatric clinics for children. behavioral health evidence-based models and behavioral health federally funded grant programs results are also described.

Riverview Hospital. *The goal of Riverview Hospital is to: provide comprehensive, family-centered treatment of children and youth with serious mental illness and related behavioral and emotional problems who cannot be safely assessed or treated in a less restrictive setting.*

Riverview Hospital is faced with significant challenges that hamper its ability to provide comprehensive, family-centered treatment. The presence of an on-site OCA monitor, and implementation of a strategic plan with the hands-on support of the Director of Planning and Program Development, appear to be contributing to recent progress in addressing the facility's problem areas. There have been improvements in the work environment and improved functioning in some hospital operations.

Extended Day Treatment Program. *The goal of the Extended Day Treatment Program is to: reduce problem behaviors, promote competence, and prevent placements in more restrictive clinical environments, such as residential treatment or inpatient hospitalization (and ease the transition of children leaving a higher level of care).*

Extended Day Treatment obtained information from parents and guardians who report on surveys and in focus groups that the program has helped improve their children's functioning. More quantifiable measures of the efficacy of the program, such as percent of children who do not go to a more restrictive clinical environment, however, are not available due to data quality issues. The current program lead has taken steps to improve both the quality of the data as well as service delivery. It is anticipated that reduction of problem behaviors and an increase in child competence will be enhanced through adoption of the proposed family-focused model.

Residential Treatment Program. *The goal of the Residential Treatment Program is to: provide structured out-of-home treatment for children whose behavioral health needs are too acute to address in the community.*

Residential Treatment analyzed data submitted by contractors to assess changes in functioning and placement following discharge. Improvements in functioning are seen for one-third of the children and deterioration for one-fifth of the children. Because there are no targets set regarding what percent are expected to show improvements in functioning, or what percent are expected to discharge to a less restrictive environment, this performance cannot be assessed.

Therapeutic Group Homes. *The goal of the Therapeutic Group Homes is to: provide a setting for youngsters for whom a family resource is not readily available; that has clinical, educational, recreational, and vocational services within the community to address the medically necessary goals for achieving relational support with caretakers and others in the community; and that provides children with assistance in improving relationships at school, work and/or community settings.*

Therapeutic Group Homes are in the process of being opened in communities across the state. An RFP has been issued to hire a program evaluator to examine the success of the Risking

Connections Model and outcomes of the program. The focus of the program lead is currently on establishing new group homes. To date, there is no information on the efficacy of the homes. Monitoring and evaluation is limited in scope to the licensing regulations and PNMI/Medicaid requirements.

KidCare. *The goal of KidCare is to: enhance and develop comprehensive, coordinated, community-based mental health services to ensure children have access to appropriate services and receive them in the least restrictive environment possible, and avoid unnecessary out-of-home residential care.*

KidCare appears successful in avoiding out-of-home residential or inpatient care for 91 percent of the children and families served by the Emergency Mobile Psychiatric Services. Slightly more than half receive an array of intensive services, including wraparound services, and care coordinators are considered quite successful in securing needed services for children. A sizeable number of caregivers, however, are dissatisfied with certain services such as substance abuse treatment, extended day treatment, in-home services, residential care, and Emergency Department visits, the latter perhaps due to the weak memoranda of understanding between KidCare and the local Emergency Departments.

Outpatient psychiatric clinics for children. *The goal of Outpatient Psychiatric Clinics for Children (Child Guidance Clinics) is to: promote mental health and improve functioning in children, youth, and families, and to decrease the prevalence and incidence of mental illness, emotional disturbance, and social dysfunction.*

It is unknown the degree to which outpatient psychiatric clinics for children have improved functioning in children, youth, and families, and decreased the prevalence and incidence of behavioral health problems. Steps are being taken to improve the quality of data submissions by the clinics. A trauma-focused evidence-based model is being introduced that appears promising.

Behavioral Health evidence-based models. *The goals of Behavioral Health Evidence-Based Models are: through implementation of such a model, beneficiaries (depending on the model) will have reductions in the need for institutionalization (In-Home Child and Adolescent Psychiatric Services (IICAPS)); reduction or abstinence in substance use, improvement in school functioning, decrease in delinquent behavior and improvement in general family functioning (Multi-Dimensional Family Therapy (MDFT)); or to address the needs of adolescent juvenile offenders with serious behavioral problems (Multi-Systemic Therapy (MST)).*

The evidence-based model MDFT shows promising results in reduction or abstinence in substance use and a decrease in delinquent behavior. The IICAPS promising practice shows positive impact in reducing the need for institutionalization and improving behavioral health problems. There is an absence of summary information on the overall efficacy of MST.

Behavioral Health Federally Funded Grant Programs. *The goals of Behavioral Health Federally Funded Grant Programs are: through implementation of the grant programs, beneficiaries (depending on the program) will have stronger community-based (Hartford Youth Project) and coordinated statewide substance abuse treatment services (Adolescent Substance*

Abuse Treatment Coordination), transformed mental health service delivery for young children (Building Blocks), and services through a school-based system of care that is more inclusive of children with serious behavioral health needs (PARK).

The federally funded projects have led to positive substance abuse treatment outcomes, and partnerships with school systems in addressing the behavioral health needs of youngsters. There are collaboration and partnership challenges in developing the coordinated statewide system of substance abuse treatment, and in hiring the staff for mental health service delivery for young children.

Table VI-9 provides specific results from the 37 monitoring and evaluation efforts reviewed within behavioral health services.

Table VI-9. Specific Results for Major Programs Within Behavioral Health Services
For Riverview Hospital:
<ul style="list-style-type: none"> • In a DCF child fatality review, it was found that bureaucratic obstacles compromised efforts by hospital staff to collaborate with colleagues in other systems; medication management and interventions and discharge and aftercare were weak. • In a Joint Commission accreditation site visit in October 2006, there were just four areas that had recommended improvements, one of which required a response/corrective action ("pain is assessed in all patients"); all the other standards were met. • A joint program review conducted in 2006 by BCQI, Office of the Ombudsman, and OCA found that, while the department had taken steps to enhance the services of the hospital and to meet the needs of the children, the hospital continues to have difficulties effectively meeting the needs of the children it serves. • The joint program review found unevenness in the effectiveness of service delivery. Some units use a coordinated team model with a philosophy of care that is child focused and child sensitive, while the majority of units were more rigid, focusing on behavioral control approaches with more punitive interventions. • The OCA Riverview Hospital Monitor noted that there is a strategic plan implementation group, and changes in executive management appear to have had a positive impact on the work environment—there is a lot less staff turmoil. • The OCA Riverview Hospital Monitor has concerns about staff following physician orders, defining seclusion, use of restraints and seclusion, and transition planning.

For Extended Day Treatment:

- Most parents and guardians surveyed by the program lead were satisfied with EDT services, and agreed that EDT helped improve their child's functioning.
- Concerns were raised regarding the lack of, limited, or ineffective clinical services, most notably family therapy, home-based family work, and crisis intervention services. There is a need to adopt a more comprehensive, family-focused philosophy and practice approach, with families having a more central role.
- The development of a model of care, in partnership with stakeholders, is currently under way to restructure and strengthen the EDT program through the adoption of a comprehensive family-focused philosophy and practice approach that places families at the core of all aspects of service delivery.
- Extended Day Treatment programs are licensed and as such, must adhere to regulations as verified through site visits.
- The current program lead for Extended Day Treatment has taken steps to improve the poor quality of the data currently submitted monthly and aggregated quarterly, make site visits to assess the quality of service (and require corrective actions as needed), and solicit stakeholder perspectives on Extended Day Treatment.
- Although required by performance-based contracting, DCF is unable to currently produce reliable results for outcome measures such as prevention of placement in more restrictive environments.

For Residential Treatment:

- Aggregated results provided by residential treatment contractors found two-thirds of discharged children had a successful course of treatment as rated by the providers.
- Children who entered residential treatment from an out of home placement were more likely to be discharged to a parent or relative (41.2% of discharges had entered care from the care of a parent or relative, and 48.3% were discharged to a parent/relative).
- Almost one-third (30%) showed an improvement in functioning (10+ point improvement in functioning on Global Assessment of Functioning scores).
- Almost one in five (18.8%) was discharged to a more restrictive setting.

For Therapeutic Group Homes:

- 46 homes have been opened as of October 2007.
- There are 8 more to be opened; it is getting much harder to open homes due to community resistance.
- The homes have been instructed to use a service delivery model called, "Risking Connections Model."
- Oversight of the therapeutic group homes is provided by the Licensing Unit, program lead, and PNMI/Medicaid site visits/reviews conducted by the Program Review and Evaluation Unit.

For KidCare:

- A CHDI study of family satisfaction found general satisfaction with services for at least half of the caregivers surveyed; however, a significant minority expressed dissatisfaction with services their children received.
- The services that generated the greatest dissatisfaction from caregivers who said the service was not helpful for their children were: substance abuse treatment, extended day treatment, in-home services, residential care, and Emergency Department visits.
- The MOUs with local Emergency Departments are weak.
- Many of the children served by KidCare received an array of intensive services, with slightly more than half receiving some type of wraparound services.
- Emergency Mobile Psychiatric Services provided interventions for approximately 1,218 families per quarter with just nine percent requiring inpatient or residential care; one-quarter stepped down to routine outpatient care and community support, and 16 percent had crises that resolved and were now stable.
- In a CHDI evaluation of the Care Coordination, parents were highly favorable--overall, care coordinators had considerable success in securing services for children.

For Outpatient Psychiatric Clinics for Children:

- Outpatient Psychiatric Clinics for Children are licensed and as such, must adhere to regulations as verified through site visits.
- The current program lead for Outpatient Psychiatric Clinics for Children has taken steps to improve the poor quality of the data currently submitted monthly and aggregated quarterly, and make site visits to assess the quality of service (and require corrective actions as needed).
- Although functioning is purported to be assessed by the clinics (using the OHIO scale), there are currently no reliable results for outcome measures.
- A trauma focused evidence-based model is being implemented in six clinics; it is anticipated to extend to 18 clinics within three years; Yale is working with clinicians to obtain fidelity with the model.

For Behavioral Health Evidence-Based Models:

- For adolescents receiving MDFT, 60% abstained from substance use 30 days prior to discharge (12% had a significant reduction in drug use and 11% a significant reduction in alcohol use at discharge).
- For adolescents receiving MDFT, there was a decrease in delinquent behavior with the great majority (86%) avoiding re-arrest during MDFT treatment.
- For children and adolescents receiving the promising practice IICAPS, there have been reductions in the need for institutionalization as demonstrated by a decrease in the number of inpatient admissions, and a decrease in inpatient lengths of stay for those who have had to be admitted.
- Positive problem improvements demonstrate that IICAPS is capable of treating and managing children with serious behavioral health problems in home and in the community.
- The results from recipients of Multi-Systemic Therapy are at the individual client level and have not been compiled or analyzed; definitions of measures are not explained in the reports given to service providers.

For Behavioral Health Federally Funded Grant Programs:

- The Hartford Youth Project participants had positive treatment outcomes including reductions in alcohol and marijuana use, intoxication, peer drug use, illegal activity, and 5+ school absences; they also had reduced juvenile justice and residential treatment placements.
- PARK project staff built a strong partnership with the school system in Bridgeport (viewed as "best practice").
- The Adolescent Substance Abuse Treatment Coordination project lacks collaboration/active participation on the grant management team by mental health, CSSD, family organizations, and evaluator.
- Families who participated in Building Blocks and met with the site visit team reported that they are happy with service; however, hiring delays have limited the number of families served.

Source: PRI staff analysis based on 37 monitoring and evaluation efforts from 2002-2007.

Detailed Monitoring and Evaluation Results within Juvenile Services

This section provides information about the results from monitoring and evaluation efforts related to CJTS and Parole Services.

***CJTS.** The mission of CJTS is to: prepare boys committed to the Department of Children and Families and placed in a secure facility for successful community re-entry by providing innovative educational, treatment, and rehabilitative services. There are six goals for CJTS: 1) create, cultivate, and maintain a therapeutic environment at CJTS; 2) develop and implement a comprehensive community re-entry system that builds upon each child's unique strengths and needs; 3) promote family partnerships with CJTS and enhance family participation in their child's growth, development, and treatment; 4) promote a commitment to Continuous Quality Improvement through implementation of a comprehensive CQI program; 5) develop, implement, and maintain a comprehensive staff development program; and 6) improve the cost-effectiveness of the facility by maximizing the utilization of resources.*

There have been improvements to CJTS within its initial five years of operation. Improvements have included changes in punitive policies and more treatment efforts to address substance abuse, clinical, and vocational needs. Given the improvements in CJTS service delivery, attention should now turn to improving recidivism rates and other outcome measures.

***Parole Services.** The goal of Parole Services is to: help youth successfully integrate back into their communities through supervision.*

Many recent changes have occurred within Parole Services. There are new programs being offered, more frequent and consistent visitation and supervision, and a plan to implement a comprehensive service delivery system. The success of Parole Services overall in meeting the goal of helping youth successfully integrate back into their communities is unknown.

Table VI-10 provides specific results from the 16 monitoring and evaluation efforts reviewed for CJTS and Parole Services.

Table VI-10. Specific Results for Major Programs Within Juvenile Services
For CJTS:
<ul style="list-style-type: none"> • Two-thirds of the boys were found to have substance abuse issues, and a substance abuse treatment program was implemented at CJTS. • Through changes in policies and programming, such as staff no longer carrying handcuffs and shackles, based on multiple sources, there has been a dramatic reduction in critical incidents, and the use of restraint and seclusion. • Educational programming has expanded to include art therapy, cooking, and vocational/job readiness; there is more clinical treatment, positive leisure time activities, mentors, and more evening and weekend activities. • The recidivism rate for 121 boys discharged from CJTS during Sept. 1, 2005 -April 10, 2006, was 35 percent (22 percent returned to CJTS and 13 percent went into adult criminal system).
For Parole Services:
<ul style="list-style-type: none"> • Inconsistent contact by parole workers with children and families that occurred several years ago has been changed so that all children at home are required to be seen every two weeks by parole. • The array of services has been expanded to include STEP, Targeted Re-entry, Functional Family Therapy and families as allies; however, the effectiveness needs to be evaluated. • A parole manual and job-related training curriculum have been developed; parole staff have received training in motivational interviewing, supervision, and Balanced and Restorative Justice. • A plan has been developed to implement a comprehensive service delivery system (CONCAP).
Source: PRI staff analysis based on 16 monitoring and evaluation efforts from 2002-2007.

Detailed Monitoring and Evaluation Results within Prevention Services

This section provides information about the results from monitoring and evaluation efforts related to the Wilderness School, Positive Youth Development Initiatives (PYDI), and the Youth Suicide Prevention Program.

Wilderness School. *The goal of the Wilderness School is to: foster positive youth development by providing students with an experience that promotes self-improvement, specifically in such areas as self-esteem, responsibility, and interpersonal skills.*

The Wilderness School appears to benefit nearly all the youth referred to the program. Increases have been reported in self-confidence and self-reliance of the participants, including foster youth who are transitioning to college and other post-secondary experiences.

Positive Youth Development Initiatives. *The goals of the Positive Youth Development Initiative include: strengthening families and good parenting behaviors (Strengthening Families Program) and preventing or reducing substance use (All Stars Program).*

Some of the positive youth development initiatives appeared effective in strengthening families and good parenting behaviors while others targeted at preventing or reducing substance use appeared less effective. Additionally, some evidence-based models used in the positive youth

development initiatives understated the resources needed to implement the models with fidelity and overstated the generalizability of the model to some of the settings in Connecticut.

Youth Suicide Prevention. *The goal of Youth Suicide Prevention is to: distribute materials and provide training related to prevention of youth suicide.*

Efforts have been made to educate school personnel, DCF social workers, community providers, police, and youth service bureaus in suicide prevention. The goal of distributing material and providing training related to prevention of youth suicide has been met; while difficult to ascertain, it would be beneficial to know what effect, if any, these efforts have had on preventing suicides.

Table VI-11 provides results from the nine monitoring and evaluation efforts reviewed for the Wilderness School, Positive Youth Development Initiatives, and Suicide Prevention.

Table VI-11. Specific Results for Major Programs Within Prevention Services
For Wilderness School:
<ul style="list-style-type: none"> • There was a reported increase in self-confidence and self-reliance for youth who participated in the Wilderness School program. • Nearly all (95%) referring agents said the Wilderness School benefited their students. • The Wilderness School is licensed by the Department of Public Health as a camp; it does not currently offer licensure of wilderness programs. • The Department of Public Health found the Wilderness School to be in compliance with 115 of 121 licensing standards; changes were made to correct the minor areas out of compliance.
For Positive Youth Development Initiatives:
<ul style="list-style-type: none"> • After participating in the Strengthening Families Program, parents reported a substantial increase in their good parenting behaviors, families reported having more fun and relaxing together; they viewed the program as helpful and supportive. • There was a doubling of the proportion of youth in the Strengthening Families Program who reported listening to their parents'/caregivers' point of view, and almost all youth (97%) perceived that the program had helped them, with over half (57%) reporting changes in how things are done together as a family. • All Stars participants showed little change on measures of alcohol use in the pre- and post-tests; however, recent cigarette use was reportedly lower, with no one reporting smoking in the last 30 days on the post-test. • External evaluators found that some program developers of PYDI evidence-based models understated the resources needed to implement the program with fidelity; and different contexts have unique sets of challenges (e.g., issues with translated materials (Spanish not available or incorrectly translated)).
For Youth Suicide Prevention:
<ul style="list-style-type: none"> • Mini-grants for suicide prevention efforts were issued to several schools. • College students, faculty and staff, DCF social workers and community providers were trained in Youth Suicide Prevention. • Youth Suicide Prevention mailings were sent to all schools, police chiefs, Youth Service Bureaus and DCF area offices.
Source: PRI staff analysis based on nine monitoring and evaluation efforts from 2002-2007.

Detailed Agencywide Results

This section provides information about the results from monitoring and evaluation efforts related to agencywide efforts that occurred within the DCF Office of the Ombudsman, DCF Division of Research and Development, Office of the Child Advocate and agencywide advisory groups. Although much is occurring agencywide at DCF, the results reviewed here are specific to monitoring and evaluation efforts that have been conducted to examine the department as a whole and its ability to achieve its mission and agencywide goals.

DCF as a whole. *The mission of DCF is to: protect children, improve child and family well-being, and support and preserve families. These efforts are accomplished by respecting and working with individual cultures and communities in Connecticut, and in partnership with others.*

There are limited agencywide results. Based on the modest information available, little can be concluded about the department's overall performance. Table VI-12 shows specific results from the nine agencywide monitoring and evaluation efforts examined.

Table VI-12. Specific Agencywide Results

- The Division of Research and Development found that staff are concerned about the way *Juan F.* exit measures are being evaluated and utilized; family-centered and culturally competent principles to meet the mission are not consistently understood or implemented within area offices or facilities.
- The Child Poverty and Prevention Council January 2007 Progress Report found that children's mental health care had been enhanced with \$1 million for Flex Funding.
- A 2006 child fatality review found no DCF mental health policy, a paucity of appropriate residential programs, and inadequate awareness of suicide risks.
- The Office of the Child Advocate found a lack of good assessment of child safety, and failure to accurately determine if abuse is taking place.
 - Cases often lack a complete assessment of family functioning and needs, and parental progress is only assessed by class attendance.
- There was an increase in use of the Office of the Ombudsman from 2005 to 2006 (for inquiries and complaints).

Source: PRI staff analysis based on nine monitoring and evaluation efforts from 2002-2007.

Summary of Results From Key Monitoring and Evaluation Efforts

Overall

- External monitoring results are most positive and investigations most negative.
- The agencywide results were more negative than any of the mandate areas.
 - Staff are concerned about the *Juan F.* measures as well as lack of staff adoption of a family-centered, culturally competent approach to service.
 - There is no good assessment of child safety or mental health policy, while flex funding is seen as an enhancement for children's mental health care.

Within Child Protective Services

- Great progress has been made on the *Juan F.* exit outcome measures.
 - There is consistent compliance with 16 of the 22 measures.
 - More improvement is needed on treatment plans and needs met.
- Connecticut continues to struggle with federal requirements.
 - The department has failed to comply with AFCARS foster care and adoption data requirements since the initial 2001 assessment.
 - Connecticut met two of six national outcome standards (foster care re-entries and stability of foster care placements).
 - Connecticut met conformance with four of seven national systemic factors (quality assurance system; training; service array; and foster and adoptive parent licensing, recruitment, and retention).
- Connecticut is one of the few New England states that has shown substantial compliance in its last two Title IV-E Foster Care Eligibility Reviews.
 - The state had improved the content and timeliness of court orders to remove a child from his/her home.
- Hotline services have improved greatly in the past two years in their timeliness of commencement and completion of investigations.
- Connecticut was far behind most other states in having adoptions occur within 24 months of a child's entry into out of home care.
 - DCF made great progress in improving the timeliness of adoptions.
 - The *Juan F.* court monitor considers the 9.1 percent adoption disruption rate "unacceptably high."
- Foster homes are decreasing despite recruitment and retention efforts.
- At twice the cost, SAFE Home was found to be no more effective than foster care in reunification and reducing the number of placements.

Within Behavioral Health Services

- Riverview Hospital faces significant challenges that hamper its ability to provide comprehensive, family-centered treatment.
 - The on-site OCA monitor and strategic plan should help advance services received by children at the hospital.
- Caretakers report that Extended Day Treatment has helped improve child functioning; data issues make more objective measures unavailable.
- Following Residential Treatment, one-third of children have improved functioning while one-fifth show deterioration.

- Therapeutic Group Homes are in the process of being opened; to date there is no information on program efficacy; however, the department is in the process of hiring a program evaluator to assess all the therapeutic group homes.
- KidCare appears to have been successful in several areas.
 - Most children in crisis served by the Emergency Mobile Psychiatric Services (91 percent) avoided residential or inpatient care.
 - Care coordinators are considered quite successful in securing needed services for children.
 - A sizeable number of caregivers, however, report dissatisfaction with substance abuse treatment and other services.
- Effectiveness of Outpatient Psychiatric Clinics for Children is unknown.
 - Steps are being taken to improve the quality of data submissions by the clinics.
- Evidence-Based Models in general appear effective.
 - Multi-Dimensional Family Therapy shows promising results in reduction or abstinence in substance use and a decrease in delinquent behavior.
 - Intensive In-Home Child and Adolescent Psychiatric Services shows promise in reducing the need for institutionalization and improving behavioral health problems.
- The federally funded projects have led to positive substance abuse treatment outcomes (Hartford Youth Project), and partnerships with schools in addressing serious behavioral health needs (PARK Project).

Within Juvenile Services

- There have been improvements to CJTS over five years of operation.
 - There were changes in punitive policies; more treatment efforts occurred to address substance abuse, clinical, and vocational needs.
- Many recent changes have occurred within Parole Services.
 - New programs are being offered, and there is more frequent and consistent visitation and supervision.
 - Success of Parole Services is unknown due to lack of data.

Within Prevention Services

- The Wilderness School appears to benefit nearly all referred youth.
 - Increases have been reported in self-confidence and self-reliance of participants, including transitioning foster youth.
- Some of the Positive Youth Development Initiatives appear effective in strengthening families and good parenting behaviors while others targeted at preventing or reducing substance use appear less effective.
 - Some evidence-based models understated the resources needed to implement and overstated the generalizability of the model.
- Youth Suicide Prevention has taken steps to educate school personnel, DCF social workers, community providers, police, and others.

Chapter VII

Findings and Recommendations

The Legislative Program Review and Investigations Committee study of DCF monitoring and evaluation was aimed at assessing the effectiveness of the current accountability system and identifying needed improvements. An effective results-based monitoring and evaluation system is important for three main reasons:

1. It provides an agency with feedback from multiple sources on actual outcomes and assesses progress toward desired goals.
2. It allows managers, policymakers, and stakeholders to know where the agency is going, why it is successful or not, and how to make improvements.
3. In the end, it helps an agency such as DCF provide better services for children and families and make better use of taxpayer resources.

In reviewing and analyzing DCF's self-evaluation activities and the oversight of DCF carried out by the courts, federal agencies, the legislature, outside investigative entities, and advisory groups, the program review committee found many areas of strength but also notable deficiencies, gaps, and redundancies. This chapter summarizes the committee's findings concerning agency goals, and its assessment of the overall monitoring and evaluation system and each major component -- internal efforts, external efforts, outside investigations and reviews, and advisory group activities. It also reviews the answers to the following main PRI study questions:

- How is progress tracked by DCF and others?
- Is the system for monitoring and evaluating DCF providing feedback on how well the agency is meeting its goals?
- What has DCF accomplished?
- Are the findings from monitoring and evaluation efforts used to make changes to agency policies, programs, and services that improve outcomes for children and families?
- What changes can be made to the DCF accountability system to help the agency better meet the needs of children and families?

To put the assessment of DCF monitoring and evaluation in context, the program review committee staff applied a framework for child welfare quality improvement developed by the National Child Welfare Resource Center for Organizational Improvement (NCWRC) of the Muskie School at the University of Southern Maine. NCWRC is one of seven technical assistance and training organizations funded by the Children's Bureau of the U.S. Department of Health and Human Services to support state agencies that serve children and families. The center helps states with strategic planning, facilitating stakeholder involvement, implementing quality improvement, and evaluating outcomes.

NCWRC framework. In 2002, the center developed a framework for child welfare quality assurance that includes five key elements all agencies should consider in creating new

systems or “energizing” existing systems. (Core components of the framework are outlined in Appendix G.) It is based on examples from ongoing quality improvement efforts in a number of state child welfare agencies, federal requirements, research and management studies, and national quality assurance standards developed for other settings. The framework’s five main elements are outlined in Table VII-1.

The program review committee’s findings and recommendations about DCF monitoring and evaluation in terms of the NCWRC framework elements also are summarized in Table VII-1. As the table indicates, changes recommended by the committee seek to strengthen each element within the Department of Children and Families. No matter how an agency is organized, better outcomes from programs and services are more likely if managers have an effective system for tracking, reviewing, using, and reporting on results.

Ultimately, the point of monitoring and evaluation is to ensure programs and services are having desired results. The committee recommendations outlined in this chapter are intended to promote a value expressed by many staff and stakeholders during the study -- a value of results-based decision making focused on achieving better outcomes for children and families. Taken together, the committee recommendations are aimed at making the current DCF accountability system more effective by:

- making agency goals explicit;
- integrating quality improvement activities and incorporating best practices throughout the agency;
- improving the quality and quantity of available data on programs and services; and
- promoting the use of results information from all sources, both within and outside of the agency, to better meet the needs of children and families.

Agency Goals

Specific, measurable, attainable goals are a critical first step for successful monitoring and evaluation efforts. Defining an agency’s desired outcomes, ideally with input from all stakeholders, is the foundation for an effective quality improvement system. Clear goals are needed to guide policy and practice; they can also formally communicate performance expectations to all staff and to the public.

As discussed in detail in Chapter I, numerous goals have been established for DCF overall, for each of its mandate areas, and for most of its many programs and services. *Some agency goals clearly define expected outcomes; however, a significant number primarily relate to how services are delivered rather than the end result. Few have been developed with input from families, providers, and other stakeholders and existing program goals rarely incorporate the department’s guiding principles (e.g., family centered, culturally competent, community-based).*

Table VII-1. Framework for An Effective Quality Improvement (QI) System

Main Elements (NCWRC Framework)	Committee Findings about DCF	Committee Recommendations
Agency has adopted outcomes and standards	<p>No single compilation of all goals within agency, across all mandate areas and programs</p> <p>Most current goals focus on how services are delivered (process) rather than outcomes for children and families</p>	Strategic planning process with community/stakeholder involvement
Quality assurance and quality improvement are incorporated throughout the agency	<p>Fragmented; pockets of strength (e.g., <i>Juan F.</i> Exit Plan compliance activities, area office QI process, residential facility licensing, evidence-based models for behavioral health in-home services) and major gaps (e.g., ineffective use of findings from internal and contracted program evaluations, special reviews, no compilation and comparison of results data from all sources)</p> <p>Weak procurement process and ineffective performance-based contracting</p>	<p>Dedicate staff resources to integrating, analyzing, and reporting on outcomes related to all the goals and mandate areas of the agency</p> <p>Maintain central repository for study findings</p> <p>Adopt best practices for contract management</p>
Data and information are gathered	Gaps in outcome data; inadequate, fragmented, and incompatible automated information systems	<p>Improve LINK, as well as integrate all information systems</p> <p>Integrate findings information from all sources (inside and outside agency)</p>
Data and information are analyzed	Minimal agencywide analysis; lack of capacity to use data gathered	<p>Expand internal capacity for research and analysis</p> <p>Establish strong research relationship with academic/research institute partners</p>
Analysis and information are used to make improvements	<p>Fragmented; some positive developments (Area Office Quality Improvement teams, Risk Management and Decision Support Units, Behavioral Health Partnership service utilization and needs data)</p> <p>Trying to develop culture of results-based decisions (ROM information system, research scientist on staff, use of logic models, Results-Based Accountability participation)</p>	<p>Centrally collect all information produced; widely distribute results (all levels of agency, policymakers, stakeholders)</p> <p>Require formal response to results-based findings, recommendations</p> <p>Strengthen external accountability mechanisms (e.g., state, area, and facility advisory groups) and eliminate redundant/ineffective reporting</p>

Source: PRI staff analysis.

Further, while the department has produced a number of plans, none reviewed by the committee staff for this study were found to reflect the full scope of DCF's broad mission. At present, there is no single department document containing and making explicit all agency goals.

Research on best practices for quality improvement in child welfare organizations shows that effective systems start with clearly defined outcomes. An accepted way to make both agency goals and standards for programs and services explicit, is through one comprehensive strategic plan for meeting the needs of children and families.

Despite a longstanding (since 1979) statutory mandate for agencywide strategic planning, a multi-year, comprehensive master plan has never been implemented. Periodically, DCF has prepared planning documents that have partially addressed the requirements of this law. No agencywide strategic plan has been issued since 2000. The department did prepare a multi-year action plan for complying with the *Juan F.* consent decree exit plan in 2004. A revised action plan focused on strategies for improving agency performance concerning two fundamental *Juan F.* outcome measures -- appropriate treatment planning and meeting needs of children and families -- was developed in May 2007. However, neither document integrates the agency's full mission and the values represented in its guiding principles with mandate area outcome goals.

In addition, the department policy manual section on mission, values, critical issues, strategic goals, and department strategies has not changed since 1996. While it is not necessarily inaccurate, it does not reflect the agency's latest thinking or its current mission and vision. Also, the present driving force of the agency -- the *Juan F.* 22 Positive Outcomes for Children -- is not represented in the policy manual, and there is still no official department policy concerning DCF's behavioral health mandate.

Some department staff are working on a project called the Accountability Framework, which is intended to incorporate into one management document primary DCF goals, results, indicators for those results, and related key practice and performance considerations. The time frame for completing this document has been postponed in order to concentrate on other quality improvement initiatives within the agency. Among the most important is development of an internal qualitative case review process that the department anticipates implementing on a pilot basis over the next year. It is part of DCF's effort to prepare for the next federal Child and Families Services Review scheduled for the fall of 2008. An effective qualitative case review process also is considered essential for termination of Judicial Branch monitoring of compliance with the *Juan F.* consent decree.

The program review committee believes compiling all the goals guiding DCF programs and services into a single source still needs to be made a priority. It is the necessary first step to integrating the many expectations of the agency and ensuring that desired results are clear and consistent. At present, there are some department goals that can be viewed as conflicting; for example, the national child welfare standards and *Juan F.* exit plan outcome measures concerning reunification can require strategies that seem at odds with standards and measures for timely adoption.

The process of integrating all agency goals in one place would be an opportunity to address such issues. While it may not be possible to resolve every one, the challenges in carrying

out DCF's broad mission will be better recognized. It will also make clear to all agency staff, other agencies, and the public what the department is trying to achieve.

A strategic planning document with clearly defined goals, relevant measures of progress, and well-developed action steps that reflect the full scope of the department's mission is essential for effective DCF monitoring and evaluation. The significant improvements in agency practice and procedure that have occurred over the past three years in response to the *Juan F.* exit plan process are evidence of the success of this approach. Therefore, **the program review committee recommends:**

The current statutory provision for a Department of Children and Families biennial five-year master plan shall be repealed and replaced with a mandate for ongoing strategic planning. Specifically:

Beginning July 1, 2008, the department shall start the process of developing a vision, mission, and strategic goals with the advice and assistance of representatives of the children and families served by the agency, public and private providers, advocates, and other stakeholders.

The department should dedicate staff, under the direction of the commissioner or deputy commissioner, to: 1) prepare a strategic planning document that includes action steps and time frame for implementation to fulfill the vision, mission, and goals developed with stakeholders; 2) track and report on progress in achieving the plan's goals at least annually; and 3) regularly review, revise, and update the department's strategic plan as needed.

The first plan shall be completed and submitted to the legislature and the governor by July 1, 2009. The department's plan shall be submitted to the agency's State Advisory Council for Children and Families for review and comment prior to submission to the legislature and governor. Progress in carrying out the plan shall be reported to the council by the DCF commissioner at least quarterly and to the legislature and governor annually.

Strategic planning is beneficial for any state agency, and DCF is one of the few that has experience in developing a successful plan and process. The planning process recommended by the committee incorporates effective elements from the *Juan F.* exit plan process that ensure continuous review and updating. There are, however, two major differences.

First, the scope of this strategic planning process is agencywide; it includes all populations covered by DCF's broad mission. Unlike other plans developed by the agency, it should create a vision that consolidates the agency's goals for every mandate area and integrates services throughout the department that are designed to achieve them. Second, stakeholders are expected to be partners, which is a central DCF value. Together, they should develop the agency's vision, mission, and goals.

The recommended process, which requires strong participation from groups outside the agency, should be inclusive and transparent. The department has been involved in a successful

strategic planning process – the recent statewide juvenile justice planning initiative. It should serve as the model for developing an agencywide plan and explicit system goals with the advice and assistance of all stakeholders.

Overall System Assessment

To assess the effectiveness of DCF monitoring and evaluation activities, PRI committee staff analyzed a representative sample of major internal, external, outside investigations and reviews, and advisory group efforts to track the agency’s progress toward its goals. (The methodology for the staff analysis is described in detail in the introduction to this report.) The main purpose was to identify strengths as well as areas in need of improvement within the current accountability system. Figure VII-1 summarizes what the committee learned about the system based on the staff analysis. Committee findings about the system overall and for each of the four main sources of DCF monitoring and evaluation are presented in more detail below.

Is the focus of DCF monitoring and evaluation on agencywide goals, mandate areas, or specific programs? *The program review committee found that the focus is not on agencywide goals, as just 7 percent of all the efforts examined applied to the department overall. However, the committee found when analyzing only investigative monitoring and evaluation efforts, the focus is on agencywide goals at least 40 percent of the time. Nearly one-third of efforts concerned a general mandate area (30 percent), most often child protective services (82 percent). The remaining two-thirds of efforts were for specific programs within the various mandate areas.*

Figure VII-2 provides a breakout of the monitoring and evaluation efforts when programs are grouped within their respective mandate areas. Nearly half of the monitoring and evaluation efforts examined in this study are within the child protective services category (44 percent), followed by the behavioral health services category (29 percent). Little attention is given to the prevention services mandate area.

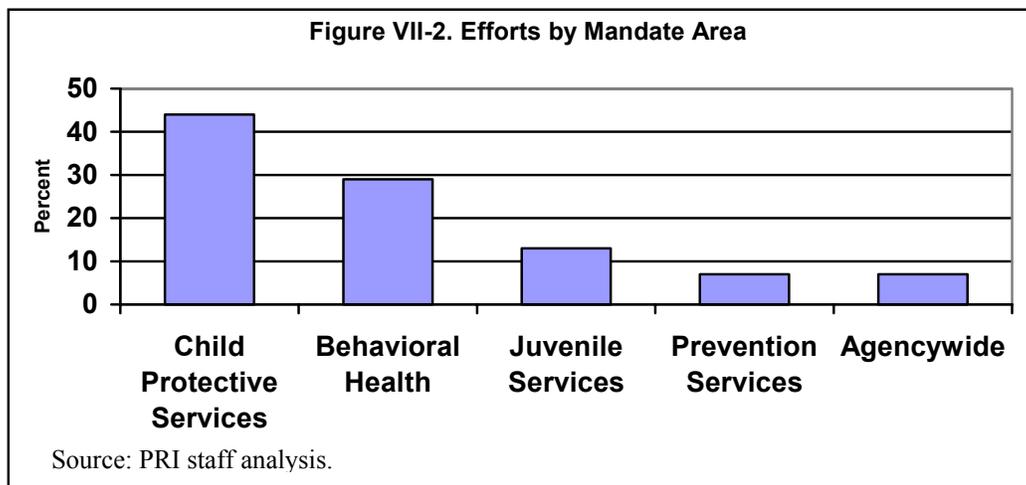
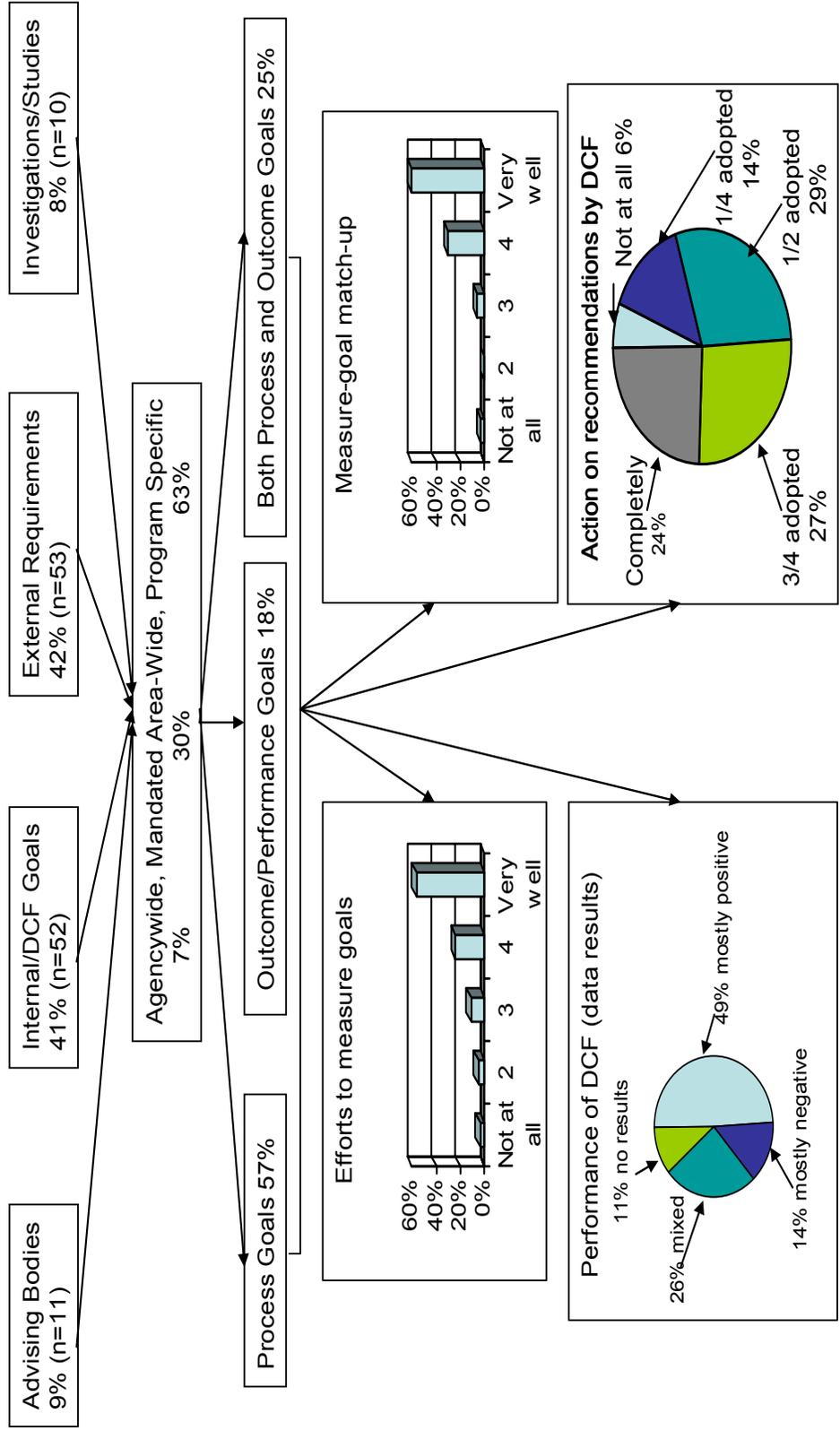


Figure VII-1. Overall System Assessment

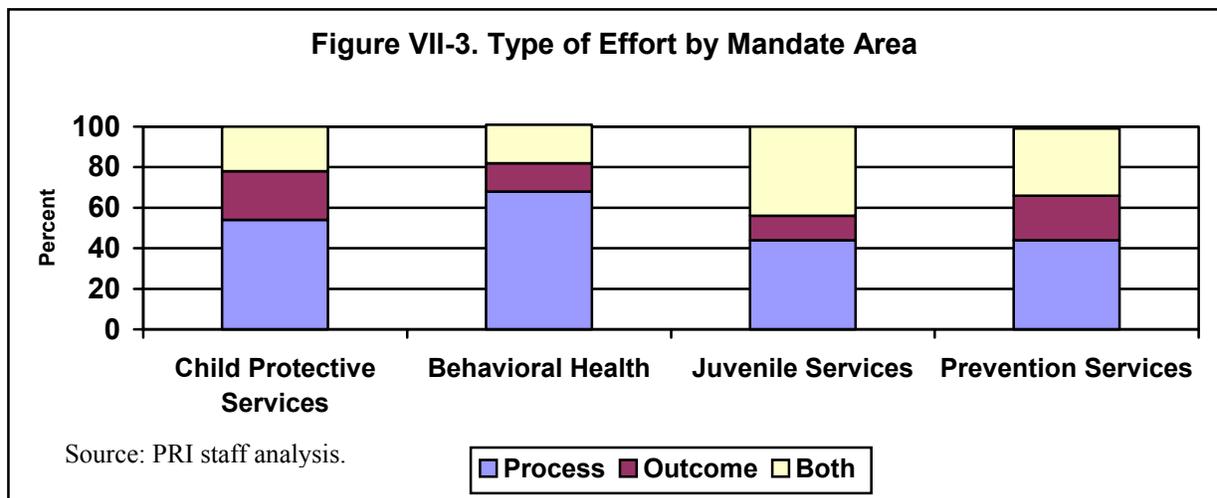


Note: Figure percents are based on PRI staff analysis of 126 efforts to monitor and evaluate DCF.

Source: PRI staff analysis.

What is tracked: process (service delivery), outcome (end result), or both? The PRI committee found that *more than half of all monitoring and evaluation efforts focus solely on process goals or issues (57 percent of efforts)*, with progress on goal attainment limited to the delivery of service to the exclusion of outcome or impact. *On the other hand, one-quarter (25 percent) contain both process and outcome goals or issues, and 18 percent focus solely on outcomes.*

Figure VII-3 shows the type of effort for each of the mandate areas. The highest proportion of process monitoring and evaluation occurs within the behavioral health mandate area (68 percent). Combining the “outcome only” and “both process and outcome” categories, the greatest proportion of monitoring and evaluation of outcomes occurs within the juvenile services mandate area (56 percent).



Are the goals and issues studied S.M.A.R.T.? On a scale from 1 to 5, where 5=very positive, the goals and issues subject to monitoring and evaluation efforts had the following average ratings:

- Specific=4.40
- Measurable=4.40
- Attainable=4.56
- Relevant=4.87
- Trackable=4.73

Based on the results of the S.M.A.R.T. ratings, *overall, monitoring and evaluation goals or study questions are specific, simple, concise, and clearly understood.* Achievement of the goals is readily measurable and results interpretable. Further, the goals are realistic and within reach, and the issues or questions can be readily answered by the monitoring and evaluation effort. The goals and issues studied also are highly relevant to the accomplishment of the agency or program mission and progress can be readily tracked over time. Thus, *overall, the goals and issues studied are stated in a way that lends them to being readily monitored and evaluated.*

Two exceptions were found to the overall positive rating of goals and issues. *Goals or issues that were the subject of outside investigative monitoring and evaluation efforts were found by the PRI committee to have mixed ratings on measurability.* The measures were not specified or sometimes open to interpretation (e.g., “adequate”), and baseline data were missing. Additionally, the goals and issues monitored and evaluated by *advisory groups generally were found to be weak in specificity and measurability.*

How well do the measures used match up with the goals being monitored and evaluated? The PRI committee found an average 4.46 rating. This is interpreted to mean that *the measures employed by the monitoring and evaluation efforts are both comprehensive and logically related to the goal.* Study questions are logically related to the study approach and addressed comprehensively.

The goals and issues chosen to be studied are stated in a way that lends them to being readily monitored and evaluated. They tend to be specific, simple, concise and clearly understood. Exceptions are: the lack of specificity and measurability of advisory group goals or purpose; and the measurability of the subjects of outside investigations and reviews.

Overall, the measures match up with the goals; they are logically related and not chosen simply for ease of measurement. In general, the information collected is of good quality with little missing information. One exception is the poor measurement efforts found for performance-based contracts.

How good a job was done in collecting information to ascertain progress in attaining goals or answer the study question? The PRI committee rated this attribute as 4.24. This is interpreted to mean that, in general, *the information collected through monitoring and evaluation efforts is of good quality with little missing information.*

In what areas were the monitoring and evaluation findings used to make changes? There was no statistically significant difference in the use of findings depending on the source of monitoring and evaluation.

Table VII-2 shows that *measurement findings were most often used for changes to services to children and families, identification of organizational barriers, and identification of resource barriers. Conversely, measurement results were least often used for seeking legislative changes.*

Area	Number
Services to children and families	86
Identification of organizational barriers	77
Identification of resource barriers	71
Policies	64
Training	63
Legislative	13

Source: PRI staff analysis.

Were the recommendations stated clearly, did they flow logically from the findings, and did they contain actions? Not all monitoring and evaluation efforts contained recommendations. Of the 126 examined by PRI staff, slightly less than half contained recommendations (47 percent). Investigations/Outside Reviews have the most recommendations (90 percent) and external efforts the least (26 percent). Noteworthy is that not all advisory groups have recommendations, despite their charge to provide recommendations to the department. On a scale from 1 to 5, where 1=not at all, to 5=very much so, *PRI staff on average rated the recommendations as clear (4.45), logical (4.81) and containing actions (4.59).*

Were the recommendations adopted? Examining the recommendations from monitoring and evaluation efforts, PRI staff estimated the percent of recommendations that were adopted. On a scale from 1 to 5, where 1=not at all, to 5=completely, the average rating was 3.49. This rating is interpreted to mean that *between 50 to 75 percent of the recommended changes were adopted per monitoring and evaluation effort.* Additionally, the percent of recommendations adopted from external sources were significantly greater than the percent of recommendations adopted from outside investigations and reviews (3.83 vs. 2.86).

Assessment summary. Current efforts are concentrated primarily within child protective services and behavioral health services. As seen in Table VII-3, these two areas represent the largest investment by DCF, serve the greatest number of clients, and receive the largest allocation of financial resources. Less attention is given to juvenile services and prevention and little agencywide monitoring and evaluation occurs.

The emphasis of the current monitoring and evaluation system is on process or how services are delivered. It is important to assess service delivery as well as outcomes for children and families. Both pieces of information are valuable. To replicate a program with positive outcomes, for example, one would need to have a good understanding of the service delivered and aspects of the program that are viewed favorably. However, whether services are having their intended effect and meeting children's needs must be given more attention, a conclusion also reached by the court monitor, child advocate, and federal reviewers.

The monitoring and evaluation findings tended to be used by DCF most frequently to make changes to services for children and families, and to identify organizational and resource barriers. In general, between 50 to 75 percent of recommended changes from monitoring and evaluation efforts were adopted.

Children and families benefit when findings and recommendations from effective monitoring and evaluation are used to better meet their needs. Positive changes in programs and services have resulted, for example, from the *Juan F.* consent decree, the *Emily J.* settlement agreement, DCF's licensing activities, and federal grant evaluations. Regardless of whether the feedback is positive or negative, it can help the agency improve its performance. Finally, multiple monitoring and evaluation efforts provide a more complete understanding of a program, mandate area, or the agency as a whole rather than relying on a single source. Perspectives from outside the agency combined with internal monitoring and evaluation information provides a more comprehensive picture of DCF performance.

TABLE VII-3. PROGRAM FUNDING AND SELECTED CLIENT INFORMATION: FY 06

MANDATE AREA	KEY PROGRAMS	EXPENDITURES (IN MILLIONS)	SELECTED CLIENT INFORMATION
AGENCYWIDE		\$ 754.9	
CHILD PROTECTIVE SERVICES	<ul style="list-style-type: none"> • <u>Community-Based Services</u> <ul style="list-style-type: none"> ▪ Hotline ▪ In-Home (family preservation, parent aide, substance abuse screening) • <u>Out-of-Home Services</u> <ul style="list-style-type: none"> ▪ Foster Care, Adoption, Subsidized Guardianship, Relative Caregivers, Independent Living, SAFE Homes, Shelters • <u>Area Offices</u> 	<p>\$ 395.0</p> <p>\$ 33.9</p> <p>\$ 203.1</p> <p>\$ 157.9</p>	<ul style="list-style-type: none"> - 43,500 reports of abuse/neglect received; 7,568 reports substantiated - 3,400 families received in-home child protection services - Averaged 3,216 children in foster care - 1,210 children living with licensed relative caregivers - Over 700 youth in independent living situations - Finalized 498 adoptions - Total caseload: 17,770 (as of 6/06)
CHILDREN'S BEHAVIORAL HEALTH SERVICES	<ul style="list-style-type: none"> • <u>Community-Based Services</u> <ul style="list-style-type: none"> ▪ KidCare (Emergency Mobile Psychiatric, Intensive in-home treatment, Outpatient Clinics, Extended Day Treatment) • <u>Out-of-Home Services</u> <ul style="list-style-type: none"> ▪ Residential Treatment, Therapeutic Group Homes • <u>State Operated Facilities</u> <ul style="list-style-type: none"> ▪ Riverview Hospital ▪ High Meadows ▪ Connecticut Children's Place (CCP) 	<p>\$ 259.1</p> <p>\$ 66.2</p> <p>\$ 133.6</p> <p>\$ 52.3</p>	<ul style="list-style-type: none"> - Community service capacity about 2,000 children - 874 in residential treatment - Riverview's average daily census about 80 children - High Meadows serves about 110 children/year - CCP serves approximately 150 children/year
JUVENILE SERVICES	<ul style="list-style-type: none"> • <u>Community-Based</u> <ul style="list-style-type: none"> ▪ Parole Services, Aftercare for Delinquent Youth • <u>Out-of-Home Placement</u> <ul style="list-style-type: none"> ▪ Residential Treatment for Delinquent Youth • <u>State Operated Facility</u> <ul style="list-style-type: none"> ▪ Ct. Juvenile Training School (CJTS) 	<p>\$ 58.1</p> <p>\$ 13.3</p> <p>\$ 16.8</p> <p>\$ 23.7</p>	<ul style="list-style-type: none"> - About 1,200 delinquent youth committed to DCF for out-of-home care annually - Approximately 500 parole cases in 2006 - CJTS average daily census about 100 boys
PREVENTION SERVICES	<ul style="list-style-type: none"> • <u>Fund/directly provide various primary prevention programs</u> (e.g., child abuse prevention, positive youth development; early childhood services, diversion projects; public awareness campaigns) • <u>State Operated Facility</u> <ul style="list-style-type: none"> ▪ Wilderness School 	<p>\$ 2.7</p> <p>\$ 2.1</p> <p>\$ 0.6</p> <p>\$ 40.0</p>	<p>Served approximately 8,000 (does not include those reached through public awareness campaigns)</p>
AGENCY MANAGEMENT			

Sources of Data: Governor's Budget, FY 08-09; DCF.

What the committee study reveals most clearly about the DCF monitoring and evaluation system is the fragmentation of current efforts and a lack of integration of the feedback produced. DCF needs to ensure all findings information comes together and is analyzed so patterns of deficiency can be identified and best practices shared.

This appears to be a main role for the agency's Risk Management Unit, but it has only three staff who at times are diverted from this task by other projects. Further, the structure of both this unit and the Decision Support Unit, another unit that supports results-based management, have been unsettled since the PRI study began. Roles and reporting relationships are still evolving and vacancies remain in key management positions.

As described in Chapter II, the department's Service Evaluation and Enhancement Committee (SEEC) is the central mechanism for tracking available results information to "red flag" patterns of poor performance or undesirable outcomes.

While the idea is to have all areas of the department that are needed to address critical issues participating in this monitoring and evaluation process, in practice, key staff are often missing. Furthermore, the PRI committee found SEEC efforts have concentrated on emergency situations with private providers. **The program review committee recommends:**

the department should reinforce and expand the role of the Service Evaluation and Enhancement Committee in integrating monitoring and evaluation efforts across the agency and initiating proactive intervention on agencywide issues.

In addition to integrating efforts to avert and solve performance problems of private providers, SEEC, or a similar mechanism, should be identifying and addressing issues that go beyond the jurisdiction of a single bureau or program. One example of an issue greatly in need of an agencywide consolidated approach within DCF and with other agencies is girls' services.

Strengthening the agency's capacity for integrating results data, in combination with the strategic planning initiative recommended earlier, will bring DCF much closer to the effective monitoring and evaluation system outlined by the national resource center framework noted earlier. By adopting such practices, DCF can be more effective in meeting the needs of the children and families it serves.

Department information systems. To facilitate the integration of results data, DCF needs system technology that supports the combined practices of all four mandate areas. The systems that currently serve the department are not integrated nor can they communicate with each other.

The technology serving the department has been developed around services, not around the children and families in a consumer centric model. Similar to other states, Connecticut's SACWIS system (LINK) was built by technicians, programmers, and case workers to meet federal child protective services reporting requirements and not necessarily to use the data in performing analysis or managing the continuum of care. The system was designed to support transactional reporting functions and report on the key federal outcome requirements. It does not,

however, provide useable data to supervisors or the necessary analytic capability to improve outcomes. Table VII-4 summarizes the challenges with the current LINK system.

Table VII-4. Summary of Current LINK System Challenges	
Challenge	Description
Inflexibility	<p>If data entry errors occur, the case worker cannot make changes even when the error can have major implications for the entire case.</p> <p>DCF currently has a full-time staff person dedicated to correcting LINK errors.</p> <p>Due to the changing dynamics of child welfare practice, the system requires multiple enhancements; however, making changes can require a tremendous amount of work.</p>
Inaccurate reporting of placement of children	<p>If the legal status of a child is changed, the caseworker is not required to change the placement. Additionally, if the placement changes, the worker is not required to account for whether the child’s legal status has changed.</p> <p>The system also does not include all placement arrangements, particularly non-paid placements; therefore, not all types of placements can be documented. For example, if a child ran away, the system does not force DCF to account for the run-away status. If a child is sent home but is still under DCF care, the placement field may not reflect this information.</p>
Response time	<p>Due to the infrastructure required to support the technology, different area offices experience various degrees of performance; some note that performance is so prohibitively slow, it inhibits work productivity.</p>
Userability	<p>DCF employees estimated it can take anywhere from three to six months for a caseworker to feel comfortable with LINK, and that excludes additional training time required when workers change, for example, from the investigations area to the foster care unit.</p>
Obsolescence	<p>LINK is currently 10 years old. There is the possibility that in the near future the vendor will no longer support the infrastructure or make it prohibitively expensive to make corrections. LINK relies on PowerBuilder technology, which has a very narrow market share. It has become increasingly costly and difficult to locate technicians skilled in and willing to work on a PowerBuilder project.</p>
Non-compliance with federal requirements	<p>The SACWIS system is not federally compliant with 15 of 87 federal measures. Other states are experiencing similar problems, although many, including New York, New Jersey, and Wisconsin, (and Washington D.C.) have decided to redesign their systems and move toward web-based technology.</p>
Fragmentation	<p>Users cannot access LINK to obtain all information about a child and his/her family (e.g., involvement with the juvenile justice system or Riverview Hospital).</p>
Source: PRI staff analysis.	

Technology can enable DCF to move toward a model that integrates the bureaus and the services offered in each. An independent analysis is needed to determine the specific technological requirements necessary to integrate the department. Moving toward a web-based system will allow simple and easy use that mirrors current navigation of the internet. In addition, productivity improvements resulting from less administrative work due to ease and flexibility of the system are estimated to range between 20 and 30 percent.

Upgrading the current system to a web-based system would also address the problem of varied performance reliability experienced by some of the area offices. Additionally, web-based technology would allow the servers to be located in closer proximity to the DOIT mainframe, creating consistent performance for all the offices. Moving to a web-based system would also help with business continuity in the event of a disaster. LINK must currently be loaded onto a computer in order to gain access to information. With a web-based system, caseworkers would be able to access the system from any computer.

Federal SACWIS funding is available to move towards a web-based system. In addition, the federal government through the Centers for Medicare and Medicaid Services will support initiatives with an interoperability²⁸ focus up to 90 percent, since many of the children are served by Medicaid.

Integrating all data systems would also assist the provider community. Although providers send data to DCF, they currently do not receive information back. Integrating data systems within the department and creating a web-based interface would allow providers to enter data directly into the DCF system and receive information back instantaneously. Lastly, DCF would be able to interface with the other agencies that serve many of the same children and their families such as the Judicial Branch, DDS, and DMHAS.

DCF does not have the internal expertise to handle a technology redesign. Additionally, given the longevity and importance of systems, it would benefit Connecticut to leverage the experiences of other states through hiring external advisors. **Therefore, the committee recommends:**

DCF shall hire an external consultant to:

- 1) perform a gap analysis²⁹ and workflow analysis with the focus on integrating the functions of the department with technology modeled to support the service model;**
- 2) develop a project plan; and**
- 3) develop a request for proposals to procure the team needed to integrate the data systems and replace the LINK system.**

²⁸ Refers to the process of effectively integrating services, technologies, and support functions within and across departments to better serve families and meet the needs of an increasingly technology-focused work force.

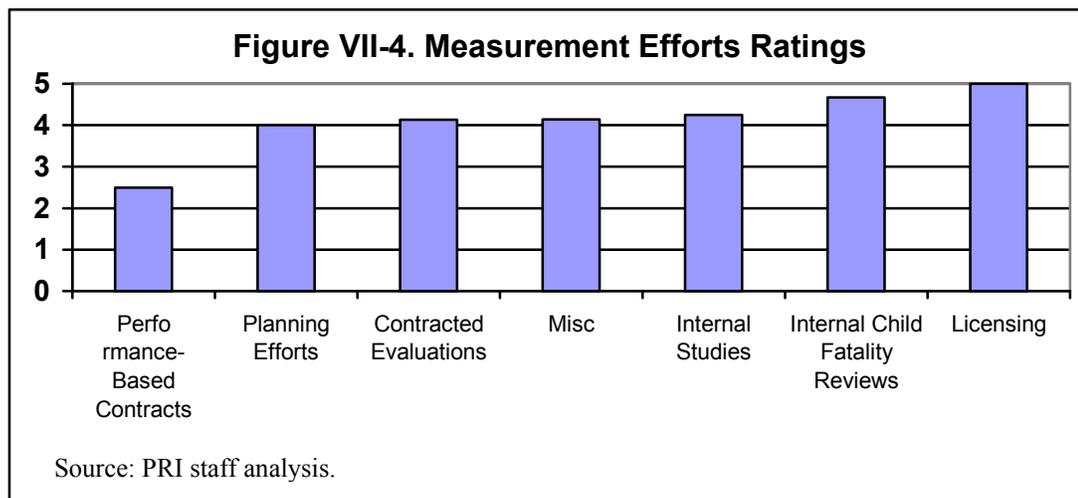
²⁹ Refers to identifying technology requirements and assessing existing capabilities to determine where needs are not being met.

All of DCF’s information systems, and LINK in particular, have required a large investment by the agency. However, given the status of their information systems, it is time to look to the future to assess the needs for current demands on practice rather than pour more money into an antiquated and inefficient system. The mandate for DCF covers three major service systems, Child Welfare, Juvenile Justice and Behavioral Health, yet the information systems do not support an integrated view of children and their families. DCF serves the most vulnerable citizens and public officials need accurate information quickly.

Internal Efforts

Based on the committee assessment of DCF’s own monitoring and evaluation efforts, recommendations are made to improve the system. Recommendations include improvements to the department’s performance-based contracting, internal special reviews of child fatalities, and receipt and review of feedback and suggested programs or program enhancements.

Information collected. In general, the information collected for internal monitoring and evaluation efforts is of good quality with little missing information. However, there were differences across the different types of internal monitoring and evaluation efforts. Figure VII-4 shows that *performance-based contracts had the poorest measurement efforts and licensing the best measurement efforts.*



Issues with measurement for performance-based contracts were that only the number of participants and demographic information was provided in the required quarterly reports; all other data were missing or not reported for many of the contracts. The only outcome measure included in the quarterly report is “reason for service discontinuation,” which is inaccurate/incomplete, and is part of the data “scrubbing” currently underway. It is unclear how success would be determined, and how DCF would know whether the goals were attained.

Further, there were instances when data requirements were specified in contract, but not submitted regularly by the provider. The contract for extended day treatment services, for example, requires a provider to meet performance standards such as “80 percent of children/youth will not require placement in a more restrictive setting” and “75 percent of children/youth will maintain or increase their school attendance.” Also, in the few other instances where requirements were specified in contract, the target or goal to be attained was not specified. For example, a contract for emergency mobile psychiatric services requires a provider to submit client outcome data on functioning and symptom relief, but does not specify a percent or degree of improvement goal. **Therefore, the program review committee recommends:**

DCF performance-based contracts should specify the data required from providers. Performance standards or expected outcomes should be stated in the contract. DCF should monitor data submissions for accuracy.

The department has recognized the need to make expectations for provider performance more explicit and based on relevant research and recognized quality standards. To accomplish this objective, the agency, in partnership with providers, has started to implement a logic model approach for contract development. The PRI committee believes using this model, which is a systematic method of linking program activities to desired outcomes, can improve contract monitoring and evaluation efforts as recommended.

Sometimes data were submitted by providers and DCF took no action to review, aggregate, or analyze the information. Data that are time-consuming for providers to collect may not be summarized or analyzed because they are not necessary. **Therefore, the program review committee recommends:**

DCF should review currently required data elements from providers and determine whether they are necessary or analyzed in any way. Data elements that are unnecessary should be eliminated and additional data elements that pertain to outcomes should be added to performance-based contract requirements.

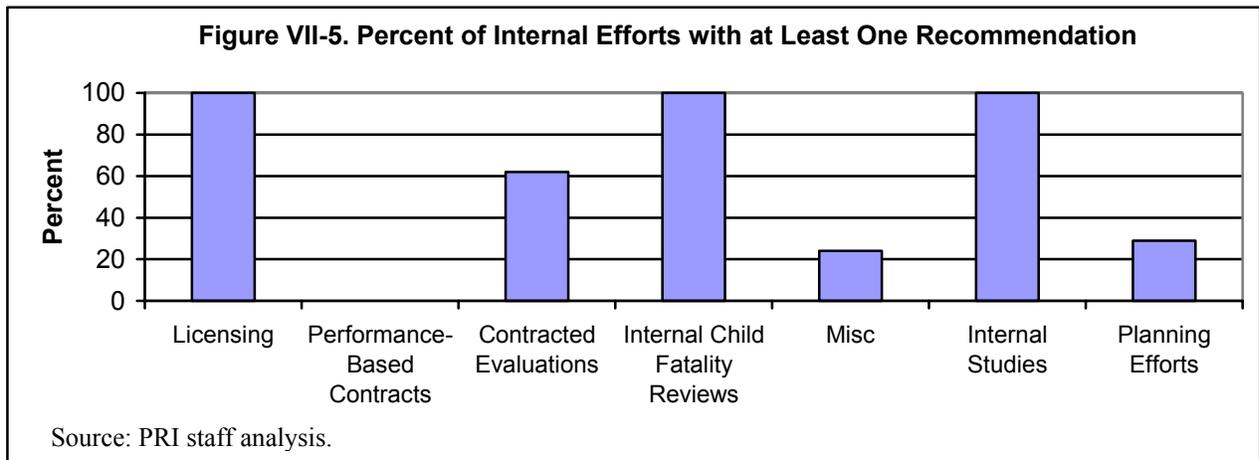
Additionally, data that are determined to be necessary, and required as such in provider contracts, should be summarized and analyzed by DCF. The department has currently chosen not to use information collected from some automated systems due to reliability concerns. While an accurate automated system would be ideal, until such a system exists, monitoring and evaluation of contract requirements can and should be done manually.

There is currently little accountability and knowledge of whether a provider is meeting contract expectations, and consequences are rare for providers even when DCF is aware of the situation. In a few instances, the Program Review and Evaluation Unit has prepared some comprehensive reports on residential treatment centers based on the data required from provider contracts on service delivery and effectiveness for each child in care. These useful reports, which are not shared with providers and appear to receive limited attention from within the department, include information on placement at discharge, change in functioning/GAF score, reason for discharge, and discharge status. **Therefore, the program review committee recommends:**

DCF shall compile necessary required data elements to compare actual and expected outcomes based on the performance-based contract. Failure to meet contract expectations should result in discussion and joint plans for progress in meeting expectations.

Until automated systems are deemed reliable, DCF should monitor contract expectations manually. Summary reports should be shared with providers so that they may monitor their performance against the aggregated data. Reports should be distributed to providers and DCF staff made more aware of the existence of these reports.

Recommendations from internal efforts. Not all internal monitoring and evaluation efforts contained recommendations. Of the 52 examined by PRI, slightly more than half contained recommendations (54 percent). Figure VII-5 shows the percent of monitoring and evaluation efforts containing at least one recommendation.



As would be expected, performance-based contracts have no recommendations. On the other hand, all licensing efforts, internal studies, and internal child fatality reviews examined had recommendations. *Surprisingly, one-third of the contracted evaluations paid for by DCF did not contain recommendations.* The PRI committee believes that recommendations that logically flow from a study's findings are a key ingredient to subsequent changes or improvements.

Contracted evaluations. There is some confusion and concern regarding what happens to recommendations received by the department. This study found that *a substantial proportion of recommendations are adopted; however, this information is not necessarily known or shared across divisions of DCF or with contracted evaluators.* A formal process would be useful whereby DCF recommendations are reviewed and determinations made about their adoption or, if not adopted, the rationale for that decision. This function does not currently exist. Further, *there should be a formal tracking system to monitor implementation of recommendations and the occurrence of any anticipated outcomes as a result of adopting the recommendation.* A good practice would be for DCF to review and formally respond to contracted evaluation reports, including adoption or rejection of recommendations. Through quarterly reports, DCF should

monitor the implementation of recommendations and progress in achieving any anticipated outcomes as a result of adopting recommendations.

Evaluation library. Additionally, with staff turnover and changes in assignments, previous monitoring and evaluation efforts including study recommendations are not always known by staff who could benefit not only from the recommendations, but from the results of previous studies. There is currently no central repository for study reports as well as the contractor assessment forms required by the Office of Policy and Management. Because centralizing knowledge of previous efforts, results, ratings, and recommendations would be both inexpensive to do, and beneficial to many, the **program review committee recommends:**

A central repository should be created by DCF of contracted research and evaluation reports and internally produced research and evaluation reports. This repository should be accessible and searchable by all DCF staff and should include the Office of Policy and Management (OPM) feedback form as applicable.

Strengths. The internal monitoring and evaluation performed by DCF has a number of strengths. The licensing function is organized and effective. Forms and protocols are well documented. Monitoring via site visits to facilities and programs occurs regularly, and any deficiencies require correction before a license will be reissued.

The DCF licensing unit does a thorough and effective job of inspecting provider facilities and programs that fall within their purview. Of the DCF-run facilities, Riverview Hospital is accredited by the Joint Commission and CJTS is preparing to become accredited by the American Correctional Association. The Wilderness School is licensed by the Connecticut Department of Public Health. While there is consideration of DCF accreditation by the Council on Accreditation (COA), there is currently no accrediting or external licensing body reviewing High Meadows and Connecticut Children's Place. Therefore, until COA accreditation of DCF occurs, the **program review committee recommends:**

The DCF licensing unit should expand internal self-monitoring by inspecting High Meadows and Connecticut Children's Place, the two DCF facilities not currently under external licensure or accreditation. The licensing unit should follow the child care facilities regulations standards used to inspect external residential treatment facilities similar to High Meadows and Connecticut Children's Place.

Another strength within the internal monitoring and evaluation performed by DCF is the internal special review process for child fatalities and other critical incidents conducted jointly by the DCF Director of Research and Development and the Child Welfare League of America. In interviews conducted for this study with a variety of agency staff and external organizations, including the Office of the Child Advocate, PRI staff was told repeatedly *the recently redesigned special review process is a significant improvement over the prior system, and addresses very difficult events in a positive, objective, and supportive manner.* It is also one of the few efforts that examines agencywide goals and performance throughout the department.

The special review effort could be strengthened further by requiring a formal response from the DCF commissioner regarding recommendations from the internal child fatality review. A forum for discussion that includes all relevant managers and area office directors would further expand the lessons-learned philosophy of the process. Follow up of recommendations should be monitored by quality improvement staff, and be an automatic agenda item for quality improvement team meetings. **Therefore, the program review committee recommends:**

The department should establish an internal written policy for responding to recommendations from the internal special reviews of child fatalities and other critical incidents. The policy should require a corrective action plan be developed, implementation of accepted recommendations be monitored, and a status report be prepared for the commissioner every 90 days. A forum to discuss results and lessons learned should be scheduled with managers and key staff from all relevant areas of the department within 45 days of release of the report.

An additional monitoring and evaluation system strength revealed by the PRI study is the *effective research relationship the department has developed with the Child Health and Development Institute (CHDI) and its affiliate, the Connecticut Center for Effective Practice (CCEP)*. For a number of years, CHDI and CCEP have provided high quality, timely feedback on the effectiveness of a wide variety of children's behavioral health services funded by the Department of Children and Families. The department has used the results of the work of the institute and the center to improve program operations and the effectiveness of mental health and substance abuse services for children and families across the state.

At present, CHDI and the center provide a broad scope of evaluation services to DCF under a multi-year, open-ended contract related to the state KidCare initiative. The contract permits the institute and DCF to define research projects as needed and it has also been amended to incorporate additional, related evaluation issues as they come up during the research process. It is not clear how the present arrangement will be affected when the current contract expires. Newly enacted state procurement laws and OPM policies may require CHDI to provide all future services on a project-by-project competitive basis.

Applying this policy to CHDI, a nonprofit, independent research institute that works in partnership with public and private academic institutions, appears counterproductive. The existing contractual arrangement permits the institute and the center to provide DCF with much-needed expertise to implement and monitor the effectiveness of evidence-based behavioral health service models. CHDI and CCEP can both consult with the department about best practices, provide technical assistance on developing service systems, and conduct research-based program evaluations.

Requiring DCF to use a separate RFP process for every CHDI evaluation service would limit the responsiveness, timeliness, and usefulness of the institute's work for the department. Child welfare agencies in several other states effectively use ongoing partnerships with academic or other independent research institutions to increase their capacity for program evaluation, quality assurance, and system development. **Therefore, the committee recommends:**

DCF should be permitted to establish a long-term research partnership with the Child Health and Development Institute and its affiliate, the Connecticut Center for Effective Practice, through a multi-year, sole source contract to carry out a broadly defined research and evaluation agenda related to the agency's mission.

Another strength exists with the establishment of the Behavioral Health Partnership and the development of its Administrative Service Organization. *The process to create the BHP was transparent and informed by the experience of all DCF stakeholders.* It has fostered a strong cooperative relationship between DCF and DSS concerning behavioral health matters for children and families. The ASO now provides DCF with extensive data previously unavailable that can be and is used to assess the quality of behavioral health services and providers, determine service effectiveness, and examine needs for new services.

Constituencies within and outside of DCF, however, have expressed concern over the ASO role of matching children with appropriate services and placements, given the organization's limited case-specific information and minimal knowledge of children and their families. Since the ASO is in its first year of implementation, it is too soon to know the extent of problems of this nature. The Behavioral Health Partnership Oversight Council has authority to monitor this issue and it also should be addressed in the upcoming independent evaluation of the ASO being carried out for the council.

Another internal DCF monitoring and evaluation strength is the agency's Office of the Ombudsman. The function, which had been informal and scattered through the agency, was recently consolidated into one unit, with specifically assigned professional staff, protocols for handling inquiries, and an information system to track calls. Ombudsman staff assigned as liaisons to all DCF facilities and offices meet regularly with agency staff and clients. *With its clarified role and significantly expanded staffing, the DCF ombudsman has improved the agency's ability to receive and respond to external feedback from children and families, providers, and members of the public.*

The committee further found that many areas of quality improvement strengths have been developed throughout the department in response to the *Juan F.* exit plan. For example, the agency decentralized its operations to create smaller area offices, each with a quality improvement manager and requirements for quality improvement teams responsible for developing and implementing local quality improvement plans. Also, the ROM system was developed to provide all managers and staff with performance measurement data.

The 105 staff in the department's continuous quality improvement bureau have been directed to focus on supporting efforts to achieve better results rather than meet compliance standards. The agency has also been working to develop research and analysis capacity, through the bureau's Risk Management and Decision Support units, which are intended to support results-based management practices throughout the agency. DCF also hired a full-time research scientist to provide advice and technical assistance on performance measurement and outcomes analysis.

As noted in Chapter II, the Risk Management Unit supports the work of the department's Service Evaluation and Enhancement Committee by integrating certain performance data--particularly concerning private providers of residential services--for review and development of needed corrective actions. The SEEC function is another monitoring strength in the agency. However, after reviewing three years of meeting minutes, the PRI committee found that SEEC responses to incidents were not always handled in a timely manner.

In addition, there appeared to be inadequate attention to reviewing patterns to avert a crisis. For example, over a nearly three-year period, critical incidents and significant events were noted repeatedly at one residential facility. In response, SEEC had the Program Review and Evaluation Unit review the facility. While the review was expected to be completed within three weeks, the final review was not issued until a year and a half later. Following the review, critical incidents concerning the facility continued to be reported to the agency's Hotline.

One factor contributing to the SEEC's inability to ensure a timely response to problem providers is the lack of resources for ongoing oversight and support of the entities under contract to the agency. Currently, program leads, who are agency staff with other full-time responsibilities, including bureau chiefs and program directors, have primary responsibility for provider support and technical assistance. They do not have the time to focus on building partnerships with the department-contracted service providers.

In the past, the department had staff positions in its area offices assigned to oversee contracted providers. In addition to contract management, these staff could build and maintain positive relationships with the many facilities and community-based organizations that work for the department. These positions were eliminated under budget cuts made during the state fiscal crisis several years ago.

During interviews with provider groups and department staff, it was noted that several other agencies have developed effective ways to work in partnership with their providers. For example, in the past, DMHAS used a model where a team composed of a fiscal staff person and a program staff person were assigned to work with each provider. While the program staff had the day-to-day connection with service operations, program, fiscal, and information system people would all meet regularly with providers. At these meetings, the staff from the three areas with provider responsibilities and the provider would talk about performance issues, consider solutions to problems, and make necessary decisions for corrective action.

The committee believes this approach of combining contract management, evaluation, technical assistance, and support would improve the department's partnerships with its providers. Therefore, the program review committee recommends:

DCF should reexamine the role of its program lead position and consider the allocation of time necessary for this responsibility. DCF should also develop a team approach for working with contracted providers that will ensure contract obligations are being met, provide assistance when necessary so that programs do not reach a crisis point, and support and assist programs with quality improvement.

Deficiencies. A deficient area is the monitoring of contracted services. As noted by the Arizona Office of the Auditor General, “Contract monitoring helps protect funds and the clients being served by identifying and reducing fiscal or program risks as early as possible. Specifically, monitoring helps ensure that contractors comply with contract terms and conditions, that performance expectations are achieved, and that any problems are identified and resolved in a timely manner.”³⁰

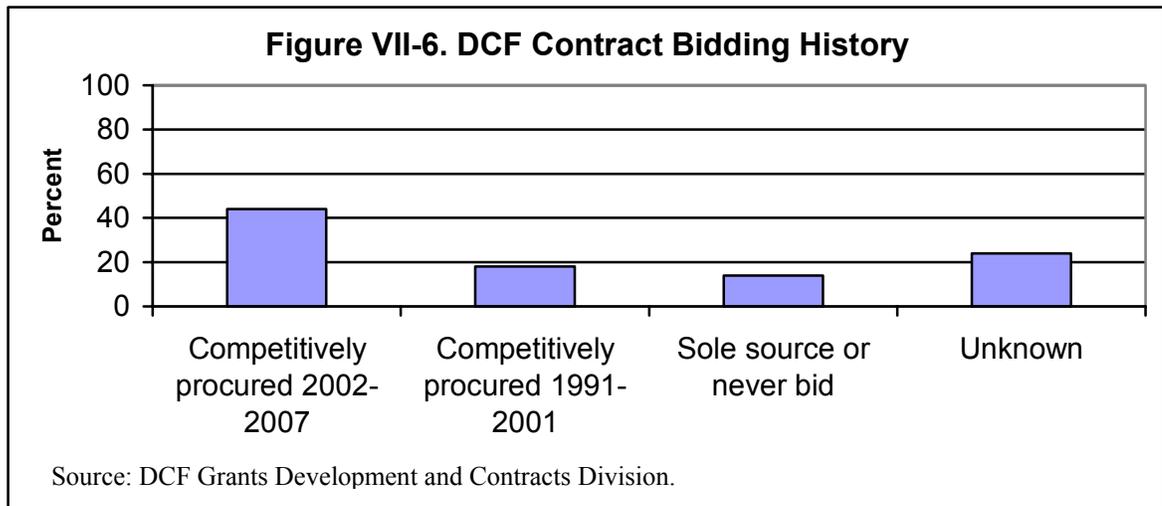
The report further cited four best practices in contractor monitoring identified by the National State Auditors Association.³¹ As shown in Table VII-5, based on interviews and document examination, the committee found little if any evidence of use by DCF of contractor monitoring best practices.

Table VII-5. Evidence of Use by DCF of Contractor Monitoring Best Practices	
Best Practice	Evidence of DCF Use of Best Practice
Uses qualified monitoring staff	DCF monitoring of providers and implementation of contract requirements is haphazard at best, often relying on the interest and time available of the program lead, ranging from active to a vacant position.
Conducts periodic on-site reviews and observations	Visits were conducted twice a year in Arizona; however, DCF program leads are juggling multiple responsibilities and often do not have the necessary time nor a protocol to follow in making and processing such visits. Licensing site visits occur once every two years for some programs, and their scope of examination is limited to regulations.
Addresses contractor performance deficiencies promptly	Best practices call for monitoring staff to immediately address deficiencies in contractor performance, including poor quality of service, failure to perform all or part of the contract, and chronically late report submissions. PRI staff found no evidence of this best practice in DCF contract monitoring.
Verifies billing invoices	Best practice calls for monitoring staff to review all invoices for payments against contract terms and pricing. No payment should be made unless the work is satisfactory and in accordance with contract terms. The DCF Grants Development and Contracts Division appears to have the majority of staff dedicated to fiscal administration and monitoring of contracts; however, the committee found that provider payment occurred regardless of satisfaction with the service provided.
Source: PRI staff analysis.	

³⁰ Performance Audit of the Department of Economic Security, Division of Children, Youth and Families—Prevention Programs, State of Arizona, Office of the Auditor General, July 27, 2007.

³¹ National State Auditors Association. *Contracting for Services: A National State Auditors Association Best Practice Document*. Lexington, KY: National State Auditors Association, 2003.

In examining the competitive bidding process, the committee also found that of 93 DCF services offered by contracted providers totaling \$193,078,587 annually, 18 percent had last gone out to bid in 2001 or earlier (see Figure VII-6). The Grants Development and Contracts Division, which provided PRI with the information on when contracts had last gone out to bid, classified nearly one quarter (24 percent) as “unknown” (totaling \$13,584,800 annually).



The committee further found that in many instances the data requirements are vague and not specified in the contract. For example, the contract states that the provider will “submit required statistical, financial and programmatic reports necessary for establishing payment schedules and grant formulae, monitoring and evaluation and the establishment of MIS.” In other instances the required information is specified in the contract, may or may not be collected, and is often not analyzed due to concerns about the quality of the data.

While concerns regarding performance-based contracting are discussed throughout this chapter, an additional area for improvement is the relationship between the provider and DCF staff charged with oversight of implementation of the service. Other state entities, such as the Court Support Services Division, reportedly work very closely with their contractors, including sitting in on hiring interviews and helping to provide support if there are struggles or issues related to implementation of evidence-based models. DCF does not maintain a similar relationship with its providers. Such a partnership would be valuable in getting needed services to the children and families of DCF. **Therefore, the committee recommends:**

Considering contractor monitoring best practices, DCF should examine the roles of staff within the Grants Development and Contracts Division to determine whether some of the 19 positions could be reallocated from the financial/accounting function of contract management to program development and implementation support activities.

PRI staff, in gathering the information needed to assess the internal monitoring and evaluation efforts of DCF, also had some difficulty in locating contracts. While many of the contracts are stored in an electronic library database accessible on the DCF intranet, other

contracts, such as PSAs, are not online, nor are federal grants received by the department. The current library does not maintain prior contracts online. The contract library could be made more complete by scanning in paper copies of any grants or contracts missing from the electronic library, and retaining the previous year's contracts. **Therefore, the program review committee recommends:**

DCF should maintain a centralized and complete electronic grants and contracts library on the department's intranet. Grants and contracts missing should be scanned into the library. Previous year's contracts should be maintained for future reference.

Another deficiency is the lack of a formal process for soliciting feedback on the satisfaction with a provider prior to renewal of a contract. *While it is certainly the case that there are limited options for particular services due to the paucity of providers, nevertheless, substandard service should not continue to be funded without some required improvements.* In the past, there were DCF staff assigned to oversee contracts in each of the regional offices. With the transition from five regional offices to 14 area offices, and other funding challenges, this effort was disbanded. Area office staff and program leads should be in a position to assess the services provided by a contractor and their input should be a pre-requisite to contract renewals. **Therefore, the committee recommends:**

The department should require the Grants Development and Contracts Division to receive and review feedback from area office and program lead staff on the performance of a provider before deciding to renew a contract. If concerns are raised about a provider, then discussions with the appropriate parties should occur and a performance improvement plan developed.

The committee became aware of deficiencies in the development of new services. There is confusion among providers regarding their ability to make suggestions to the department and subsequently bid on any future related requests for proposals. While contract administration must adhere to the highest standards possible, DCF, OPM, the OAG, and others affected by this issue should develop a process whereby programming suggestions from these experts is welcomed and providers are not penalized or subsequently barred from submitting a bid to provide the service. **Therefore, the program review committee recommends:**

A workgroup should be convened by the department and the Offices of Policy and Management and the Attorney General to clarify the guidelines regarding contract bidding and related programming suggestions.

Based on the principle of partnership, providers should receive a response from DCF to a formally submitted idea. PRI staff was told of instances when the department did not respond to a formal suggestion, or responded informally many months later. *As a way to demonstrate the value that the department places on the providers, the department should publicize a clear format and process for providers to submit program ideas to the department.* The ideas then deserve a careful review by the appropriate staff within DCF, and a formal response and any next

steps conveyed to the provider submitting the suggestion. **Therefore, the committee recommends:**

DCF should develop a protocol for providers to submit suggested programs or program enhancements. A form for submitting the idea should be developed and timelines for response from DCF publicized.

Another deficiency is the lack of DCF staff with analytic abilities. Absent the capacity to analyze data collected as required by the performance-based contracts, the information cannot be used in any meaningful way. In general, department managers acknowledged a critical shortage of analytic staff in the department able to assume such responsibilities. PRI staff was told by management that one barrier is the limitation of the current DCF job classifications. Managers attempting to fill analytic positions rely on luck that they can find a social worker who would be capable of analytic work. **Therefore, the program review committee recommends:**

DCF should work with DAS to develop: 1) an appropriate job classification for staff positions within the agency responsible primarily for research and analysis; and 2) recruitment strategies for obtaining personnel with the necessary qualifications to fill them.

Furthermore, the department should increase its internal analytic capacity. The size and scope of the Risk Management Unit staff should be expanded to include the following duties in addition to compiling information to support the SEEC function: interpreting data produced by the ASO; compiling contracted evaluation results; maintaining the research repository recommended earlier; supporting agency strategic planning activities; and sharing outcome, best practices, and result information agencywide.

Another deficiency found was that there is no standard criteria whereby staff determines when to hire external evaluators to assess programs. Decisions are based on individuals within the agency and when they feel it is necessary regardless of the type of program or size of the program. **Therefore, the committee recommends:**

For programs exceeding \$20 million in funding, DCF should require an external evaluation be conducted to assess the outcomes of the program.

Another deficiency was found in relating the monitoring and evaluation recommendations to the findings of the study. In several instances, it was unclear what finding or result was being addressed by the recommendation. Additionally, action steps were developed to implement the recommendations; however, the recommendation being addressed by the action plan step was not necessarily understood. Third, the action was not always within the control of the receiving agency or department, making it difficult to influence accomplishment of the action. **Therefore, the program review committee recommends:**

DCF should develop and issue guidelines for staff and consultants regarding the format for final evaluation reports.

For example, report findings should be paired with the associated recommendation to assure that the recommendation is logically related to the finding. Also, recommendations should be numbered and any subsequent action plan should refer to the numbered recommendation and include the recommendation itself. Additionally, when action plans are developed, the actions should be within the control of the receiving agency or department.

Until recently, there appear to have been deficiencies in the monitoring and evaluation of licensing of foster parents. During the past year, the department has been researching best practices, and has revised its foster care structure and procedures. The Office of Foster Care Services issued a plan in June 2007 outlining recruitment and retention strategies and new quality improvement activities including: implementation of a pre-disruption conference policy; enhancement of the PRIDE foster parent training curriculum; and development of a client level data set. Additionally, the Office of Foster Care Services plans to incorporate uniform performance indicators with specific employee performance standards, intensify efforts to partner with the community, and provide foster parents with mechanisms to provide feedback.

At present, foster parents undergo relicensure every two years. Foster and Adoption Support Unit social workers visit foster parents every quarter, assessing such areas as family composition, physical dwelling, sleeping arrangements, and updates on children. Visitation and treatment plans are discussed, as well as child-related concerns and any other issues.

Another area of potential deficiency concerns the department's internal process for handling child abuse and neglect reports filed against DCF employees. A conflict of interest arises whenever an agency is investigating itself. In addition, the committee became aware that DCF is not in compliance with a statutory reporting requirement concerning abuse and neglect reports for delinquent children (C.G.S. § 17a-103c). This statute requires DCF, upon the receipt of a report of suspected abuse or neglect of any child committed to the department as a delinquent, to notify the child's attorney in the delinquency proceeding. According to the Public Defender, no reports have been received since January 2007. Given the conflict of interest concerns and the department's noncompliance, **the program review committee recommends:**

The Office of the Child Advocate should undertake an investigation to assess adequacy and integrity of the internal process for reviewing and responding to allegations of staff child abuse and neglect. It should also examine compliance with C.G.S. § 17a-103c.

Gaps. Considering DCF internal efforts only, there appear to be gaps in the internal monitoring and evaluation efforts to assess outcomes. Almost two-thirds of all internal monitoring and evaluation efforts focus solely on service delivery (process) rather than on outcomes, or end results. There also appear to be gaps in the internal monitoring and evaluation of the agency as a whole, with agencywide efforts accounting for just six percent of all internal efforts examined.

The strategic planning process recommended earlier is intended to get at this gap. The new planning process can also begin to address a related deficiency -- the lack of significant input from children and families, community groups, and other external stakeholders in the quality improvement process. This problem was noted in 2002 by the *Juan F.* consent decree

Technical Advisory Committee, and remains an issue, according to a wide range of outside constituencies interviewed by committee staff.

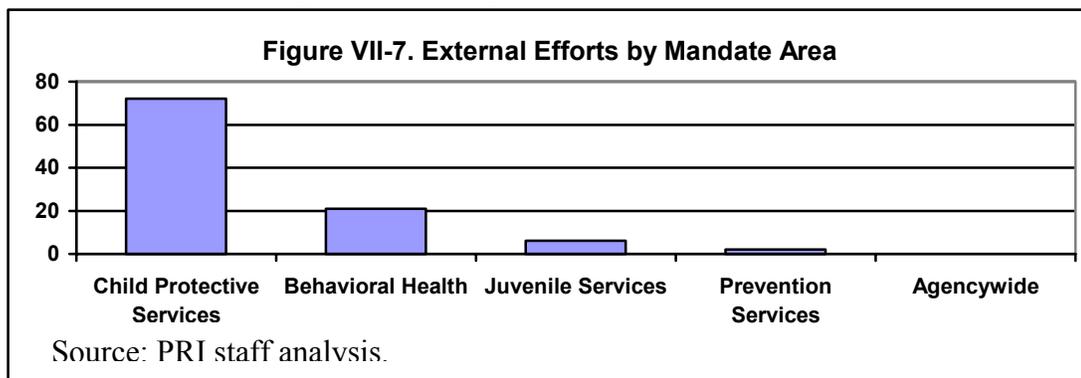
Redundancies. Considering the internal efforts only, there appear to be redundancies in the monitoring and evaluation efforts, particularly for the *performance-based contracts* within the behavioral health mandate area. For example, the same demographic information on a client is required to be entered into two separate databases in order to receive payment and satisfy the data submission requirements of the contract (via Advanced Behavioral Health).

Another redundancy is in the *development and use of individual facility automated databases*, often in ACCESS, rather than use of an agencywide information system.

External Efforts

The committee assessed external monitoring and evaluation efforts and made a series of recommendations. The proposed improvements encompass statutory reporting requirements, multiple treatment plan requirements, and treatment plan conferences.

Where external monitoring and evaluation occurs. Figure VII-7 provides a breakout of external monitoring and evaluation efforts by mandate area. *The largest number of external monitoring and evaluation efforts examined in this study are within child protective services (72 percent).* Approximately one-fifth (21 percent) are within behavioral health services, 6 percent within juvenile services, and 2 percent within prevention services.

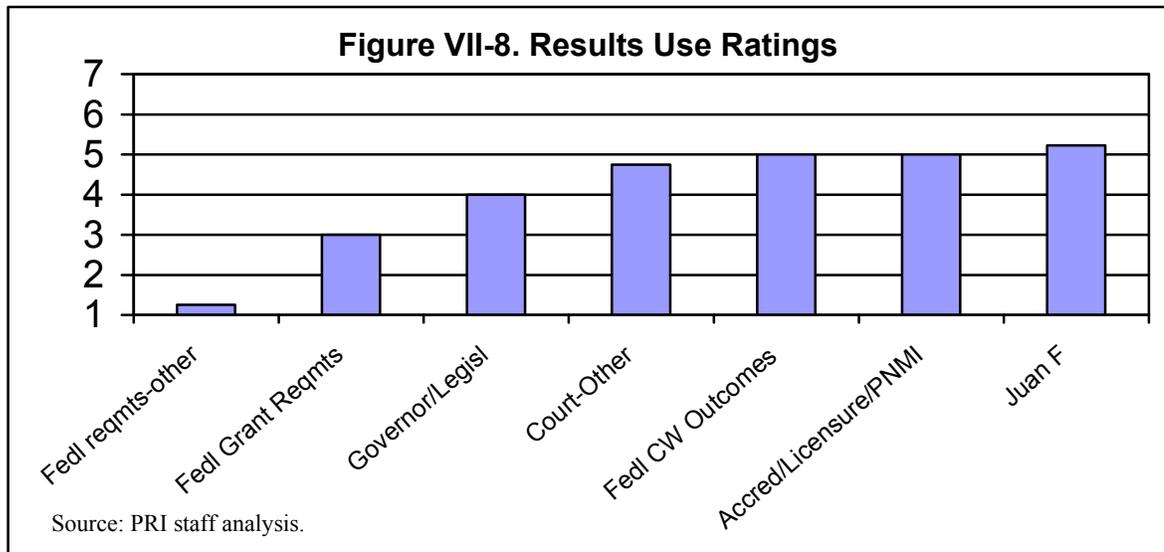


Goals and issues studied. Overall, the external goals and issues studied are stated in a way that lend them to being readily monitored and evaluated. One exception found by the committee was DPH licensing of the Wilderness School. DPH does not have a category for wilderness schools and, therefore, licenses it as a camp. Since the DCF Wilderness School is not a camp, **the committee recommends:**

Wilderness School staff should work with the Department of Public Health to develop a more appropriate licensure as a wilderness school rather than as a camp.

Results use. Figure VII-8 shows the external efforts that resulted in the greatest use of monitoring and evaluation results were: *Juan F.* outcome measures; accrediting body, external licensure, and PNMI/Medicaid; and federal child welfare outcomes. Other federal requirements

(other) such as AFCARS, CFSR, and Title IV-E Foster Care Eligibility Reviews, had results that were least likely to be used to identify organizational or resource barriers, changes to policies, training, or services to children and families, or to seek legislative changes.



Statutory reporting requirements. The committee found many of the required statutory reports have either never been issued or were only issued immediately following the establishment of the statute. Additionally, many reports now are obsolete or replaced by more recent, similar information requirements. Also, the legislature has rarely, if ever, taken steps to obtain missing plans or reports.

Therefore, the committee believes several could be eliminated without loss of accountability. In fact, reducing the number and clarifying their purposes could focus department attention on the most significant aspects of its performance and information related to results. Committee recommendations regarding each statute concerning DCF are summarized in Table VII-6. Overall, the committee proposes two statutory reports be replaced and 11 statutory reports found to be redundant and unnecessary be repealed. Specifically, **the program review committee recommends:**

Replace the following statutory reports:

- a) **DCF biennial five-year master plan (C.G.S. § 17a-3);**
- b) **DCF annual report on the Connecticut Juvenile Training School (CJTS) (C.G.S. § 17a-6b and C.G.S. § 17a-6c); and**

Repeal the statutory reports listed below:

- c) **Children’s Behavioral Health Advisory Committee (CBHAC) annual local systems of care status report (C.G.S. § 17a-4a(e));**
- d) **CBHAC biennial recommendations on behavioral health services (C.G.S. § 17a-4a(f));**

- e) **Quarterly hospital reports to DCF on psychiatric care (C.G.S. § 17a-21);**
- f) **KidCare Community Collaborative annual self-evaluations (C.G.S. § 17a-22b);**
- g) **DCF/DSS five-year independent longitudinal evaluation of KidCare (C.G.S. § 17a-22c(c));**
- h) **DCF monthly report to legislature on children in subacute care in psychiatric or general hospitals who cannot be discharged (C.G.S. § 17a-91a);**
- i) **Cost-benefit evaluation of juvenile offender programs (C.G.S. § 46b-121m);**
- j) **Licensed child care facilities annual reports (C.G.S. § 17a-145);**
- k) **DCF annual evaluation reports on Unified District #2 to the education commissioner (C.G.S. § 17a-37(d));**
- l) **DCF to conduct studies to evaluate effectiveness (C.G.S. § 17a-3(a)(6)); and**
- m) **Adoption Advisory Committee report (C.G.S. § 17a-116b(g)(3)).**

The committee recommends enhancing one of the statutory requirements with a more inclusive directive. Since CJTS is required to prepare an annual report that is then reviewed by the CJTS advisory group, **the program review committee recommends:**

All DCF facilities shall be required to produce an annual report for their respective advisory groups. The report shall contain at a minimum the following:

- a) **aggregate profiles of the residents;**
- b) **description and update on major initiatives;**
- c) **key outcome indicators;**
- d) **costs associated with operating the facility; and**
- e) **description of education programs and outcomes.**

The CJTS advisory group found the process of producing an annual report helpful to the members and the facility. It gives the members information from which to make recommendations both formally and informally. The advisory group is an important component in this recommendation; its members are directly connected to the facility and likely to have a strong interest in the annual report.

The effectiveness of the *Juan F.* exit plan process is attributed to several key elements: having clear, measurable goals; comprehensive, objective, and ongoing monitoring and evaluation activities carried out by the *Juan F.* court monitor's office; and the extensive internal quality assurance system established by DCF in response to the exit plan requirements. First, there are the internal quality improvement division and exit plan unit activities aimed at collecting and analyzing results data and then developing corrective actions aimed at meeting the *Juan F.* outcome measures. Second, the area offices have quality improvement plans for meeting the

Table VII-6. Committee Recommendations Regarding Statutory Reporting Requirements

Mandate Area	Reporting Requirement	Status	Recommendation/Reason
AGENCYWIDE	DCF biennial five-year master plan C.G.S. §17a-3 (PAs 79-165, 86-15)	2000 the last year; Now Exit Planning serves as DCF plan.	Repeal and replace with earlier recommendation for a mandated strategic plan.
BEHAVIORAL HEALTH	CBHAC annual local systems of care status report C.G.S. §17a-4a(e) (PA 00-188) – 2003 was the last report	2003 is the only report that was done.	Repeal; See recommendation for combining CBHAC and the SAC.
	CBHAC biennial recommendations on behavioral health services C.G.S. §17a-4a(f) (PA 00-188)	2003 is the only report that was done.	Repeal; See recommendation for combining CBHAC and the SAC.
	Quarterly Hospital reports to DCF on psychiatric care C.G.S. §17a-21	Produced monthly from August 1999 – July 2005. Now the ASO has taken over this responsibility.	Repeal; Reporting is now handled by the ASO reporting.
	KidCare Community Collaborative annual self-evaluations C.G.S. §17a-22b (PA 00-2 June Sp Sess, PA 01-2 June Sp Sess)	Currently fulfilling through the BHP “report card.”	Repeal; Reporting now done through the Behavioral Health “report card.”
	DCF/DSS 5-year independent longitudinal evaluation of KidCare C.G.S. §17a-22c(c) (PA 05-280, replaced earlier provisions requiring status reports	Completed by CHDI.	Repeal. No longer necessary, evaluations were completed by CHDI as required.
	Behavioral Health Reporting: 1. BHPOC annual report 2. BHP external, independent evaluation 3. DSS/DCF annual BHP evaluation 4. DCF annual report on estimated costs savings due to BHP	Either completed or in progress.	Maintain.
	DCF monthly report to legislature on children in subacute care in psychiatric or general hospitals who cannot be discharged C.G.S. §17a-91a (PA 99-279)	ASO is now handling this reporting requirement.	Repeal; Reporting is now handled by the ASO.
JUVENILE JUSTICE	DCF annual report on CJTS C.G.S. § 17a-6b and 17a-6c (PA 03-251, first annual report due Feb 4, 2004; PA 04-89, adjudicated youth first report due June 1, 2004)	All reports completed.	Replace with recommendation that requires all DCF facilities to produce annual reports.
	CPEC cost-benefit evaluation of juvenile offender programs C.G.S. § 46b-121m (PA 00-172)	Completed. One time review.	Repeal; Report was completed so it's no longer necessary.

Table VII-6 continued. Committee Recommendations Regarding Statutory Reporting Requirements

Mandate Area	Reporting Requirement	Status	Recommendation/Reason
PROTECTIVE SERVICES	DCF annual status report on all committed children and on central registry and permanency plan monitoring system C.G.S. §17a-91 (status report since 1973; registry and monitoring system required by 17a-110 since 1999)	2001 was the last year the report was completed.	Maintain.
	DCF Kinship Navigator Program annual report to legislature C.G.S. § 17a-98	Beginning in 2008.	Maintain First report will not be issued until 2008.
	Licensed child care facilities annual reports C.G.S. § 17a-145	Information faxed from the facilities but it is already collected by the department through other means.	Repeal; Duplication of reporting. Information collected through licensing and contracts.
OTHER	DCF annual evaluation reports on Unified District #2 to the education commissioner C.G.S. § 17a-37(d)	DCF was unable to provide copies.	Repeal; Intent met by Department of Education reporting requirements for all school districts.
	DCF to conduct studies to evaluate effectiveness C.G.S. § 17a-3(a)(6)	Done on an ad hoc basis.	Repeal; See related recommendation.
	SAC issue any reports deemed necessary (optional) C.G.S. § 17a-14	None ever issued.	Maintain.
	Adoption Advisory Committee report at least annually C.G.S. § 17a-116b(g)(3) (PA 99-166)	2002 was the only year a report was produced.	Repeal; See recommendation that repeals this inactive advisory group.

Source: Connecticut General Statutes and PRI staff analysis.

Juan F. outcome indicators: area office teams are responsible for development and implementation; and quality improvement program supervisors in each area office oversee these efforts.

The *Emily J.* and *W.R.* court monitoring processes also are strengths within the external monitoring and evaluation system. Many of the parties interviewed by committee staff also cited greatly improved coordination of children’s mental health services across agencies, systems, and within communities, as a highly desirable side-benefit of the judicial oversight process from both of these cases.

In general, follow-up efforts related to federal class action lawsuits have proved an effective means of improving services through strong monitoring and evaluation. To a large extent, this is because feedback on results from court monitors must be used by DCF to achieve better outcomes for children and families. However, court monitoring is an expensive and time-

consuming endeavor. Some have also noted that it may impede development of an agency's internal capacity for and commitment to continuous quality improvement. According to the *Juan F.* court monitor, a critical part of his role is to help DCF build its own capacity for quantitative and qualitative analysis and institute an agencywide culture of results-based management.

The committee also found *the results-based accountability process, discussed in Chapter III, represents an effective mechanism for legislative monitoring and evaluation of DCF.* It incorporates the best practices of continuous quality improvement: defined outcomes and standards; relevant data collection and analysis; and use of results to identify strengths and areas in need of improvement. The principles and procedures of results-based accountability also closely correspond with the main quality improvement initiatives that are underway and being planned by the department.

At this time, results-based accountability is still a pilot project within the appropriations process. *For the two uses of RBA by DCF, the committee found that a more comprehensive set of measures is needed.* For example, the purpose of foster care is “to provide for the health, safety, permanency and development of children who cannot remain in the care of their birth parents.” Yet the three RBA measures of performance are limited to percentages regarding single foster care placements, completed multi-disciplinary examinations, and foster parents accessing training. The process, however, has the potential of providing legislators and the public with an objective, systematic, and comprehensive way to assess how well the department is achieving its goals.

Another strength is the monitoring and evaluation efforts required by federal grants. The department has secured several large, multi-year grants, primarily from the federal Department of Health and Human Services Substance Abuse and Mental Health Services Administration. Up to 20 percent of SAMHSA grants, for example, are required to be allocated to program evaluation. The evaluations are conducted by external evaluators--often hired from local universities such as Yale University and the University of Connecticut—with strong backgrounds and experience in program evaluation. Additionally, in-depth SAMHSA site visits often occur in years two and four of a grant, with formal evaluations, feedback, and required responses included in the process. *The research and evaluation reports produced from these federal grants would be beneficial to current and future DCF efforts; however, their distribution is limited.* **Therefore, the committee recommends:**

Research and evaluation reports produced through federal grant requirements should be included in the report repository recommended earlier concerning contracted evaluation reports and internally produced research products.

Additionally, because of the high quality of the research and evaluation conducted on these new federal grant-funded programs, the research and evaluation reports produced should be useful in future decision making regarding continuance of the program once the funding has ended. *Monitoring and evaluation is only as good as the information that is used in decision making, and results from federal grants may not be considered by DCF when planning for upcoming programs and services.* For example, the Hartford Youth Project began with SAMHSA funding, and PRI staff were told that the program is viewed nationally as a model

community-based, early intervention strategy that has been quite successful. The program should be strongly considered for full continuation beyond federal funding, and replicated in other parts of the state. **Therefore, the committee recommends:**

DCF should adopt a written policy requiring that formal results from research and evaluation reports produced from federal grants be reviewed and considered when agency managers make decisions concerning future funding and/or continuation of programs developed with federal grants.

Deficiencies. The LINK data system mentioned earlier is relied on heavily for federal outcomes and requirements. In comparison to other New England and comparable states, Connecticut lags in development of an accurate, reliable SACWIS system (i.e., LINK). A federal Child and Family Services Review site visit is scheduled for September 2008, and DCF must comply with federal requirements that it currently does not meet. Additionally, PRI staff were told several times by DCF managers that federal reviews, such as the CFSR review, are anticipated to maintain the progress made as a result of the *Juan F.* consent decree once the exit plan has been satisfied.

Gaps. Concerning external efforts only, there are gaps in the external monitoring and evaluation efforts expended for behavioral health, juvenile justice, and prevent mandate areas. For example, 88 percent of mandate area efforts are for child protective services, and programs with two or more external monitoring and evaluation efforts are all within the child protective services mandate area (foster care, adoption, and hotline).

There also appear to be gaps in external efforts in assessing outcomes, with prevention services and behavioral health services focusing their efforts on processes of service delivery rather than on end results. Another gap in external efforts is the lack of agencywide external monitoring and evaluation efforts.

Redundancies. Considering external efforts only, there appear to be redundancies in *case reviews*. The review of child records occurs as part of the *Juan F.* court monitoring, court efforts, and federal child welfare outcomes. Treatment plans, for example, are examined for the *Juan F.* consent decree and PNMI/Medicaid reimbursement, with requirements slightly different for the treatment plans.

DCF is currently working on this issue; it is important to get the discrepancy resolved to satisfy *Juan F.* outcome requirements as well as federal reimbursement—up to 25 percent—for therapeutic group homes. **Therefore, the committee recommends:**

DCF should convene a workgroup including program leads, a representative from the *Juan F.* court monitor's office, and DSS to develop a treatment plan and review process that satisfies both the internal DCF and PNMI federal requirements.

Further, concerns have been raised regarding the absence of parents and other important members of the team when a treatment planning conference is held. Treatment plans have been viewed as weak and a deterrent to complying with the *Juan F.* consent decree requirements. Connecticut law requires that DCF develop a treatment plan for every child in its care, and that

the plan be reviewed at least once every six months (C.G.S. § 17a-15). Another state law requires the juvenile court to order “specific steps” for parents to take in order to facilitate family reunification (C.G.S. § 46b-129).

The specific steps are developed via a court-facilitated Case Status Conference, which usually occurs within eight weeks of filing a court petition. At this conference, key stakeholders discuss the issues that led to the state intervention and what services will be provided to assist the parent(s) in addressing issues and ultimately leading to reunification with their children.

The DCF treatment plan is developed separately and at approximately the same time as the court’s specific steps process. This may result in inconsistent plans and absence of important stakeholders in the process. Additionally, treatment plans may or may not be included in court files and reviewed by attorneys.

Some believe that integrating the court-ordered specific steps and the DCF treatment plan would strengthen the entire treatment planning process. The plan would be the result of discussion among parents (who are usually present at the court proceeding), children, DCF social workers, and attorneys. The fuller participation and development of a single, consistent treatment plan, would lead to a more comprehensive and higher quality plan (a deficiency cited in the *Juan F.* consent decree monitoring). A further advantage to this merging of the two treatment planning efforts is that it would ensure that implementation of the treatment plan occurs as they would be steps or actions that are court-ordered. **Therefore, the program review committee recommends:**

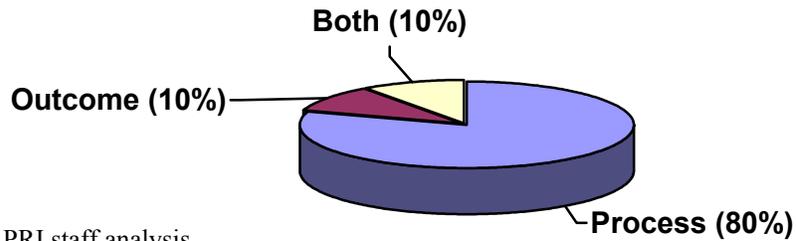
A pilot program should be created to assess the feasibility of conducting one treatment plan conference to be held at court that combines: the Specific Steps identified during the initial case status conference at court and the corresponding DCF treatment plan conference currently held in the area office.

Outside Investigations and Reviews

The Legislative Program Review and Investigations Committee also assessed the outside investigations and reviews and recommended improvements related to the department’s response to the Office of the Child Advocate and the Child Fatality Review Panel as well as support for the Office of the Child Advocate’s data management system.

Process vs. outcomes. More than three-quarters of all investigative monitoring and evaluation efforts focus solely on process goals or issues (80 percent of efforts), with evaluating progress on goal attainment limited to the delivery of service to the exclusion of outcome or impact (see Figure VII-9). This finding is consistent with the expectation for facility investigations and child fatality reviews. Additionally, 10 percent contain both process and outcome goals or issues, and 10 percent focus solely on outcomes.

Figure VII-9. Type of Effort for Outside Investigations and Reviews



Source: PRI staff analysis.

Goals and issues studied. The goals or issues that were the subject of outside investigations and reviews were found to be fairly specific, simple, concise, and clearly understood. Mixed ratings occurred on how measurable the investigation goals or issues were, based on concerns that the measures were not specified or sometimes open to interpretation (e.g., using the term “adequate”). Baseline data was also missing.

Recommendations. Examining the recommendations from outside investigations and reviews, the committee found that between 25 to 50 percent of the recommended changes were adopted per investigation/review effort. The fact that a majority of the improvements proposed in OCA and CFRP reports are not implemented by DCF does not seem to be related to deficiencies in the recommendation format. The recommendations analyzed were found to be clear, logical, and action-oriented. According to agency staff and Office of the Child Advocate personnel, DCF has never disputed findings outlined in the OCA investigations and child fatality reviews, and generally is in agreement about needed changes.

The monitoring and evaluation work of the Child Advocate and the Child Fatality Review Panel has contributed to improvements with significant impact, such as new policies and resources for domestic violence services in area offices, the adoption of better risk assessment and decision making procedures for child protective services cases, and reductions in the use of restraints for children in DCF facilities. The committee believes the department should be directing its attention to and making better use of the results of the investigative efforts of OCA and the Child Fatality Review Panel. **The program review committee recommends:**

The statutes concerning the Office of the Child Advocate and the Child Fatality Review Panel shall be amended to require the Department of Children and Families, and other state entities subject to OCA and CFRP investigative activities, to provide a written response to formal recommendations made by the child advocate and the panel for improving state services provided to children.

The agency response should: include proposed corrective actions to address identified problems; have a time frame for implementation of improvements; and be provided to OCA or CFRP within 45 days of receipt

of the recommendations. Copies of the agency response also should be submitted to the legislative committees of cognizance and the appropriations committee.

Strengths. The outside investigations and reviews carried out by OCA and CFRP strengthen the DCF monitoring and evaluation system in several key ways. Both entities provide an external perspective on how well the department is achieving its goals and are two of the few ongoing sources of agencywide performance evaluation. The Office of the Child Advocate and the Child Fatality Review Panel also have statutory responsibility and authority to look across state agencies and systems to identify problems and propose solutions in the meeting the needs of all children and families in Connecticut.

Another strength of the Office of the Child Advocate is its function as an independent place for parents, providers, and citizens to make known their concerns and complaints about public services for children. OCA, through its use of on-site monitoring staff, also permits objective, external monitoring and evaluation of day-to-day operations at DCF facilities.

The child advocate, while serving as an independent source of assessment of state agency performance, has acted collaboratively with department staff and other external reviewers, such as the attorney general's "whistleblower" staff and the *Juan F.* court monitor's office. These efforts have addressed a potential for redundancy in areas of the child fatality reviews and in-depth evaluations of agency programs and facilities. Both OCA and CFRP have taken steps to avoid this by participating in the DCF/Child Welfare League of America special review process. OCA recently conducted a joint facility review of Riverview Hospital with the department quality improvement staff, and works with the agency's Office of the Ombudsman to resolve citizen complaints.

Deficiencies. There appear to be deficiencies in how measurable the OCA and CFRP goals or issues are because of vague measures and a lack of baseline data.

The effectiveness of outside investigative efforts also is impeded by resource deficiencies. The Office of the Child Advocate receives copies of all DCF critical incidents reports (estimated at about 8-10 per day); OCA staff review them to determine if further information or follow up is needed. OCA staff also process about 1,000 calls from the public per year. While some of the office's casework related to citizen calls has shifted to the DCF Office of the Ombudsman, a substantial number of cases still are opened for in-depth investigation by the child advocate and her staff. Based on its own ombudsman activities, OCA opened between 170 to more than 360 cases per year during Fiscal Years 04 through 06.

To handle this workload, OCA supplements its nine professional staff with interns and graduate students, especially to help with research projects and data analysis. In addition, the on-site monitor positions that OCA was authorized to hire to report on conditions at CJTS and Riverview Hospital following investigations at those facilities are funded by DCF.

Limitations of its data management system, however, particularly for its ombudsman activities, continue to prevent ready analysis of trends, as well as tracking responses to and the final resolution of cases based on citizen complaints. Estimates of the costs to upgrade the OCA

automated information system are relatively modest (under \$200,000 plus annual maintenance costs of about \$12,000). However, as a small agency, the child advocate’s office is a low priority customer of the state Department of Information Technology; it is not scheduled to receive services from that agency for a number of years. A small investment in new technology could greatly increase the effectiveness of OCA monitoring and evaluation efforts that already improve services for children and families. **Therefore, the program review committee recommends:**

The resources necessary to improve the OCA data management system should be provided during the next fiscal year, either by DOIT making this project a priority or through funding for a consultant to design and implement an upgraded system for the child advocate’s office.

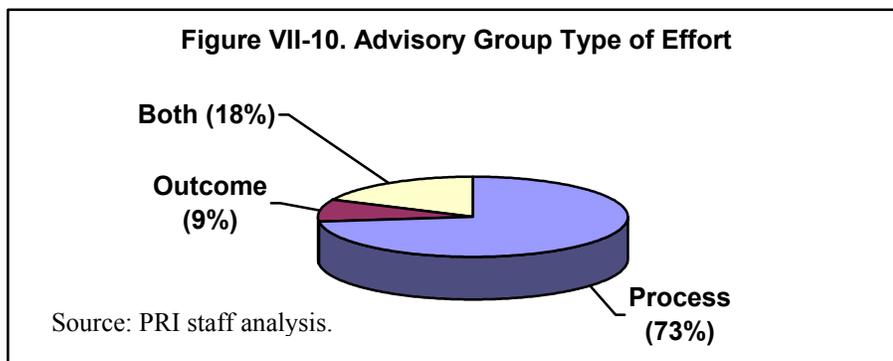
Gaps. Considering the outside investigations and reviews only, there appear to be gaps in the monitoring and evaluation efforts in that more than three-quarters of all OCA monitoring and evaluation efforts focus solely on process goals or issues, excluding outcome or impact.

Advisory Group Efforts

Based on the committee’s examination of the DCF advisory groups in statute, recommendations are made to improve the system. The recommendations include clarifying the statutory charge for advisory groups, improving communication between and among the department and advisory groups, funding, and repealing inactive advisory groups.

Process vs. outcomes. Figure VII-10 shows that *almost three-quarters of all monitoring and evaluation efforts by advisory groups focus solely on process goals or issues* (73 percent of efforts), with evaluating progress on goal attainment limited to the delivery of service to the exclusion of outcome or impact. On the other hand, 18 percent contain both process and outcome goals or issues, and 9 percent focus solely on outcomes.

Issues studied. Overall, the advisory group goals or study questions are not especially specific or measurable; however; they are considered realistic and within reach and the issue or question can readily be answered by monitoring and evaluation effort.



Information collected. In general, the information available for advisory group monitoring and evaluation efforts is not of good quality with a fair amount of missing information. This is partly due to the voluntary nature of advisory groups; they lack staff and resources, and must instead rely on DCF or other sources for information.

Recommendations. Between 25 to 50 percent of the recommended changes were adopted by DCF per advisory group. In interviews with various advisory groups, PRI staff was told that DCF did not always seriously consider their recommendations. The department's responsiveness should be improved through the following proposals for clarifying the roles of advisory groups, as well as for promoting greater partnership.

Strengths. There were several strengths found in examining the DCF advisory group efforts. Area office advisory groups appear to be effective when there is a strong partnership between DCF and the board. For example, both the Norwich Area Advisory Council and Bridgeport Area Advisory Council have good working relationships with their respective area offices.

In Norwich, a partnership has developed where the council chairperson sits in on the office's monthly Quality Improvement Team meetings and a representative from the area office attends advisory council meetings. In Bridgeport, the Area Director attends the area advisory council meetings and provides monthly statistics reports that provide a basis for feedback from the members. Both formats open up communication, give council members a better understanding of what is occurring within the DCF area office, and enable them to find areas where they can assist their local area offices and vice versa. These models provide a formal mechanism for receiving continuous feedback and information sharing allowing for a stronger partnership. **Therefore, the committee recommends:**

DCF should establish a policy for area office advising bodies to adopt a model whereby advising body members attend DCF area office quality improvement meetings, and DCF area office representatives attend advising body meetings, furthering promotion of a partnership.

A strength was also found with the CJTS advisory group. The group includes representatives from: community providers, the public defender's office, the Middletown mayor's office, and the juvenile court, among others.

At each meeting, CJTS staff present facility updates and distribute a summary report on critical incidents. The members of the board actively participate, offering suggestions on different ways to look at the data to understand trends, as well as other feedback on facility services and programs. Facility staff openly accept recommendations and appear to value the advisory group input. In addition to this informal feedback, state statute requires the CJTS advisory group to submit an annual report to the legislature, with clear guidelines for information it must contain. CJTS staff initially prepares the report, which is reviewed by the advisory group. The advisory group then develops recommendations that are included in the submitted document.

Deficiencies. In many cases, *the statutory charges of the advisory groups are weak in specificity and measurability.* The committee found that it was not always clear what DCF needed from the advisory group, and goals and issues studied were not always specific. Thus, their achievement was unclear and information could be interpreted in several ways. Lack of clarity in purpose or charge may contribute to the low activity level for some of the advisory councils. The State Advisory Council for Children and Families and some Area Advisory Councils struggle to identify their function and purpose. Many groups want to help DCF improve its performance but are uncertain about the best way to accomplish that goal.

For example, Riverview Hospital's advisory group activity has ebbed and flowed in the past few years without clear direction from the facility or agency leadership. After many months of not meeting, the hospital's board was reinstated by the new acting superintendent in January 2007. Prior to her appointment, the advisory group lacked focus and was composed mostly of DCF employees. The group recently appointed a chair and is in the process of formalizing its structure and reaching out to expand the diversity of its membership. In the upcoming year, the advisory group plans to monitor progress with the facility's strategic plan and work on developing better relationships between Riverview Hospital and the community.

The citizen advisory group for High Meadows, initially established due to community concerns, has not met since January 2007. In the past it met quarterly and informally provided suggestions to facility staff. The Connecticut Children's Place advisory group also is inactive at present.

It is at the discretion of the DCF commissioner to establish facility advisory groups. However, all DCF-run facilities should have an external advisory group to turn to for advice and also to whom they are accountable. Because not all facility advisory groups are as strong as the CJTS advisory group, **the program review committee recommends:**

DCF facility advisory boards shall be required by statute and it shall be mandated that all boards respond to their facility's annual report and that they add recommendations deemed necessary.

Further, the roles and expectations of these advisory groups should be clarified by reflecting in statute their role as oversight entities for department facilities with responsibilities to assess outcomes and offer recommendations promoting programmatic or facility goals.

The committee also believes it is critical for DCF to have, through the State Advisory Council for Children and Families, an effective external advisory group composed of key stakeholders including parents, providers, and community leaders that can examine agencywide issues, assess overall performance, and hold the agency accountable for results. The SAC should be a major consumer of the agency's quality improvement information, tracking trends, looking into needs, and examining outcomes within and across mandate areas.

To fulfill this role, it will need some dedicated resources, as busy professionals and parents cannot be expected to provide meaningful oversight and advice without staff support. **Therefore, the program review committee recommends:**

The role of the State Advisory Council for Children and Families should be strengthened to include monitoring the agency's progress in achieving its goals as well as offering assistance and an outside perspective. The board's statute shall be written to clarify this role and DCF's participation with the board concerning strategic planning. The council's meetings should be held at locations that facilitate participation by members of the public, such as the Legislative Office Building, and its agendas and minutes should be posted on the DCF website. The department should provide the council with funding for administrative support services and to ensure members representing families from across the state can serve on the council.

The committee also found monitoring and evaluation efforts across the area office advisory groups could be strengthened, and the potential for redundant efforts reduced, by sharing data collection strategies and ideas. To strengthen communication and sharing across the area office advisory groups, as well as with the SAC, **the committee recommends:**

DCF should establish an electronic mechanism, for example a blog, where members of the area office advising bodies can share information with each other, the SAC, and vice versa. Additionally, minutes and agendas from all meetings should be posted on the DCF website.

PRI found another deficiency in that only two of the department's three federally-required Citizen Review Panels receive funding to fulfill their role. Currently FAVOR receives \$30,000 for the administration of its Citizen Review Panel while the SAC does not receive any funding for its panel activities. To enable all three federally-required Citizen Review Panels to fulfill their mandate, **the program review committee recommends:**

DCF should fund all three required Citizen Review Panels equally.

Another deficiency is in the current structure and operation of the Connecticut Behavioral Health Advisory Council. Similar to other advisory groups, CBHAC wants to help improve DCF; however, it also struggles over the best way to accomplish that goal. In the past, members have felt there has been no response to their recommendations and it is unclear if they were ever received by the SAC. To strengthen the functioning of CBHAC and to ensure its input is given attention, **the committee recommends:**

Connecticut Behavioral Health Advisory Council should be incorporated into the State Advisory Council for Children and Families as opposed to remaining a separate entity.

Gaps. There appear to be gaps in the monitoring and evaluation efforts with several inactive or nonproductive advisory groups. As discussed in Chapter V, the committee found two inactive groups whose purpose is currently being met by the department through other means. Therefore, **the program review committee recommends:**

Repeal the statutory requirement for the Adoption Advisory Council (C.G.S. § 17a-116b).

Repeal the statutory requirement for the CJTS Public Safety Committee (C.G.S. § 17a-27f).