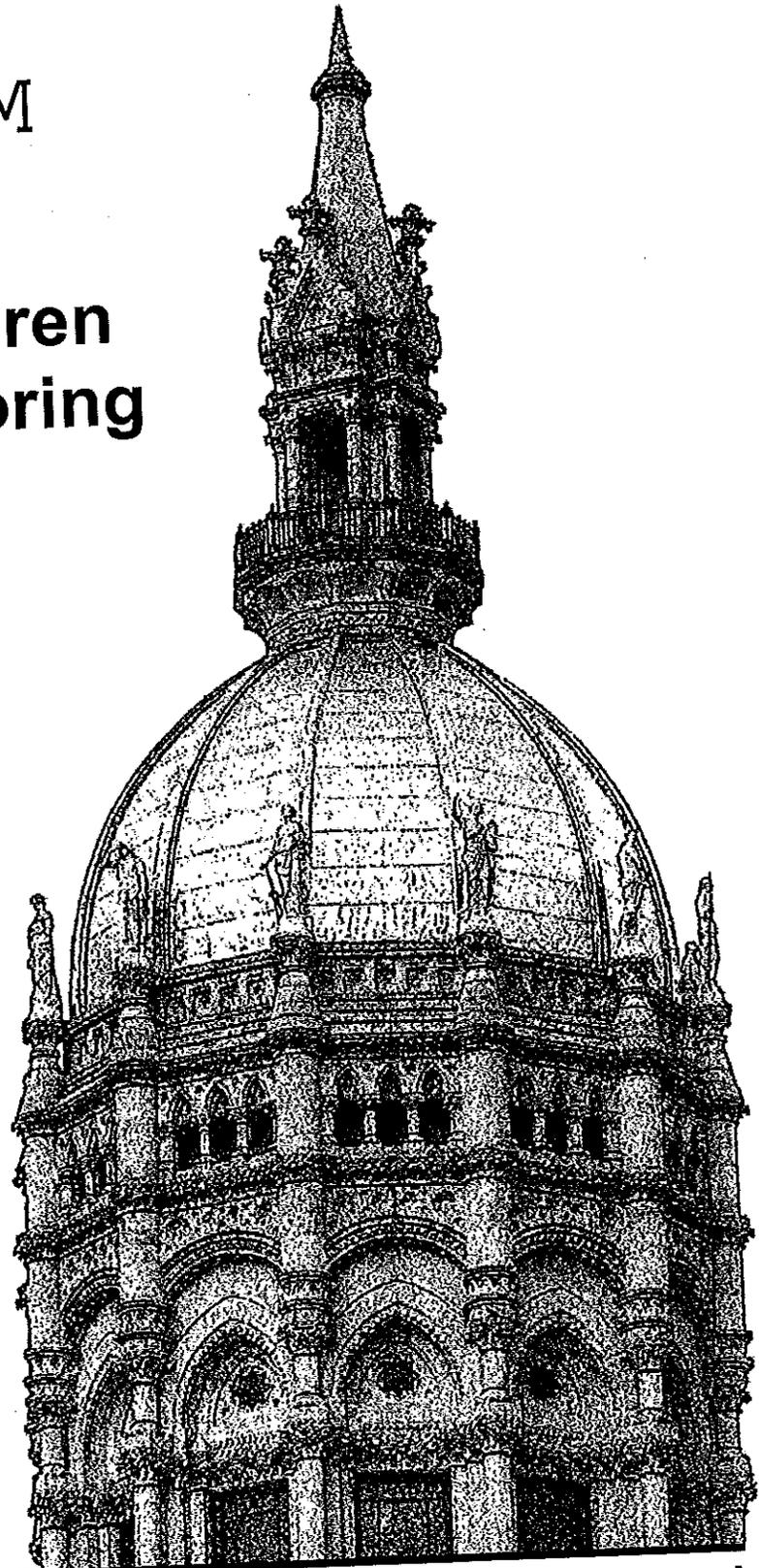


EXCERPTS FROM

**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.

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DEPARTMENT OF CHILDREN AND FAMILIES MONITORING AND EVALUATION
December 2007

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Chapter I

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.

Table I-1. Facilities Operated by DCF	
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.

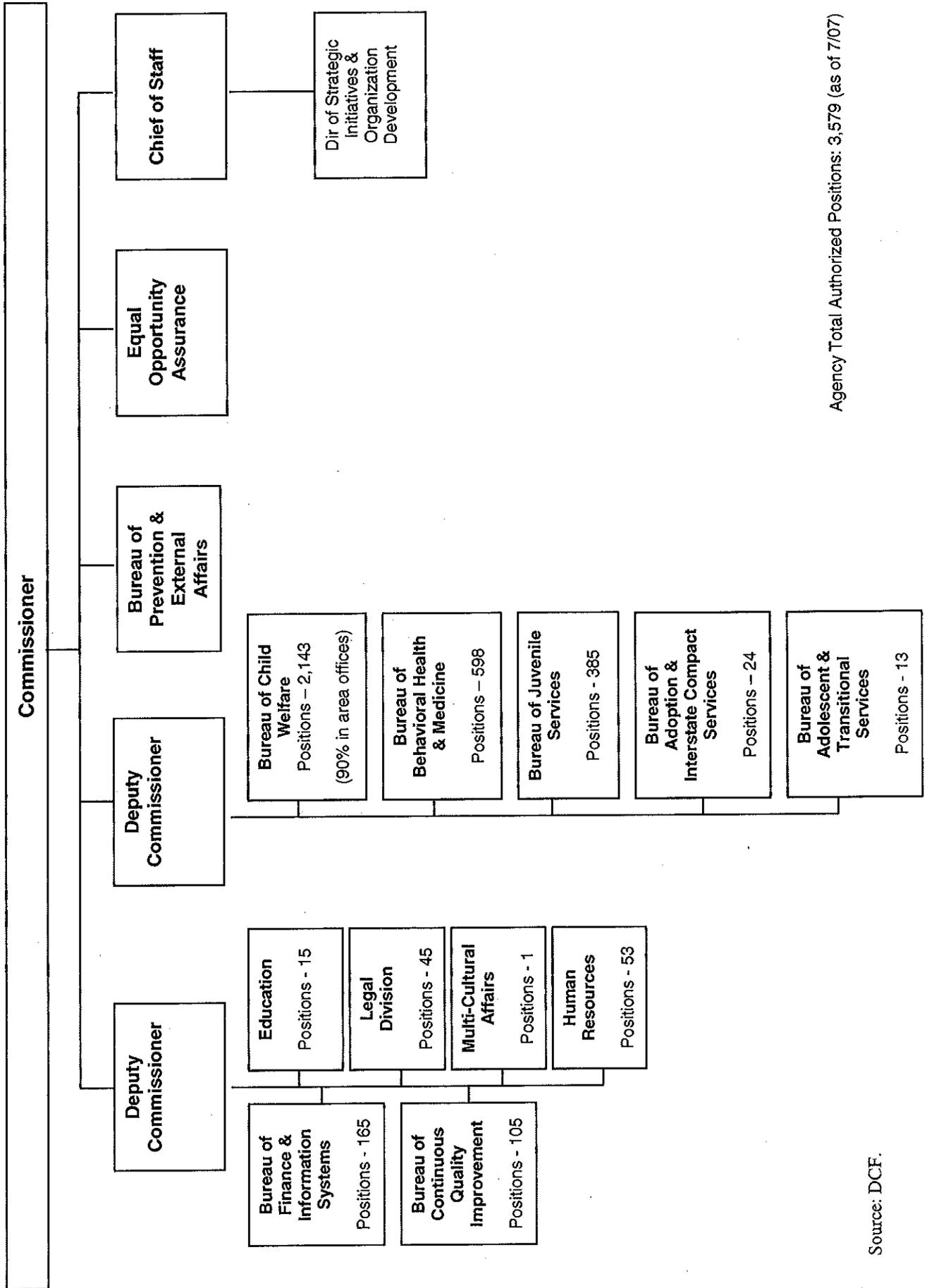
Organization and Budget

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.

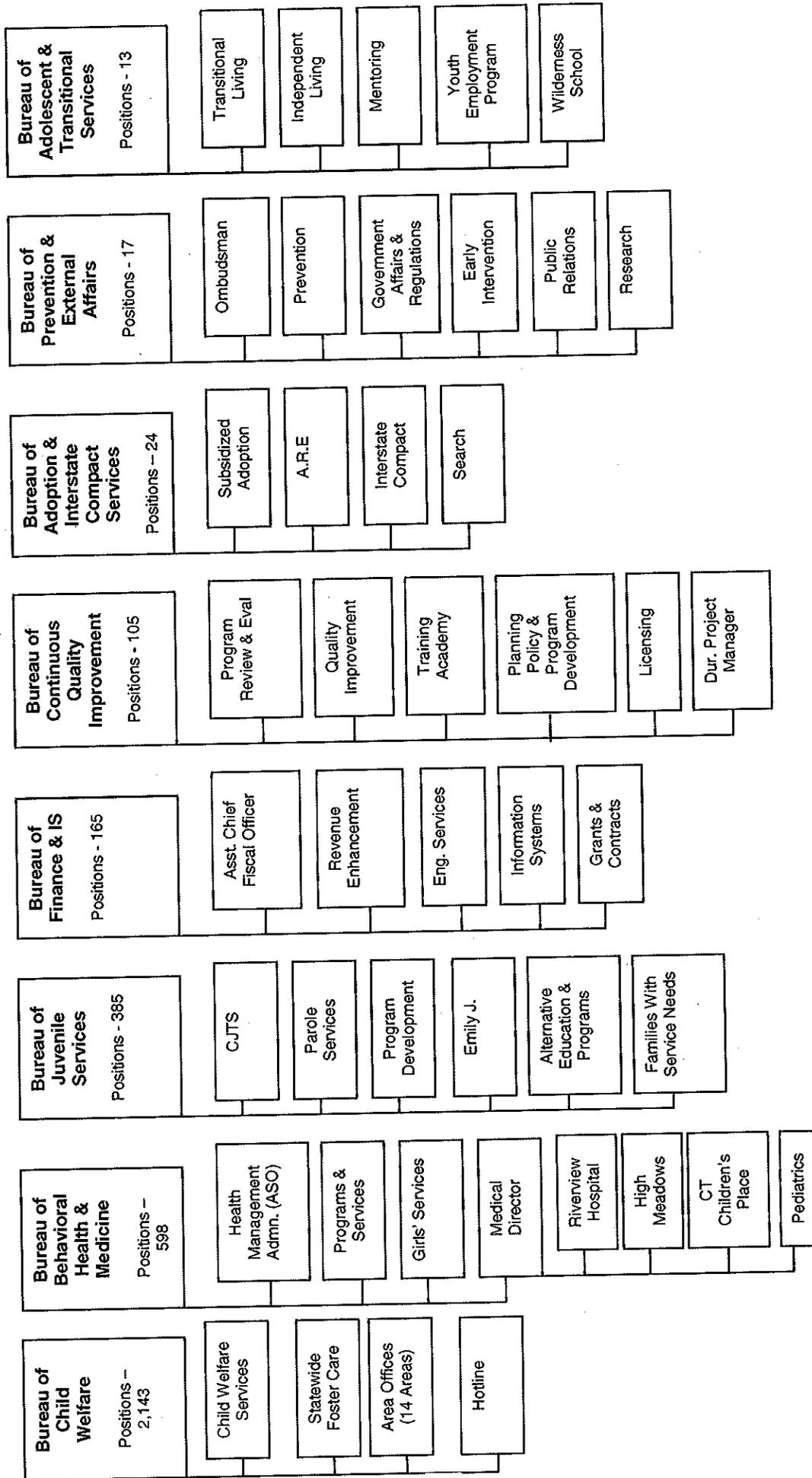
Responsibility for the fourth DCF mandate area is centered in the *Prevention Division* of the agency's Prevention and External Affairs Bureau. There are three central office prevention staff, and prevention liaisons have been appointed within each DCF area office and facility. The prevention staff in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

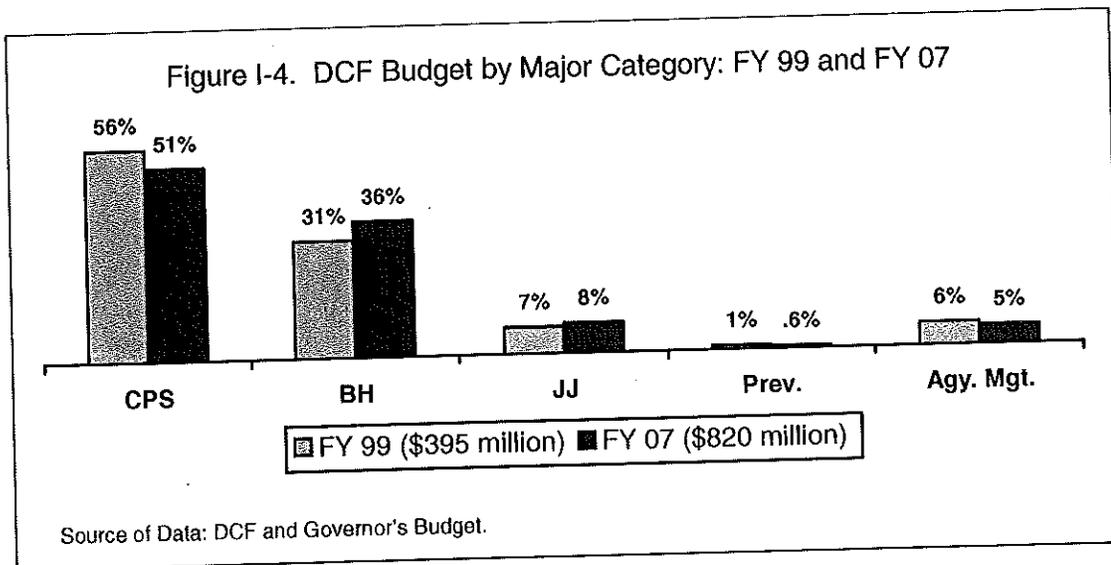
Management services, which account for less than 5 percent of the total DCF budget, include all the administrative infrastructure functions that support the agency's programs and facilities for children and families. In addition to all fiscal, human resources, legal, and contracting activities, agency 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.

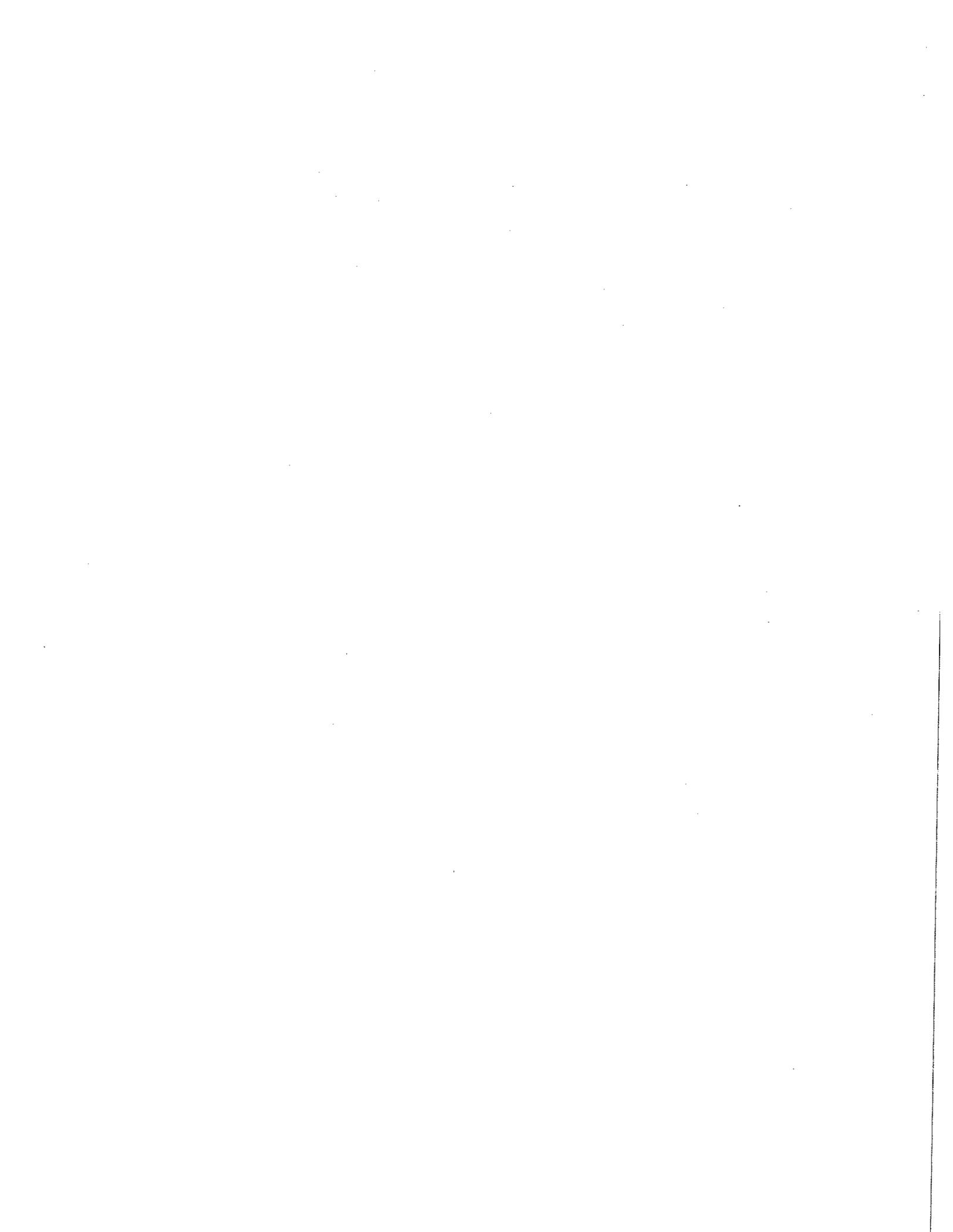
Figure I-4 compares the portion of the department budget expended on each major category -- child protective services (CPS), behavioral health (BH), juvenile justice (JJ), prevention, and agency management -- in FY 07 with those for FY 99, the time of the committee's last program review of the agency. 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).





Appendix C

DCF: Developments Since 1999

In 1999, the program review committee study of DCF found long-standing deficiencies in the areas of agency management and strategic planning. The study also revealed little integration of funding and activities across protective services, behavioral health, and juvenile justice systems, an overall lack of leadership, and weak, fragmented accountability. In particular, the committee found the agency's behavioral health and juvenile justice mandates had suffered from lack of attention and resources, largely because of DCF's focus on the *Juan F.* child welfare lawsuit. The main goals of establishing a consolidated children's agency back in 1974—strong leadership on children's issues and comprehensive, integrated community-based services that promote the well-being of children and families—had not been achieved.

For many years, experts and practitioners have agreed comprehensive services, with a single point of entry, coordinated delivery, and flexible funding, result in better outcomes for troubled children and their families. Research studies also support the many benefits of providing a broad range of integrated, community-based human services.

There was no evidence in 1999 (or now) linking effective service delivery to a particular organizational model (e.g., a consolidated agency, an umbrella agency, coordinated independent agencies, etc.). According to national experts, what seems more important than any specific structure is: having clear policy to guide decisions on programs and services; ways to systematically assess results; strategic planning to achieve measurable goals; and a strong management commitment to quality assurance and continuous improvement.

However, the agency's lack of progress in integrating children's services despite 25 years of consolidation, and the domination of its protective services mandate due to the *Juan F.* consent decree, led the program review committee to look beyond trying to "fix" DCF to incorporate these critical elements. To strengthen the chances of achieving the department's mission, the final 1999 report recommended a comprehensive reform of the state system for serving children and families, briefly described below.

1999 Study Recommendations

The DCF report accepted by the program review committee in November 1999 proposed implementing a new structure and system for providing children's services that centered on:

- enacting a clear state policy on children and families focused on outcomes;
- establishing an independent secretary for children, responsible for
 - regularly evaluating goals and results,
 - coordinating policies, programs and resources across agencies involved in children's services to achieve the goals, and
 - implementing a community-based children's service delivery system statewide.

The report also recommended existing department mandates be reorganized, to ensure strong management for each one, by:

- transferring DCF behavioral health responsibilities to DMHAS, specifically to a new children's behavioral health division;
- transferring DCF juvenile justice services as well as Judicial Branch responsibilities for juvenile detention to a new, separate entity;
- retaining all child protective services responsibilities in DCF; and
- placing responsibility for overseeing all prevention efforts with the new secretary for children.

The committee's proposed realignment grew out of concerns that the agency was dominated by its protective services mandate, due both to the serious nature of child abuse and the impact of the 1991 *Juan F.* consent decree. At that time, DCF had made little progress in implementing required reforms of its child protection system and there was no strategy for achieving compliance with the consent decree. Without an action plan for exiting the *Juan F.* consent decree, it seemed unlikely the department would be able to give adequate attention needed to its equally important, if not as critical, behavioral health, juvenile justice and prevention mandates.

Post-study action. In 2000, the program review committee raised legislation to implement the report recommendations and held a public hearing. PRI favorably reported out a bill containing the proposed realignment of DCF functions, which then was referred to the committee of cognizance where no further action was taken.

The proposed restructuring of the department was not supported by DCF and most of the children's services advocacy organizations and associations of private service providers for two main reasons:

1. placing responsibility for children's behavioral health services and juvenile justice in separate state agencies would increase bureaucracy and not improve services to children and their families; and
2. an office of the secretary for children would duplicate administrative functions and only add more government.

Additionally, the complexity of implementing such a large-scale reform was and is a significant barrier to any major structural change. Pending litigation in several areas of children's services has been another factor inhibiting major reorganization. While the specific recommendations from the 1999 study were not embraced, it seems fair to say the findings contained in the final report contributed, to some degree, to the many legislative and administrative changes that have been made to state policies and programs for children and families since 2000.

Developments Since 1999

A number of changes in internal capacity and operations, as well as new and revised state and federal policies, have affected the Department of Children and Families and how it carries

out its responsibilities since the 1999 PRI study was completed. One dramatic difference is lower caseloads for the agency's social workers, a factor that contributes to more timely performance of important protective services functions (e.g., investigations, visits, permanency planning). In recent years, DCF has consistently met the caseload standards required for its child welfare staff (17-20 cases per worker depending on their assignment) under the *Juan F.* consent decree.

Structural changes made in the agency since 1999 include a separate bureau that oversees behavioral health and medical functions. The types and amounts of DCF community-based mental health services have greatly expanded. The department also has improved automated information systems and more capacity for internal quality improvement functions than it did in 1999.

One of the most significant developments for DCF is the on-going implementation of the court-approved exit plan for the *Juan F.* consent decree. The agency now has a strategic "roadmap" for ending federal judicial oversight of the state's child protection services system.

Major developments related to DCF operations that program review staff has identified to date are highlighted in Table C-1. Despite the many changes that have occurred since 1999, there are continued concerns about the department's ability to meet the needs of at-risk children and families. The ultimate question is: do DCF clients have better outcomes as a result of the state services they receive?

The importance of tracking results, and targeting corrective actions to achieve and sustain desired outcomes, was recognized by the *Juan F.* plaintiffs. A primary goal of the original consent decree and current exit plan is to ensure that DCF has strong internal capacity for continuous quality improvement through self-monitoring and evaluation.

Further, experts agree an effective accountability system is essential for ensuring programs and services have desired results, and that public and private resources are used efficiently. This requires the following elements: clear goals; good quality performance measures; strong communication and reporting on results; and a commitment from managers and decision makers to use this feedback to achieve and sustain desired outcomes. Each of these elements were assessed through the current PRI study of the DCF monitoring and evaluation system.

Table C-1. Developments Related to DCF Services Since 1999

In 1999	As of 2007
<i>Limited progress in complying with 1991 Juan F. consent decree</i>	Exit plan with 22 specific outcomes approved and DCF implementing action plan to achieve compliance; as of June 2007, department had met and sustained compliance with 15 measures for at least 2 consecutive quarters
<i>Neglect of children's behavioral health mandate</i>	<ul style="list-style-type: none"> ▪ Dedicated behavioral health bureau created in DCF ▪ Children's Behavioral Health Advisory Committee to the DCF State Advisory Council established ▪ Written agreement between DCF and DMHAS regarding transition services for children entering adult system
<i>Lack of comprehensive, integrated, community-based services</i>	<ul style="list-style-type: none"> ▪ Five DCF regions replaced with 14 service areas with intent of stronger local relationships and better service coordination ▪ CT Community KidCare system (25 collaborative behavioral health service networks) in place statewide; KidCare system incorporated within Behavioral Health Partnership between DCF and DSS ▪ WR settlement agreement expands community-based services for children with complex behavioral health needs, with more collaboration among DCF, DMHAS, and DMR ▪ Emily J. settlement increases community-based services for juveniles and collaboration between the courts (CSSD) and DCF
<i>Juvenile justice population lacking appropriate services</i>	<ul style="list-style-type: none"> ▪ Emily J. settlement agreement provides more community-based "wraparound" services to divert juveniles from detention ▪ Revisions to FWSN law include more community-based services for status offenders ▪ Reforms implemented at DCF secure facility for delinquent boys (CJTS) to improve assessment, treatment, and discharge planning
<i>Lack of focus on prevention</i>	<ul style="list-style-type: none"> ▪ Children's Trust Fund resources expanded (to 18 staff and a current budget of \$15 million) ▪ Small central office prevention division (3 staff) created and prevention liaisons assigned in area offices
<i>Absence of national child welfare outcome standards for States</i>	<ul style="list-style-type: none"> ▪ Federal Child and Family Services Review process established to measure states against national child welfare outcomes; DCF implementing corrective actions from the first (2002) review
<i>Modest attention to quality improvement</i>	<ul style="list-style-type: none"> ▪ DCF Bureau of Continuous Quality Improvement created, area office quality improvement teams put in place, Administrative Case Review process implemented, automated "Results-Oriented Management" information system established
<i>Fragmented complaint process for children, families and others</i>	<ul style="list-style-type: none"> ▪ Independent DCF ombudsman (with 8 staff) created to receive and resolve specific complaints "in a way that is in the best interests of children"
<i>Inadequate automated information system and poor quality data</i>	<ul style="list-style-type: none"> ▪ Improvement in the reliability of the central child welfare information system; management reporting capability (ROM) added that allows tracking of performance at all levels for key protective services functions

Appendix D

History of DCF

Major events related to the Department of Children and Families and the delivery of services to at-risk children in Connecticut over time are presented in Figure D-1. As the figure indicates, the predecessor agency to the DCF, the Department of Children and Youth Services (DCYS), was established in 1969. DCYS was created to oversee the state's two secure facilities for adjudicated juvenile delinquents (the Meriden School for Boys and Long Lane School for Girls). At that time, and since the Juvenile Court was created in 1941, the judicial branch was and still is responsible for juvenile detention and probation, in addition to all court proceedings related to juveniles.⁴

Also at that time, protective services for abused or neglected children, including adoption and foster care, were carried out by the State Welfare Department. Behavioral health services for Connecticut residents of any age were the responsibility of the Department of Mental Health (DMH). That agency operated or funded a number of mental health and substance abuse programs for children and youth, including psychiatric hospital units for adolescents and outpatient clinics for children, until the late 1970s.

Legislation enacted in 1974 (S.A. 74-52) mandated the transfer of services for "dependent, neglected and uncared for children" from the welfare department, to DCYS. The act also established a study commission, comprised of state agency heads and mental health experts, to: 1) develop a transfer plan for psychiatric and related services for children and adolescents within the mental health department; and 2) provide the legislature with recommendations for further consolidation of children's services.

The study commission report issued in 1975 outlined the structure and duties of a cabinet level agency -- an expanded Department Children and Youth Services -- responsible for: "... the care and treatment of delinquent, dependent, neglected, uncared-for, mentally ill and emotionally disturbed children, while guarding against the possibility of any preventable harm coming to any of them." The proposed department structure incorporated: significant citizen participation through statewide, regional, and facility advisory groups; regionalized service delivery and liaisons with private, nonprofit providers; and a strong evaluation, research and planning office. The commission's plan also recommended the agency be organized to promote coordinated service delivery, early intervention and prevention, and treatment based on a child's needs rather than disability category or legal status.

Public Act 75-524 implemented the commission's recommendation for a consolidated children's agency structure. Connecticut was the first state to create a state agency with jurisdiction over all major spheres of child welfare services -- child protection, behavioral health,

⁴ In Connecticut, unlike all but two other states (North Carolina and New York), juveniles are defined as persons under age 16. Individuals age 16 and over who violate the law are, under most circumstances, treated by the courts as adults and subject to adult probation requirements and incarceration in adult correctional facilities. However, beginning in 2010, Connecticut juvenile court jurisdiction will be extended to 16 and 17 year olds (P.A. 07-04, June SS).

juvenile delinquency, and prevention. The goal of this consolidation was both improved leadership on children's issues and the development of a "seamless" service delivery system, from prevention to aftercare, that promotes the sound development of all children and youth.

Policy changes. No fundamental changes have been made to the structure or scope of the state children's agency since the original consolidation although its name was changed to the Department of Children and Families in 1993. Most subsequent legislative actions have centered on policies and programs that:

- promote community-based, family-focused, child-centered services, such as the state's KidCare behavioral health initiative begun in 2000;
- create prevention and early intervention programs, such as Healthy Families, an effort to work with high-risk families to reduce abuse and neglect of infants⁵; and
- improve program accountability through various statutory requirements for outcome measures, data collection and tracking, and independent performance evaluations.

A major shift in the emphasis of DCF practice, from family reunification to child safety, occurred in the mid-1990s in response to the deaths of several children in state foster care. Legislation enacted in 1995 (P.A. 95-242) established two new entities to protect children and prevent abuse and neglect, an independent Office of the Child Advocate (OCA) and the Child Fatality Review Panel (CFRP).

Also during the 1990s, new federal laws stressing permanency goals for children in state custody went into effect, requiring child welfare agencies to reduce time spent in temporary out-of-home placements and to increase adoption rates. The federal government began conducting Child and Family Services Reviews (CFSRs) in FY 01 to ensure state child welfare agencies conform to federal requirements related to the safety, permanency, and well-being of children in their care. Under state law enacted in 1999 (P.A. 99-166), DCF was specifically mandated to set standards for permanency plans for the children in its care, monitor implementation of each child's plan, and establish an advisory group to help promote adoption of children difficult to place.

In the last five years, a number of major changes have been made to the department's juvenile justice program. After decades of unsatisfactory performance, Long Lane School, the state residential facility for adjudicated male and female juvenile delinquents, was closed in February 2002. It was replaced by the Connecticut Juvenile Training School (CJTS), a maximum security facility for boys only, which opened in 2001. To date, no secure facility specifically for delinquent girls has been developed; they currently are placed in various private residential treatment programs and sometimes older girls are placed at the state's adult correctional facility for women in Niantic.

Most recently, the General Assembly enacted a bill to incorporate 16 and 17 year olds into the juvenile justice system, effective July 1, 2010 (P.A. 07-4, June SS). This legislation, based on the recommendations of the Juvenile Jurisdiction Planning and Implementation

⁵ Most recently, the Healthy Families program was revamped as the Nurturing Families Network and transferred from DCF to the Children's Trust Fund Council in 2005.

Committee established in 2006 (P.A. 06-18), could significantly expand DCF's responsibilities for delinquency-related services. It has also prompted reexamination of the governor's plan to close the Connecticut Juvenile Training School as a juvenile correctional facility during 2008.

Court cases. The action that has had the most influence on DCF operations over the past decade is the 1989 *Juan F. v. O'Neill* federal class action lawsuit and its resulting settlement plans. Alleging the state did not adequately protect the children in its care, the lawsuit raised issues regarding the policies and practices of the then Department of Children and Youth Services in the following areas: investigation of abuse and neglect cases; foster care and other out-of-home placements; medical and mental health care; adoption; staffing; and management.

The parties agreed to mediate a resolution to the suit and, with the help of a settlement judge, negotiated a consent decree that was ordered by the U.S. District Court in January 1991. An independent monitor solely responsible to the trial judge for the case was later appointed to track and report on the department's compliance progress. The federal court also ruled the consent decree requires no less than 100 percent compliance and that the state must provide the funding necessary to implement its mandates.

Efforts to achieve compliance with the *Juan F.* consent decree have dominated agency resources and activities ever since it was ordered. The department's budget and workforce have substantially increased to improve social worker caseload ratios, the timeliness of case management functions, and the availability of appropriate services for children committed to the agency, as called for by the consent decree provisions.⁶ The agency's multimillion dollar automated information system known as LINK, and an internal training academy for all DCF staff, were also put in place to meet consent decree requirements.

Over the years, a series of corrective action agreements and revised monitoring orders have been developed by the parties and the court to address disputes over noncompliance. Since 1999, DCF, in conjunction with the other parties and the court monitor have focused on developing and implementing a plan for "exiting" court oversight that contains specific performance goals and a set timeframe for meeting them. The first exit plan, approved by the court in February 2002, has been revised several times and now contains 22 outcome measures that are monitored on a quarterly basis. The quarterly progress report issued June 20, 2007 by the *Juan F.* court monitor's office states DCF is in compliance with a majority of the current exit plan requirements but still faces challenges in several areas (i.e., treatment planning and meeting children's needs).

Two other federal class action lawsuits, *Emily J.*, which was filed in 1993, and *W.R., et al v. Connecticut Department of Children and Families* from 2002, also have had an impact, although to a lesser extent, on the agency. The *Emily J.* case was brought on behalf of children placed in juvenile detention centers and affected both the Judicial Department and DCF. An initial settlement agreement reached in 1997 established requirements that applied primarily to the Judicial Department. Under a second settlement agreement reached in 2002, DCF and the Judicial Department were both ordered to carry out a corrective action plan for improving

⁶ Between FY 91 and FY 07, the total DCF budget grew from about \$152 million to close to \$1 billion. Over the same time period, the agency workforce went from about 1,700 to nearly 3,500 permanent full-time employees.

screening, assessment, planning, and service delivery to children in the juvenile justice system with mental health needs.

In 2005, a third court-ordered agreement targeted DCF and called for development of new or expanded community based-services for children involved with the juvenile court. DCF is working with the Court Support Services Division (CCSD) of the Judicial Department to develop and implement a plan for services.

Plaintiffs in the recently settled *W.R.* case claimed the state failed to provide the continuum of services that would allow certain DCF clients with mental health needs to live successfully in the community. After almost a year of negotiating, the parties to this class action suit reached a settlement in April 2007, which was subsequently approved by the General Assembly.

Figure D-1. Major Events Related to Children's Services in Connecticut

2007	<ul style="list-style-type: none"> • DCF issues <i>Juan F.</i> Action Plan for improving performance on exit plan outcomes • <i>W.R.</i> class action settlement agreement finalized • <i>Emily J.</i> case closed • Law to expand jurisdiction of juvenile court to 16 and 17 year olds effective 2010 enacted
2006	<ul style="list-style-type: none"> • <i>Juan F.</i> Exit Plan modified to incorporate new case review method and additional data reporting • Federal court orders management authority be returned to DCF, disbands task force
2005	<ul style="list-style-type: none"> • Revised <i>Emily J.</i> settlement agreement requires community services for juveniles • Governor announces plan to close CJTS in 2008 • DCF, in collaboration with DSS, mandated to implement the Connecticut Behavioral Health Partnership community-based service delivery system, which incorporates KidCare
2004	<ul style="list-style-type: none"> • Revised <i>Juan F.</i> Exit Plan establishes 22 specific goals • DCF issues "Positive Outcomes for Children," a plan to guide <i>Juan F.</i> compliance efforts
2003	<ul style="list-style-type: none"> • Federal court orders management authority for DCF be given to three-member task force headed by <i>Juan F.</i> court monitor
2002	<ul style="list-style-type: none"> • DCF closes Long Lane School • First exit plan for <i>Juan F.</i> consent decree negotiated and approved by court • Federal class action lawsuit claiming DCF failed to provide adequate services to youth with serious mental health issues, <i>W.R. v. DCF</i>, filed
2001	<ul style="list-style-type: none"> • DCF opens Connecticut Juvenile Training School for delinquent boys • Federal Administration for Children begins Child and Family Services Review (CSFR) process of state child welfare agencies
2000	<ul style="list-style-type: none"> • DCF, in consultation with DSS, mandated to develop, fund, and evaluate KidCare community-based behavioral health service delivery system for children and youth
1997	<ul style="list-style-type: none"> • DCF required by law to implement, within available appropriations, a "system of care" planning process for children with mental health needs • Children's Trust Fund Council established as independent agency with authority to fund community-based child abuse prevention programs
1995	<ul style="list-style-type: none"> • Independent Office of the Child Advocate and Child Fatality Review Panel established
1994	<ul style="list-style-type: none"> • DCF responsibility for substance abuse services for children clarified in statute
1993	<ul style="list-style-type: none"> • DCYS agency name changed to Department of Children and Families • Federal class action lawsuit regarding juvenile detention conditions, <i>Emily J. v. Weicker</i>, filed
1991	<ul style="list-style-type: none"> • <i>Juan F.</i> consent decree approved; requires significant child welfare system reforms, substantial increase in DCYS staff and program funding
1989	<ul style="list-style-type: none"> • Federal class action lawsuit alleging state's failure to protect children in DCYS custody, <i>Juan F. v O'Neill</i>, filed
1988	<ul style="list-style-type: none"> • Interagency agreement transfers authority for children's substance abuse services to DCYS
1983	<ul style="list-style-type: none"> • Children's Trust Fund created to coordinate and fund child abuse prevention efforts
1981	<ul style="list-style-type: none"> • State program for juveniles committing status offenses, Family with Service Needs (FWSN), goes into effect
1975	<ul style="list-style-type: none"> • Psychiatric services for children transferred to DCYS as recommended by study commission
1974	<ul style="list-style-type: none"> • Transfer of protective services to DCYS mandated; commission to study and recommend consolidation of children's services created
1972	<ul style="list-style-type: none"> • DCYS revamps Long Lane School as co-educational facility for juvenile delinquents
1969	<ul style="list-style-type: none"> • Department of Children and Youth Services, the state juvenile correction agency, established as state's juvenile correction agency (to operate the two state facilities for juvenile delinquents, Long Lane School for Girls and Meriden School for Boys)
1965	<ul style="list-style-type: none"> • State Welfare Department responsible for children's protective services
1953	<ul style="list-style-type: none"> • State Department of Mental Health, responsible for psychiatric services for adults and children, established
1941	<ul style="list-style-type: none"> • Juvenile Court, responsible for court proceedings, probation and detention for those under 16, established

