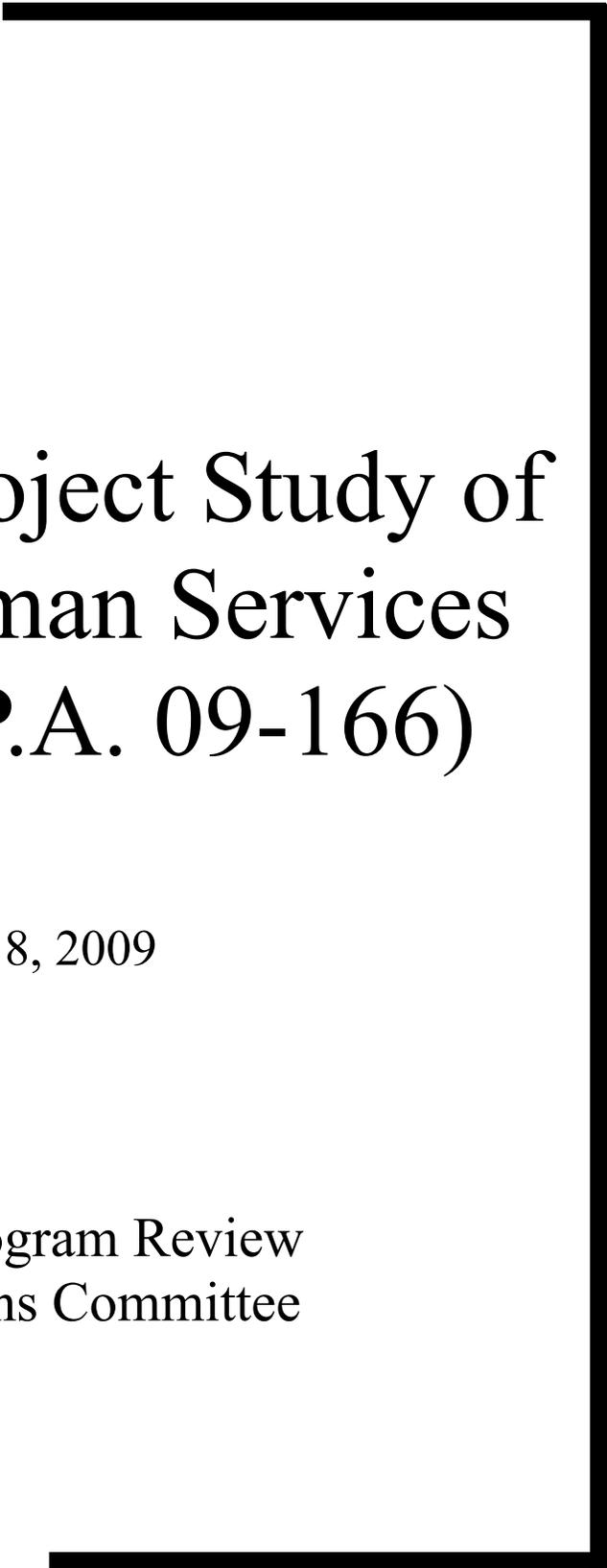


Staff Interim Report



RBA Pilot Project Study of
Selected Human Services
Programs (P.A. 09-166)

October 8, 2009

Legislative Program Review
& Investigations Committee

Introduction

RBA PILOT PROJECT: FAMILY PRESERVATION AND SUPPORT PROGRAMS

Legislation enacted during the 2009 session of the General Assembly, Public Act 09-166, requires the Legislative Program Review and Investigations Committee (PRI) to assess selected human services programs using the principles of results-based accountability (RBA), a performance-based evaluation and planning tool. In accordance with the act, the program review committee, in consultation with the human services committee and human services subcommittee of Appropriations, chose the study topic: Family Preservation and Support, a program area carried out by the Department of Children and Families.

The pilot project study was initiated by PRI to test the efficacy of a way to systematically review the performance of state agencies, programs, and policies – the results-based accountability approach currently being implemented by the Appropriations Committee. The study’s final report will include an evaluation of the pilot project itself to determine whether PRI RBA reviews should be continued in the future, potentially as a replacement to Connecticut’s existing “sunset” (i.e., automatic program termination) law. Sunset law implementation has been postponed since its first and only use in the early 1980s, due to concern that the programs and entities on the statutory review list have a limited state budget impact.

The authorizing act requires the committee’s pilot project to be completed and a report presented to the Connecticut General Assembly by January 15, 2010. This is the project’s interim progress report from the staff assigned to the study. In addition to the following brief overview of RBA, the report contains:

- Overview of DCF Family Preservation and Support (p. 5)
- RBA Population Accountability Discussion, which includes:
 - RBA Framework for Family Preservation and Support (p. 11)
 - Key Indicator Charts (p. 15)
- RBA Program Accountability Discussion (p. 23) and Performance Profiles for Selected FPS Programs (the PRI "focus" programs) –
 - Intensive Family Preservation (IFP) (p. 25)
 - Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) (p. 31)
 - Parent Aide (p. 35)
 - Supportive Housing for Families (SHF) (p. 40)
 - Flexible Funding (p. 46)
- Appendix: DCF Agency Background

Results-Based Accountability

Under P.A. 09-166, results-based accountability is defined as a method for planning, budgeting, and measuring performance of state programs that focuses on the quality of life results Connecticut desires for its citizens. The first step of the RBA approach is to identify what quality of life results are desired in the form of a broad goal called a results statement. In addition, data called “indicators,” which show how close or far the desired results are from being achieved, are selected and tracked over time, to see whether progress is being made toward the results statement. This part of RBA is termed “Population Accountability.”

The second step of RBA is “Program Accountability,” which examines some or all of the programs identified as making significant contributions to the results statement. This is accomplished by examining each program’s performance measures through answering the questions:

- 1) What did we do? (i.e., program outputs in terms of quantity)
- 2) How well did we do it? (i.e., program outputs in terms of quality) and
- 3) Is anyone better off? (i.e., program outcomes in terms of results for clients)

Further differentiating itself from other study approaches, RBA calls for data about programs to be presented in charts, with trends identified, whenever possible.

RBA in Connecticut. The work of the program review committee always seeks to answer the first two program performance questions, and many studies additionally address the third, and most difficult, outcome evaluation question. However, no prior PRI study has been executed – from study development through the reporting of findings and recommendations for improvement – purposefully using an RBA approach. This report, unlike traditional PRI interim documents (“briefing reports”), is organized according to the RBA approach, supplemented with some additional information for context. It looks different from other committee work and further format revisions are likely as the PRI staff continues to develop better ways of presenting the RBA materials that are created throughout the pilot project.

The Appropriations Committee has been using an RBA approach within selected areas of the legislature’s budget process since 2005. That committee is working to incorporate RBA as a tool for determining whether the public is better off because of state expenditures made in selected areas and where future appropriations may have the most positive impact. The Appropriations Committee’s RBA work has been assisted by The Charter Oak Group LLC, a consulting firm, and Mark Friedman, the RBA developer who is a consultant to governments and nonprofit organizations. Over the last two years, the legislature’s nonpartisan Office of Fiscal Analysis has also taken on substantial RBA tasks. (A more thorough explanation of the history of Connecticut’s RBA work will be included in the project’s final report.) An additional purpose of this pilot project will be to explore ways the program performance and outcome evaluation work of PRI can be better used to support and promote further results-based decision-making by the Appropriations Committee and the General Assembly as a whole.

Study Topic Selection

To assist the program review committee and other legislators in choosing the topic for the RBA pilot project, PRI staff undertook a three-pronged review of the human services area of Connecticut state government. This included: 1) examination of human services department budgets, program websites, and reports; 2) review of publications on human services issues by state and national research and advocacy organizations and experts; and 3) conversations with a number of nonpartisan Connecticut legislative staff and representatives of some major stakeholder groups. PRI staff used that information to formulate several topic options, which were researched further. Committee staff then ranked the topics according to several criteria:

- clearly fits within an RBA framework (i.e., defined program with clear inputs and outcomes);
- not otherwise under review or undergoing restructuring;
- under state legislative control;
- significant in terms of resources and/or clients;
- data are available or collectible by PRI staff; and
- scope is within PRI capacity, given allocated staffing and project timeframe.

The proposed topic options were presented in an RBA format – including population and program level background information – with ranking information to the legislators responsible for topic selection under the public act. The legislators reviewed the proposals and unanimously agreed that Family Preservation and Support programs carried out by the Department of Children and Families would be the best topic for the purposes of the pilot project study.

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Family Preservation and Support

Overview

Family Preservation and Support (FPS) programs administered by the Department of Children and Families were selected as the study topic for the PRI pilot project in accordance with the provisions of P.A. 09-166 (described earlier, see Introduction). Family Preservation and Support includes all of the agency's programs and services intended to keep at-risk families together and reunify those who have been separated by a child's out-of-home placement.

In general, these programs are consistent with accepted child welfare practice and based on research that shows children have the best outcomes when they can safely remain with their families or in the most family-like environment possible. Certain family preservation services have been required by federal law since passage of the 1980 Adoption Assistance and Child Welfare Act.

Given the broad goal, it is not surprising the department's family preservation and support efforts comprise a wide array of programs. A current inventory provided to PRI staff by DCF lists 20 different programs the agency considers to contribute significantly to the preservation and support of families. In addition to these programs, Flexible Funding (Flex Funds), which the agency uses to meet a wide variety of needs for many types of clients, is an important resource for helping to keep or reunify children with their families. An overview of all FPS programs including Flex Funds follows, while details on each program are provided below in Table 1.

FPS program overview. Some FPS programs are open only to families involved in DCF abuse and neglect (A/N) cases; others can be accessed by any child or family in need of the specific services offered. Families may participate simultaneously in multiple programs that have different but generally complementary purposes (e.g., boost parents' household management skills and improve children's behavioral health).

Half of the 20 programs included in the department's FPS inventory are aimed at helping families with potential or confirmed child maltreatment situations by improving the family's functioning or environment. Despite this shared goal, the administration of the programs is split within DCF: Six of these 10 programs are administered by the department's Bureau of Child Welfare (CW), while the other four are administered by its Bureau of Behavioral Health and Medicine (BH). (An overview of the Department of Children and Families, including its current organization and resources, as well as selected information on major activities, is provided in the Appendix.) Two of the programs are tailored for parents with substance abuse problems.

The other half of the DCF family preservation and support programs primarily assist children with clinical behavioral health issues (mental health and substance abuse problems). These programs are included in the FPS inventory because they attempt to stem children's out-of-home placement (into residential treatment or hospitalization) due to severe behavioral health problems. All of these programs are under the jurisdiction of the agency's behavioral health bureau, except for one that is within the DCF Bureau of Prevention.

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FPS Program Details

A summary of each of the 20 FPS programs and department Flexible Funding is provided in Table 1. The programs and resources vary tremendously in terms of DCF cost and numbers of clients served, as the table indicates:

- The median program cost to DCF is approximately \$1.48 million.
- In addition to Flexible Funding (\$26.6 million, serving 9,281 families), the family preservation and support effort with highest cost to DCF is Outpatient Psychiatric Clinics for Children (nearly \$11.8 million, serving 13,837 children).
- Therapeutic Mentoring (\$0.20 million, serving 50 youth) and Substance Abusing Families at Risk (\$0.22 million, number served not provided) are the two lowest-cost programs.
- The median number of client families served per program is 424.

Altogether, Family Preservation and Support programs, together with flexible funding, account for less than nine percent of DCF’s annual budget.

| Table 1. DCF Family Preservation and Support Programs and Resources (FY 09) | | | |
|---|--|-------------------------------|--|
| <i>Program and Bureau (Child Welfare – CW – or Behavioral Health – BH)</i> | <i>Description - Duration</i> | <i>Annual Capacity</i> | <i>Current DCF Funding* (FY 09 in millions)</i> |
| FOCUS PROGRAMS AND RESOURCES | | | |
| <i>For Families with an Open Abuse/ Neglect Case</i> | | | |
| Intensive Family Preservation (IFP) (CW) | In-home intervention services to strengthen family, prevent removal or facilitate immediate reunification; serves higher risk families than Parent Aide - 12 wks | 1,290 families | \$5.76 |
| Parent Aide*** (CW) | In-home parenting education and supports - 17 wks | 1,991 families | \$4.25 |
| Supportive Housing for Families (SHF) (BH) | Housing assistance, intensive case management for DCF-involved families to prevent removal, allow reunification, when problem is inadequate housing; housing provided in conjunction with DSS - 2 yrs | 500 families | \$7.01 |
| <i>For Any Children/Families with Need for Specific Services Offered (May Have Open Abuse/Neglect Case)</i> | | | |
| In-Home Behavioral health Service (IHBS): Intensive In-home Child and Adolescent Psychiatric Services (IICAPS) (BH) | Intensive home-based clinical treatment and supports to improve child and family functioning, reduce need for child institutional psychiatric care, for children at risk of or just discharged from inpatient treatment - 21 wks | 640 children | \$2.94 |

PRI RESULTS-BASED ACCOUNTABILITY PROJECT

| Table 1. DCF Family Preservation and Support Programs and Resources (FY 09) | | | |
|---|--|---------------------------------|--|
| <i>Program and Bureau (Child Welfare – CW – or Behavioral Health – BH)</i> | <i>Description - Duration</i> | <i>Annual Capacity</i> | <i>Current DCF Funding* (FY 09 in millions)</i> |
| Flexible Funds (CW) | Discretionary funds available for broad array of services and supports – duration varies | In FY 09, served 9,281 families | \$26.61 |
| OTHER PROGRAMS | | | |
| <i>For Families Experiencing Problems (May Also Participate in Child Behavioral Health Services)</i> | | | |
| Integrated Family Violence/Family Viol. Outreach** (CW) | Crisis and support services, in-home if possible, to domestic violence victims and their children with open DCF case - 3 mo. | 725 families | \$0.90 |
| Intensive Safety Planning (ISP) (CW) | Very short term in-home intervention to address safety issues in families with open DCF A/N case to foster reunification - 24 days | 456 families | \$1.42 |
| IHBS: Family Based Recovery (FBR) (BH) | Intensive in-home or community based intervention combined with adult SA treatment, for families that include infants and toddlers exposed to parental substance abuse; priority to open DCF cases - 12-18 mo. | 60 families | \$1.48 |
| Multidisciplinary Team (CW) | Multidisciplinary investigations for physical/sexual abuse cases to help suspected victims of serious A/N and their families – duration varies based on investigation | Not provided by DCF | \$1.15 |
| Parent Ed & Assessment (PEAS)*** (CW) | Home-based parenting education for families with children up to age 8 in open DCF A/N case (family preservation) - 6 mo. | 392 families | \$0.86 |
| Project SAFE (Joint program with DMHAS) (BH) | Priority access for parent to substance abuse evaluation and outpatient treatment if recommended, in family with open DCF A/N case (family preservation or reunification) – duration varies | 150 families | \$1.73 |
| Substance Abusing Families at Risk (SAFAR) (BH) | Assessment, prenatal education, case management and referral services for mothers of high risk newborns; includes incarcerated women and pregnant and parenting women substance abusers – duration varies | Not provided by DCF | \$0.22 |
| <i>For Children / Families Dealing with Child Behavioral Health Problem (May Have Open Abuse /Neglect Case, and/or Open Juvenile Justice Case)</i> | | | |
| Family Support Team (BH) | Home-based therapeutic services for children with a serious emotional disturbance (SED) at risk for out-of-home care, needing reunification, in DCF BH services - 12 mo. | 249 families | \$7.19 |
| Hartford Youth Project | Community-based substance abuse education, case management, assessment, referral services for youth | 100 youths and their families | \$0.44 |

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| Table 1. DCF Family Preservation and Support Programs and Resources (FY 09) | | | |
|---|---|---|--|
| <i>Program and Bureau (Child Welfare – CW – or Behavioral Health – BH)</i> | <i>Description - Duration</i> | <i>Annual Capacity</i> | <i>Current DCF Funding* (FY 09 in millions)</i> |
| (BH) | with substance abuse problems, mainly Hartford residents - 14 mo. | | |
| IHBS: Family Substance Abuse Treatment Service (FSATS) (BH) | Intensive home-based substance abuse treatment services based on family recovery model for Hartford children in detention where there is evidence of parental substance abuse - 9-11 mo. | Not provided by DCF | \$1.06 |
| IHBS: Functional Family Therapy (FFT) (BH) | Intensive home-based clinical intervention and supports to stabilize children with SED at risk of out-of-home care, whose families have limited resources - 4 mo. | 396-492 DCF-involved youths; 143-167 youths on parole | \$1.86 |
| IHBS: Multi-Dimensional Family Therapy (MDFT) (BH) | Intensive home-based clinical interventions for children 11-17 with substance abuse needs at imminent risk of removal/return home from residential care - 21 wks | 256 families | \$1.58 |
| IHBS: Multi-System Therapy – Problem Sexual Behavior (PSB) (BH) | Intensive home-based clinical interventions for youths with problem sexual behavior - 6-8 mo. | 14 youths and their families | \$0.25 |
| Neighborhood Place (Prevention) | After school and summer drop-in outpatient mental health services for New Haven children and families – duration not provided | 66 families | \$0.25 |
| Outpatient Psych. Clinics for Children (BH) | Outpatient mental health services for children with diagnosable condition and their families with emphasis on family, school, and community – duration varies | 6,599 DCF clients; 7,238 other | \$11.78 |
| Therapeutic Mentoring (BH) | Individualized, interactional activities to promote one-on-one positive relationship between trained mentor and child involved in juvenile justice or court and have mental health problems - 6-9 mo. | 50 youths | \$0.20 |
| <i>TOTAL DCF FUNDING</i> | | | \$78.94 |
| <i>% TOTAL DCF FY 09 BUDGET</i> | | | 8.6% |
| NOTES: | | | |
| * Represents DCF funding <u>only</u> ; other resources, particularly for behavioral health programs that include services funded through KidCare/Connecticut Behavioral Health Partnership (e.g., Medicaid fee-for-service) can be significant; for example, payments for IICAPS services made through the Behavioral Health Partnership are estimated to total millions of dollars annually. | | | |
| ** Family Violence Outreach being phased out and replaced by Integrated Family Violence program | | | |
| *** Redesigned/to be combined during FY 10 as Family Enrichment Services (FES) | | | |

PRI RESULTS-BASED ACCOUNTABILITY PROJECT

Service delivery. All Family Preservation and Support programs are operated by private providers under contracts with the department; DCF does not directly provide any of the programs' services. The providers' contracts specify the scope of services required and many include program performance measures. PRI staff anticipates presenting information on the development, renewal, and oversight of FPS provider contracts in the final report. The Program Review Committee's 2007 report, *DCF Monitoring and Evaluation*, noted major weaknesses in the agency's contracting process, which may have been addressed in the last two years.

Program monitoring and evaluation. Program oversight varies among the FPS programs. In general, program oversight requires strong data collection and analysis capacity. Until recently, DCF had required its contracted behavioral health programs to submit certain client and service information via its automated Behavioral Health Data System (BHDS); child welfare program providers were required to submit information in varying formats and levels of detail. However, in July 2009, the department began to implement an entirely new provider data system expected to provide higher-quality data that is more useful for understanding how all contracted programs are performing. The new system, Programs and Services Data Collection & Reporting System (PSDCRS), is being phased in, starting with behavioral health services. Eventually, it will encompass Bureau of Child Welfare programs.

DCF began the effort to overhaul its program data systems because, according to staff, it had become evident that major changes were needed to ensure accountability. The department's computer systems have been an ongoing problem, as addressed in the 2007 PRI report mentioned above. Prior program performance measures and data analysis capabilities were insufficient, data quality was poor, and web-based access (e.g., for data entry) was lacking.

The department's program managers, providers, and research staff working on the new system considered for approximately nine months the measures PSDCRS would include for each behavioral health program. Some of their efforts involved using logic models to understand what could reasonably be expected as program outputs and outcomes, and then devising data items to allow those results to be measured. An extensive training in the new system for contracted program providers also was planned and began in the spring of 2009. Initial information produced through the new system may be available to PRI staff before completion of the RBA pilot project study. In the meantime, this study draws on provider data obtained and kept by DCF through means other than the previous (BHDS) or new (PSDCRS) automated systems.

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Population Accountability

RBA Accountability Framework

The results-based accountability approach examines performance and outcomes at two levels, population and program. Accountability for population-level results is broadly shared, with many agencies and programs, public and private, responsible for contributing to the achievement of statewide goals. To clarify what results a department or program under review through RBA should be accountable for, the following three questions are answered:

1. Why does the department or program under review exist? Specifically, what ultimate goal – framed as a “quality of life results statement” that applies to an entire target population (i.e., all children, adults, and families in the service area) – is it intended to help reach?
2. What is the role of the department or program in working toward the results statement? Are there many other contributors and who are the main partners?
3. What results can logically be expected of the department or program under study?

For this study, PRI staff has answered these questions by developing an RBA framework for the Family Preservation and Support programs carried out by the Department of Children and Families. This framework is presented as a one-page chart (see Figure 1: RBA Framework) later in this section. The framework structure was based on similar charts developed by the legislature’s nonpartisan Office of Fiscal Analysis and an outside consultant, The Charter Oak Group LLC, hired by the General Assembly to assist with RBA implementation.

1. Why does the department or program exist?

Quality of Life Results Statement for a Population. The quality of life results statement is the ultimate desired result to which the department or program under study contributes. This study is examining DCF’s Family Preservation and Support programs, so the relevant results statement (shown at the top of the chart) is: “Connecticut children grow up safe, healthy, and ready to lead successful lives.” This results statement’s population (i.e., who it is about) is, “Connecticut children.” The statement was developed by committee members with input from other legislators.

Indicators. Under the RBA approach, progress toward the results statement should be measured by examining data from three to five population-level indicators that capture the statement’s different aspects. The indicators developed by the PRI staff for this study are listed below the results statement. Data related to each indicator are presented in separate descriptions that follow the RBA Framework chart.

Due to the project’s limited staff resources and the study’s mandated focus on evaluating performance at the program level, only one indicator was chosen for each aspect of the results statement. To deeply engage in constructive work at the population level – to make a concerted

effort in reaching the results statement – multiple indicators for each aspect would be examined in a report card format. For the final report, PRI staff plans to produce a report card at least for the safety aspect of the results, which is most closely related to the desired results of the DCF programs under study.

2. What is the role of the department or program in working toward the results statement?

Partners. While the Department of Children and Families FPS programs have an important role in achieving the results statement, they are only one of many entities that contribute to the well-being of children and families in Connecticut. Many other programs, organizations, and individuals – both inside and outside state government – are partners who play significant roles in protecting and supporting children. The wealth of partners means that DCF should not be held solely accountable for progress toward the results statement.

Strategies. As the Framework shows, state government employs several major strategies to make progress toward the results statement. DCF is the main state agency responsible for one strategy – protecting children at risk of abuse and neglect – and a core partner for two others – promoting children’s health (through its role as the state children’s behavioral health agency) and supporting and preserving families. It should be noted that the department is responsible for using all the strategies to support the well-being of children in its care and custody (i.e., children in foster care and those placed in residential treatment, group homes, and other out-of-home settings, as well as committed delinquents). At the same time, it is clear there are many other state agency partners who implement each strategy to achieve the results statement; therefore, again, DCF should not be held solely accountable for progress. It may be reasonable, however, to expect DCF to play a leadership role in partnering with those inside and outside of state agencies to work toward effectively implementing the strategies, especially in the strategies in which the department plays a key role.

DCF’s roles. The department’s main roles in protecting and promoting the well-being of children are outlined in the Framework. Major agency programs related to each role are also listed. As the chart shows, Family Preservation and Support is one set of programs among many within the department. FPS programs (along with the assignment of a social worker to each family) are the primary way DCF carries out its strategy of maintaining child safety in-home and strengthening the family’s capacity to meet child needs. DCF may be expected to be held accountable for the performance of its program areas.

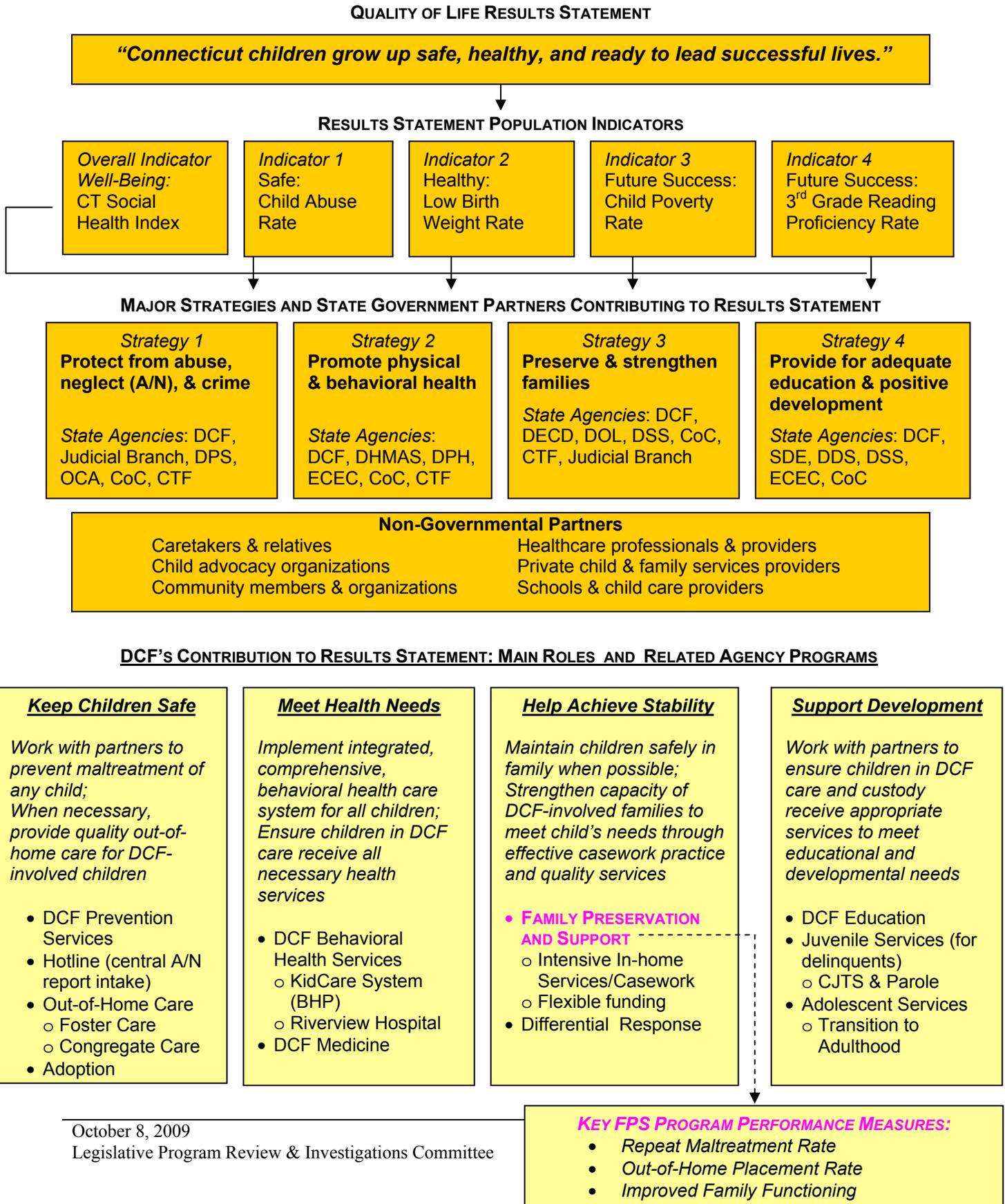
3. What are the key results that can be expected of the programs under study?

Program Performance Measures. The key performance measures for FPS program client families, highlighted at the bottom of the RBA Framework, are: 1) children are free from repeat maltreatment; 2) children remain in-home; and 3) improved family functioning. These are the basic measures for which, at the client level, DCF may logically be made accountable for FPS programs. PRI staff is compiling and examining data on these measures for each of the five focus programs included in this study.

| State Agency Acronyms Used in Figure 1. RBA Framework | |
|--|--|
| CoC | Commission on Children |
| CTF | Children’s Trust Fund |
| DCF | Department of Children and Families |
| DDS | Department of Developmental Services |
| DMHAS | Department of Mental Health and Addiction Services |
| DOL | Department of Labor |
| DPH | Department of Public Health |
| DPS | Department of Public Safety |
| DSS | Department of Social Services |
| ECEC | Early Childhood Education Cabinet |
| OCA | Office of the Child Advocate |
| SDE | State Department of Education |

Population Accountability

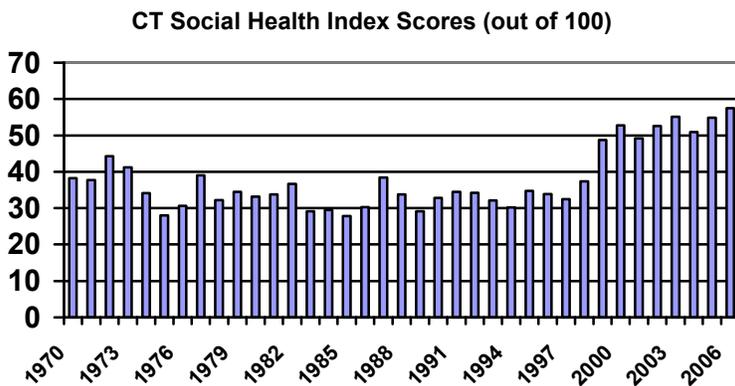
Figure 1. RBA Framework



Population Accountability
Indicators of Results Statement Progress

Overall Indicator (Well-Being): Connecticut Social Health Index (SHI)

The Social Health Index is a composite calculation of 11 quality of life indicators designed to represent the well-being of Connecticut residents. A joint effort of the General Assembly, the Commission on Children, and a nonprofit foundation, the SHI was developed in 1994 to monitor state-level performance and track trends in social, economic, and health conditions that impact children, youth, and adults.



Source: The Social State of Connecticut 2008

Trends: Sustained, significant improvement after 1999 (better)

Story Behind the Baseline:

The state’s Social Health Index is at its highest level since its beginning data year (1970). Scores consistently have been very close to or above 50 since 1999. In all prior years, the highest value was 44.3 (1972), 11% lower than the 50 mark. The lowest score was 27.8 in 1985, 44% lower than 50.

Despite the substantial increases over prior decades, SHI scores for the 2000s are still far below 100, the best possible value.

Specific areas in need of improvement, as well as areas where progress is being made, can be identified by analyzing the performance of each component indicator of the index. These are: infant mortality; child abuse; youth suicide; high school dropouts; teenage births; unemployment; average weekly wages; no health insurance; violent crime; affordable housing; and income variation.

Since the index began, there have been significant reductions in the areas of infant mortality, teen births, high school dropouts, and unemployment. Average weekly wages also improved, but child abuse, no health insurance, violent crime, and income variation worsened. Youth suicides and affordable housing showed no clear positive or negative longer-term trends. Five-year trends for violent crime and average weekly wages, as well as income variation, reveal declining performance and no health insurance in the short term has not changed.

Current Efforts to Turn the Curve: With the exception of the Commission on Children, neither the legislature nor state agencies appear to be routinely using the SHI to assess areas of problem social performance and develop strategies for addressing them. COC included several proposals in its latest RBA report (March 2009) for addressing the lack of progress in reducing income variation and increasing affordable housing (e.g., maximizing federal stimulus dollars to ensure basic needs are met). To improve the well-being of children, the commission proposed support for strategies that address low birth weight, which has shown an increased prevalence recently.

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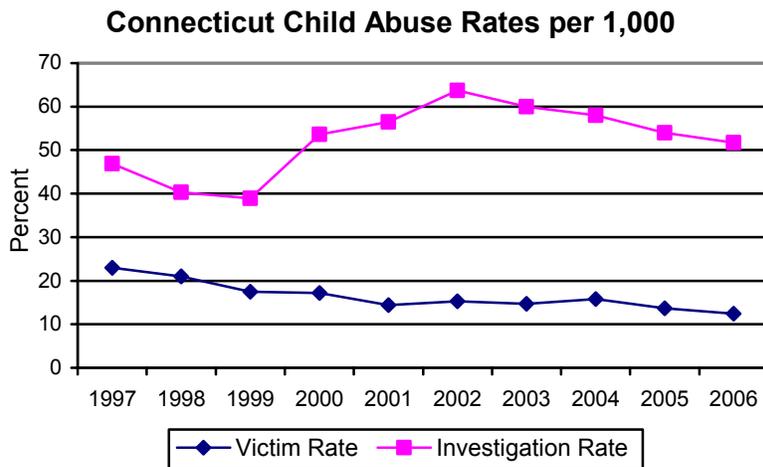
While not specifically citing Social Health Index findings, several legislative and executive initiatives aimed at improving progress in problems areas highlighted by the index have been undertaken in recent years. These include: the Child Poverty and Prevention Council, which is working on a statewide agenda to reduce the number of children living in poverty in Connecticut by 50 percent over 10 years; and the Early Childhood Education Cabinet, which has set goals and is developing an action plan concerning age-appropriate development, health and school readiness, and academic success for the state's young children (ages birth to nine).

Most recently, a legislative task force on the recession and children was created in June 2009 to review trends in programs and services that support basic needs of children and families (e.g., housing, child care, and employment). The task force, which is bipartisan and broadly representative of stakeholders, also will issue recommendations on appropriate budget and policy actions to streamline services and improve access to programs.

Population Accountability
Indicators of Results Statement Progress

Indicator 1: Connecticut Child Abuse Rates (Safety)

The incidence of child abuse and neglect within a population is a widely used measure of the safety and well-being of children and families. For many federal research and evaluation purposes, child abuse rates are based on numbers of children who are the subject of maltreatment reports received and investigated, or substantiated (confirmed as abuse/neglect victim), by state child protection agencies. Rates often are calculated per 1,000 children under age 18.



Source: Child Welfare League of America, NDAS

Trend: Decline in both rates since 2002 (better)

Story Behind the Baseline: Child abuse and neglect rates are affected by many factors far beyond the control of any single state agency. The economy and social conditions, in particular, have a strong influence on the numbers of alleged maltreatment reports that are made to child welfare agencies. Child abuse reports tend to increase during economic downturns, when families are under more stress and have fewer resources to meet basic needs.

Investigated reports of alleged abuse and neglect can be viewed as a broad indicator of how well public and private efforts at the state level are addressing the needs of at-risk children and families. A recognized high risk factor for child abuse and neglect cases is a history of previous reports, regardless of whether they were substantiated. In general, numbers based on substantiated reports (child victim rates) are considered a more reliable indication of the extent of maltreatment as they: a) represent cases determined to meet set legal and practice criteria; and b) are less influenced by negative events (e.g., publicity about an abused child’s death) that can trigger spikes in reports to protective services agencies.

In Connecticut like the rest of the nation, child abuse rates worsened over time from the 1970s into the early 2000s. (It is unclear whether these changes reflected more abuse and neglect, or heightened awareness and the advent of mandated reporting.) More recent trends suggest that while child abuse and neglect remains a serious problem, rates are on the decline. Connecticut’s investigated abuse rate peaked at 63.7 per 1,000 children in 2003; since then, it has decreased each year, dropping to 51.7 reports per 1,000 children in 2006. Similarly, the rate of children determined to be victims of abuse or neglect reached its lowest level over a recent 10-year period – 12.4 per 1,000 children under age 18 – in 2006. (Child abuse rates validated by the federal government lag the raw data reported by states by two years; DCF does not issue rate information other than validated federal numbers.)

Current Efforts Turn the Curve: Experts point out that child abuse is preventable through effective intervention and education efforts, as well as strong child protective services. According to a recent agency RBA report to the legislature, DCF has been considering ways to enhance its array of primary

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prevention and early intervention services by continuing to shift resources to this relatively small program area. The agency is also planning to undertake a major initiative called Differential Response System (DRS) as a way to decrease its abuse and neglect caseload and better support at-risk families. Implementation of DRS will likely occur on a pilot basis at some point in the upcoming calendar year.

The Commission on Children proposed several strategies for reducing the state's child abuse rates in its 2009 RBA report. They included: expanding a proven, research-based model of home visitation ("Child First") that helps the state's most vulnerable families stay out of the DCF protective services system; increasing fatherhood policies and programs to reduce single-parenting stressors; and increasing research-based interventions that promote family stability and improve family functioning within the community.

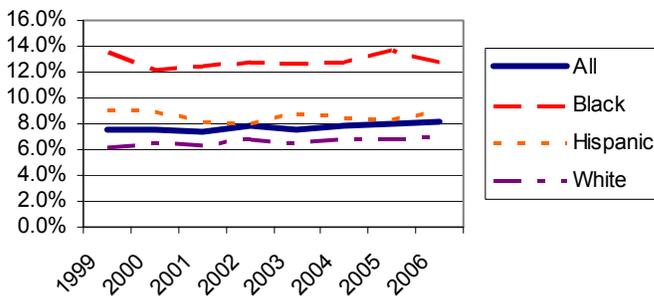
Primary prevention of child abuse is the sole mission of the Children's Trust Fund (CTF), which provides resources for prevention programs that support and strengthen high-risk families. During the past fiscal year, CTF initiated several pilot projects to expand the work of its statewide home visitation program, Nurturing Family Network.

Population Accountability
Indicators of Results Statement Progress

Indicator 2: Low Birth Weight Babies Rate (Health)

Low birth weight is commonly used as measure of maternal and child health, and research has shown low birth weight is associated with a variety of negative health and developmental characteristics. In Connecticut, low birth weight is monitored as an indicator by the Women’s Health Subcommittee of the Medicaid Managed Care Council, the Connecticut Early Childhood Education Cabinet, and the HUSKY insurance program, according to DPH.

Percent of Low Birth Weight Babies in Connecticut



Source: DPH

Trends: Slight increase overall (worse); Small increases for Blacks and Whites (worse); Small decline for Hispanics (better)

Story Behind the Baseline:

Connecticut’s low birth weight rate (the percent of babies weighing less than about 5.5 pounds) increased to 8.2% in 2006, from a recent low of 7.4% in 2001. The state’s 2006 rate is slightly lower than the U.S. rate (8.4%). However, there are persistent and wide ethnic differences: Minority population babies had a low birth weight much more often

than White infants – double for Black infants, and one-third more for Hispanic babies (1999-2006). These gaps began larger than at present; they have narrowed over time, due to slight increases in the White low birth weight rate. (Over the longer-term – since 1990 – there have been small declines in the rate of low birth weight among Blacks and Hispanics.)

Low birth weight is influenced by a variety of factors, including: mother’s health and behaviors, preconception and prenatal care, multiple gestation, and environment. There is a growing body of research associating low birth weight with later cognitive disabilities, Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder, motor difficulties, Type II diabetes, coronary heart disease, stroke, and hypertension. One research project, presented at a national conference and being considered for publication, studied a large group of siblings and found low birth weight has negative effects on adult health, education, labor force participation, and earnings.

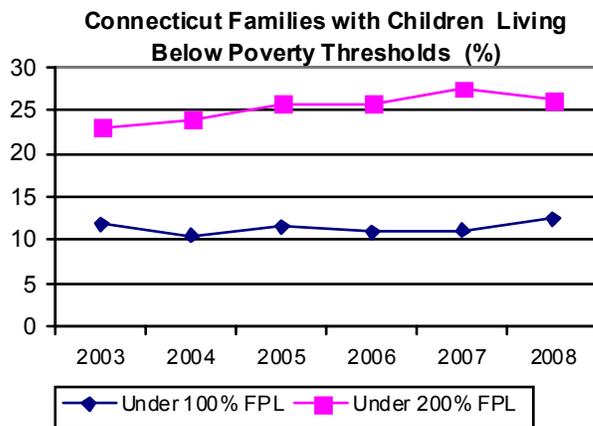
Low birth weight has immediate fiscal consequences for the state. The Connecticut Public Health Department (DPH) noted, “On average, each low birth weight event among HUSKY A enrollees added \$52,217 in [birth-related] hospitalization charges.”

Current Efforts to Turn the Curve: DPH recognizes that the increasing low birth weight rate and the differences among ethnicities are problems. The department released a report in 2008 that recommends several steps to take to eliminate the disparities, including: improving women’s access to quality care; promoting a certain model of prenatal care; boosting WIC and Medicaid enrollment among women; addressing violence and environment; partnering with the medical community to address low birth weight; increasing activities to promote male involvement; conducting more research regarding the disparities; and launching collaborations with other state agencies. The report also notes two initiatives DPH was beginning to implement: a smoking cessation program for pregnant women at several local health centers and a Sexual Violence Prevention Plan.

Population Accountability
Indicators of Results Statement Progress

Indicator 3: Connecticut Child Poverty Rates (Future Success)

Research shows living in poverty is associated with many negative outcomes for children. A standard definition of poverty is 100% of the Federal Poverty Level (FPL), which currently is an annual income of about \$22,000 for a two-parent, two-child family. The Connecticut Child Poverty and Prevention Council (CPPC) uses the percent of families with children under 18 who fall below the 100% threshold as the state child poverty rate. CPPC also tracks families below 200% FPL rate because Connecticut has a high cost of living and that amount more closely corresponds to the state's self-sufficiency standard.



Source: CPPC

Trends: Slight fluctuation with recent rise in 100% Federal Poverty Level rate (worse); Increase in 200% FPL rate is greater than accounted for by improved 100% FPL rate (worse)

Story Behind the Baseline: More than one-quarter of all Connecticut families with children under 18 meet the federal definitions of poor (under 100% of FPL) or low-income (under 200% of FPL). Except for 2008, the portion of families with children living in poverty increased every year since 2003; the aggregate change (over 2003-2008) was nearly 20%.

The growth through 2007 in portion of 200% poverty families (4.5 percentage points) appears mostly due to movement of some new Connecticut families into this low-income range (either previously living in the state, or not) – and not to the slight decline in poor category (100% poverty) over the same period (0.7 percentage points). The impact of the current recession is reflected in sharp 1.4% increase in poor (100% poverty) families with children between 2007 and 2008.

Connecticut's rates of low-income and poor families with children are significantly lower than the national rates, which are 39% and 18%, respectively, at present. However, child poverty varies tremendously across the state. In 2000, seven towns had child poverty rates (100% of FPL) above 23% - including Hartford at 47% - while 38 towns had less than 2%. More than six in ten Latino children and nearly half of Black children are in low-income families, compared to 15% of White children. Most low-income parents (76%) are working.

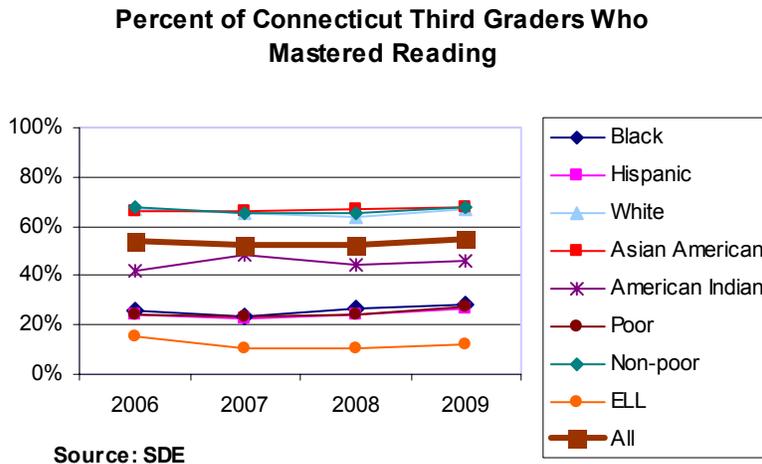
There is a strong body of research associating poverty with impaired child development (cognitive, behavioral, social, and emotional) and poor health, both of which have negative effects lasting into adulthood. Child poverty, in particular, is associated with unfavorable educational and employment outcomes later in life.

Current Efforts to Turn the Curve: In 2008, the CPPC adopted 12 recommendations to help meet its goal of reducing child poverty by 50% over ten years. The recommendations address income, education, and social safety net matters, as well as family structure and support. The CPPC hired consultants to conduct economic modeling that can show which recommendations would have the greatest effects on reducing child poverty. That analysis was presented to the CPPC in June 2009 and is under review.

Population Accountability
Indicators of Results Statement Progress

Indicator 4: Third Grade Reading (CMT) Proficiency (Future Success)

Connecticut's Early Childhood Cabinet uses the same indicator for its RBA efforts because early student performance is thought to be strongly associated with future educational success.



Trends: Stable overall (neutral); Small increases across all ethnic groups (better) except whites (worse); Small increase for poor children (better); Small declines for ELLs (worse)

Story Behind the Baseline: Reading performance improved for every student subgroup in 2009, in some cases reversing slight downward trends. However, performance continued to vary dramatically among subgroups: Fewer than 30% of

Black, Hispanic, poor, and English Language Learner students met the state goal, while more than 55% of Asian American, White, and non-poor students were at that level. (A student belongs to several subgroups, based on ethnicity, free lunch receipt as a proxy for family poverty, and whether a student is an English Language Learner.) Overall, 54.6% of Connecticut third-graders are meeting the state's reading goal level.

A student's educational progress and achievement is influenced by many factors. Research has shown strong links between achievement and: the child's prior development; family factors including stress, family physical and learning environment, income, parent occupation, and parent education level; and school factors, most notably teacher quality.

Current Efforts to Turn the Curve: The Early Childhood Cabinet's RBA report cards note that SDE is aware of the differences in student performance and the need to continue to improve. The department is addressing the achievement gap by focusing on assisting Priority School Districts, requiring new teachers meet a certain standard on a pre-service reading test, and including literacy as a part of district and school improvement plans, among other efforts. The Early Childhood Cabinet has led efforts to improve pre-primary school preparation by: expanding school readiness program capacity in Priority School Districts; improving preschool facilities; moving toward an early childhood education quality monitoring and improvement plan; and developing an effort to understand and improve the early childhood education workforce.

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Program Accountability

DCF Family Preservation and Support Focus Programs

This study examines the performance of DCF Family Preservation and Support programs, one of many contributors to the results statement: “Connecticut children grow up safe, healthy, and ready to lead successful lives.” As the agency with primary responsibility for these programs, it is fair to hold the Department of Children and Families accountable for the results of these programs in terms of program implementation – the RBA questions of how *much* and how *well* did we do – and impacts on clients’ lives – the RBA question of whether anyone is *better off*.

Given the staff and time constraints of the PRI pilot project, only a limited number of DCF Family Preservation and Support programs could be examined in detail using the results-based accountability approach. The four following FPS programs, in addition to Flexible Funding – the department-wide mechanism for purchasing goods and services to meet individualized client needs – were selected as the focus of the project’s RBA program accountability efforts:

- Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)
- Intensive Family Preservation (IFP)
- Parent Aide
- Supportive Housing for Families (SHF)

Each of the five programs supports multiple strategies in reaching the results statement. For example, Intensive Family Preservation works directly to protect children from abuse, neglect, and crime (Strategy 1 on the RBA Framework) and preserve and strengthen families (Strategy 3), but also will connect children in client families with needed health and education resources as needed (Strategies 2 and 4, respectively).

Selection process. Selection of the focus programs was driven by size of client population and costs, as well as legislator interest. Due to legislative interest in child welfare prevention-oriented activities, priority was given to these programs with an emphasis on preservation rather than reunification. Intensive Family Preservation, Parent Aide, and SHF were chosen because they are the most costly family preservation programs. IICAPS was selected to represent an FPS program with a behavioral health emphasis, since this service area has experienced strong growth in recent years. Finally, legislators were highly interested in continuing in-depth examination of Flexible Funding, based on concerns raised during budget hearings. It is important to note Flexible Funding serves DCF children and families beyond those involved in Family Preservation and Support programs. While not a discrete FPS program, Flexible Funding is considered a crucial tool for helping at-risk families meet their children’s needs and stay together in the community.

Performance Profiles. Interim documents called Program Performance Profiles have been developed for each of the five focus programs and are included in this section. Information

PRI RESULTS-BASED ACCOUNTABILITY PROJECT

contained in the profiles is organized according to the three key RBA performance questions: what did we do; how well did we do it; and, is anyone better off? Performance measures related to each question were developed by PRI staff based on program documents and conversations with DCF program managers. Then, these measures were discussed with the program managers to ensure critical aspects of the program were captured.

Any performance measure data presented in the interim Performance Profile should be considered preliminary. Initial data received to date for some programs are included in the relevant profile; other information has been requested and will be addressed in the final report – either presented, or included as part of the Data Development Agenda. It should be noted that a key part of the RBA evaluation approach, the Story Behind the Baseline (i.e., what is causing trends in performance), has not been developed for this report. That information will be included in the final report. Further, while data on “How much did we do?” performance measures was fairly readily available, information on the quality and outcomes of services was less so, particularly in time for this report.

The PRI Performance Profiles are more detailed than typical RBA presentations of program information in order to accurately convey the study’s progress to date. Committee staff expects to prepare a one- or two-page RBA Report Card for each program for the final study product and the more detailed completed profiles may be provided as supporting documents.

The final section of each interim Profile called “Follow-up Areas” describes issues that PRI staff has found to date and plans to explore further for the final report. In the final report, this section will be replaced by “Recommendations,” with a focus on no- and low-cost ideas.

Follow-up areas across programs. At this time, PRI staff has identified three topics that cut across programs and will be examined for the final report. They are:

- Area office variation: To what extent do area offices differ in their implementation (including eligibility criteria and service expectations) of programs and oversight of providers? How does any variation found, impact clients (e.g., outcomes, equity)?
- DCF Central Office oversight differences among programs: How does the variation in what data is required of providers affect the agency’s ability to effectively manage its programs? What are the roles of various offices and staff regarding program oversight? More generally, how could DCF oversight of programs be improved?
- Contracting methods: How does DCF determine provider contract amounts? Do the amounts given reflect contractors’ actual workload, and are they associated in any way with performance differences?

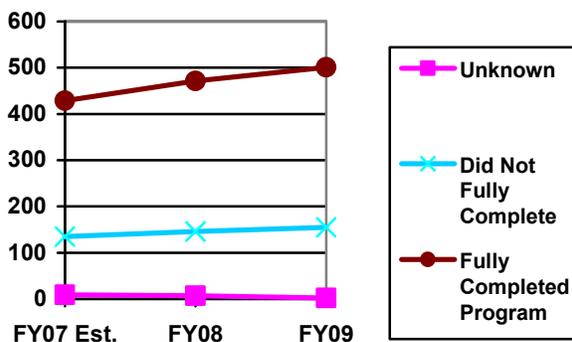
Program Performance Profile Intensive Family Preservation (IFP)

| <u>Program Background</u> | |
|---------------------------|---|
| Purpose (BH) | Reduce immediate safety threats to prevent child out-of-home placement |
| Target Population | Families with an open DCF abuse / neglect case at high risk of out-of-home placement, just reunified, or with an upcoming reunification |
| Services | In-home visits to provide: mitigation of safety problems; links to community services (including therapeutic interventions); parenting education; and crisis intervention, over five hours each week (minimum), for up to 12 weeks; worker is available 24 hours a day |
| Partners | <ul style="list-style-type: none"> • 17 contracted providers: One serves clients out of four area offices, one out of three area offices, three out of two area offices, and 12 out of a single area office • Other community agencies that provide services through referrals from IFP workers |

I. How Much Did We Do?

The charts and analysis presented in this Performance Profile (and all others in this interim report) rely on the data given by providers to DCF. It appears that the data for at least a few programs might not capture all clients served; this is especially true for IFP, based on the large discrepancy between the number of clients included in the data, and the number of client slots funded by DCF. This issue will be addressed further in the final report.

Performance Measure 1a: Program Services Received



Trend: Small increase in clients served; Small increase in stable completion rate; Fewer clients' completion rate unknown in FY 09 (better)

DCF's data indicate 658 DCF families who began IFP services in FY 09 have ended their participation in IFP (in either FY 09 or by Sept. 22 of FY 10). Of these, about 76% completed the program successfully; 24% had received some services but did not complete.

Over the past three years, the program appears to have served more people each year (8.9% increase in clients in FY 08, 5.4% increase in FY 09) and kept the completion rate stable. However, it is unclear whether the increase in clients served was a true increase, or merely a reflection of more clients being reported by the providers. It should be noted that DCF funded 1,290 IFP client slots in FY 09. The FY 09 IFP data covers about 51% of that amount. (Preliminarily, it does not appear providers are "cherry-picking" the best cases for reporting to DCF,

Program Performance Profile Intensive Family Preservation (IFP)

based on data presented in “II. How *Well* Did We Do It?.”)

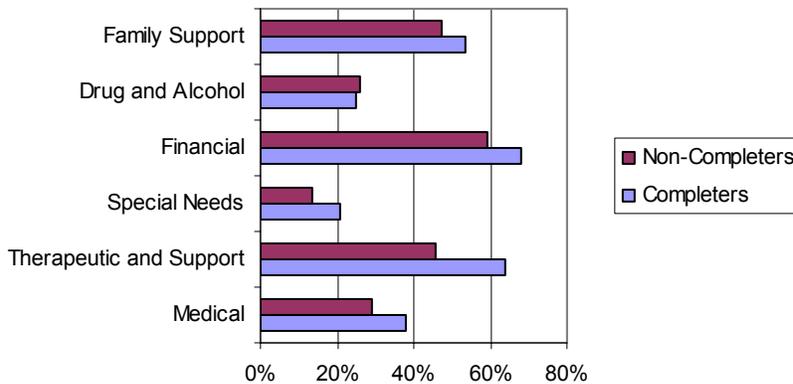
The completion status is unknown for a small and declining number of clients included in the data (7 in FY 08, and 2 in FY 09).

Story Behind the Baseline: Explanations for this chart’s data trends will be included in the final report.

Data Note: In fall 2006, the IFP contract scope of services was revised to include a new standardized assessment (described later) and a new, web-based data collection tool. The data collection tool was phased in through early 2007; the first complete available data is for March 2007. The FY 07 estimate presented in the chart above annualized March-June 2007 numbers. DCF is attempting to provide older program data for inclusion in the final report.

Performance Measure 1b: Types and Amounts of Program Services Received

Types of Services Received by IFP Clients

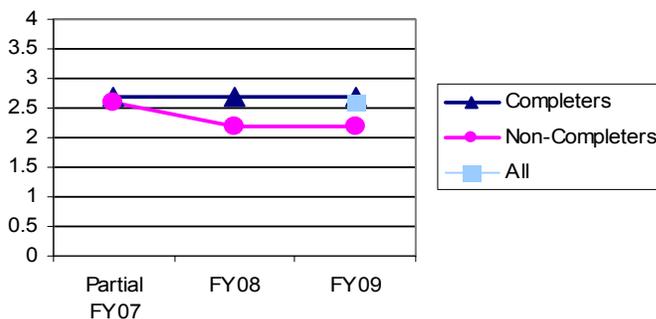


Trend: More than half of completers receive assistance with family, financial, and/or therapeutic matters; Except for substance issues, completers are more likely than non-completers to receive each type of assistance

These data are from FY 09; the percent receiving services has changed in only a few ways over FY 07-FY 09. There has

been an increase (from 17% to 25%) in completers receiving substance abuse services, and decreases in non-completers receiving medical assistance (49% to 29%) and family support services (62% to 47%).

Average Number of Service Types Received Per Client



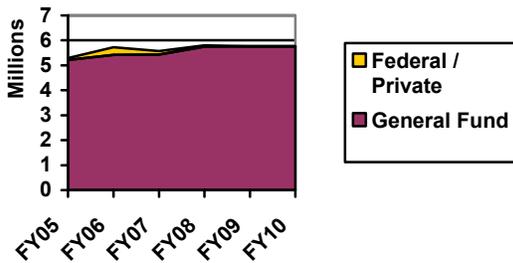
Trend: Average number of service types was stable for program completers (neutral); Non-completers’ amount of service types dropped somewhat (worse)

Reported IFP clients who began services in FY 09 received, on average, 2.6 types of services. Completers continued to receive 2.7, while non-completers who started IFP in FY 07 received 2.6 but those who began in FY 08 or FY 09 received 2.2.

Program Performance Profile Intensive Family Preservation (IFP)

Story Behind the Baselines: The relationship between whether a client completes IFP and the number of program services received is unclear. Non-completers could receive fewer service types for a number of reasons (e.g., might be less willing to more fully engage, needs might be less fully understood by IFP workers who are with them for a shorter amount of time, shorter service duration meant less opportunity to offer different services). Explanations will be presented in the final report.

Performance Measure 2: Resources Used



Trend: Small fluctuations, then flat

Expenditures grew 8% in FY 06, declined slightly in FY 07, and since FY 08 have held at almost \$5.8 million. The General Fund has covered nearly all costs. (Note: The FY 10 amount was projected by DCF in August 2009.)

Story Behind the Baseline: Although theoretically one would examine Performance Measures 1 and 2 together, and therefore conclude that the number of IFP clients served increased (by 5.4%) and the completion rate remained the same – despite level funding – this analysis cannot be made confidently due to the question of data completeness.

DCF submitted a request for substantially more IFP funding – an additional \$2.1 million in the first year, and \$2.8 million annually beginning in the second year (raising the total to \$8.6 million in FY 11) – to increase the number of clients that may be served, as part of both the midterm FY 09 budget adjustments (in December 2007) and the FY 10-11 biennium proposal (in November 2008). Neither request was fulfilled.

II. How Well Did We Do It?

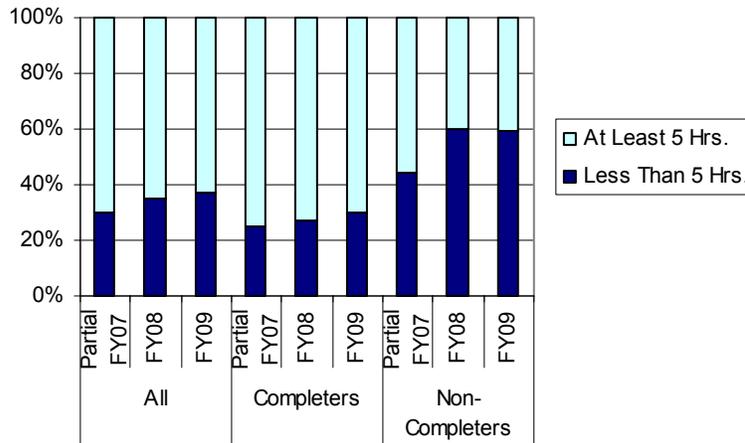
Data outlined below but not presented are being compiled or have been requested for presentation in the final report. Key items that are not available within the study timeframe will be added to the project's Data Development Agenda.

Program Performance Measures

1. *How well was client demand met: Numbers of clients on IFP waitlist*
2. *Whether the IFP service volume standards were met*

Program Performance Profile Intensive Family Preservation (IFP)

a. Five hours of face-to-face services provided weekly by IFP worker



Trend: Increasing number are not meeting five-hour standard (worse); On average, non-completers consistently have fewer hours of face-to-face services than completers

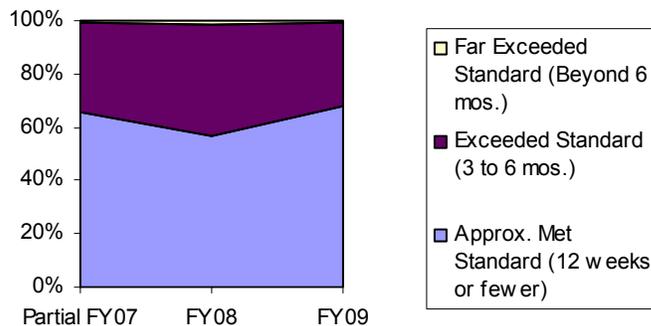
More than one-third (37%) of all reported IFP clients who started the program in FY 09 received less than the model's standard of 5 hours of face-to-face services. Completers' services much more frequently meet the standard, than non-

completers (30% compared to 59%). The face-to-face hours spent has been declining among all three groups over the last three FYs.

Story Behind the Baseline: Explanations for this chart's data trends will be included in the final report. It is interesting to note that although the hours of service have declined, and hours of service are lower for non-completers, the program's completion rate has remained stable. This will be explored for the final report.

b. Two visits made weekly by IFP worker

c. Maximum duration of 12 weeks: Data presented below for program completers, only (since program non-completers, by definition, end participation early)



Trend: Fluctuating; recently, more meeting – i.e., not exceeding – the standard (better)

Sixty-eight percent of reported program completers who began IFP in FY 09 participated for about 12 weeks or less (i.e., did not receive services much beyond the maximum duration). This is an improvement over

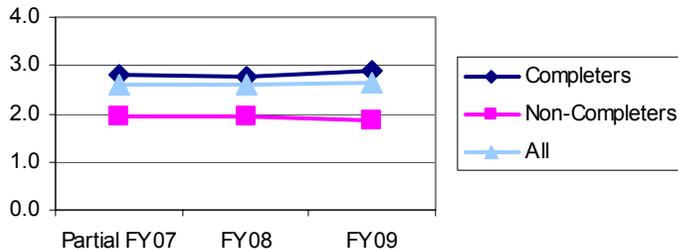
58% in FY 08, and even over 65% in FY 07. Non-completers (not included in chart above) who began in FY 09 ended participation in the program at 6.5 weeks, on average (not shown) – well below the program's intended duration because, as non-completers, they by definition stopped participation early.

Story Behind the Baseline: Explanations for this chart's data trends will be included in the final report.

Program Performance Profile Intensive Family Preservation (IFP)

d. Monthly joint home visits with the DCF family worker and the IFP worker

**Number of Joint Monthly Home Visits Over
Program Participation**



Trend: Slightly higher number of average monthly joint home visits overall and for completers, and slightly fewer visits for non-completers

Reported IFP program completers who started the program in FY 09 had an average of about 3 (2.9) joint visits, which meets the target when considering the average service duration is about 3 months. IFP non-completers had an average of 1.8 visits, which makes sense given their shorter term of program participation.

Further examination of the data is necessary to determine what percents of completers and non-completers had the appropriate number of monthly joint home visits, given their length of engagement in the program.

Story Behind the Baseline: Explanations for this chart's data trends will be included in the final report.

e. Biweekly specific case conferences between the family's IFP worker and the family's DCF case worker

3. *Whether the IFP service timeframe standards were met:* Time between –
 - a. Program intake and:
 - i. Assessment by worker: Five business days
 - ii. Development of IFP plan: Two weeks
 - b. Second assessment administration and program discharge
4. *Whether the IFP staff was experienced and educationally qualified*
5. *Why non-completers did not successfully finish the program*
6. *Whether clients were satisfied with program services*
7. *The per-client cost of the program, compared to alternative options*
8. *Whether provider performance varied substantially (examining differences among contractors in 1-7 above)*
9. *Impact of Client Characteristics on Program Completion*

Additionally:

10. *Provider satisfaction:* PRI staff will collect data from providers regarding their satisfaction with DCF's administration of the program and with the effectiveness of the IFP model.

Program Performance Profile
Intensive Family Preservation (IFP)

III. Is Anyone Better Off?

Program Performance Measures

1. *Children are free from repeat maltreatment*
2. *Children remain in their homes (i.e., avoid out-of-home placement)*

DCF does not regularly track child welfare client outcomes, by program, on repeat maltreatment or placement after program services have ended. In 2007, department staff performed short-term outcome analysis for a small group of IFP clients (93 families); DCF plans to soon repeat this work with a more recent client cohort. (The work examined a range of possible child welfare outcomes within six months of program intake, i.e., about three months beyond the average length of participation, using the department’s LINK system.) The IFP client data providers are to submit to DCF does not include IFP workers’ reports on maltreatment and out-of-home placement as of program exit.

PRI staff is considering undertaking outcome analysis that examines the child welfare outcomes in the short- and long-term (e.g., six months and two years after program completion). If DCF and PRI staff time is insufficient to complete the analysis before the final report is due, then these items may be added to the Data Development Agenda.

3. *Family functioning is improved*

Since 2006, IFP has used the Global Appraisal of Individual Needs-Quick (GAIN-Q), a proprietary assessment, to measure caregiver well-being in a variety of domains (including substance abuse, mental health, stressors) at the start and end of program services. (The assessment results guide the development of the family’s plan for IFP services.) Due to provider complaints, and concern over whether the instrument accurately captures family functioning, the department is considering whether to replace GAIN with a different uniform assessment.

GAIN data has been requested and will be included in the final report.

Follow-up Areas

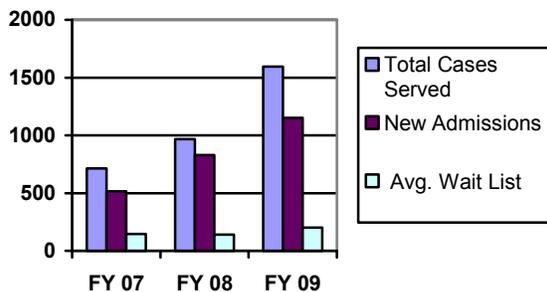
- **Providers’ IFP client data reporting:** Are providers under-reporting client data to DCF? If so: 1) Why; 2) What has DCF done to improve provider reporting; and 3) What further steps could be taken to improve reporting? If not: Why are providers serving far fewer clients than they are funded to serve?
- **Comparison to other IFP models:** How do Connecticut’s IFP program characteristics, completion rates, and outcomes compare to evidence-based family preservation models used by other states?

**Program Performance Profile
Intensive In-home Child and Adolescent Psychiatric Services
(IICAPS)**

| <u>Program Background</u> | |
|----------------------------------|---|
| <i>Purpose (BH)</i> | Reduce need to institutionalize children with serious psychiatric problems; decrease problem severity and increase functioning of child and family |
| <i>Target Population</i> | Children with a psychiatric diagnosis, exhibiting complex behavioral health needs, <u>and</u> either returning from or at imminent risk of out-of-home treatment |
| <i>Services</i> | Intensive, home-based treatment and interventions (e.g., individual/family/group therapy, psychiatric evaluation, case management, parent education/skill development, 24-hour crisis intervention, and aftercare) provided to child and family by clinical team for an average duration of 24 weeks, with actual length of service based on need; extensions possible with DCF approval |
| <i>Partners</i> | <ul style="list-style-type: none"> • 14 contracted providers with 18 total sites • Community-based agencies, individual clinicians, schools, courts/Judicial Branch that serve the target population and make referrals to IICAPS • Connecticut Behavioral Health Partnership/Department of Social Services (fee-for-service payments through KidCare/Medicaid) • Yale Child Study Center (consultation and evaluation for the IICAPS network) |
| <i>Outside Evaluation</i> | Considerable performance and outcome data are developed for the IICAPS program by an outside contractor, Yale Child Study Center. For an annual fee of about \$507,000 the Center: gives clinical and programmatic consultation and training to all providers; conducts an annual provider credentialing process; helps assure program model fidelity; maintains the IICAPS services database; and provides quarterly and year-end reports on performance and outcomes overall and by provider. |

I. How Much Did We Do?

Performance Measure 1: Clients Served



Trends: Numbers served increasing each year; Little change in wait list size (worse)

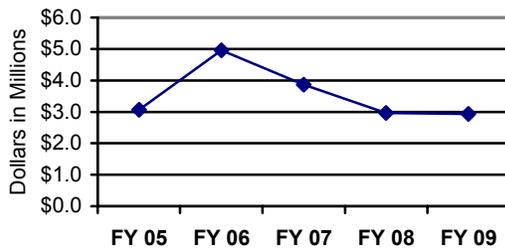
Over the past three years, total cases served more than doubled, growing from 714 to 1,595 (124%). New admissions increased at the same rate while service demand, as evidenced by wait list numbers, has been fairly steady (monthly average of about 140 to 200).

Program Performance Profile Intensive In-home Child and Adolescent Psychiatric Services (IICAPS)

Story Behind the Baseline: Substantial expansion of program capacity occurred with a shift from just DCF grant funding to participation in the fee-for-service system of the state’s managed behavioral health care program for children, the Connecticut Behavioral Health Partnership (BHP) beginning in FY 06. Client increases also are the result of recent contract agreements with the Court Support Services Division (CSSD) for IICAPS sites to provide services to juvenile justice system clients, many of whom are funded through BHP. The impacts of CSSD contracts and BHP funding on the program will be examined in more detail in the final report.

Performance Measure 2: Program Resources

DCF Expenditures for IICAPS



Trends: Recent DCF funding flat after steep drop (neutral)

During the past five years, DCF annual expenditures for the IICAPS program peaked at just under \$5 million and recently leveled off at about \$3 million. However, *DCF funding is only a small fraction of current program resources.* Services are eligible for Medicaid funding but data on those payments are not readily available.

Story Behind the Baseline: Initially, the main funding for IICAPS was through a DCF state grant program and a small amount of federal grant funds. Since FY 07, the bulk of IICAPS services are paid for with Medicaid monies through the state’s Behavioral Health Partnership. At the request of PRI staff, annual BHP expenditure data are being compiled by provider and overall and should be ready for inclusion in the final report.

II. How Well Did We Do It?

Data outlined below are being compiled or have been requested for presentation in the final report. Key items not available within the study timeframe will be added to the project’s Data Development Agenda.

Program Performance Measures

1. **How well demand for services is met**
 - a. Numbers of children on waiting list
 - b. Time on waiting list: DCF plans to develop and analyze this information in the near future, possibly in time for the final report
 - c. Referrals by source/status (e.g., DCF, Juvenile Courts, private clinician)

2. **Whether completion rates meet expectations**
 - a. Numbers and rates of planned discharges (completions)
 - b. Reasons for premature (unplanned) discharge

Program Performance Profile
**Intensive In-home Child and Adolescent Psychiatric Services
 (IICAPS)**

3. *Whether IICAPS service duration, intensity, and caseload criteria are met*
 - a. Length of service on average (24 weeks)
 - b. Client contact (e.g., portion of clients seen a minimum of 3 times per week);
 - c. Staff caseloads (IICAPS recommendation 8-9 per team)
 - d. Operating hours (i.e., 24-hour crisis intervention 52 weeks per year; in-home Monday – Friday, 9 a.m. – 8:00 p.m.)
4. *Whether IICAPS service timeframe criteria met*
 - a. Initial intake interview within 48 hours of referral
 - b. Complete service plan 30 days later
5. *Whether IICAPS clinical tools and data management criteria met*
 - a. Portion of providers using tools as required
 - b. Portion of providers with satisfactory data systems
6. *Whether staff have required qualifications, training, and supervision ,*
 - a. Portion of treatment teams met composition requirements (one clinician with a master’s degree and license, one mental health counselor with a bachelor’s degree)
 - b. Portion of staff that attend mandatory 15 hour training series
7. *Whether providers meet IICAPS credentialing standards*
 - a. Portion of providers fully credentialed
8. *Whether clients are satisfied with program services and operations*
9. *Whether providers are satisfied with administration of the program and the effectiveness of the IICAPS model:* PRI staff will collect input from program providers
10. *Per-client costs over time and in comparison to program alternatives*
11. *Whether performance on above measures varies among providers*

III. Is Anyone Better Off?

Data related to client outcome measures are being compiled for inclusion in the final report.

Program Performance Measures

1. Children will have reduced utilization of institutional care

For the IICAPS program, the Yale Child Study Center on behalf of DCF, collects, analyzes, and reports on: the numbers of admissions to inpatient/residential treatment and ED visits; the numbers of patients with admissions and visits; and the number of treatment days involved in those admissions and visits, both for the six months prior to IICAPS intervention and during the intervention. The data are reported by provider and overall. PRI staff is compiling this information for presentation in the final report.

Program Performance Profile
**Intensive In-home Child and Adolescent Psychiatric Services
 (IICAPS)**

2. *Children will have improved functioning and decreased problem severity*

To track improvement in child and family functioning, the Center uses a standardized, evidence-based assessment tool (the Ohio scales), which is administered at intake and at discharge, both planned and premature, to clients (parents, and children who are old enough be assessed on their own). The client’s clinical team also completes one aspect of the assessment. These data also will be compiled by PRI staff for the final report.

3. *Children are maintained safely at home*

The department does not routinely monitor measures of child safety and stability in protective services terms (i.e., reported abuse/neglect, repeat maltreatment or out-of-home placement rates other than psychiatric admissions) for IICAPS clients. PRI staff is working with the department to development information on the DCF status and abuse/neglect experience of children and families during their IICAPS intervention and for a period following program completion.

Follow Up Areas

- **Long duration:** Why is the average length of IICAPS services well above the model’s initial recommended duration and apparently increasing? What are the program cost and capacity implications?
- **Pooled funding:** What is the impact of the split funding sources (DCF grants, Medicaid fee-for-service through BHP) on accountability, capacity, and in promoting partnerships across agencies?
- **Impact on inpatient care:** Is IICAPS making a contribution to the larger population-level trend of more admissions by those under age 18 to inpatient psychiatric care but for shorter amounts of time? Could that have positive impacts on treatment access and costs overall?

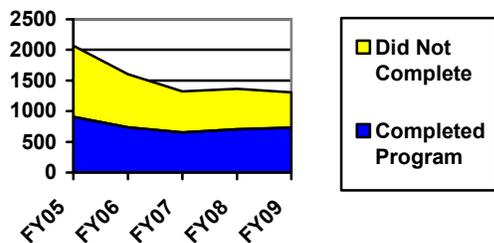
Program Performance Profile
Parent Aide

| <u>Program Background</u> | |
|----------------------------------|---|
| Purpose (BH) | Improve parenting and life skills to prevent repeat abuse / neglect |
| Target Population | Families with an open DCF abuse / neglect case at low to medium risk of out-of-home placement |
| Services | In-home visits to provide: parent education and skill-building; assistance with basic needs; and links to community services and supports, over two hours each week (minimum), for up to 17 weeks; worker is available 24 hours a day |
| Partners | <ul style="list-style-type: none"> • 24 contracted providers, including two municipalities and three hospitals (two providers work out of two area offices and 22 work out of a single area office) • Other community agencies that provide services through referrals from Parent Aide workers |
| Upcoming Changes | DCF is working with the contracted providers to redesign and combine Parent Aide and the smaller Parent Education and Assessment Services (given to families with DCF open cases whose children are young and at less risk for out-of-home placement) into a new parenting improvement program, Family Enrichment Services (FES). Currently implementation of the new program is set to begin November 1, 2009. |

I. How Much Did We Do?

The charts and analysis presented in this Performance Profile (and all others in this interim report) rely on the data given by providers to DCF. It appears that the data for at least a few programs, including Parent Aide, might not capture all clients served, based on a discrepancy between the number of clients included in the data, and the number of client slots funded by DCF. However, for Parent Aide, it is unclear whether the gap between clients included in the data and client slots reflects provider under-reporting. DCF reported in interviews that some Parent Aide providers are serving fewer clients than contracted due to excessively long service duration – a problem the department is attempting to resolve in its program redesign. This issue will be addressed further in the final report.

Performance Measure 1: Program Services Received



Trend: Total number served dropped from FY 05 to FY 07 and been stable since; Program completion rate has steadily improved (better)

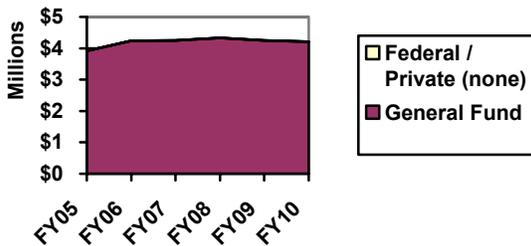
Providers reported that 1,306 DCF families began participation in Parent Aide in FY 09. Of these, about 56% completed the program. The completion rate has steadily increased since FY 05, when it was 44%. At the same time, since FY 07 the program has been seeing far fewer families.

Program Performance Profile Parent Aide

It should be noted that DCF funded 1,991 Parent Aide client slots in FY 09. The FY 09 Parent Aide data covers about 66% of that amount.

Story Behind the Baseline: Explanations for this chart's data trends will be included in the final report.

Performance Measure 2: Resources Used



Trend: Initial small increase, then flat (neutral)

The projected expenditures for FY 10 were \$4,211,987. Expenditures grew more than 8% in FY 06, from about \$3.9 million to \$4.2 million, but since then have held steady, with no changes greater than 2%. The General Fund covers all Parent Aide costs. (Note: The FY 10 amount was projected by DCF in August 2009.)

Story Behind the Baseline: DCF has not submitted any recent requests to change Parent Aide funding.

II. How Well Did We Do It?

With one exception (see 9. below), DCF does not routinely collect this type of data for the Parent Aide program; many of the items below were collected in the past (for the last time, in 2005) for the Juan F. consent decree resource allocation work (the PARA plan). DCF's Bureau of Quality Improvement collects other Parent Aide data monthly from providers (see 9. below and the next page). PRI staff plans to contact providers to determine whether they keep any of the data below, and if so, to request it for inclusion in the final report.

Program Performance Measures

1. **How well was client demand met**
 - a. Numbers of clients on Parent Aide waitlist

2. **Whether the Parent Aide service volume standards were met**
 - a. Two hours of face-to-face services provided weekly by Parent Aide worker
 - b. Maximum Parent Aide duration of 17 weeks
 - c. Monthly joint meetings to review progress with the Parent Aide worker and the DCF case worker

3. **Whether the Parent Aide service timeframe standards were met:** Time between –
 - a. Program intake and:
 - i. Initial home visit: One week
 - ii. Assessment and Individual Service Plan development: 30 business days
 - b. Termination:
 - iii. Notifies case worker five days before
 - iv. Sends case summary to DCF within 10 days after

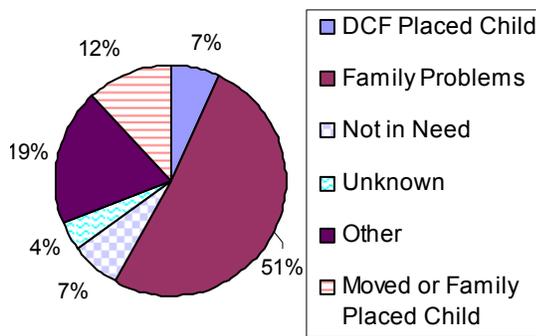
Program Performance Profile
Parent Aide

4. *Whether the Parent Aide staff was experienced and educationally qualified*
5. *Whether clients were satisfied with program services*
6. *The per-client cost of the program, compared to alternative options*
7. *Whether provider performance varied substantially (examining differences among contractors in 1-7 above)*

Additionally:

8. *Provider satisfaction*: PRI staff will collect data from providers regarding their satisfaction with DCF's administration of the program and the service model

9. Reasons Parent Aide Workers Give for Why Families Do Not Complete The Program



Trend: Stable FY 05-FY 09 (neutral; not shown because trend was stable); Difficulties working with families accounted for about half of non-completions

Difficulties working with families included: “family failed to engage,” “family not available for services,” family terminated services,” and “potential for violence too high to continue service.”

“Other” and “unknown” together account for nearly one-quarter of non-completions.

Story Behind the Baseline: Explanations for this chart's data trends will be included in the final report.

III. Is Anyone Better Off?

Program Performance Measures

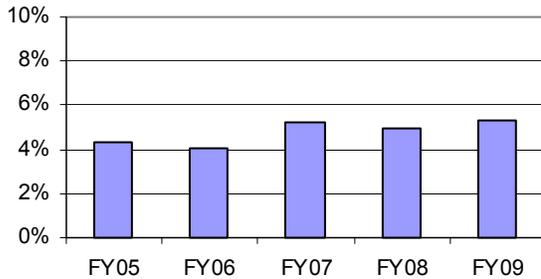
1. *Children are free from repeat maltreatment*
2. *Children remain in their homes (i.e., avoid out-of-home placement)*

DCF's Continuous Quality Improvement Bureau collects from providers repeat maltreatment and out-of-home placement data for Parent Aide families who are engaged in the program. Overall data is presented below.

As noted previously, the department does not track child welfare client outcomes, by program, on repeat maltreatment or out-of-home placement after the specific program services have ended. PRI staff is considering undertaking outcome analysis that examines the child welfare outcomes in the short- and long-term (e.g., six months and two years after program completion). If DCF and PRI staff time is insufficient to complete the analysis before the final report is due, then these items may be added to the Data Development Agenda.

Program Performance Profile
Parent Aide

Repeat Maltreatment

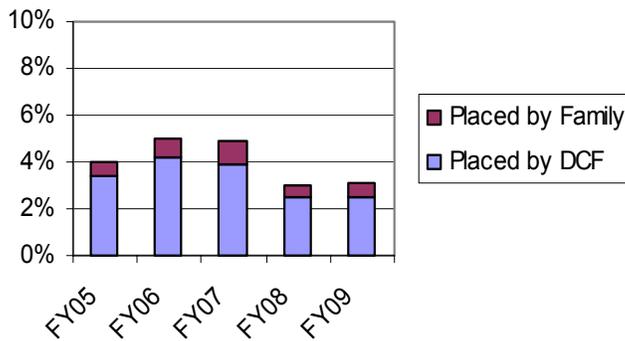


Trend: Generally stable – about 5% repeat maltreatment – after a small increase in FY 07 (neutral)

In FY 09, 5.3% of families reported to be receiving Parent Aide services had substantiated repeat maltreatment (69 of 1,306 families). The repeat maltreatment rate has hovered around 5% for the last three FYs.

Story Behind the Baseline: Explanations for this chart’s data trends will be included in the final report.

Out-of-Home Placement



Trend: Lower in last two years (better)

Of reported Parent Aide client families in FY 08 and FY 09, 2.5% had children placed out-of-home while receiving program services; another 0.5% voluntarily placed their children out-of-home. These rates are somewhat lower than in FY 05-FY 07.

Story Behind the Baseline: Explanations for this chart’s data trends will be included in the final report.

3. Family functioning is improved

The Parent Aide program does not use a family or head-of-household assessment that is standardized across providers. Consequently, there is no way to examine how families’ functioning has changed after receiving Parent Aide services.

The new Family Enrichment Services program that is replacing Parent Aide and a similar service will require providers to use a standardized assessment that DCF central office staff, DCF area office staff, and providers developed by drawing upon components of existing assessments. The assessment administered at program exit is being developed but will “mirror” the intake assessment. Therefore, changes in family functioning over the course of program services will be captured.

Program Performance Profile
Parent Aide

Follow-up Areas

- **Ensuring new data collection tool is useful:** Will the data collection tools for the new Family Enrichment Services include appropriate outcome measures and monitoring? PRI staff intends to check that this will happen.
- **Providers' Parent Aide client data reporting:** Are providers under-reporting client data to DCF? If so: 1) Why; 2) What has DCF done to improve provider reporting; and 3) What further steps could be taken to improve reporting? If not: Why are providers serving far fewer clients than they are funded to serve (e.g., excessively long service duration, as suggested by DCF)?
- **Comparison to other Parent Aide models:** How do Connecticut's Parent Aide program characteristics, completion rates, and outcomes compare to Parent Aide models used by other states? Are any of these models evidence-based? Will the new Family Enrichment Services program have the characteristics of the most effective models (if any such models are found)?

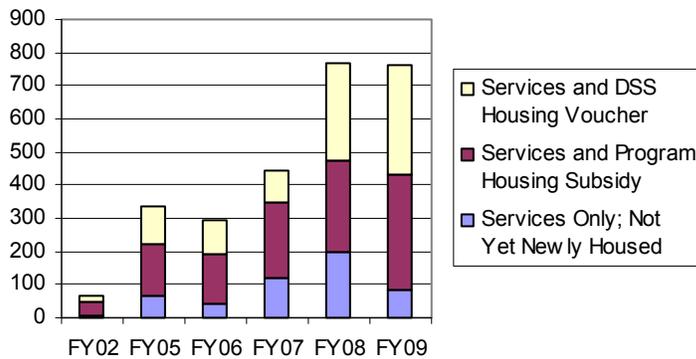
Program Performance Profile
Supportive Housing for Families (SHF)

| <u>Program Background</u> | |
|-----------------------------------|--|
| <i>Purpose (BH)</i> | Guide families through process of acquiring permanent, adequate housing and provide case management services to preserve and reunify those families |
| <i>Target Population</i> | Families with an open DCF abuse / neglect case either at risk of out-of-home placement due to housing or experiencing housing barrier to reunification |
| <i>Services</i> | Throughout program participation, meet with client family’s head of household at least once a week, for a minimum of one-hour, to provide: household management and parenting education, links to community services, links to education and employment resources, and crisis intervention. For housing aspect of program, provide: guidance with housing search and through DSS housing voucher (Section 8 voucher or Rental Assistance Program certificate) process, and access to program housing stipend if suitable new housing is found before DSS voucher is obtained. Services can last up to two years from program entrance (even after DCF case has closed), with the family’s SHF worker on-call 24 hours a day. |
| <i>Partners</i> | <ul style="list-style-type: none"> • One contracted provider and its 8 sub-contractors • Clients’ pre-SHF providers of services (e.g., substance abuse, mental health) • Community agencies that provide services through referrals from SHF workers • A team of University of Connecticut (UConn) faculty and graduate students on contract with the provider to conduct evaluations of SHF; FY 09 cost of \$38,937. |
| <i>Anticipated Changes</i> | <p>DCF reports current budget constraints are driving an effort to change the program – specifically, to vary program services based on client circumstances. The program relies on a supply of DSS housing vouchers to provide clients with permanent housing. When the supply of DSS vouchers is severely limited (as program managers report has been the case recently), clients with new housing rely on SHF housing subsidies, which come from program funds. Consequently, SHF has less money available to deliver program services and so needs to either serve far fewer people, or develop less costly ways to provide services.</p> <p>DCF and the contracted provider have been working to develop tiered services (e.g., clients with severe problems receive SHF as currently offered; clients with mild or moderate problems receive less intensive or different bundles of services). They are piloting a new client assessment tool that could help SHF workers assign clients to the appropriate tier.</p> |

Program Performance Profile Supportive Housing for Families (SHF)

I. How Much Did We Do?

Performance Measure 1a: Program Services Received – Services and New Housing



Trend: Families served are increasing

At the end of FY 09, 760 families were being served in SHF. Of these, about 89% had newly received stable housing through the program, while only 11% (a 5-year low) were just receiving services (i.e., had not yet been newly housed).

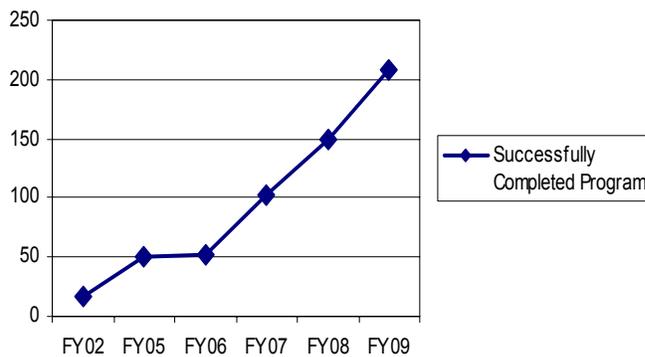
The number of clients being served at the end of the fiscal year has

grown unevenly in recent years. The program has clearly grown much larger since FY 02 (69 clients being served), the first year for which data was available. In FY 07 and FY 08, the client count grew by 52% and 72%, respectively, but it shrank a little in FY 06 and FY 09.

It is important to note that clients receive services for more than one year, so the same client families will be included across the annual counts (point-in-time or cumulative) of families being served. The program managers reported that 1,664 client families had been served (either completed the program, or did not) since the program’s inception (September 1998, through August 2009).

Story Behind the Baseline: Program staff note that the number of new clients (those most likely to be just receiving services – not yet newly housed) that can be served changes with how much SHF program funding and DSS housing funding is received. (See “Program Background” on previous page for more information.)

Performance Measure 1b: Program Services Received - Completion



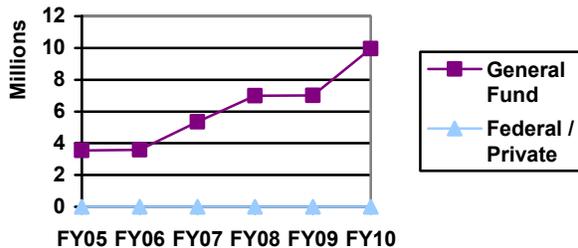
Trend: Increasing (neutral because lacks data on non-completers)

The number of SHF clients completing the program rose to a high of 209 in FY 09, a 40% rise over FY 08. The number of completers has increased substantially each year since FY 06.

Story Behind the Baseline: Data on non-completers has been requested and will be presented in the final report, along with further explanations of these data.

Program Performance Profile Supportive Housing for Families (SHF)

Performance Measure 2a: Resources Used – SHF Program Services



Trend: Increasing (neutral)

Program services expenditures grew by 30-50% in FYs 07, 08, and 10 (if projection was accurate – the FY 10 amount was projected by DCF in August 2009). There has been no federal or private funding of this part of SHF.

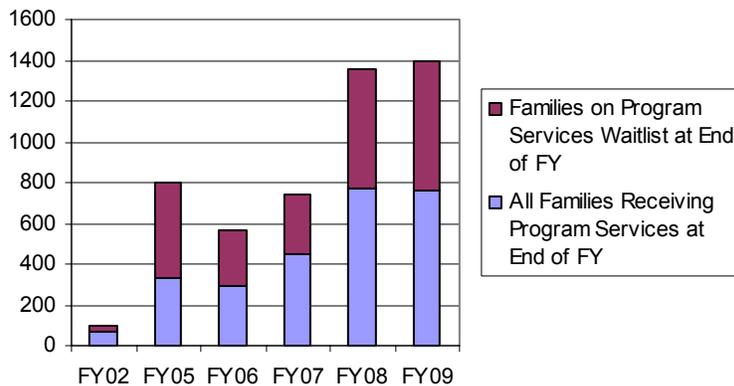
Story Behind the Baseline: Explanations for this chart’s data trends will be included in the final report. Preliminary research indicated DCF submitted one recent budget request pertaining to SHF. In January 2005 (for the FY 06-07 biennium), the department requested an additional amount – approximately \$2.4 million. It appears this request may have been partially granted.

Performance Measure 2b: Resources Used – DSS Housing Assistance

Data have been requested and will be included in the final report.

II. How Well Did We Do It?

Performance Measure 1: Met Demand for the Program



Trend: Fluctuating but consistently not meeting demand (worse)

Since at least FY 05, SHF consistently has had a long waitlist at the end of each FY. The length recently has ranged from a low of 274 families in FY 06 to a high of 632 in FY 09 – even though the program stopped accepting names for the waitlist three months before the end of the FY. As the graph shows, in several FYs, the number of families on the waitlist approaches the number of families who received services that year.

Story Behind the Baseline: The ability to meet demand for the program depends on two types of funding: 1) SHF program funding from DCF; and 2) Section 8 and RAP voucher spaces made available to SHF by DSS, which is determined by Section 8 and RAP voucher funding received by DSS.

Program Performance Profile
Supportive Housing for Families (SHF)

Additional Performance Measures

Data outlined below are being compiled or have been requested for presentation in the final report. Key items that are not available within the study timeframe will be added to the project's Data Development Agenda.

2. Waitlist

- a. How quickly referred clients moved off the program waitlist** to determine whether the lengthy point-in-time waitlist count (documented in Performance Measure 1 above) is reflective of a long delay between referral and program entry
- b. To what extent client families on the waitlist lost their eligibility for the program and whether negative results (repeat maltreatment and out-of-home placement) occurred while on the waitlist** to determine whether the stay on the waitlist is detrimental to DCF families

3. Whether the SHF service volume standards were met

- a. Minimum of one hour of face-to-face services during one visit provided weekly by SHF worker
- b. Maximum duration of two years of SHF program services

4. How quickly clients were newly housed: Program staff notes that although new housing is a key component of the program, sometimes a client family is not ready to take that step (e.g., needs to work on improving household management skills). In these cases, the SHF worker will intentionally wait to move forward with new housing.

5. To what extent, when, and why do clients end participation unsuccessfully

6. Whether clients were satisfied with program services

- a. Overall**
- b. Cultural competence:** This is a measure included in the contract, with a goal of 80% of clients being satisfied with the SHF worker's cultural competence.

7. The per-client cost of the program, compared to alternative options

8. Whether provider performance varied substantially (examining differences among contractors in 1-7 above)

Additionally:

- 9. Provider satisfaction:** PRI staff will collect data from providers regarding their satisfaction with DCF's administration of the program and with the effectiveness of the SHF model.

Program Performance Profile Supportive Housing for Families (SHF)

III. Is Anyone Better Off?

Program Performance Measures

1. *Children are free from repeat maltreatment*
2. *Children remain in their homes (i.e., avoid out-of-home placement) or are reunified with their families*

The SHF contractor collects data on these and other “better off” measures as of the client family’s program exit. The data are reported to DCF, whose SHF program lead reviews it. Some data already has been shared with PRI staff; it will be presented in the final report.

DCF does not regularly track child welfare client outcomes, by program, on repeat maltreatment or placement after program services have ended. PRI staff is considering undertaking outcome analysis that examines the child welfare outcomes in the short- and long-term (e.g., six months and two years after program completion). If DCF and PRI staff time is insufficient to complete the analysis before the final report is due, then these items may be added to the Data Development Agenda.

3. *Family functioning is improved*

Since 2006, SHF has used the North Carolina Family Assessment Scale – Reunification (NCFAS-R) for all client families at the beginning, middle (every six months), and end of program services. NCFAS measures caregiver and child well-being on a range of topics, including safety, health, environment, and family dynamics. Some NCFAS-R data has been obtained; key indicators will be presented in the final report.

4. *Families obtained better housing and remained there*

SHF collects this data as of program exit and has shared it with PRI staff. It will be presented in the final report.

The UConn evaluation team has an article in press for the *Children and Youth Services Review*. The article states that SHF clients’ housing permanency generally improved: 68% of families who began the program with temporary housing, ended with permanent housing, and 90% of client families who began the program with permanent housing, remained in it through the end of program participation. The evaluation did not track outcomes after program completion, on any measure.

5. *Caregivers’ employment status improved*

As above, the program collects this data as of program exit and has shared it with PRI staff. It will be presented in the final report.

The UConn evaluation team found that employment status improved over the course of the program. Full- and part-time employment increased, as did receipt of disability benefits, causing unemployment to drop from about 60% to 50%.

Program Performance Profile
Supportive Housing for Families (SHF)

Follow-up Areas

- **Agency partnership:** Has SHF has successfully created a partnership across agencies (DCF and DSS)?
- **Uneven supply of DSS housing assistance:** Is there a way to ensure a steadier supply of DSS housing assistance to SHF clients? In the absence of an adequate DSS voucher supply, what are the long-term feasibility implications of relying on program funds for housing subsidies? Are these implications impacted in a meaningful way by the anticipated program change of implementing tiered services?

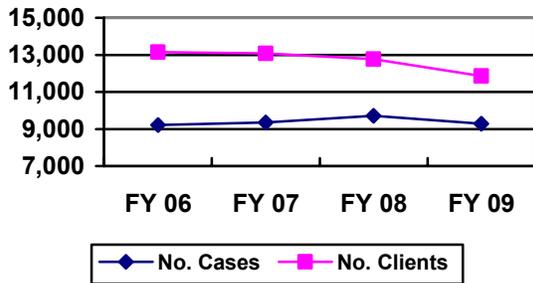
Program Performance Profile
Flexible Funding

| <u>Program Background</u> | |
|---|--|
| <i>Purpose (CW)</i> | Provide timely, individualized services and supports to prevent or delay out-of-home care or to facilitate return to home when other funding resources are absent |
| <i>Target Population</i> | Children and families involved in open DCF cases with urgent or specialized needs. Flexible funding is available for protective services (A/N) cases where children are at risk of removal from home, receiving in-home protective services, or in out-of-home placement, as well as for juvenile services cases and in certain cases where children and families are receiving only behavioral health services from the department (e.g., Voluntary Services). |
| <i>Services</i> | <p>Payment for goods and services requested by caseworkers (and approved by supervisors) that meet children’s needs and support family goals including:</p> <ul style="list-style-type: none"> • basic living items (food; clothing; emergency shelter; rent to avoid eviction; security deposits; heating/utility bills; critical home repairs; emergency housekeeping); • social/recreational programs; • mentoring and other supports; and • behavioral health treatment and evaluations. <p>Flexible Funding supplements services provided to DCF-involved families through other agency programs, including but not limited to Family Preservation and Support.</p> |
| <i>Partners</i> | <ul style="list-style-type: none"> • Statewide, hundreds of different community-based agencies, local programs, and individuals (including about 128 credentialed providers, see below) that DCF case workers hire and pay directly (with supervisor authorization/approval) to provide specialized supports and services to their clients |
| <i>Recent and Upcoming Changes</i> | <p>During FY 07, DCF established a credentialing process and fee schedule for eight categories of high-cost Flexible Funding services, including behavioral health assessments, various therapeutic and other supports, supervised visitation services. Together, spending for these credentialed categories account for about 30% of total Flex Funds expenditures.</p> <p>The Flexible Funding credentialing process is intended to formalize purchasing practices and provide better cost accountability. At present, it is administered by an outside contractor (Advanced Behavioral Health). Expansion to other costly or frequently used programs and services (e.g., summer camps, after school programs) is under consideration by the Flexible Funding Credentialing Committee, an internal DCF working group.</p> |

Program Performance Profile
Flexible Funding

I. How Much Did We Do?

Performance Measure 1. DCF Children and Families Served



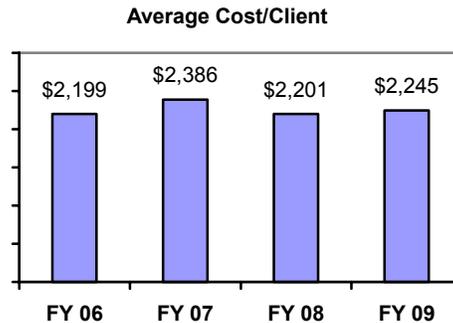
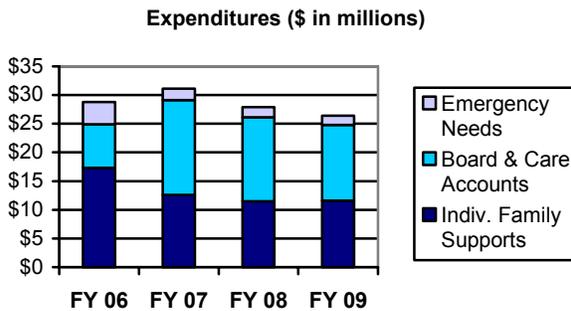
Trend: Recent, slight drop off

Since FY 06, over 9,000 DCF open cases per year, most involving multiple clients (i.e., family members - parent, child, siblings), have received Flex Funds.

Story Behind the Baseline: The department's use of Flexible fFunding was greatly expanded in recent years, in part to improve performance on the *Juan F. Consent*

Decree exit plan outcome measures. As a result, significant numbers of DCF clients, including most of the in-home services caseload, are provided with individualized goods and services paid for with flex funds. Recent drops in case and clients numbers are related to the cuts being made by the governor and legislature to all agency budgets in response to the state's current fiscal crisis (see Performance Measure 2, below).

Performance Measure 2. Program Resources



Trends: Decreasing overall expenditures; average costs relatively steady (neutral)

The department's Flexible Funding resources peaked at nearly \$29 million in FY 07 and have decreased each following year, by 10% and 5% respectively. On average, cost per client has experienced only small fluctuations, ranging from about \$2,200 to \$2,400 since FY 06.

Story Behind the Baseline: In response to recommendations from the DCF court monitor and national research findings, the legislature significantly increased Flexible Funding appropriations beginning in FY 05 as a way to improve the department's performance in meeting the needs of children and families in its care. Funding levels grew from about \$5 million in the early 2000s to annual expenditures of over \$25 million since FY 06. The current state budget crisis has resulted in spending reductions but resources allocated to Flexible Funding remain substantial.

Program Performance Profile Flexible Funding

By category, a relatively small portion of Flexible Funding (e.g., about 6 % in FY 09) is spent through the Emergency Needs Account, which includes basic necessities like food, clothing, and shelter-related expenses for families with children at risk of removal from home. The bulk of expenditures is discretionary spending on goods and services for cases with children in foster care or at risk of out-of-home placement (paid from agency's Board and Care Accounts) and for families receiving in-home protective services cases (paid from the Individual Family Supports Account). Data quality issues (because of staff coding errors related to Flexible Funding uses), however, limit the reliability of analysis of spending by category. Agency accounting changes instituted for Flexible Funding since FY 05 also complicate cost comparisons and analysis. PRI staff is considering ways the department may be able to develop useful program cost information for the final report.

It should be noted children and families can receive flexible funding through several other sources, not represented in these amounts, such as certain Judicial Branch/CSSD programs for juvenile offenders. There also is a small (about \$1.5 million) Flexible Funding account that can be used for children with certain behavioral health needs who *not* involved with DCF.

II. How Well Did We Do It?

Except for expenditure information, the department does not routinely collect program performance data about Flexible Funding.

The DCF Court Monitor's office twice examined and reported on the department's use of Flexible Funding (in 2004 and 2006) by analyzing data gathered from a random sample of 100 cases that involved requests for flexible funding. Information was collected through case record review and social worker interviews about: appropriateness of the requests (i.e., funds were necessary to support the case goals, the expenditure met identified needs); barriers to obtaining goods and services through alternative means; amounts, frequency, and types of requests; payment timeframes; and family participation in the process.

PRI staff will present certain data from the Court Monitor studies in the final report and will be considering whether this type of analysis can be replicated within the study timeframe or should be added to the Data Development Agenda.

Program Performance Measures

1. ***How well demand is met***
 - a. Flexible Funding requests and expenditures over time, by category and area office
2. ***Whether goods and services met identified case needs***
 - a. Portion of cases with evidence that funding clearly met needs/supported case goals
3. ***Whether flex funds were used when other sources of payment for goods and services were unavailable***
 - a. Portion of cases with documentation of obstacles to providing services through established DCF accounts or other state/community agencies
4. ***Whether costs were reasonable***
 - a. Flexible Funding costs compared payments under other programs for similar goods /services

Program Performance Profile
Flexible Funding

- b. Variation in costs for same goods/services across area offices
5. ***Whether area offices are consistent in using Flexible Funding***
 - a. Spending by category
 - b. Per-case and per-client costs
 - c. Use of credentialed providers as required
 - d. Compliance with authorization process
 - e. Client eligibility (e.g., DCF status, maximum amount)
 6. ***Whether staff are satisfied with program services and operations:*** PRI staff will obtain input from DCF area office directors and perhaps case workers
 7. ***Whether clients are satisfied with program services and operations***
 8. ***Whether providers are satisfied with administration of the program:*** PRI staff will gather input from providers

III. Is Anyone Better Off?

Data related to client outcome measures are being developed, as discussed below. Key information that remains unavailable within the study timeframe will be added to the project's data development and/or research agenda.

Challenges to examining whether DCF-involved children and families are better off because of Flexible Funding are many.

- First, Flexible Funding generally is provided for multiple purposes and in combination with other services, making it difficult to define and isolate the impact.
- Second, Flexible Funding itself is not a discrete, centrally managed program. Instead, within general policy guidelines, each area office sets its own priorities and operating procedures for administering its annual Flexible Funds allocation.
- Third, client and expenditure data are tracked through agency financial systems and any details about how Flexible Funding was used to address client needs must be gathered from individual case records, which are created and maintained by each social worker on DCF's automated data system (LINK).
- Fourth, the department acknowledges there are data quality problems regarding existing Flexible Funding information because of fairly extensive miscoding and data entry errors. Further, it is unclear to PRI staff at present whether the many expenditure categories currently used for Flex Funds are meaningful.
- Finally, based on studies conducted to date (including a 2004 independent evaluation of a Connecticut pilot flexible funds program for non-DCF children with behavioral health disorders), the research design required to determine flexible funding effectiveness is complex (e.g., random samples, control groups, sophisticated analysis) and likely costly.

Program Performance Profile Flexible Funding

The department is considering undertaking a scientific evaluation of flexible funding but is unsure when and if resources will be available for this purpose. PRI staff will be tracking this effort and include in the final report any progress made, as well as additional steps needed, toward developing the data outlined below.

Program Performance Measures

1. *Children are free from repeat maltreatment*
2. *Children remain in their homes (i.e., avoid out-of-home placement) or are reunified with their families*
3. *Child and family well-being is improved*

Follow Up Areas

- **Administrative efficiency:** Is there unnecessary duplication of effort (e.g., currently each office creates own payment control process) and more opportunity for centralizing certain functions (e.g., determining “reasonable costs” for non-credentialed services, creating payment control processes)?
- **Program oversight:** Are current levels adequate for effective quality assurance and improvement? At present, one staff person, who reports to a cross-agency committee, oversees all aspects, from monitoring trends in expenditures to conducting site visits of credentialed providers.
- **Data issues:** Why is an annual needs assessment to identify best uses for Flexible Funding (as called for by department policy) lacking? What can be done to improve overall data quality (e.g., address extensive Flexible Funding goods and services coding errors in LINK system and usefulness of expenditure categories)?
- **Information resources:** Do staff have access to good information about alternative payment sources for Flexible Funding goods and services (e.g., up-to-date inventory of community resources)? Are there adequate policies about checking for other resources?

Appendix

Agency Profile: Department of Children and Families

Agency Background

| | |
|--|--|
| Mission | To protect children, improve child and family well-being, and support and preserve families. |
| Mandates | <p>As the state’s consolidated children’s agency, responsible by statute for:</p> <ul style="list-style-type: none"> • Protective Services for any child at risk of abuse/neglect by a caregiver • Behavioral Health Services for all children under age 18 • Juvenile Justice Services for juvenile delinquents • Prevention Services related to child abuse/neglect, children’s mental illness and substance abuse, juvenile delinquency |
| Target Population | Children and families who have experienced or are at risk of abuse and neglect, behavioral health problems, and delinquency |
| Main Partners | <ul style="list-style-type: none"> • Other state and federal agencies serving children and their families • Community-based organizations including private service providers • Children and families in need of agency services and related advocacy groups |
| Federal Court Oversight of Child Welfare System | <p>Consent decree. A federal class action lawsuit (<i>Juan F.</i>) aimed at reforming Connecticut’s child welfare system was settled through a consent decree approved in 1991. DCF efforts to implement improvements mandated by the consent decree are overseen by an independent, full-time, court-appointed monitor. The increased attention and resources prompted by the consent decree resulted in a number of changes in agency operations over time, including lower caseloads, better information systems, and expanded community-based and in-home services for children and families involved with the department. However, after nearly a decade of court oversight, concerns continued over service quality and the ability of DCF to meet the needs of children in its care.</p> <p>Exit plan. Starting in 1999, a number of revisions to consent decree provisions and the monitoring process were negotiated to focus efforts on positive outcomes for DCF-involved children and families. In 2004, the monitor and the parties, with court approval, developed an exit plan that contains measurable outcomes and performance standards for: 1) achieving compliance with <i>Juan F.</i> consent decree provisions concerning child safety, permanency, and well-being; and 2) ending court oversight of DCF.</p> <p>To exit from the consent decree, the department must reach and maintain certain performance levels on 22 specific outcomes, which include, among others, set rates for repeat maltreatment, out-of-home placements, timely permanency through family reunification or alternatives, and meeting children’s individual needs.</p> <p>Status. The court monitor reports each quarter on DCF exit plan progress. The agency’s compliance status and findings from the most recent exit plan quarterly report are summarized under Selected Agency Performance Measures, below (p. 7).</p> |

PRI RESULTS BASED ACCOUNTABILITY PROJECT
Agency Profile
Department of Children and Families

| <u>Main DCF Activities</u> | |
|---|---|
| Agency-wide Client Services | How Much |
| <ul style="list-style-type: none"> • Casework with DCF-involved children and families provided by the agency's social work staff to achieve safety, permanency and well-being, including: <ul style="list-style-type: none"> ○ Assessment and treatment planning ○ Case management (arranging and coordinating care/services) ○ Counseling and referral | <p><i>Total FY 08 caseload (protective services): 17,525</i></p> <p><i>Social Worker caseload: 15-20 (maximum); 13 (est. average)</i></p> |
| <ul style="list-style-type: none"> • Education Services (K-12) provided through the DCF-operated school district (Unified School District II) to children in residential treatment (in state-operated and in some cases private facilities) | <p><i>Total students served: 913 (FY 08)</i></p> |
| <ul style="list-style-type: none"> • Medical Services to assure children in DCF care and custody receive optimal health care through case-specific consultation and oversight by central office resource staff (e.g., pediatrician, pediatric nurse practitioners, psychiatrist) | |
| <ul style="list-style-type: none"> • Ombudsman's Office activities, which involve receipt, investigation, and attempted resolutions of inquiries and complaints about department services from clients, providers, and the public | <p><i>Calls handled: 5,048 (CY 08)</i></p> |
| Child Protective Services | How Much (Total FY 09 Budget: \$464 million) |
| <ul style="list-style-type: none"> • Receive all reports of alleged abuse/neglect through 24-hour central Hotline; screen and refer to field staff (area offices) for investigation | <p><i>During FY 08 –</i> <i>Reports Received: 37,314</i> <i>Investigated: 24,429 (66%)</i></p> |
| <ul style="list-style-type: none"> • “Field Operations” – 14 DCF Area Offices conduct investigations to substantiate abuse/neglect; carry out casework to meet needs of children and families in open protective services cases | <p><i>Substantiated Cases: 6,639 (FY 08)</i> <i>(27% of Investigated)</i></p> |
| <ul style="list-style-type: none"> • When possible, provide supports and services to maintain children safely at home and strengthen families | <p><i>Families receiving in-home services: 4,010 (as of Sept. 08)</i></p> |
| <ul style="list-style-type: none"> • When safety and/or child's needs require out-of-home placement, provide care in least restrictive, most family-like setting including: <ul style="list-style-type: none"> ○ Foster families, private foster care and licensed relative care ○ Therapeutic Group Homes (TGHs) and other congregate care facilities (e.g., SAFE Homes) • Recruit, license, and support foster care providers | <p><i>During FY 08 –</i> <i>Foster Care: 3,112 children, on average</i> <i>Relative Care: 878 children</i> <i>273 beds in 54 TGHs</i> <i>178 beds in 15 SAFE Homes</i> <i>Licensed foster care providers: 3,312 (as of 7/1/08)</i></p> |

PRI RESULTS BASED ACCOUNTABILITY PROJECT
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| | |
|---|--|
| <ul style="list-style-type: none"> • When reunification with child’s family is not possible, establish another permanent home through: <ul style="list-style-type: none"> ○ Adoption ○ Subsidized Guardianship, which offers financial assistance to help relatives care for children as adoptive parents (but parental rights are not terminated) | <p><i>During FY 08 – Adoptions finalized: 634; 4,780 children received adoption subsidies Subsidized guardianships: 234 granted</i></p> |
| <ul style="list-style-type: none"> • Assist youth in DCF care to transition to adulthood successfully through specialized case management and supports (e.g., housing, educational, vocational assistance) | <p><i>800 youth in independent living programs (on average)</i></p> |
| Children’s Behavioral Health Services | How Much (Total FY 09 Budget: \$329 million) |
| <ul style="list-style-type: none"> • Provide appropriate mental health and substance abuse assessment, treatment and aftercare services to address the behavioral health needs of Connecticut children through: <ul style="list-style-type: none"> ○ Connecticut Community KidCare, a system of care model designed to enhance access to a full continuum of community-based, residential, and inpatient care, and deliver appropriate behavioral health services in the home or community whenever possible • With the Department of Social Services, manage publicly funded behavioral health services for children through the Connecticut Behavioral Health Partnership (BHP), with the assistance of an outside Administrative Services Organization (Value Options) | <p><i>549 children in residential treatment (Sept. 08)</i></p> <p><i>2,300 children served by intensive, in-home clinical services (Sept. 08 capacity)</i></p> |
| <ul style="list-style-type: none"> • Provide behavioral health services to children with serious mental health and substance abuse problems whose families are not DCF-involved (Voluntary Services) | <p><i>About 1,000 families served annually</i></p> |
| <ul style="list-style-type: none"> • Fund, license, and monitor a range of behavioral health services for DCF clients that are operated by contracted private program providers | |
| <ul style="list-style-type: none"> • Operate three state residential treatment facilities for children with behavioral health problems: <ul style="list-style-type: none"> ○ Riverview Psychiatric Hospital (98-bed inpatient facility for patients ages 5 -18) ○ High Meadows (42-bed intensive treatment facility for adolescent males usually with multiple problems; scheduled for closure in FY 10) ○ Connecticut Children’s Place (CCP) (54-bed residential diagnostic center for children and youth ages 10-18) | <p><i>During FY 08 – Riverview: 236 children served High Meadows: 95 children served (calendar yr. avg.) CCP: 117 children served</i></p> |

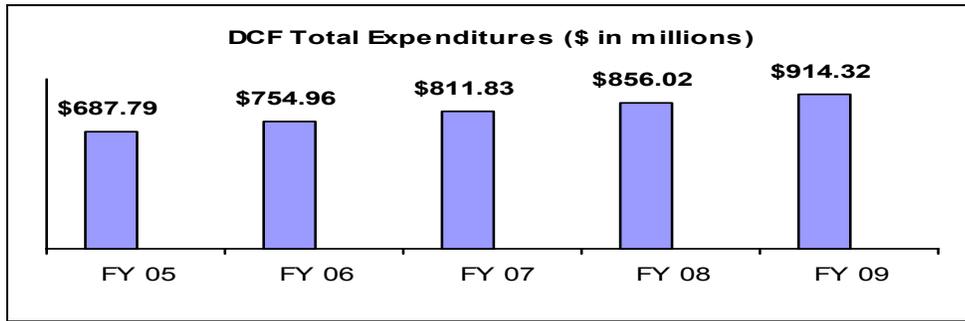
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| Juvenile Services | How Much (Total FY 09 Budget: \$71 million) |
|---|---|
| <ul style="list-style-type: none"> • Provide services for children involved in the juvenile justice system to help them successfully re-integrate into their communities while maintaining community safety through: <ul style="list-style-type: none"> ○ Secure residential treatment in state-operated facility for male delinquents, Connecticut Juvenile Training School (CJTS) ○ Contracted residential treatment programs for juveniles ○ Community-based services and supervision (juvenile parole) | <p><i>Annually serve about 1,200 committed delinquents</i></p> <p><i>During FY 08 – CJTS Admissions: about 200</i></p> <p><i>Parole: 628 children served (467 males; 161 females)</i></p> |
| Prevention Services | How Much (Total FY 09 Budget: \$6 million) |
| <ul style="list-style-type: none"> • Provide and fund a range of services to prevent or help children and families transition from DCF involvement and promote positive youth development, including: <ul style="list-style-type: none"> ○ Parent education and support ○ Early children intervention programs ○ Suicide prevention ○ Mentoring ○ Juvenile Review Boards ○ DCF-operated Wilderness School (outdoor program for troubled youth; closure in FY 10 recommended by governor) <p>Note: Another, separate agency, The Children's Trust Fund (CTF), funds and administers a number of state and federally funded primary prevention programs and initiatives aimed at preventing child abuse and neglect. CTF spending for child abuse prevention services totaled about \$16 million in FY 09 (estimated agency expenditures).</p> | <p><i>Wilderness School: 700 youths served annually</i></p> |
| Agency Management and Administration | How Much (Total FY 09 Budget: \$44 million) |
| <ul style="list-style-type: none"> • Support efficient and effective service delivery to DCF clients through a variety of central office functions including: <ul style="list-style-type: none"> ○ Fiscal Services (which encompasses contract management and information systems) ○ Human Resources ○ Legal Services ○ Quality assurance and improvement (which encompasses research and evaluation and the agency Training Academy that is responsible for workforce development/professional development) | <p><i>During FY 08 – Training Academy: 2,572 staff attended pre-service and/or in-service training sessions</i></p> |

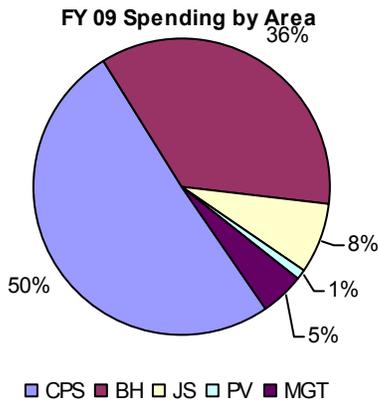
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Resources

- Total DCF expenditures reached over \$900 million in FY 09; adjusting for inflation, this represents a 20% increase over FY 05 spending.

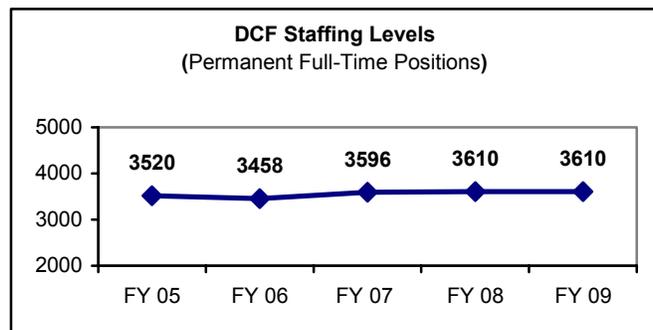


- General Fund monies account for at least 96% of the annual agency budget; DCF received between approximately \$17 million and \$26 million in federal funds per year over the past five years.



- The bulk of DCF spending – over 85% in FY 09 – is allocated to child protective services (CPS) and behavioral health (BH) budget areas.
- Much smaller portions are spent on juvenile services (JS) for the delinquent population and the agency’s prevention (PV) efforts (under 10% for both).
- Management expenses consistently are approximately 5% of the department’s total budget.

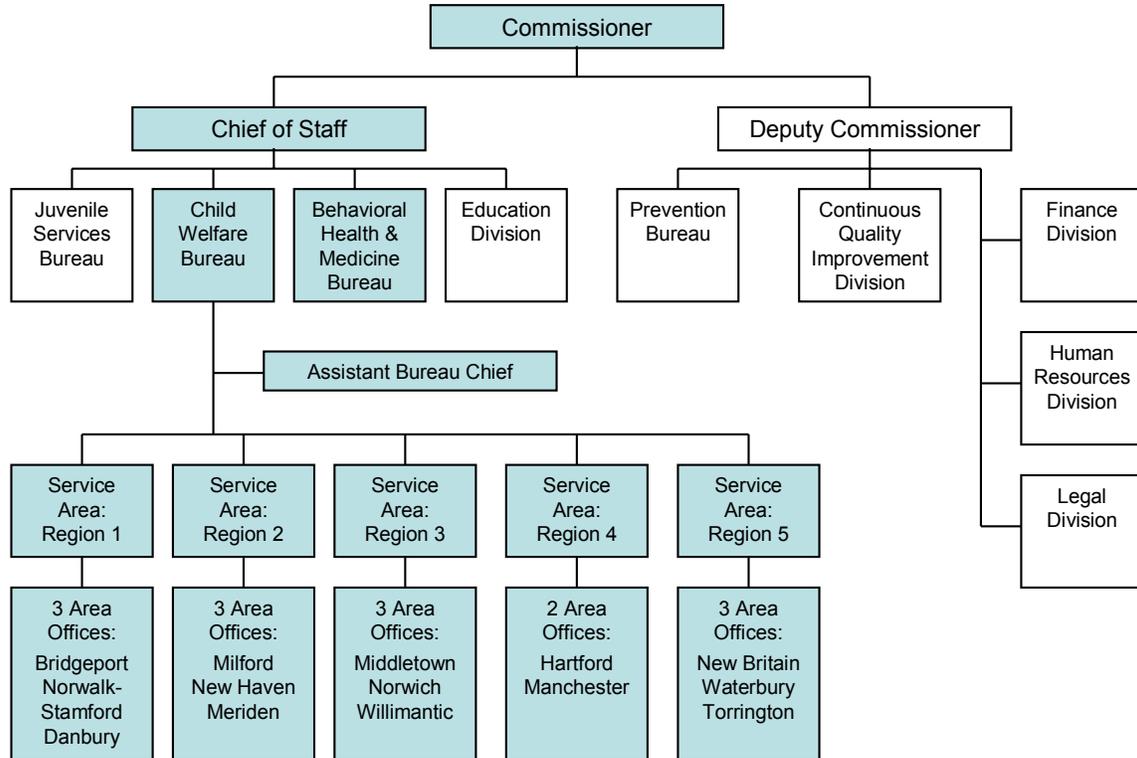
- DCF staff resources have remained relatively steady over the past five fiscal years at about 3,500 to 3,600 permanent full-time positions.
- In response to the state’s recent retirement incentive program, 169 DCF employees (nearly 5% of total full-time positions) from across the agency retired effective July 1, 2009.



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Organization

Department of Children and Families: August 2009*



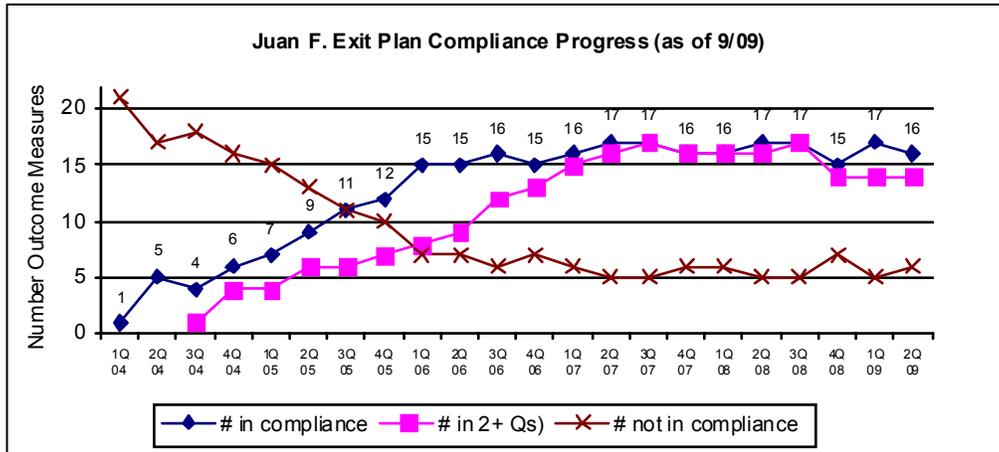
- Newly reorganized effective August 2009 (partly in response to personnel losses under the latest state Retirement Incentive Program)
- Bureaus consolidated (from 6 to 4); several offices and divisions realigned or combined
- 14 Area Offices now overseen by 5 new Service Area Directors
- New Assistant Child Welfare Bureau Chief position created to oversee central office protective services functions (e.g., Hotline, foster care and adoption, quality improvement)
- Quality improvement functions created within each bureau and service area; supplement existing Continuous Quality Improvement Division

**Shaded boxes indicate responsibility for Family Preservation and Supports*

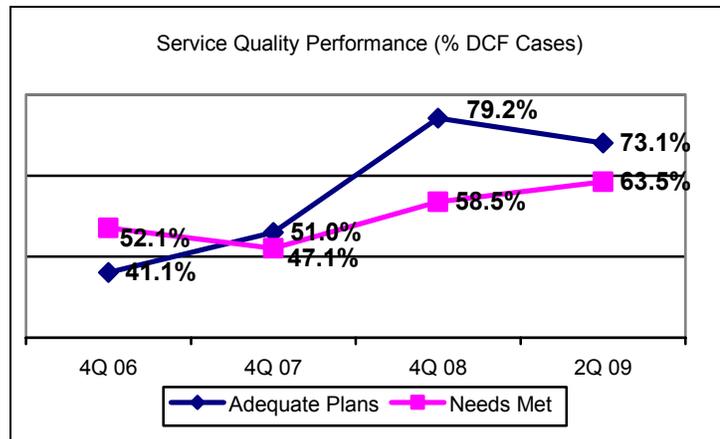
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Selected Agency Performance Measures

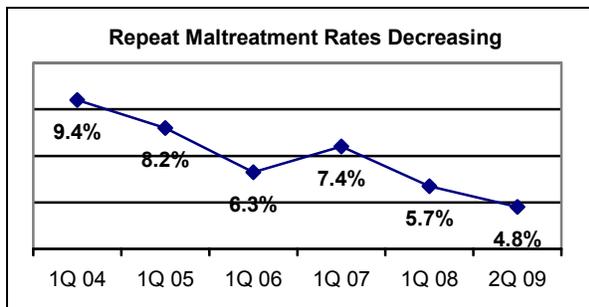
- Over the last three and half years, DCF has been in compliance with at least 15 and as many as 17 of the 22 exit plan outcome measures related to child safety, permanency, and well-being.*



- Performance on two exit plan outcome measures critical to quality services – **adequate treatment planning** and **meeting children's needs** – are improving but still well below targets ($\geq 90\%$ and $\geq 80\%$, respectively).
- As of June 2009, 73% of DCF protective services cases had adequate treatment plans and identified service needs were met in almost 64% of such cases.



Agency Performance Related to Family Preservation and Support Programs:



- Less repeat maltreatment: Rate dropped from over 9% to less than 5% (2004 - 2009)
- Fewer children in out-of-home care: 6,422 (Sept. 04) to 5,396 (Sept. 08)
- Fewer children in residential care: 889 (April 04) to 549 (Sept. 08)
- More in-home clinical services and supports: 2,300 capacity in 2009 from virtually none prior to 2005

* Compliance with all 22 outcomes measures must be maintained for at least two consecutive quarters before exit plan termination can be considered

