

*STATE OF CONNECTICUT*

# **Child Poverty and Prevention Council**

## **January 2008 Progress Report**

**For submission to the  
Honorable M. Jodi Rell, Governor**

**and members of the  
Appropriations Committee, Education Committee,  
Human Services Committee, Public Health Committee  
and Select Committee on Children of  
the Connecticut General Assembly**



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## I. EXECUTIVE SUMMARY

In June 2006, Governor Rell signed into law Public Act 06-179, An Act Concerning State Investment in Prevention and Child Poverty Reduction and the Merger of the State Prevention and Child Poverty Councils. This public act combined two councils -- the active Child Poverty Council and the inactive Prevention Council -- into one coordinated body. The purpose of the Child Poverty and Prevention Council is to:

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

As required by Connecticut General Statutes Section 4-67x, this annual report of the Child Poverty and Prevention Council contains:

- 1. A report on the progress made toward meeting the child poverty reduction goal and the extent to which state actions are in conformity with the plan.**

According to the most recent figures from the Current Population Survey, child poverty in Connecticut declined from 12.4% in 2005 to 10.3% in 2006. However, a more valid measure of child poverty is a three-year average which shows child poverty increasing slightly from 11.6% in 2003-2005 to 11.7% in 2004-2006. These figures represent all children in households with income below 100% of the federal poverty level.

Poverty among children below 200% of the federal poverty level remained level at 25.8% in both 2005 and 2006. A three-year average of children in households with income below 200% of the federal poverty level increased from 24.2% in 2003-2005 to 25.1% in 2004-2006.

In 2005, the Council released its ten-year plan to reduce child poverty by fifty percent in Connecticut. The report contains 67 recommendations organized under six major objectives: enhancing families' income and income-earning potential; helping low-income families build assets; enhancing affordability of healthcare, housing childcare, and early childhood education; supporting safety net programs for families with

multiple barriers; enhancing family structure and stability; and further study.

Previous annual reports from the council showed that 33 public policy actions were taken in 2005 implementing council recommendations and 39 actions were taken in 2006 implementing council recommendations. This report documents 40 public policy changes in 2007, including state budget increases and legislative changes, which implemented council recommendations. In all, state budget increases impacting children in poverty were well over half a billion dollars in FY08 alone.

Currently, the council is actively engaged in work to prioritize its 67 recommendations and focus its short-term efforts on a limited number of achievable proposals. This work has consisted of a five-step process, including: 1) selecting target populations; 2) bringing in a panel of national experts to review all 67 recommendations and offer consensus suggestions using national research and proven practices; 3) utilizing Results Based Accountability approach; 4) creating an economic model to assess which policies will reduce child poverty by 25-50%; and 5) developing a state grant and community model where 6 to 7 municipalities will work to decrease child poverty.

To-date, the council has completed the first two steps. Step One was establishing the following three target populations at the September 2007 meeting of the Child Poverty and Prevention Council:

- Birth to age five;
- Late teen and young adult (16-24)
- Working poor families.

On Friday, December 7, the Connecticut Child Poverty and Prevention Council completed Step Two by hosting a panel of national experts to discuss proven strategies to reduce child poverty. The panel offered recommendations to the council about which among the 67 recommendations have a sufficiently strong evidence base to support their potential effectiveness in reducing child poverty. The expert panel – which included two economists, two developmental psychologists and two policy analysts – scrutinized the council's recommendations based on three main criteria: evidence of impact, cost-effectiveness, and timeframe. They identified four major areas of policy and thirteen specific policies for which there is evidence to support their likely effectiveness in short-term child poverty reduction. In addition, they made one process recommendation. The four major areas of policy were: family income and income earnings potential, education, income safety net, and family

structure and support. The recommendations are described in Section V of the report and the experts' draft report is contained in Appendix C.

At the January 4, 2008 meeting, the Child Poverty and Prevention Council accepted the recommendations of the newly formed "grid working group" which identified priority issues to be further researched and developed. Acceptance of these recommendations by the Council is a first step toward identifying issues that can be considered for implementation in the near term, although some proposals will require additional evaluation before the council can make specific recommendations. The report of the "grid working group" is contained in Appendix F.

Step Three has been commenced by Charter Oak consultants, who will be assisting with Results Based Accountability (RBA) analysis.

Step Four will be started in early 2008 by issuing a Request for Proposals for economic modeling to evaluate the anticipated impact of the strategies adopted to reduce child poverty. It is anticipated that the January 2009 report of the Child Poverty and Prevention Council will contain the council's priority recommendations.

**2. A report on the state's progress in prioritizing expenditures in budgeted state agencies with membership on the council in order to fund prevention services;**

The report identifies measures for the Council's eleven prevention goals to provide a sense of where the state stands currently with regard to each goal:

- Increase access to stable and adequate housing;
- Increase the percentage of pregnant women and newborns who are healthy;
- Decrease the rate of child neglect and abuse;
- Increase the percentage of children who are ready for school at an appropriate age;
- Increase the percentage of children who: learn to read by third grade, succeed in school, graduate from high school, enter post-secondary education, and successfully obtain and maintain employment as adults;

- Decrease the percentage of children who are unsupervised after school;
- Reduce unhealthy behaviors among youth (e.g. teen pregnancy, smoking, auto accidents);
- Decrease the incidence of child and youth suicide;
- Decrease the incidence of juvenile crime;
- Increase the positive involvement of fathers with their children; and
- Encourage ongoing future leadership on child poverty and prevention issues.

The report also contains a copy of each state agency’s report on prevention services (see Appendix D). Each state agency represented on the Council provided a report on at least two prevention services provided by their agency. Prevention services are defined as “policies and programs that promote healthy, safe and productive lives and reduce the likelihood of crime, violence, substance abuse, illness, academic failure and other socially destructive behaviors”. The agency prevention programs described are:

<p><b>Children’s Trust Fund</b>  The Stranger You Know  Family Empowerment Initiative  The Help Me Grow Program  Kinship and Grandparent Respite Fund  Nurturing Families Network  The Parent Trust Fund  Shaken Baby Syndrome Prevention  Children’s Legal Services</p>	<p><b>Department of Developmental Services</b>  Family Supports  Birth to Three</p>
<p><b>Department of Children and Families</b>  Positive Youth Development Initiative  Youth Suicide Prevention  Shaken Baby Syndrome Prevention  Head Start Collaboration</p>	<p><b>Department of Public Health</b>  Asthma Program  Child Day Care  Community Health Centers  Family Planning Program  Immunization Program  Injury Prevention Program  Lead Poisoning Control  Newborn Screening  Obesity Prevention Program  Oral Health  Rape Crisis and Prevention Services  Tobacco Use Prevention and Control  Women Infants and Children</p>

	Youth Violence/Suicide Prevention
<b>Department of Education</b> Even Start Early Childhood/School Readiness	<b>Department of Social Services</b> Fatherhood Initiative Emergency Shelter for Victims of Domestic Violence Teen Pregnancy Prevention
<b>Department of Mental Health and Addiction Services</b> Best Practices Initiative Local Prevention Council Programs Prevention Framework Incentive Grant Youth Suicide Prevention Initiative Regional Action Councils Statewide Service Delivery Agents Tobacco Regulation and Compliance	<b>Office of Policy and Management</b> Delinquency Prevention Program

### 3. Examples of Successful Interagency Collaborations

The Council has identified the following examples of successful interagency collaborations to meet the child poverty and prevention goals. These initiatives include:

- Supportive Housing.** The Connecticut Supportive Housing Initiative is a collaboration between the Departments of Mental Health and Addiction Services (DMHAS), Social Services (DSS), Economic and Community Development (DECD), the Connecticut Housing Finance Authority (CHFA), and the Office of Policy and Management (OPM). Supportive housing is permanent affordable housing matched with a range of support services designed to break the cycle of homelessness. The purpose is to enable formerly homeless persons to achieve stability and maintain self-sufficiency in the community. After successfully completing a 300 unit demonstration program, the State embarked on the pilots initiative to create 650 supportive housing units, and then Governor Rell’s Next Steps initiative to create an additional 1000 units.
- Mental Health Transformation.** In response to the President’s New Freedom Commission on Mental Health and federal action agenda, Governor M. Jodi Rell charged 14 key state agencies and the Judicial Branch to transform all mental health services and associated systems to offer the state’s citizens an array of accessible services and supports that

are culturally responsive, person and family-centered, and have as their primary aim the promotion of resilience, recovery, and inclusion in community life. Connecticut intends the outcome of a successful transformation to be a recovery-oriented system of mental health care that will offer the State's citizens meaningful choices from among an array of effective services that will build on personal, family, and community assets, and will be offered in an integrated and coordinated fashion within the context of locally-based and managed systems of care, thereby ensuring continuity of care both over time and across agency boundaries.

- **Governor's Early Childhood Research and Policy Council.** The Governor's Early Childhood Research and Policy Council was established by Executive Order #13 of Governor M. Jodi Rell in February 2006 to engage leadership from the governmental, higher education, business, and philanthropic communities with regard to early childhood strategic planning and investment partnerships. The Council has 31 members appointed by the Governor and is co-chaired by three persons from the philanthropic community, the business community, and the education community.
- **Connecticut Birth to Three System.** Birth to Three, under Part C of the Individuals with Disabilities Education Act, was designed to be an interagency system since there is no one agency in any state that can meet all the needs of infants and toddlers with disabilities and their families. The exact design of each state's system is up to the state lead agency, as advised by the Interagency Coordinating Council which meets bi-monthly. In Connecticut, that Council includes representatives from: the Departments of Education, Social Services, Public Health, Children and Families; the Board of Education and Services for the Blind; the Office of Protection and Advocacy; the Commission on the Deaf and Hearing Impaired; parents, providers, legislators, and physicians.
- **Connecticut Youth Suicide Prevention Initiative.** In June 2006, DMHAS was one of eight states to receive funding from the federal Substance Abuse Mental Health Services Administration (SAMHSA)/Center for Mental Health Services (CMHS) to enhance suicide prevention efforts across the nation. Building on existing State agency collaborations, DMHAS established MOAs with the Depts. of Public Health, Children and Families (DCF), Social Services, and Education and the Judicial Branch to conduct the CT Youth Suicide Prevention Initiative (CYSPI). The Initiative builds on the recommendations of the Connecticut Interagency Suicide Prevention Network's 2005 Connecticut Comprehensive Suicide Prevention Plan, the Connecticut Youth Suicide Advisory Board, and the

CT Mental Health Transformation Initiative. Connecticut received the three-year, \$1.2 million CMHS grant to develop, implement, and evaluate comprehensive, evidence-based youth suicide prevention and early intervention strategies that may be sustained over time and expanded throughout the state.

- **Connecticut's Strategic Prevention Framework Initiative.** Connecticut's Strategic Prevention Framework State Incentive Grant (CT SPF) is a five-year cooperative agreement with SAMHSA's Center for Substance Abuse Prevention administered by the Department of Mental Health and Addiction Services. DMHAS through the Governor's office, has been designated the lead role to establish a governance structure, including a SPF SIG Advisory Committee (SSAC) to guide the CT SPF, as well as a State Epidemiological Workgroup (SEW) to assess substance use and consequences at the State level. With these entities, DMHAS developed a State Strategic Prevention Plan to guide and support State and community-level interventions. The involvement of State agencies and key stakeholders is a crucial aspect of the CT SPF. The Advisory Committee comprises representatives from the CT Departments of Children and Families, Public Health, Corrections, Education, and Transportation, Office of Policy Management, Court Support Services, DEA, academics, law enforcement agencies, and community providers/coalitions including the lead agency for the OJJDP-funded underage drinking initiative and experts on multiculturalism. Twenty eight coalitions statewide have been funded to mobilize and build prevention capacity and infrastructure in order to prevent the onset and reduce the progression of underage drinking and related problems in Connecticut communities.

## II. BACKGROUND

### A. State Prevention Council

The State Prevention Council was created under Public Act 01-121, An Act Concerning Crime Prevention and a State Prevention Council, to evaluate and promote prevention work in the State of Connecticut. In essence, the mandate was to establish a prevention framework for the state, develop a comprehensive state-wide prevention plan, offer recommendations to better coordinate existing and future prevention expenditures across state agencies and increase fiscal accountability.

The Council met regularly to ensure that the requirements of the public act were implemented in a comprehensive manner. The membership of the Council included representatives from the Office of Policy and Management, the Chief Court Administrator, and the Commissioners of the departments of Children and Families, Education, Mental Health and Addiction Services, Mental Retardation, Public Health and Social Services.

One of the main tasks of the Prevention Council was the development of a statewide prevention plan. The Council conducted research, analysis and deliberated extensively during the planning and development phase of the plan. The plan included four major recommendations that served to advance formation of comprehensive approaches for prevention within the state. The recommendations were to:

- increase public awareness of the value of prevention
- strengthen state and local networks involved in prevention
- improve data collection on prevention programs
- share and implement best practices

The Council felt that these recommendations, when implemented, would provide the Council with the information and tools necessary to effectively evaluate and analyze prevention initiatives in the state and set priorities for future prevention programming. The State Prevention Plan was submitted to the General Assembly in 2003.

As stipulated in the public act, the Governor's Budget for the 2003-2005 Biennium included a prevention report with recommendations for appropriations for primary prevention services administered by state agencies

that served on the State Prevention Council. The report was released in February 2003.

In 2003, the legislature enacted Public Act 03-145, An Act Concerning the State Prevention Council and Investment Priorities, which required the Council to continue its work to foster the development and implementation of a comprehensive and coordinated statewide system of prevention in Connecticut. In January 2004, the Prevention Council's progress report was submitted to the General Assembly. This report highlighted statewide prevention initiatives within the policy domains of Early Childhood Development and Youth Development and its relationship to the four recommendations.

In accordance with the stipulations set forth in the public act, the Council submitted its final prevention report in March 2004. The report highlighted the accomplishments and outcomes for statewide prevention initiatives.

## **B. Child Poverty Council**

In the Spring of 2004, the Connecticut legislature enacted Public Act 04-238, An Act Concerning Child Poverty establishing a Child Poverty Council. The Council was charged with recommending strategies to reduce child poverty in the State of Connecticut by fifty percent (50%) within ten years.

The legislation required that the Council consist of the following members or their designees: the Secretary of the Office of Policy and Management; the President Pro Tempore of the Senate; the Speaker of the House of Representatives; the Minority Leader of the Senate and the Minority Leader of the House of Representatives; Commissioners of the Department of Children and Families, Education, Higher Education, Labor, Mental Health and Addiction Services, Mental Retardation, Public Health, Social Services, Corrections, Transportation, Economic and Community Development, Health Care Access; the Child Advocate, the chair of the State Prevention Council, the Executive Director of the Children's Trust Fund, and the Executive Director of the Commission on Children.

The Council engaged in numerous strategies to gather the appropriate data to assist in the formation of its recommendations and presented its first report to the Legislature in January 2004. The report contained 67 recommendations to reduce child poverty in Connecticut by fifty percent over a ten year period. The recommendations were organized under six major objectives:

- enhance families' income and income-earning potential;
- help low income families build assets;

- enhance affordable health care, housing, child care and early childhood education;
- support safety net programs for families with multiple barriers;
- enhance family structure stability; and
- further study child poverty issues and solutions.

In July 2005, the legislature enacted Public Act 05-244, An Act Concerning the Implementation of the Recommendations of the Child Poverty Council. This public act made the executive director of the Commission on Human Rights and Opportunities a member of the Child Poverty Council and required the Council to meet at least twice a year to review and coordinate state agency efforts to meet the goal of reducing child poverty by 50% by June 30, 2014. The Council's annual implementation reports to the legislative committees included progress made toward meeting this goal. The Council continued its work to develop strategies to implement, monitor and report on the implementation of the recommendations.

A number of the Council's recommendations were proposed by Governor Rell and enacted by the legislature in FY 2006-07 and, in January 2006, the Child Poverty Council submitted a report on progress made towards the implementation of the plan to meet the child poverty reduction goal and the extent to which state actions were in conformity with the plan.

### **C. Child Poverty and Prevention Council**

In June 2006, the Connecticut legislature enacted Public Act 06-179, An Act Concerning State Investments in Prevention and Child Poverty Reduction and the Merger of the State Prevention and Child Poverty Councils.

This public act requires the newly formed Child Poverty and Prevention Council to adhere to provisions of the previous councils and imposes additional responsibilities relating to prevention services. The Child Poverty and Prevention Council is comprised of members of both the Child Poverty Council and the State Prevention Councils. In 2006, the Chief Court Administrator was added to the Council.

The public act directs the Child Poverty and Prevention Council to:

- Establish prevention goals and recommendations and measure prevention service outcomes to promote the health and well-being of children and their families.

- Report to the Governor and various legislative committees on the state's progress in prioritizing expenditures for prevention services in budgeted state agencies with membership on the council including:
  - Summarizing measurable gains made toward the child poverty and prevention goals established by the Council.
  - Providing examples of successful interagency collaborations to meet the child poverty and prevention goals established by the Council.
  - Recommending prevention investment and budget priorities.

The public act also requires each state agency with membership on the council that provides prevention services to children and families to submit an agency prevention report to the Council which must be included in the Council's report to the Governor and legislature. Each agency report must include at least two prevention programs.

#### **D. Inventory**

In order to identify existing programs in Connecticut that address child poverty, the Council developed a statewide inventory in 2004. The Council developed and disseminated an inventory questionnaire to fifteen (15) state agencies to gather data on existing statewide programs that serve children and their families in the area of poverty prevention, self-sufficiency programs focused on lifting people out of poverty and/or programs that provide support services for people in poverty.

The Child Poverty Inventory is a comprehensive list of statewide programs that provide assistance to people in poverty or at risk of falling into poverty. Not all of these programs have a specific mandate to address poverty, but they may have a positive impact on lifting families and children out of poverty. This inventory will be updated for the 2009 Progress Report.

In FY 2004, the State of Connecticut funded eighty-one (81) statewide programs that provided assistance to people in poverty or at risk of falling into poverty. In FY 2004, the State allocated nearly \$2.4 billion that includes a combination of federal (\$1,089,770,825), state (\$1,278,927,574) and private (\$26,108,394) funding.

The Child Poverty Inventory is organized by agency and the programs are categorized under each agency by program types. The program types are listed under the following categories:

- Prevention (19 Programs)
- Self-Sufficiency (19 Programs)
- Support for people in poverty (43 Programs)

Of the \$2.3 billion in state funding, 31% funded prevention and self-sufficiency programs in FY 04 and 69% funded programs to provide support for people in poverty. Seventy one percent of programs are funded through the Department of Social Services, Public Health and Education. The remaining 29% is divided among the following departments: Higher Education, Mental Health and Addiction Services, Children Trust's Fund, Children and Families, Mental Retardation, Labor, Correction, and Economic and Community Development.

#### **E. Website**

The Child Poverty and Prevention Council webpage, which contains the 2005 Initial Child Poverty Plan and the 2006 and 2007 Progress Reports, is on the State of Connecticut, Office of Policy and Management Home page. The website address is:

[http://www.ct.gov/opm/cwp/view.asp?a=2997&Q=383356&opmNav\\_GID=1809](http://www.ct.gov/opm/cwp/view.asp?a=2997&Q=383356&opmNav_GID=1809)



### III. PROGRESS REPORT

This section of the report describes progress made to-date in implementing the Council's child poverty and prevention recommendations and the extent to which state actions are in conformance with the plan.

#### **Child Poverty Measures**

The Council's child poverty goal is to reduce poverty among children in Connecticut by 50% over ten years. When the Council's ten-year plan was released in 2005, the most up-to-date figures on child poverty were based on 2003 figures. Currently, the most recent figures are based on 2006 data.

The Council is focusing on reducing child poverty both among families below 100% of the federal poverty level (\$16,600 for a family of three in 2006) and families below 200% of the federal poverty level (\$33,200 for a family of three in 2006).

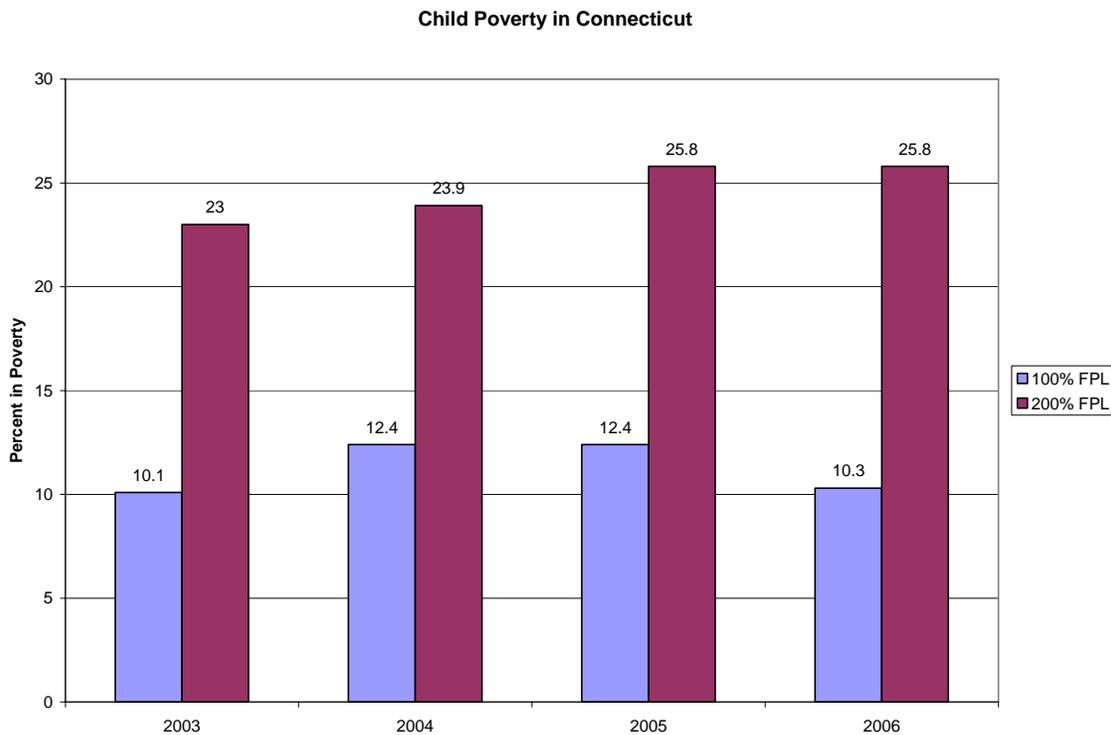
To measure the child poverty rate in Connecticut, the Council uses findings from the Current Population Survey (CPS) produced by the U.S. Census Bureau. Although the American Community Survey (ACS) uses a larger sample than the Current Population Survey (CPS), it does not produce data on 200% of the federal poverty level, so CPS data is used by the Council to measure the number of children living in families with income below 200% of the federal poverty level. The CPS is a monthly survey of households conducted by the U.S. Census Bureau for the Bureau of Labor Statistics. Using a sample of 60,000 households nationwide, the CPS collects basic labor force data by telephone and personal interviews.

Using these sources, the child poverty rate in Connecticut has been:

- In 2003, 10.1% of Connecticut children in households with income under 100% FPL and 23% of Connecticut children in households with income under 200% FPL;
- In 2004, 12.4% of Connecticut children in households with income under 100% FPL and 23.9% of Connecticut children in households with income under 200% FPL; and

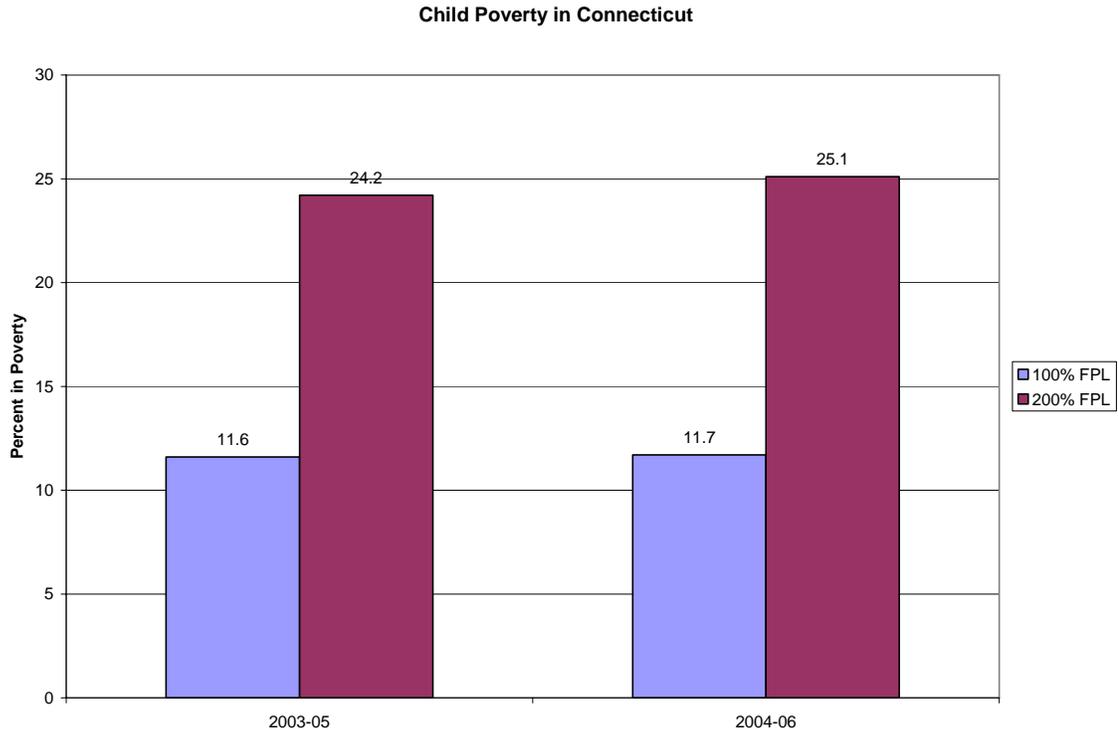
- In 2005, 12.4% of Connecticut children in households with income under 100% FPL and 25.8% of Connecticut children in households with income under 200% FPL
- In 2006, 10.3% of Connecticut children in households with income under 100% FPL and 25.8% of Connecticut children in households with income under 200% FPL.

The chart below graphically shows the child poverty rate in Connecticut.



Due to the small sample size of the Current Population Survey, a somewhat more useful measure is the three-year average of poverty. The chart below shows that the three year average for children living in poverty slightly increased for both 100% FPL and 200% FPL between the years of 2003-2005

and 2004-2006.



While this slight increase in the child poverty rate is of concern, many of the recommendations of the Child Poverty Council have either been recently implemented or will be implemented in the near future and will likely have a positive impact on the state’s child poverty rate in the years ahead. Annual progress reports by the Child Poverty Council will continue to use census data to track trends and progress toward meeting the child poverty reduction goal.

One of the major strengths of the Child Poverty Council has been the development of strong partnerships with several state agencies, the legislative branch and non-governmental agencies working towards the development of an effective, comprehensive plan of action to reduce child poverty in the state by 50% over the next ten years.

#### 2007 LEGISLATIVE SESSION

The 2007 legislative session saw dramatic changes that will result in significantly improved opportunities for Connecticut’s most disadvantaged children. These initiatives are designed to provide a long term solution to child poverty, by increasing the chances that poor children can stay healthy and achieve the skills and capabilities necessary for admission into post-secondary education and the

workforce. The state budget includes significant new funding to increase the state's investment in improving the lives of low income children. These major initiatives include:

**Early Childhood Education Initiative.** The adopted state budget adds about \$36 million over the biennium for Governor Rell's Early Childhood Initiative. This includes additional preschool slots, a comprehensive data registry for all preschool centers, increased reimbursement to achieve quality results, and expanded eligibility for the state's Birth to Three Program.

**Governor's Education Initiative.** The adopted state budget provides an historic increase in the state's share of education funding and is expected to have a significant impact on student achievement. It includes increases to Charter Schools, OPEN Choice, Magnets Schools and the Education Cost Sharing (ECS) grant and establishes a new accountability system, all of which add \$193 million in FY 08 and \$268 million in FY 09.

**Health Care.** The budget and bills such as PA 07-185 and PA 07-2, JSS, significantly enhance access to health care for low income individuals. Among the provisions are those that: increase Medicaid rates to improve access, expand eligibility for HUSKY A coverage for caretaker relatives and pregnant women, require automatic enrollment of uninsured newborns in HUSKY, requires DSS to expand HUSKY outreach, creates a planning entity, extends to age 26 the age to which insurance policies that cover children must do so, and establishes the Governor's Charter Oak Health Plan to insure the uninsured. Over \$300 million is provided in the first year of the biennium.

**Juvenile Jurisdiction.** Public Act 07-4, JSS, extends the juvenile justice system and the Families with Service Needs (FWSN) program to include 16 and 17 year olds as of January 1, 2009. This major initiative will improve the ability of youth involved with the justice system to move toward productive and stable lives as young adults. To begin the process, the Judicial Branch's budget receives over \$24 million during the biennium for court-involved juveniles. When fully annualized, costs will exceed \$100 million.

The positive response by the Governor and the legislature to the recommendations of the Child Poverty Council -- demonstrated by major investments and significant contributions made by the state in the past three years to address child poverty -- is a very encouraging beginning for the Child Poverty Council.

The Council believes that its recommendations should continue to be a high priority for decision-making during upcoming legislative sessions. By providing

some new resources and, as importantly, targeting existing resources and providing a coordinated framework, Connecticut has a real opportunity to reduce child poverty in the short and long term.

Below is a list of the Council's goals with a brief description of the actions taken in 2007 by the state to implement the plan.

### Council Goal: Reduce the number of children living in poverty in the state by fifty percent

- **Welfare Reform.** Public Act 07-160, based on recommendations of the legislative Program Review and Investigations Committee, expands eligibility to the state's safety program to include individuals who have not been sanctioned off Temporary Family Assistance (TFA). The act also provides Work Investment Boards access to records containing salary information for purposes of evaluating the Jobs First Employment Services program.
- **Increase Benefit Payments.** The adopted state budget includes an additional \$4.1 million in FY 08 and \$8.2 million in FY 09 to provide a cost of living adjustment (COLA) under the Temporary Family Assistance (TFA) and State Administered General Assistance (SAGA) programs.
- **Individual Development Accounts.** The adopted state budget provides \$100,000 in FY 08 and \$350,000 in FY 09 for Individual Development Accounts (IDA's) which are match savings accounts that assist low-income wage earners to save money to purchase specific allowable assets.
- **Urban Youth Employment.** The adopted state budget provides \$5 million in each year of the biennium for the Connecticut Youth Employment Program.
- **Nursing and Allied Health Workforce.** The budget includes \$375,000 in FY 08 and FY 09 for initiatives to address nursing and allied health workforce shortages.
- **Nursing Student Loan Forgiveness.** The budget includes \$125,000 in both FY 08 and FY 09 for nursing student loan forgiveness.
- **Study of a State Earned Income Tax Credit.** Public Act 07-1, JSS, Section 133 requires the Office of Legislative Research to conduct a study concerning a state earned income tax credit and submit the study to the

Governor and legislature by February 1, 2008. The study will include (1) the number of residents whose income, as a result of a state earned income tax credit, would rise above the federal poverty level, (2) the impact of such credit on local economies, including the amount of money received from such credit that is spent in economically distressed neighborhoods, (3) the effect of such credit on the state's labor force participation, (4) the effect of such credit on members of the armed forces of the United States, and (5) the effect of such credit on children in low-income families.

#### Council Goal: Increase access to health care

- **HUSKY Enrollment for Newborns and School Children.** Governor Rell's initiative to ensure health insurance coverage for all children in Connecticut requires DSS (PA 07-185 §4 and PA 07-2, JSS) to implement Medicaid presumptive eligibility for any uninsured newborn born in a Connecticut or border state hospital when (1) the parent or caretaker relative with whom the child resides lives in the state and (2) that relative authorizes the enrollment. It also requires that any uninsured child born in a Connecticut hospital or border state hospital be enrolled in HUSKY B under an expedited process, provided the same two conditions above are met. It requires the DSS commissioner to pay the first four months of the premiums that the family would otherwise have to pay if the children were already enrolled in HUSKY B. The budget bill contains \$10 million in FY 08 and \$17 million in FY 09 for these initiatives.
- **HUSKY Outreach.** This Governor's initiative (PA 07-185 §§ 8 & 9) requires DSS to increase outreach and maximize enrollment of eligible children and adults in the HUSKY programs. The budget contains \$1 million annually for enhanced HUSKY outreach.
- **Dependent Children Coverage Extension.** This act (PA 07-2, JSS §§ 64, 65 & 69) raises, from age 22 to 25, the age to which group comprehensive and individual health insurance policies that cover children must do so. The act extends coverage to full-time students at accredited out-of-state colleges and universities and children who live out-of-state with a custodial parent pursuant to a court order. It makes both the group and individual policy coverage provisions effective January 1, 2009.
- **HUSKY Adults Income Limit.** Legislation (PA 07-185, § 3 – AAC the HealthFirst Connecticut and Healthy Kids Initiatives) increases, from 150% to 185% of the FPL (from \$ 25,755 to \$ 31,764 annually for a family of

three in 2007) the income limit for parents of children enrolled in the HUSKY A program. This will add an additional 9,700 clients to the program when fully annualized, at a cost of \$17 million in FY 08 and \$22.7 million in FY 09. The budget bill contains these amounts.

- **Establish Charter Oak Health Plan.** The adopted state budget provides funding for the Governor's Charter Oak Health Plan initiative to provide access to health care for uninsured adults. A total of \$2 million in FY 08 and \$11 million in FY 09 is provided to design and implement the program effective July 1, 2008.
- **Primary Care Case Management.** Legislation (PA 07-2, JSS, § 16) requires DSS, no later than November 1, 2007, to develop a plan to implement a pilot PCCM program for at least 1,000 people who are otherwise eligible for HUSKY A benefits. Primary care providers participating in the pilot must provide primary medical care services to enrollees and arrange for specialty care as needed. The bill defines PCCM as a system of care in which the health care services for program beneficiaries are coordinated by a primary care provider chosen by or assigned to the enrollee. Currently, all HUSKY A beneficiaries are enrolled in managed care organizations that coordinate care, to some extent, and bear the full medical risk. The adopted state budget contains \$2.5 million in both FY 08 and FY 09 to develop this pilot.
- **Services for Medically Fragile Children.** The adopted state budget funds an additional 20 "Katie Beckett waiver" slots. The waiver presently serves 180 children. The budget contains \$800,000 in both FY 08 and FY 09 for this expansion.
- **Increased Medicaid Rates.** The adopted state budget contains \$104 million in FY 08 and \$135 million in FY 09 for Medicaid and HUSKY rate increases for acute care hospitals, chronic disease hospitals, FQHCs, physicians, clinics, dental services, vision, personal care attendants, and managed care companies. This funding will help children gain access to needed medical services.
- **Increased HUSKY Dental Rates.** In addition to the increases above, the adopted state budget provides \$20 million in each year of the biennium for increased dental rates for services provided to children enrolled in HUSKY.
- **CARES Program.** The adopted state budget provided for \$395,000 in funding appropriated to DSS for the purposes of Child and Adolescent Rapid Emergency Stabilization Services to be available for expenditure

during FY 08. These services are designed to assist children with behavioral health problems that present themselves in hospital emergency departments.

- **Disease Management.** The adopted state budget provides \$1.5 million in both years of the biennium to improve health outcomes and prevent or manage chronic diseases such as hypertension, obesity, diabetes, and asthma.
- **Statewide Electronic Health Information Technology Plan.** The human services implementer (PA 07-2, JSS, § 68) requires DPH, in consultation with OHCA and within available appropriations, to contract for the development of a statewide health information technology plan. The statewide plan must include (1) general standards and protocols for health information exchange; (2) electronic data standards to facilitate the development of a statewide, integrated electronic health information system for use by health care providers and institutions funded by the state, including standards (a) on security, privacy, data content, structures and format, vocabulary and transmission protocols, (b) for compatibility with any national data standards in order to allow for interstate interoperability, (c) permitting the collection of health information in a standard electronic format, and (d) for compatibility with the requirements for an electronic health information system; and (3) pilot programs for health information exchange and the projected costs and sources of funding. The adopted budget includes \$750,000 in FY 08 from the FY 07 surplus for this initiative.
- **Connecticut Health Information Network Plan.** The human services implementer (PA 07-2, JSS § 66) authorizes DPH and the UConn Health Center, within available appropriations, to develop a Connecticut Health Information Network (CHIN) plan. The plan must (1) include research in and describe existing health and human services data; (2) inventory the various health and human services data aggregation initiatives currently underway; (3) include a framework and options for implementing CHIN, including query functionality to get aggregate data on the state's key health indicators; (4) identify and comply with confidentiality, security, and privacy standards; and (5) include a detailed cost estimate for implementation and potential funding sources. The budget contains \$500,000 in each year of the biennium to design and implement CHIN.
- **Premium Assistance.** Public Act 07-2, JSS, incorporates Governor Rell's proposed legislation to allow DSS to assist HUSKY A clients with enrollment in their employers' health plans by developing a "wrap-around" program that will coordinate coverage between Medicaid and the

employer-sponsored insurance, assuring no loss of benefits or additional expense for the client. The adopted budget contains \$500,000 in FY 08 for this program.

- **Lead Poisoning Prevention and Remediation.** Among other provisions, the human services implementer (PA 07-2, JSS § 47 - 60) requires primary care providers (e. g. , physicians and advanced practice registered nurses) other than hospital emergency departments, to screen annually for lead every child between nine and 35 months old. The bill requires primary care providers also to conduct annual lead risk assessments for children ages three up to six. By law, health care institutions and clinical laboratories must notify the DPH commissioner and appropriate local health official within 48 hours of receiving or completing a report on a person with a lead level of 10 or more  $\mu\text{g}/\text{dL}$  of blood or other abnormal bodily lead level. The act requires them also to report the results within 48 hours to the health care provider who ordered the test. It requires this health care provider to make reasonable efforts to notify parents or guardians of the test result for a child under age three. The provider must do this within 72 hours of learning the test results. The bill requires individual and group health insurance policies to cover the bill's lead screening and risk assessments mandates. The requirement applies to Connecticut policies delivered, issued for delivery, amended, renewed, or continued on or after January 1, 2009.

#### Council Goal: Increase access to stable and adequate housing

- **Rental Assistance Program.** Governor Rell recommended annualizing \$1.8 million in the Rental Assistance Program (RAP) that in FY 07 had been funded with FY 06 carry forward dollars. The final budget annualizes the \$1.8 million as proposed by the Governor and provides \$4.25 million for additional RAP certificates in each year of the biennium.
- **Supportive Housing.** Governor Rell provided funding in her budget to provide housing subsidies and supportive services for an additional 125 individuals or families in FY 08 and another 50 in FY 09. The final budget added \$3 million in capital costs for housing development.
- **Affordable Housing.** The adopted budget provides funding in the amount of \$4 million in FY 08 from the anticipated surplus for Home CT.

Council Goal: Increase the percentage of pregnant women and newborns who are healthy

- **HUSKY Coverage for Pregnant Women.** Legislation (PA 07-185 AAC the HealthFirst Connecticut and Healthy Kids Initiatives as amended by PA 07-2, JSS, AA Implementing the Provisions of the Budget Concerning Human Services and Public Health § 9) increases the income limit for HUSKY A coverage for pregnant women from 185% to 250% of the FPL (\$ 2,852 per month for two-person household). The budget bill contains \$3.5 million in each year of the biennium to expand this coverage.
- **Support for Pregnant Women and Children under SAGA.** The adopted state budget provides \$2 million in each year of the biennium for federally qualified health centers in the State Administered General Assistance program to support medical care for un-reimbursable services for pregnant women and children.
- **Expand eligibility for Birth to Three.** Governor Rell proposed expanding the state's Birth to Three program by restoring eligibility for very low birth weight newborns (less than 1000g or 28 weeks gestation), children with significant delays in speech and biological risk factors, and expanding eligibility for children with mild or unilateral hearing loss. The adopted state budget contains \$913,507 in FY 08 and \$2.2 million in FY 09 for this initiative.

Council goal: Decrease the rate of child neglect and abuse.

- **Nurturing Families Network Expansion.** Governor Rell's budget contained \$2 million in FY 08 and FY 09 to fully annualize this program which provides intensive home visiting for new parents that are at high risk of child abuse and neglect. The final adopted state budget contains this funding as well.
- **Adding annualized funding of \$60 million to DCF.** The Governor's budget continued important program expansions to fully annualize initiatives including new group homes, expansion of intensive in-home services, establishment of intensive reunification services, increased support for multidisciplinary teams and child advocacy centers as well as expansion of the prevention-related early childhood consultation program. The final adopted state budget contains \$60 million for these efforts.

- **Additional funding of \$6 million to fund new DCF programs.** Governor Rell's budget contained funding for new initiatives including expansion of emergency mobile psychiatric services and intensive in-home services which are cornerstone programs of DCF's community behavioral health services, and increased foster care family recruitment and support. The final adopted state budget has new programming of \$6 million which also includes a Safe Harbor Respite program, a Safe Havens media campaign and diapers for needy families.

Council goal: Increase the percentage of children who are ready for school at an appropriate age.

- **Governor's Early Childhood Initiative.** The FY 2008 - 2009 Biennial Budget includes significant new funding to increase the state's investment in preschool for low income children. The budget provides for additional preschool slots over the two years of the biennium, which adds about \$6.5 million in FY2008 and \$21.5 million in FY2009. Because of the practical limitations of physical facilities and workforce, in the beginning, there will be a mix of grants to existing accredited preschool providers that have vacancies and to a limited degree, new facilities. Funding also includes \$4 million over the biennium to support the physical construction of 4,000 slots and \$600,000 over the biennium to provided assistance in space expansion development. \$3 million in FY2008 and \$2.5 million in FY2009 is recommended to create a comprehensive data registry for all of the preschool centers, along with a quality rating scale for parents and caregivers. Additional funding is not limited to the Department of Education's budget and debt service but spans three other agencies. Nearly \$4.5 million over the biennium is included for the additional cost of providing School Readiness level reimbursement for Child Development Center slots in the Department of Social Services budget and nearly \$2.2 million over the biennium for the Birth to Three Program in the Department of Developmental Services, which will restore eligibility for very low birth weight children, for children with significant delays in speech and biological risk factors and for children with mild or unilateral hearing loss. Also, \$500,000 is being added over the biennium for collaborative support and development of Early Childhood Education programs in the Department of Higher Education. All totaled, the adopted budget adds about \$36 million over the biennium for Governor Rell's Early Childhood Initiative. These investments in Connecticut's children's education will ensure that the achievement gap narrows significantly and that Connecticut's children will continue to lead the nation in academic achievement.

Council goal: Increase the percentage of children who: learn to read by third grade, succeed in school, graduate from high school, enter post-secondary education, and successfully obtain and maintain employment as adults.

- **Governor's Education Initiative.** The FY2007 - 2009 Biennial Budget significantly increases the state's share of education funding and is expected to have a significant impact on student achievement. It includes increases to Charter Schools, OPEN Choice, Magnet Schools and the Education Cost Sharing (ECS) grant and establishes a new accountability system, all of which add \$193 million in FY2008 and \$268 million in FY2009. The budget changes the Education Cost Sharing formula so that the foundation will increase from its current level of \$5,891 to \$9,687 over time; the mastery weight is eliminated; the poverty measure is changed from its current Temporary Family Assistance count that was frozen with 1997 data to the Title I count; the poverty weight is changed from 25% to 33%; the Limited English Proficiency weight is increased from its current level of 10% to 15%; the State Guaranteed Wealth Level is increased from its current level of 1.55 to 1.75; the Minimum Aid Ratio is increased from its current level of 6% to 9%, except for Priority School Districts, which will be 13%; provides that each town will receive an increase of at least 4.4% over their prior year grant; and starts to phase out the double counting of magnet school students in the formula in FY2009. It also provides that towns may use a portion of the increased ECS aid for tax relief. The budget changes the Charter Schools grant from its current level of \$8,000 to \$8,650 in FY2008 and to \$9,300 in FY2009. These changes add \$3.4 million to the budget in FY2008 and \$6.4 million in FY2009. Also, the budget changes the Magnet Schools grant so that in FY2011, at the end of a four-year phase-in, the per pupil grant for host-operated and RESC-operated magnet schools where a single district has greater than 55% of the enrollment will increase from its current level of \$5,301 to \$8,158 and the per pupil grant for RESC-operated magnet schools where no single district has greater than 55% of the enrollment will increase from its current level of \$6,500 to \$8,741. Also, no student shall be denied enrollment in a magnet school if there is space available. These changes add \$4.3 million to the budget in FY2008 and \$8.5 million in FY2009. By the end of the four year phase in, the budget will have increased by \$17 million. Finally, the budget increases the OPEN Choice grant in FY2008 so that the per pupil grant for transportation will increase from its current level of \$2,100 to \$3,250, the per pupil grant for the receiving district will

increase from its current level of \$2,000 to \$2,500, the student bonus pool will increase from its current level of \$350,000 to \$500,000 and there will be additional middle and high school support and the summer school program will be expanded. These changes add \$4.4 million to the budget in FY2008.

**Council Goals:** Decrease the percentage of children who are unsupervised after school, reduce unhealthy behaviors among youth, and decrease the incidence of child and youth suicide.

- **Urban Youth Violence Grant.** Governor Rell's budget provided \$4 million for competitive grants to non-profits and municipalities to reduce urban violence. Grants will support programs and services for children aged 12-18, including mentoring; tutoring and enrichment programs; social and cultural activities; athletic and recreational opportunities; training in problem solving, decision making and conflict resolution; and peer counseling. The adopted state budget contains \$1 million for this purpose.
- **Hartford Youth Project.** Governor Rell's budget contained \$325,000 to reflect the pickup with state funds of partial support for the Hartford Youth Project. This project works with adolescents between the ages of 10 to 17 who struggle with substance abuse problems. Services include: early identification of youth in need of substance abuse treatment; links to programs; educating parents, community leaders, and schools about substance abuse among teens; and provision of information about new treatment approaches. The final state budget contains this funding.

**Council Goal:** Decrease the incidence of juvenile crime

- **Juvenile Jurisdiction.** PA 07-4 June Special Session extends the juvenile justice system and the Families with Service Needs (FWSN) program to include 16 and 17 year olds as of January 1, 2009. To begin the process, the following funding is provided in the Judicial Department's budget for court-involved juveniles:
  - \$3.5 million each year for Families with Service Need (FWSN) Diversion to provide families with the services they need, judges with alternatives to detention and 4 positions to administer the programs,

- 11 positions and approximately \$900,000 each year for CSSD to enhance mental health and education services for court-involved juveniles,
  - 20 positions and \$5 million in FY08 and 70 positions and \$10 million in FY09 to provide juvenile probation officers and services to support the juvenile jurisdiction change. PA07-4 June Special Session changes the definition of child from 16 to 18 years of age effective January 1, 2010. These funds are needed to transition and have programs available to meet the effective date.
  - 11 positions and \$600,000 in FY09 for court staff to support the juvenile jurisdiction change. Included are 5 new judges effective April 1, 2009.
- **Boys and Girls Club Programming.** Governor Rell's recommended budget included \$325,000 in FY 09 to expand Boys & Girls Club programming for boys at or discharged from the Connecticut Juvenile Training School. The adopted state budget contains funding in both FY 08 and FY 09 for this initiative.

Council Goal: Increase the positive involvement of fathers with their children

- **Child Support Enforcement.** Public Act 07-247, a DSS legislative proposal, makes changes in state law to conform with child support provisions in the federal Deficit Reduction Act of 2005.
- **Committee on Strengthening Families.** An ad hoc committee with diverse representation from advocacy groups, communities, and three branches of state government has been established to develop recommendations.

Council Goal: Encourage ongoing future leadership on child poverty and prevention issues

- **Prevention Budget.** Public Act 07-47 extends state agency and gubernatorial reporting requirements related to child poverty and prevention.

## IV. EXAMPLES OF SUCCESSFUL INTERAGENCY COLLABORATIONS

As models for the state to follow, the Child Poverty and Prevention Council has identified the following examples of successful interagency collaborations:

- Supportive Housing
- Mental Health Transformation Grant
- Governor's Early Childhood Research and Policy Council
- Connecticut Birth to Three System
- Connecticut Strategic Prevention Framework Initiative
- Connecticut Youth Suicide Prevention Initiative

A brief description of each initiative is included below.

### **Connecticut Supportive Housing Initiative**

Back in the early 1990's, Connecticut, like most other states, was struggling with a growing homelessness problem. The solutions the state had been using up until that point – emergency shelters and housing affordability strategies – were not working. Many of the people experiencing homelessness had mental health, physical health, or substance abuse problems which inhibited their ability to maintain housing, even when a rental subsidy was provided. As a result, they were cycling in and out of expensive acute care facilities, which was costly in terms of tax dollars as well as human lives.

State leaders knew they needed a different approach. Under the leadership of the State Office of Policy and Management (OPM), the State of Connecticut teamed up with a national non-profit organization - the Corporation for Supportive Housing (CSH) - to pilot a unique solution called supportive housing. Supportive housing is permanent affordable housing matched with a range of support services designed to break the cycle of homelessness. The purpose is to enable formerly homeless persons to achieve stability and maintain self-sufficiency in the community. After successfully completing a small demonstration program, the State embarked on the Supportive Housing Pilots Initiative to create 650 supportive housing units in 2001 and then Governor Rell's Next Steps Supportive Housing initiative to create 500 additional supportive housing units was authorized and funded in 2005.

The collaboration was accomplished by bringing together five state agencies – OPM, the Department of Mental Health and Addiction Services, the Department

of Social Services, the Department of Economic and Community Development, and the Connecticut Housing Finance Authority – to coordinate funding for the housing and the supportive services. Each agency put resources on the table and worked together to develop a plan and policies for the program and a common request for proposals. This model is embodied in several working documents that can serve as templates for other communities. These include a memorandum of understanding that outlines the commitments and roles of the agencies; and the joint request for proposals that outlines quality standards and the funding process.

The Supportive Housing Pilots Initiative is significant both for its local impact as well as its national replicability. The Supportive Housing Pilots Initiative has:

- Proven to be an effective approach to ending homelessness. Hundreds of men, women and children who had been chronically homeless are now stably housed and connected to needed social, mental health, health, education services. Tenants are going back to school, reconnecting with family, getting jobs, and paying taxes.
- Saved the state significant dollars that would have been otherwise spent on crisis approaches to care, institutionalization and repetitive short term treatment. Our experience has been that the average Medicaid reimbursement for inpatient services per tenant dropped 71% from \$15,000 to \$4,500. Supportive housing is a cost-effective approach.
- Laid a foundation for future initiatives by putting into place an interagency mechanism for funding, developing a base of over 40 nonprofit providers statewide with experience in supportive housing creation, and expanding the reach of supportive housing to 30 communities. Last year the State authorized funding for an additional 500 supportive units through a new program built on these components.
- Positively impacted local communities by rehabbing rundown housing. And in other communities, formerly homeless individuals and families are integrated into apartment buildings seamlessly and successfully.

### **Mental Health Transformation Grant**

In response to the President's New Freedom Commission on Mental Health and recently released federal action agenda, Governor M. Jodi Rell has charged 14 key state agencies and the Judicial Branch to transform all mental health services and associated systems to offer the state's citizens an array of accessible services and supports that are culturally responsive, person and family-centered, and

have as their primary aim the promotion of resilience, recovery, and inclusion in community life.

Connecticut intends the outcome of a successful transformation to be a recovery-oriented system of mental health care that will offer the State's citizens meaningful choices from among an array of effective services that will build on personal, family, and community assets, and will be offered in an integrated and coordinated fashion within the context of locally-based and managed systems of care, thereby ensuring continuity of care both over time and across agency boundaries.

There are six major components to the proposed transformation efforts, consistent with the six goals recommended by the New Freedom Commission. These are: 1) Connecticut's citizens will understand that mental health is essential to overall health and will treat it with the same urgency as physical health, 2) mental health care will be person and family-driven and oriented to promoting resilience and recovery, 3) disparities in mental health care that are based on culture, ethnicity, race, or gender will be eliminated so that all citizens will be able to participate equally in the promise of recovery, 4) early mental health screening, assessment, and referral to services will become common practice, 5) excellent mental health care, supported by research, will be provided, and 6) technology will be used to increase access to care and information. In addition to these, Connecticut has added an additional goal of workforce transformation.

### **Governor's Early Childhood Research and Policy Council**

The Governor's Early Childhood Research and Policy Council was established by Executive Order #13 of Governor M. Jodi Rell to engage leadership from the governmental, higher education, business, and philanthropic communities with regard to early childhood strategic planning and investment partnerships. The Council has 31 members appointed by the Governor and is co-chaired by three persons from the philanthropic community, the business community, and the education community.

The Governor established the Council in February 2006 in recognition that early education success, beginning with readiness for Kindergarten, predicts later academic success and that investment in high-quality early childhood education results in a robust return.

The Council is charged with:

- a. Advising the Early Childhood Education Cabinet, established pursuant to Public Act 05-245, on research findings, policy solutions and strategic financing opportunities related to investments in early childhood initiatives;
- b. Recommending ways to build and support a network of early childhood researchers across Connecticut’s education systems, including academic scholars at business and other professional schools;
- c. Engaging Connecticut’s academic researchers in design of a longitudinal study of children’s development and reviewing existing research that evaluates early childhood programs;
- d. Examining, from a business perspective, possible strategies to increase the efficiency and effectiveness of Connecticut’s early care and education “industry”; and
- e. Proposing addition “return on investment” studies necessary to evaluate and support early childhood care and education, quality improvement and expansion.

**Connecticut Birth to Three System**

Birth to Three, under Part C of the Individuals with Disabilities Education Act, was designed to be an interagency system since there is no one agency in any state that can meet all the needs of infants and toddlers with disabilities and their families. The exact design of each state’s system is up to the state lead agency, as advised by the Interagency Coordinating Council which meets bi-monthly. In Connecticut, that Council includes representatives from:

- Department of Education (both preschool education and the coordinator of programs for homeless children)
- Department of Social Services
- Department of Public Health
- Department of Children and Families
- Department of Developmental Services
- Board of Education and Services for the Blind
- Office of Protection and Advocacy
- Commission on the Deaf and Hearing Impaired

Others on the Council include parents, providers, legislators, and physicians

As the lead agency for the system, DMR has interagency agreements with the following agencies and topics

Agency	Scope of Agreement
Education	Clarifies child find and transition responsibilities of Birth to Three vs. local Boards of Education. There is

	also a separate agreement related to the training of early childhood special education personnel through the Comprehensive System of Personnel Development. A joint training calendar is managed by the State Education Resource Center (SERC).
Public Health	Addresses issues of children identified through newborn hearing screening and how and when children are referred
Children and Families	Addresses issues of children who are involved in substantiated cases of abuse and how they should be referred as well as the appointment of surrogate parents for children in foster care
Social Services	Agreement with the Disability Determination Unit to identify children applying for SSI who might be eligible for Birth to Three
BESB	Agreement of how they will provide direct services to children who are visually impaired in conjunction with the child's comprehensive Birth to Three program
UConn Extension Service	Joint agreement with Dept. of Ed to produce a newsletter for parents and professionals addressing issues of children with disabilities, birth through age five
Children's Trust Fund	Agreement on the co-funding of Child Development Infoline and how referral to CDI are triaged between Help Me Grow and Birth to Three as well as how and when data can be shared
Charter Oak College	Agreement to manage the portfolio review process for individuals applying for a Birth to Three credential
Early Head Start	Agreement on planning, case management, and services for children that are dually enrolled in Early Head start and Birth to Three

Other interagency activities without an agreement:

Education-we are enrolling children in Birth to Three in SDE's public school information system. Children receive an ID number that will be theirs until they graduate from high school. This will allow both Birth to Three and SDE to retrieve longitudinal aggregate data.

Public Health – Until such time as children with mild and unilateral hearing loss are eligible for Birth to Three, Public Health has developed a “Listen and Learn”

program in which Child Development Infoline can refer those children to the three Birth to Three programs that specialize in hearing impairment and DPH will pay those programs to monitor the children's hearing.

Social Services – DSS promulgated Medicaid regulations specific to Birth to Three enabling the state to capture \$4m in federal Medicaid funding.

Administrative Services - The Fiscal Service Center handles not only the Medicaid billing for Birth to Three, but they also handle the commercial health insurance billing for the state-operated Birth to Three program.

Children and Families – Birth to Three serves on the steering committee for the SAMHSA grant to establish an effective system of care for children under the age of six in southeast Connecticut. The program is called Building Blocks.

Birth to Three has had the following impacts:

1. Connecticut Birth to Three serves 3.16% of children under the age of three in the state (based on a one-day count). While this is not as many children as we would like to serve, it is the 11th highest percentages in the country. Therefore it appears that Connecticut is doing a better job of identifying children early than 78% of the states.
2. Early intervention evaluation and plans, early intervention services, and transition conferences for children turning three are delivered in a timely manner for 94% of children and families.
3. 84% of families participating in the program report that early intervention services have helped them to help their children develop and learn
4. At least 97% of children exiting from Birth to Three have improved developmental functioning to a level nearer to their same-aged peers. At least 48% are at age level comparable to their same-aged peers at exit

Although 70% of children who exit Birth to Three at age three are eligible for preschool special education, only 49% of children who received Birth to Three services are receiving special education by Kindergarten.

### **Connecticut Strategic Prevention Framework Initiative**

Under DMHAS' leadership, Connecticut's prevention system has made substantial progress in decreasing substance use and abuse and promoting health. Aided by the federal Substance Abuse and Mental Health Services

Administration's Strategic Prevention Framework (SPF), a 5-year, \$11.8 million initiative funded by SAMHSA, 52 towns receive services aimed at reducing underage drinking. The CT SPF is a collaborative effort of several State agencies, community, and academic partners that have a long history of working together to successfully implement evidence-based health promotion strategies.

The following gains have been accomplished:

- CT youth and young adults engaged in promoting healthy behaviors among their peers
- Over 40 CT colleges and universities united to combat underage drinking on campuses
- Social Host Law has been enforced to deter providing alcohol to teens at house parties
- Retail compliance checks focused on reducing teen access to alcohol increased
- Education was provided to alcohol sellers and servers
- Members of 28 new coalitions that are developing plans and strategies to reduce underage drinking and enforce policy and laws are being supported
- Use and consequence data are being tracked to measure progress towards a healthier Connecticut

### **Connecticut Youth Suicide Prevention Initiative**

Through CT's existing youth suicide prevention infrastructure, including the Youth Suicide Advisory Board (YSAB), the Connecticut Youth Suicide Prevention Initiative (CYSPI) is supporting the following:

- High School Component: The implementation of the Screening for Mental Health, Inc.'s Signs of Suicide (SOS) High School Program, an evidence-based practice, in CT high schools;
- College Component: The implementation of the QPR Institute's Question, Persuade, Refer Gatekeeper Program and Screening for Mental Health, Inc.'s College Response Program in the CSU System;
- Training Component: The expansion of the existing Department of Children and Families (DCF)-sponsored training program in recognizing the signs and symptoms of suicidality and depression, and increase the capacity of the State's clinical workforce to assess and manage suicide risk.
- Pilot Program: The design and pilot implementation of a model program in Hartford, CT to increase the availability, accessibility, and linkages to mental health screening and treatment for youth by embedding services in the Quirk Middle School School-Based Health Center and the St. Francis Hospital and Medical Center Adolescent Clinic; and

- Statewide Campaign: A statewide youth suicide prevention education and awareness campaign that funds school and community mini-grants.

## V. Child Poverty and Prevention Council Strategic Plan

In 2007, the Child Poverty and Prevention Council began a process to re-examine and prioritize its 67 child poverty and 27 prevention recommendations. In recognition that the Council will not be able to successfully achieve its ambitious goals by 2014 unless a concerted effort is undertaken, the Council has actively engaged in a strategic effort to focus its short-term efforts on a limited number of achievable proposals and target its long-term efforts on public policy changes most likely to produce measurable outcomes.

The work of the Council this year has consisted of a five-step process, including:

### 1. Selecting Target Populations

By selecting target populations, the Council can narrow its focus and make a greater impact on certain priority populations. The three target populations agreed upon at the September 2007 meeting of the Child Poverty and Prevention Council are:

- Birth to age five;
- Late teen and young adult (16-24)
- Working poor families.

### 2. Bringing in a panel of national experts to review all 67 recommendations and offer consensus suggestions using national research and proven practices

To help focus the Council's efforts, a panel of six nationally-recognized experts was engaged to discuss proven strategies to reduce child poverty. The panel consisted of J. Lawrence Aber, Ph.D. (Professor of Applied Psychology and Public Policy at New York University), Rebecca M. Blank (Professor of Public Policy and Economics at the University of Michigan), Mark H. Greenberg, J.D. (Executive Director of the Task Force on Poverty for the Center for American Progress), Ron Haskins, Ph.D. (Co-Director of the Center on Children and Families at the Brookings Institution), Clifford Johnson (Executive Director of the Institute for Youth, Education and Families at the National League of Cities), and

Rucker C. Johnson, Ph.D. (Assistant Professor in the Goldman School of Public Policy at the University of California, Berkeley).

The expert panel met and deliberated twice by phone and once in person over the course of November – December, 2007. They scrutinized the council's recommendations based on three main criteria: evidence of impact, cost-effectiveness, and timeframe.

On Friday, December 7, the panel offered recommendations to the council about which among the 67 recommendations have a sufficiently strong evidence base to support their potential effectiveness in reducing child poverty. They identified four major areas of policy and thirteen specific policies for which there is evidence to support their likely effectiveness in short-term child poverty reduction. In addition, they made one process recommendation. The four major areas of policy, with the corresponding list of their recommendations, are:

#### FAMILY INCOME AND EARNINGS POTENTIAL

- Income tax-based assistance for workers
- Child Care
- Housing Subsidies
- Health Care

#### EDUCATION

- Early Childhood Education
- Teacher Quality
- Secondary and Post-Secondary Education

#### INCOME SAFETY NET

- High-Risk Families
- Other Safety Net Programs

#### FAMILY STRUCTURE AND SUPPORT

- Reducing Teen Births
- Marriage Penalties
- Avoiding Abrupt Benefit Changes
- Improving the Prospects of Fathers

#### AN IMPROVED MEASURE OF POVERTY TO MEASURE PROGRESS IN CONNECTICUT

The experts' full draft report is contained in Appendix C. It is the intention of the Child Poverty and Prevention Council to further research and analyze the

recommendations made by the panel of experts to determine whether and which recommendations should become priorities for the council to pursue.

### **3. Charter Oak consultants will be assisting with Results Based Accountability (RBA) analysis.**

The Child Poverty and Prevention Council's acceptance of the recommendations of the expert panel has catalyzed planning on the development of actions related to those recommendations that could be considered for action this session. A "Grid" working group (so named for the grid used to place each of the recommendations into four strategic buckets, with additional rows for the three target group areas) is being convened to begin this work. This group, which will also be referred to in this document as the Core group, will serve as the core of the working group to be convened to fully articulate indicators, strategies, and system measures for the results-based accountability framework for the Council. See Appendix F for the preliminary recommendations of the grid working group.

The following process is proposed:

- A. The "Grid" working group becomes the nucleus of the Core group. Core group members should include legislators and representatives from SDE, DSS, DOL, the Commission on Children, and OPM. Others may be members on an as-needed basis, including other state agencies, a non-governmental policy person, an advocate, an academic poverty expert and a representative from NCSL.
- B. The Core members, or their designees, will work on each of the four strategic areas (one for each of the four strategic buckets). Additional working group members will be added to the Core group as needed for each strategic area. All CPPC members, other than those in Core group, will be invited to work on at least one of these four strategic areas.
- C. An advocates group will be convened by OPM to provide input into short and long term recommendations by the Council.
- D. The short-term actions items related to the expert recommendations that the Grid working group will propose, including pilot programs, program budget enhancements, and policy changes, may then be considered this legislative session in the context of the developing results-based accountability framework. This ensures the ongoing alignment of the RBA model with the immediate actions recommended by the Grid working group, without slowing down the pursuit of those immediate actions. The strategies as developed will fully relate to any immediate actions being pursued, but will also include longer-term approaches, as well other approaches not specifically addressed by the expert panel

(consistent with the panel's admonishment that the recommendations should not be the only actions pursued).

- E. As part of the RBA process, a cross-walk of current programs and the strategic buckets will be created to assist in the identification of gaps in programs or strategies and the alignment of existing programs to the strategies.

**4. Creating an economic model to assess which policies will reduce child poverty.**

This is the next step for the Child Poverty and Prevention Council, which will be taken in early 2008. A request for proposals (RFP) will be drafted to secure an appropriate vendor to help the council with this step.

**5. Developing a state grant and community model where 6 to 7 municipalities will work to decrease child poverty.**

Working with both the state and local sectors, local communities will implement model programs.

# Appendix A

## **Public Act No. 07-47**

### **AN ACT CONCERNING REPORTING REQUIREMENTS RELATED TO THE CHILD POVERTY AND PREVENTION COUNCIL.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsections (f) and (g) of section 4-67x of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(f) (1) On or before [January 1, 2006, and annually thereafter, until January 1, 2015] January first of each year from 2006 to 2015, inclusive, the council shall report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and human services and to the select committee of the General Assembly having cognizance of matters relating to children on the implementation of the plan, progress made toward meeting the child poverty reduction goal specified in subsection (a) of this section and the extent to which state actions are in conformity with the plan. The council shall meet at least two times annually for the purposes set forth in this section.

(2) On or before [January 1, 2007] January first of each year from 2007 to 2015, inclusive, the council shall, within available appropriations, report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, education, human services and public health and to the select committee of the General Assembly having cognizance of matters relating to children, on the state's progress in prioritizing expenditures in budgeted state agencies with membership on the council in order to fund prevention services. The report shall include (A) a summary of measurable gains made toward the child poverty and prevention goals established in this section; (B) a copy of each such agency's report on prevention services submitted to the council pursuant to subsection (g) of this section; (C) examples of successful interagency collaborations to meet the child poverty and prevention goals established in this section; and (D) recommendations for prevention investment and budget priorities. In developing such recommendations, the council shall consult with experts and providers of services to children and families.

(g) (1) On or before [November 1, 2006, and on or before November 1, 2007] November first of each year from 2006 to 2014, inclusive, each budgeted state agency with membership on the council that provides prevention services to children shall, within available appropriations, report to the council in accordance with this subsection.

(2) Each agency report shall include at least two prevention services [for the report due on or before November 1, 2006, and the report due on or before November 1, 2007,] not to exceed the actual number of prevention services provided by the agency. For each prevention service reported by the agency, the agency report shall include (A) a statement of the number of children and families served, (B) a description of the preventive purposes of the service, (C) for [the report due on or before November 1, 2007] reports due after November 1, 2006, a description of performance-based standards and outcomes included in relevant contracts pursuant to subsection (h) of this section, and (D) any performance-based vendor accountability protocols.

(3) Each agency report shall also include (A) long-term agency goals, strategies and outcomes to promote the health and well-being of children and families, (B) overall findings on the effectiveness of prevention within such agency, (C) a statement of whether there are methods used by such agency to reduce disparities in child performance and outcomes by race, income level and gender, and a description of such methods, if any, and (D) other information the agency head deems relevant to demonstrate the preventive value of services provided by the agency. Long-term agency goals, strategies and outcomes reported under this subdivision may include, but need not be limited to, the following:

(i) With respect to health goals, increasing (I) the number of healthy pregnant women and newborns, (II) the number of youths who adopt healthy behaviors, and (III) access to health care for children and families;

(ii) With respect to education goals, increasing the number of children who (I) are ready for school at an appropriate age, (II) learn to read by third grade, (III) succeed in school, (IV) graduate from high school, and (V) successfully obtain and maintain employment as adults;

(iii) With respect to safety goals, decreasing (I) the rate of child neglect and abuse, (II) the number of children who are unsupervised after school, (III) the incidence of child and youth suicide, and (IV) the incidence of juvenile crime; and

(iv) With respect to housing goals, increasing access to stable and adequate housing.

Sec. 2. Section 4-67v of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

For [the] each biennial budget for the fiscal years [commencing July 1, 2007, and July 1, 2008] ending June 30, 2008, to June 30, 2021, inclusive, the Governor's budget document shall, within available appropriations, include a prevention report that corresponds with the prevention goals established in section 4-67x, as amended by this act. The prevention report shall:

- (1) Present in detail for each fiscal year of the biennium the Governor's recommendation for appropriations for prevention services classified by those budgeted agencies that provide prevention services to children, youths and families;
- (2) Indicate the state's progress toward meeting the goal that, by the year 2020, at least ten per cent of total recommended appropriations for each such budgeted agency be allocated for prevention services; and
- (3) Include, for each applicable budgeted agency and any division, bureau or other unit of the agency, (A) a list of agency programs that provide prevention services, (B) the actual prevention services expenditures for the fiscal year preceding the biennium, by program, (C) the estimated prevention services expenditures for the first fiscal year of the biennium, (D) an identification of research-based prevention services programs, and (E) a summary of all prevention services by each applicable budgeted agency identifying the total for prevention services included in the budget.

Approved May 22, 2007

## **Connecticut General Statutes**

### **Section 4-67x**

**Sec. 4-67x. Child Poverty and Prevention Council established. Duties. Ten-year plan. Prevention goals, recommendations and outcome measures. Protocol for state contracts. Agency reports. Council report to General Assembly.**

**Termination of council.** (a)(1) There shall be a Child Poverty and Prevention Council consisting of the following members or their designees: The Secretary of the Office of Policy and Management, the president pro tempore of the Senate, the speaker of the House of Representatives, the minority leader of the Senate and the minority leader of the House of Representatives, the Commissioners of Children and Families, Social Services, Correction, Mental Retardation, Mental

Health and Addiction Services, Transportation, Public Health, Education, Economic and Community Development and Health Care Access, the Labor Commissioner, the Chief Court Administrator, the Chairman of the Board of Governors for Higher Education, the Child Advocate, the chairperson of the Children's Trust Fund and the executive directors of the Commission on Children and the Commission on Human Rights and Opportunities. The Secretary of the Office of Policy and Management, or the secretary's designee, shall be the chairperson of the council. The council shall (1) develop and promote the implementation of a ten-year plan, to begin June 8, 2004, to reduce the number of children living in poverty in the state by fifty per cent, and (2) within available appropriations, establish prevention goals and recommendations and measure prevention service outcomes in accordance with this section in order to promote the health and well-being of children and families.

(b) The ten-year plan shall contain: (1) An identification and analysis of the occurrence of child poverty in the state, (2) an analysis of the long-term effects of child poverty on children, their families and their communities, (3) an analysis of costs of child poverty to municipalities and the state, (4) an inventory of state-wide public and private programs that address child poverty, (5) the percentage of the target population served by such programs and the current state funding levels, if any, for such programs, (6) an identification and analysis of any deficiencies or inefficiencies of such programs, and (7) procedures and priorities for implementing strategies to achieve a fifty per cent reduction in child poverty in the state by June 30, 2014. Such procedures and priorities shall include, but not be limited to, (A) vocational training and placement to promote career progression for parents of children living in poverty, (B) educational opportunities, including higher education opportunities, and advancement for such parents and children, including, but not limited to, preliteracy, literacy and family literacy programs, (C) housing for such parents and children, (D) day care and after-school programs and mentoring programs for such children and for single parents, (E) health care access for such parents and children, including access to mental health services and family planning, (F) treatment programs and services, including substance abuse programs and services, for such parents and children, and (G) accessible childhood nutrition programs.

(c) In developing the ten-year plan, the council shall consult with experts and providers of services to children living in poverty and parents of such children. The council shall hold at least one public hearing on the plan. After the public hearing, the council may make any modifications that the members deem necessary based on testimony given at the public hearing.

(d) Funds from private and public sources may be accepted and utilized by the council to develop and implement the plan and the provisions of this section.

(e) Not later than January 1, 2005, the council shall submit the plan, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and human services and to the select committee of the General Assembly having cognizance of matters relating to children, along with any recommendations for legislation and funding necessary to implement the plan.

(f) (1) On or before January 1, 2006, and annually thereafter, until January 1, 2015, the council shall report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and human services and to the select committee of the General Assembly having cognizance of matters relating to children on the implementation of the plan, progress made toward meeting the child poverty reduction goal specified in subsection (a) of this section and the extent to which state actions are in conformity with the plan. The council shall meet at least two times annually for the purposes set forth in this section.

(2) On or before January 1, 2007, the council shall, within available appropriations, report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, education, human services and public health and to the select committee of the General Assembly having cognizance of matters relating to children, on the state's progress in prioritizing expenditures in budgeted state agencies with membership on the council in order to fund prevention services. The report shall include (A) a summary of measurable gains made toward the child poverty and prevention goals established in this section; (B) a copy of each such agency's report on prevention services submitted to the council pursuant to subsection (g) of this section; (C) examples of successful interagency collaborations to meet the child poverty and prevention goals established in this section; and (D) recommendations for prevention investment and budget priorities. In developing such recommendations, the council shall consult with experts and providers of services to children and families.

(g) (1) On or before November 1, 2006, and on or before November 1, 2007, each budgeted state agency with membership on the council that provides prevention services to children shall, within available appropriations, report to the council in accordance with this subsection.

(2) Each agency report shall include at least two prevention services for the report due on or before November 1, 2006, and the report due on or before November 1, 2007, not to exceed the actual number of prevention services provided by the agency. For each prevention service reported by the agency, the

agency report shall include (A) a statement of the number of children and families served, (B) a description of the preventive purposes of the service, (C) for the report due on or before November 1, 2007, a description of performance-based standards and outcomes included in relevant contracts pursuant to subsection (h) of this section, and (D) any performance-based vendor accountability protocols.

(3) Each agency report shall also include (A) long-term agency goals, strategies and outcomes to promote the health and well-being of children and families, (B) overall findings on the effectiveness of prevention within such agency, (C) a statement of whether there are methods used by such agency to reduce disparities in child performance and outcomes by race, income level and gender, and a description of such methods, if any, and (D) other information the agency head deems relevant to demonstrate the preventive value of services provided by the agency. Long-term agency goals, strategies and outcomes reported under this subdivision may include, but need not be limited to, the following:

(i) With respect to health goals, increasing (I) the number of healthy pregnant women and newborns, (II) the number of youths who adopt healthy behaviors, and (III) access to health care for children and families;

(ii) With respect to education goals, increasing the number of children who (I) are ready for school at an appropriate age, (II) learn to read by third grade, (III) succeed in school, (IV) graduate from high school, and (V) successfully obtain and maintain employment as adults;

(iii) With respect to safety goals, decreasing (I) the rate of child neglect and abuse, (II) the number of children who are unsupervised after school, (III) the incidence of child and youth suicide, and (IV) the incidence of juvenile crime; and

(iv) With respect to housing goals, increasing access to stable and adequate housing.

(h) Not later than July 1, 2006, the Office of Policy and Management shall, within available appropriations, develop a protocol requiring state contracts for programs aimed at reducing poverty for children and families to include performance-based standards and outcome measures related to the child poverty reduction goal specified in subsection (a) of this section. Not later than July 1, 2007, the Office of Policy and Management shall, within available appropriations, require such state contracts to include such performance-based standards and outcome measures. The Secretary of the Office of Policy and

Management may consult with the Commission on Children to identify academic, private and other available funding sources and may accept and utilize funds from private and public sources to implement the provisions of this section.

(i) For purposes of this section, the Secretary of the Office of Policy and Management, or the secretary's designee, shall be responsible for coordinating all necessary activities, including, but not limited to, scheduling and presiding over meetings and public hearings.

(j) The council shall terminate on June 30, 2015.

(P.A. 04-238, S. 1; P.A. 05-244, S. 1; P.A. 06-179, S. 3; 06-196, S. 27.)

History: P.A. 04-238 effective June 8, 2004; P.A. 05-244 made technical changes, added executive director of Commission on Human Rights and Opportunities as council member in Subsec. (a), specified mandatory minimum number of meeting times and reporting requirements in Subsec. (f) and required development and implementation of state contract protocol in new Subsec. (g), redesignating existing Subsecs. (g) and (h) as Subsecs. (h) and (i), respectively, effective July 11, 2005; P.A. 06-179 amended Subsec. (a) to insert Subdiv. designators and substitute "Child Poverty and Prevention Council" for "Child Poverty Council", to add the Chief Court Administrator, to delete the chairperson of the State Prevention Council, to add "promote the implementation of" re ten-year plan, and to add Subdiv. (2) re establishing prevention goals and recommendations and measuring outcomes, amended Subsecs. (b) and (c) to add "ten-year" re plan, amended Subsec. (f) to insert Subdiv. (1) designator and provide that meetings held at least twice annually shall be for the purposes set forth in the section, inserted new Subsecs. (f)(2) and (g) re council and agency reports, and redesignated existing Subsecs. (g) to (i) as Subsecs. (h) to (j) (Revisor's note: In Subsec. (f)(2) the word "this" in the phrase "this subsection (g) of this section" was deleted editorially by the Revisor's for accuracy); P.A. 06-196 made a technical change in Subsec. (g), effective June 7, 2006.

# Appendix B

## COUNCIL MEMBERS

Robert L. Genuario, Chair  
Secretary  
Office of Policy and Management

Valerie Lewis  
Commissioner  
Department of Higher Education

Mark McQuillan  
Commissioner  
Department of Education

Mary Marcial  
Director of Programs  
Department of Correction

Patricia Downs  
Executive Director  
Department of Economic and  
Community Development

John McCarthy  
Legislative Liaison  
Department of Labor

Susan Hamilton  
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Department of Children and Families

Mary Mushinsky  
State Representative  
Connecticut General Assembly

Karen Foley-Schain  
Executive Director  
Children's Trust Fund

Enid Lipeles  
Public Member

Norma Gyle  
Deputy Commissioner  
Department of Public Health

Peter O'Meara  
Commissioner  
Department of Developmental  
Services

MaryAnn Handley  
State Senator  
Connecticut General Assembly

Raymond Pech  
Assistant Director  
Commission on Human Right and  
Opportunities

Dennis King  
Manager of Community Advocacy  
Department of Transportation

Christine Keller  
Judge  
Superior Court

Thomas Kirk  
Commissioner  
Department of Mental Health and  
Addiction Services

Catherine Sarault  
State Republican Office  
Connecticut General Assembly

Cristine Vogel  
Commissioner  
Office of Health Care Access

Faith VosWinkel  
Assistant Child Advocate  
Office of Child Advocacy

Michael Starkowski  
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Department of Social Services

Elaine Zimmerman  
Executive Director  
Commission on Children

### **Child Poverty and Prevention Council Staff**

Anne Foley  
Senior Policy Advisor  
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Planning Specialist  
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# Appendix C

NOT A FINAL VERSION

**Recommendations of the Expert Panel to  
The Child Poverty and Prevention Council  
December 7, 2007**

Background The State of Connecticut has enacted laws to reduce child poverty and to give priority to spending on prevention rather than crisis alleviation. Among other provisions, the laws (1) require state planning and implementation to reduce the number of children living in poverty by 50% by the year 2014; and (2) assign the Child Poverty and Prevention Council to oversee the state's work on poverty and prevention. The Council in turn made 67 recommendations to reduce child poverty in Connecticut in its Initial Plan. To help the Council and the state prioritize among its many recommendations, the Council invited a group of nonpartisan experts to review the 67 recommendations and offer recommendations about which among them have a sufficiently strong evidence base to support their potential effectiveness in reducing child poverty. The Expert Panel includes two economists, two developmental psychologists and two policy analysts, each of whom is committed to and capable of an evidence-based appraisal of the policies being considered by the Council.

The Panel has carefully reviewed all 67 recommendations and it has requested and reviewed additional data, reports, and other information provided by the Council. In addition, the Panel has met and deliberated twice by phone and once in person over the course of November-December, 2007. In this brief memo to the Council, we describe the results of our deliberations. First, we specify the criteria on which we based our recommendations. Second, we describe the policy recommendations which the Panel endorses as supported by evidence and likely to result in reductions in child poverty if implemented effectively. These are unanimous recommendations of the Panel.

### Criteria by which Connecticut's Child Poverty Recommendations were Evaluated

The Panel began its work by first discussing and then deciding *a priori* on the main criteria by which we would evaluate the Council's 67 recommendations. The Panel agreed to scrutinize each policy recommendation based on three main criteria:

1. Evidence of Impact. Is there evaluation evidence to show that this policy has a positive impact? The evidence could be experimental or non-experimental. If there is evidence of impact, is there evidence of the potential magnitude of the impact?
2. Cost-Effectiveness. If there is evidence of impact, is there also evidence of cost-effectiveness of the recommendation?
3. Timeframe. In light of the goal to reduce child poverty by 50% by the year 2014, how likely is it that the recommendation would contribute to reduction of child poverty within that timeframe?

There are numerous political and technical challenges to the passage and implementation of evidence-based policies. While we discussed and were cognizant of these important feasibility challenges, the Panel endeavored to restrict itself to the evidence base for its recommendations (assuming effective implementation), leaving political and technical challenges to the political and policy processes in the state.

With our three criteria as our guideposts, we have identified four major areas of policy and thirteen specific policies for which there is evidence to support their likely effectiveness in short-term child poverty reduction. In addition, we make one critical process recommendation. It is to these recommendations which we now turn.

#### A. FAMILY INCOME AND EARNINGS POTENTIAL

The Panel notes very strong support in the research literature for the notion that work is the principal path out of poverty in the U.S. States and the nation face the challenges of how to raise employment rates among poor families, including low-skilled, low-education parents; to assure that work in even low-wage jobs helps families escape

poverty; and to support parents' continued development of their earnings potential. We offer four policy recommendations to help the state meet these challenges and thereby reduce poverty.

1. Income tax-based assistance for workers. Among the most successful strategies to incentivize low-wage work and thereby reduce child poverty are those that create incentives to enter employment and increase hours of work through an earned income tax credit structure. Connecticut should:

- Mount new awareness and outreach activities to increase the uptake of the federal Earned Income Tax Credit by eligible families.
- Establish a refundable state Earned Income Tax Credit to supplement the earnings of low-wage parents.

## 2. Child Care

In order to incentivize low-income parents to work full-time and full-year (which is necessary to escape poverty), affordable, accessible and good quality child care is indispensable. Good evidence exists for the general proposition behind the Council's recommendations in this area, that increasing access to affordable child care will help reduce child poverty by lowering the cost of work. Subsidies should be available for all low-income families, at least up to 200% of the poverty line.

## 3. Housing Subsidies

In a state with high housing costs, rental assistance is critical to improve low-income families' ability to meet basic needs and to reduce residential instability. The panel recommends that the state find ways to expand rental assistance, structured in ways to both increase poor families' income and their incentives to work.

#### 4. Health Care

Lack of health insurance coverage among low-income parents discourages adults from leaving welfare and going to work, and also affects the health of children because adults without health insurance are less likely to take their children for preventive health care. Out-of-pocket medical expenses also create economic burdens for low-income parents. We are impressed with the health care coverage now available to low-income adults and children in Connecticut. We recommend efforts to assure that all eligible parents and children actually receive the health care for which they are eligible, and that the state make efforts to further expand coverage to non-parental caretakers with whom children reside.

### B. EDUCATION

The research evidence strongly supports the efficacy of a second path out of poverty: education. Clearly, while state legislation sets child poverty reduction goals in the short-term (50% by 2014), improvements in education will likely require a longer-term time horizon to achieve a reduction in child poverty. We recommend three education policy strategies which the research literature supports:

#### 1. Early Childhood Education

High-quality early education has the potential to narrow the poverty and race gaps in school achievement and thereby improve life chances and reduce child poverty in the long run. In addition, evidence suggests that making preschool full-day, full-year and making K-3 education full-year will increase female labor supply and thereby support work as a principal path out of poverty in the near term as well.

#### 2. Teacher Quality

Among the most urgent problems facing K-12 education is the unequal distribution of high-quality teachers. If the state were able to significantly

increase the proportion of highly qualified teachers in low-income schools, the achievement of low-income children would improve. While there is no clear evidence of how best to achieve this goal, the state should build upon promising strategies that have been developed in communities across the nation.

### 3. Secondary and Post-Secondary Education

While early education and teacher quality strategies necessarily entail longer time horizons to achieve their full impact, one set of evidence-supported education strategies can help reduce child poverty in the shorter term. The Council's recommendations designed to increase cash assistance and other forms of support for post-secondary education have a strong evidence base supporting potential effectiveness. Strategies to provide assistance for community college, vocational education and English as a Second Language instruction are supported by both experimental and non-experimental research findings on the increasing return to post-secondary education.

Many youth still cannot enter post-secondary education because they drop out before completing high school. The Panel notes several evidence-based strategies to reduce school drop-outs that we recommend to increase the proportion of poor youth who are prepared to enter post-secondary education options.

## C. INCOME SAFETY NET

We recommend two evidence-supported strategies to improve the income safety net:

### 1. High-Risk Families

There is clear evidence that a growing proportion of single mothers are neither employed nor receiving cash assistance. Most of these parents experience multiple barriers to work. Without intensive case management and employment-related services to both identify and reduce barriers, some parents will remain both unemployed (no earnings) and out of the safety net (no other cash welfare).

This places their children at risk of deep and persistent poverty. Our primary recommendation is for the state to consider helping the high-risk population of parents who have the most serious difficulties sustaining employment, both those receiving and not receiving TANF.

## 2. Other Safety Net Programs

Many low-income working families are eligible for (primarily federally funded) income support benefits which they do not receive. We recommend that the state work to increase uptake among eligible families in food stamps, child nutrition, SSI, energy assistance, and other programs that provide income support

## D. FAMILY STRUCTURE AND SUPPORT

Children in married couple families experience about one-fifth the poverty rate experienced by children in female-headed families. Poverty would fall and child development would be augmented if a larger share of Connecticut children were in low-conflict married-couple families.

### 1. Reducing Teen Births

Reducing teen births is one way to lower the share of children in single-parent families. There are a number of programs for youth that have been shown to reduce teen births and promote healthy development. As many youth as possible, especially poor and minority youth, should be enrolled in these programs.

### 2. Marriage Penalties

The Connecticut tax code should be scrutinized to ensure that all marriage penalties are removed.

### 3. Avoiding Abrupt Benefit Changes

Connecticut welfare programs should be amended so that parents receiving welfare benefits, especially Temporary Assistance for Needy Families, food stamps, Medicaid, and housing, do not face an abrupt loss of benefits.

### 4. Improving the Prospects of Fathers

There is increasing evidence that young, especially minority, males are dropping out of school and failing to enter the work force and that these problems are contributing to low rates of marriage, the rise of lone parenting, high child poverty, and a disturbing share of children whose fathers are imprisoned.

Programs should be adopted that help males complete high school and make the transition to the labor force. Policies that increase work incentives, such as wage subsidies, should also be considered. The nation's welfare policies have focused almost exclusively on mothers; it is time that we broaden our scope and create

policies that will also help struggling fathers. Connecticut deserves credit for increasing the amount of child support given directly to families when families receive TANF assistance. With the agreement of custodial mothers, child support policy on arrearages could be modified to help fathers who agree to pay in the future,

There is strong evidence to support the contention that one of the driving forces behind high child poverty rates is the decline of marriage through non-marital births, divorce and declining rates of marriage. However, at this point, there is still relatively little known about effective strategies for promoting healthy marriages. Connecticut would do itself and the nation a considerable service to mount creative new efforts to develop and test new strategies on these fronts. At the same time, the state should be mindful of the realities that a significant share of low-income children are in and are likely to be in single-parent families, and that a strategy to address child poverty must assist and not disadvantage these families and children.

#### E. AN IMPROVED MEASURE OF POVERTY TO MEASURE PROGRESS IN CONNECTICUT

The current U.S. official measure of poverty is inadequate as a measure of progress. It is based only on cash income and does not reflect in-kind income (such as food stamps, child care subsidies, or housing subsidies) or tax-based income (either taxes paid or tax refunds received through the EITC). Moreover, the thresholds used in the current measure are based on data about family expenditures in the 1950s, and have only been adjusted for inflation since originally established in the 1960s. In order to measure progress in the resources available to low-income families, Connecticut needs to utilize an alternative measure of poverty, such as that recommended by the National Academy of Sciences. The benchmark from which progress is measured should be based on this alternative measure, as well as any future change in poverty. The state may want to use a “depth of poverty” measure rather than a “count of the poor” measure. It may also want

to utilize other measures of progress, such as student achievement, high school graduation, or health status.

## FINAL COMMENTS: IMMEDIATE VS. LONG-TERM CHANGES

The most immediate impacts on child poverty will be achieved in three key areas: tax-based work supports, child care assistance, and safety net programs. Expenditures in each of these areas are likely to be directly correlated with the alleviation of hardship among children and families. In addition, the potential for increasing enrollments of eligible children and families in programs financed, wholly or in part, by the federal government presents attractive opportunities for the state to make progress in reducing child poverty through relatively modest investments in these areas.

At the same time, it is important for the State of Connecticut to make progress in areas of education and family structure and support that can enhance future earnings, bolster family stability, and reduce the need for work supports and safety net programs over time. The evidence in support of high-quality early childhood programs is particularly strong, but investments in such programs by themselves cannot be expected to produce significant child poverty reductions by 2014. Other initiatives designed to improve education and work-related skills and to foster growth in the number of two-parent families also deserve careful consideration for their potential long-term impacts.

# Appendix D

## STATE OF CONNECTICUT AGENCY PREVENTION REPORT

November 2007



A REPORT TO THE CHILD POVERTY AND PREVENTION  
COUNCIL

## **I. Background**

### **Child Poverty Council and Prevention Council**

In the Spring of 2004, the Connecticut legislature enacted Public Act 04-238, An Act Concerning Child Poverty establishing a Child Poverty Council. The Council was charged with recommending strategies to reduce child poverty in the State of Connecticut by fifty percent (50%) within ten years.

In June 2006, the Connecticut legislature enacted Public Act 06-179, An Act Concerning State Investments in Prevention and Child Poverty Reduction and the Merger of the State Prevention and Child Poverty Councils.

The State Prevention Council was created under Public Act 01-121, An Act Concerning Crime Prevention and a State Prevention Council to evaluate and promote prevention work in the state of Connecticut. More specifically, the Council's charge was to establish a framework for the state, develop a comprehensive state-wide prevention plan and offer recommendations to better coordinate existing and future prevention expenditures across state agencies and increase fiscal accountability. The State Prevention Council fulfilled its mandatory obligation and presented its final report in March of 2004.

The public act combined the two councils- the Child Poverty and Prevention Council into one coordinated body. The Child Poverty and Prevention Council is comprised of membership from both councils.

This public act requires the newly formed Child Poverty and Prevention Council (CPPC) to:

- Establish prevention goals, recommendations and measure prevention service outcomes to promote the health and well-being of children and their families.
- Report to the Governor and various legislative committees on the state's progress in prioritizing expenditures for prevention services in budgeted state agencies with membership on the council including:
  - Summarizing measurable gains made toward the child poverty and prevention goals established by the CPPC.
  - Providing examples of successful interagency collaborations to meet the child poverty and prevention goals established by the CPPC.
  - Recommending prevention investment and budget priorities.

The public act also requires each state agency with membership on the council that provides prevention services to children and families to submit an agency prevention report to the Child Poverty and Prevention Council by November 1, 2006 and November 1, 2007 and must be included in the Council's report to the Governor and legislature. Each state agency represented on the Council provided a report on at least two prevention programs or services provided by their agency. The first State Agency Prevention Report was submitted to the Council in November 2006.

In May 2007, Governor Rell signed into law Public Act 07-47, An Act Concerning Reporting Requirements relating to the Child Poverty and Prevention Council. This public act extends the annual reporting requirements of the Child Poverty and Prevention Council Annual Progress Report through January 2015. The public act also extends the annual reporting requirement of the State Agency Prevention Report through November 2014. Additionally, the public act requires state agencies that serve on the council and provide prevention services to children and families include in their report a description of performance-based standards and outcomes included in relevant contracts and report on performance-based vendor accountability protocols.

This report represents the second State Agency Prevention Report.

## **II. Development of the State Agency Prevention Reports**

Each agency represented in this report designated one staff person to serve as the single point of contact from their agency to work with OPM to complete the 2007 State Agency Prevention Report. The contact person distributed all requests for information from OPM to the appropriate division within their agency and forwarded the responses to OPM.

The following agencies are included in this report: the Office of Policy and Management, Departments of Children and Families, Education, Mental Health and Addiction Services, Developmental Services (formerly known as Mental Retardation), Public Health, Social Services, and the Children's Trust Fund.

For the purpose of this report, prevention is defined as:

*Policies and programs that promote healthy, safe and productive lives and reduce the likelihood of crime, violence, substance abuse, illness, academic failure and other socially destructive behaviors.*

This definition spans multiple fields and encompasses many types of prevention services. In an effort to focus the scope of the agency's prevention report and refine this broad definition the agencies reported on primary prevention programs that serve children 0-18 and their families. Primary prevention refers to programs designed to prevent or eliminate at risk behavior before a problem occurs and promotes the health and well-being of children.

## **III. State Agency Reports**

This section of the report represents an array of primary prevention services that provide intensive, comprehensive and family-centered resources and support that reduces or eliminates high risk behavior and promotes the health and well-being of children and families. Each state agency was given the option to select and report on two or more primary prevention programs that positively impact children aged 0-18 and their families.

Each report includes the following:

- a brief description of the purpose of the prevention program
- the number of children and families served
- long-term goals, strategies, performance-based standards and outcomes and performance-based vendor accountability
- a statement on the overall effectiveness of prevention within the agency
- methods used to reduce disparities in child performance and outcomes by race, income level and gender

The departments of Corrections, Labor, Higher Education, Economic and Community Development, Office of Health Care Access, Office of Workforce Competitiveness, and the Judicial Branch, determined that their prevention programs did not meet the definition of primary prevention, and therefore, no reports from these agencies are included in this report.

The state agency prevention programs included in this report are as follows:

**Children’s Trust Fund**

The Stranger You Know  
Family Empowerment Initiative  
The Help Me Grow Program  
The Kinship and Grandparent Respite Fund  
Nurturing Families Network  
The Parent Trust Fund  
Shaken Baby Syndrome Prevention Project  
Children’s Legal Services

**Department of Children and Families**

Positive Youth Development Initiative  
Youth Suicide Prevention  
Shaken Baby Syndrome Prevention Project  
Head Start Collaboration

**Department of Developmental Services**

Birth to Three  
Family Supports

**Department of Mental Health and Addiction Services**

Best Practices Initiative  
Local Prevention Council Programs  
Strategic Prevention Framework State Incentive Grant  
CT Youth Suicide Prevention Initiative  
Regional Action Councils  
Statewide Service Delivery Agents  
Tobacco Regulation and Compliance

**Department of Public Health**

Asthma Program  
Child Day Care  
Community Health Centers  
Family Planning Program  
Immunization Program  
Injury Prevention Program  
Lead Poisoning Control  
Newborn Screening  
Nutrition, Physical Activity & Obesity Prevention Program

**Department of Education**

Even Start

Early Childhood Programs/School Readiness

Oral Health

Rape Crisis & Prevention Services

Tobacco Use Prevention & Control

Women Infant & Children

Youth Violence/Suicide Prevention

**Department of Social Services**

Emergency Shelter for Victims of Domestic  
Violence

Fatherhood Initiative

Teen Pregnancy Prevention

**Office of Policy and Management**

Title V Delinquency Prevention Program

## Children's Trust Fund

**Program Name:** The Stranger You Know

**Program Description:** The Stranger You Know is a child sexual abuse prevention program that offers insight into how the molester thinks, acts and operates to parents and community service providers. The program offers tips throughout the hour and a half presentation on how to have significant conversations about sexual safety with children. Presentations are being offered in communities across Connecticut.

**Number of children and families served:** 175 professionals and parents participated during 2006- 2007.

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**Program Name:** Family Empowerment Initiatives

**Program Description:** Family Empowerment Initiatives include 8 prevention programs that assist high-risk groups of parents with children of various ages. The programs are co-located in various settings including a school, a substance abuse center, a prison, a domestic violence shelter, a child guidance center and a public housing project where families may be addressing other issues. These programs help families to address a whole range of issues including parenting and family relationships.

**Number of children and families served:** 840 children and families were served during 2006 – 2007.

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**Program Name:** The Help Me Grow Program

**Program Description:** The Help Me Grow Program is a prevention initiative that identifies and refers young children with behavioral health, development and psychosocial needs to community-based services. The program bridges the gap between children with early signs of developmental problems and the services designed to address them. The program also offers an *Ages and Stages* child development tracking system for interested parents of children ages 4 months to 5 years. The program serves children who may not be eligible for the state's Birth to Three or preschool special education programs, yet are still at risk for developmental problems.

**Number of children and families served:** 15,398 children and families served by the program since January 1, 2000.

**Program Name:** The Kinship and Grandparents Respite Fund

**Program Description:** The Kinship and Grandparents Respite Fund awards small grants to orphaned or abandoned children and the court-appointed relative guardians they live with. The Trust Fund provides funding to 10 probate courts to administer the program. The grants provide for a range of activities including tutoring, camp, fees for a variety of programs and extra-curricular experiences, clothing, eyeglasses and other basic necessities and respite for the caregivers.

**Number of children and families served:** 2,206 children and families serviced from July 5, 2006 through June 6, 2007.

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**Program Name:** Nurturing Families Network (NFN)

**Program Description:** This program operates out of twenty-nine birthing hospitals in the state and in 10 community centers in the city of Hartford and 8 centers in New Haven. NFN provides education and support for all interested new parents and intensive home visiting services for parents identified as most at risk. The NFN reaches more than 4,000 first time families each year and has offered home visiting services to approximately 3,243 vulnerable families at risk of abusing, neglecting or abandoning their children. The program is expanding to eight neighborhood service areas in the New Haven and is expecting to reach an additional 250 vulnerable families through its home visiting services. The home visitors become involved during the mother's pregnancy and continue working with the family, on average, for nineteen months. The home visitors teach child development and help the family to bond with and take hold of their responsibility to their child. Seventy percent (70%) of the time fathers are involved. Home visitors support the parent to finish school, to secure a job, and to find and utilize the services of a pediatrician. They connect families to Women Infant and Children (WIC) and to counselors and others in the community who can help. The Network also offers intensive group support to parents and extended family members. The program teaches the family appropriate expectations for their children and fosters empathetic understanding and strategies for enhancing the well being of children. Approximately 600 families have participated in the Nurturing Program each year.

**Number of children and families served:** 26,192 children and families served since the program began.

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**Program Name:** The Parent Trust Fund

**Program Description:** The Parent Trust Fund provided 29 grants to offer classes to parents to help improve the health, safety and education of children by training parents in leadership skills and by supporting the involvement of parents in community affairs.

**Number of children and families served:** 600 parents were served during 2006 – 2007.

**Program Name:** Shaken Baby Syndrome

**Program Description:** The Shaken Baby Prevention project trains hospital based medical professionals and community service providers throughout Connecticut on integrating a national model of prevention into their practice. The training program has been widely accepted into many local high schools' health and well-being curriculum. Three regional trainers provide outreach, education and support to the community on preventing shaken baby syndrome.

**Number of children and families served:** 350 participants have attended presentations during 2006-2007.

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**Program Name:** Children's Legal Services

**Program Description:** The program provides experienced lawyers for indigent children who will give them a voice and represent their best interests in family court. The program also provides a Children's Law Line that provides information about legal questions or concerns about children.

**Number of children and families served:** 283 children were represented during 2006 – 2007.

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**Long-Term Agency Goals:** The goal of the Children's Trust Fund is to prevent child abuse and neglect and to ensure the positive development of children.

The funds appropriated to the Children's Trust Fund are used to support community efforts that assist families. The community programs are designed to engage families before a crisis occurs – to actually keep abuse and neglect from happening.

This strategy is working. The programs supported by the Children's Trust Fund are making a difference in the lives of children and their parents while reducing the number of families that enter the state child welfare system.

**Strategies:** To achieve its goal the Trust Fund:

- Conducts research to better understand and assess areas of risk for child abuse and neglect, finds the most effective ways to assist families, and develops strategies for improving the skills of service providers.
- Funds broad-based prevention efforts in communities that have been shown to address known risk factors for child abuse and neglect, including poverty, substance abuse, domestic violence, and social isolation.
- Funds programs that include a strong focus on matters that affect the well being of children including improving parent-child bonding and interaction, parenting skills

and family relationships, healthy living and health care access, and developmental monitoring.

- Offers a range of program services to meet the needs of all families.
- Trains human services staff in prevention approaches and strategies to engage and assist culturally diverse and vulnerable families.
- Supports a network of agencies that work together to support families around their multiple needs.
- Increases public awareness and participation in efforts to prevent child abuse and neglect.

**Performance Based Standards:** Across all programs the Trust Fund is looking for statistically significant change that can be tied to program efforts. Contractor performance standards for the Nurturing Families Network are assessed annually by comparing each contractor's outcomes with the statewide aggregate outcomes on all evaluation and process measures. The statewide aggregate outcomes serve as the minimum performance standard for this purpose.

**Performance-Based Outcomes:**

- Reduced rate and severity of child abuse and neglect.
- Improved parent –child interaction and parenting skills.
- Connection to health care providers, high immunization rates.
- Gains in household stability, education, employment.
- Less financial hardship, access to more resources.
- Enhanced family relationship and parent well-being.
- Increases in developmental monitoring and access to services.
- Enhanced child well being over time.

**Measure of Effectiveness:** Several studies conducted at the University of Hartford's Center for Social Research show that programs supported by the Trust Fund are successfully providing support and assistance to high-risk families. The studies show that these programs are reducing the incidence and severity of child abuse and neglect and are helping parents to take hold of their responsibilities and to become better caregivers. Highlights of this research follows:

- The incidence and severity of child abuse and neglect in the high-risk families served by the Trust Fund is much less than expected.
- The evaluation of its Nurturing Families Network (NFN) shows the incidence of abuse and neglect to be well below that of high-risk families not participating in this type of program; 3% compared to 19%.
- The immunization rate for two-year old children whose families are involved in the program is 93% compared to 73% for two years olds with similar demographic background on Medicaid.

- A significant percentage of the parents are completing high school, becoming employed and moving out of financial hardship.
- The percentage of mothers establishing independent households increased from 53% to 93% in the second year of program involvement. This is a significant outcome, likely to ensure the future safety of children, given the high number of mothers who were living in abusive or violent or potentially violent households at the start of their program involvement.
- Families are also improving parent-child relationships as well as parenting capacity, attitudes and behavior.

Other research on home visiting shows that the early intervention reduces rates of tobacco and alcohol use, episodes of running away, behavioral problems, arrests, convictions, and sexual promiscuity among teenagers whose families had been reached in this way.

Research on other Trust Fund efforts have found that health care providers have increased their use of developmental surveillance and referrals of at risk youth following training.

**Performance -Based Accountability:** For the larger Trust Fund programs, a continuous quality improvement team has been established to review practice guidelines, training needs and program protocols. The policies are written into a manual that guides program implementation efforts at each site. The Trust Fund staff monitors the sites compliance and effectiveness in implementing the program in accordance with these policies.

The Trust Fund staff works with each contractor to develop an Individualized Program Plan each year. The plan identifies areas in need of attention or improvement and strategies for achieving the identified goal. The sites are responsible for reporting on their progress implementing the plan and the results of their efforts.

**Methods:** The Trust Fund uses intensive home visiting, developmental surveillance and early identification of developmental delays and behavioral problems, and parent engagement to reduce racial and economic disparity.

**Intensive multi-focused home visiting:** Several studies have found that home visiting services reduce disparities in child performances and outcomes by race and income level.

One study, conducted by the Missouri Department of Elementary and Secondary Education, found that children enrolled in preschool - whose families participated in a home visiting program - scored significantly higher on all measures of intelligence, achievement, and language ability than children in the comparison group whose families did not receive home visiting services.

The parents who participated in the home visiting program were mostly young, poor, undereducated, single heads of household. Their children shattered the conventional wisdom that they would perform poorly in school. The children did as well as the national norm for children their age - with roughly 15% exceeding the national norm. The children out performed a comparison group of children from wealthier and more stable families not considered at risk for poor outcomes (study available upon request).

**How does Help Me Grow reduce disparities by race, income level and gender...?**

The National Research Council's report *Neurons to Neighborhoods* (Shonkoff and Phillips, 2000) and RAND's analysis of early childhood interventions, *Investing in Children*, (Karoly et al, 1998) indicate that high quality early intervention programs can have very positive results for those children receiving services. These included increases in short and long term academic achievement, reduction in grade retention rates, and reductions in special education referrals and reduction in teenage pregnancy.

The Help Me Grow program offers universal access to anyone in Connecticut who has concerns about their child's learning, behavior or development. Thousands of families have been connected to critical early intervention programs. Help Me Grow provides training to child health providers on developmental screening and connection to services. The Help Me Grow staff has visited over 50% of Connecticut's pediatric and family practices. Based on this research project, funded through the Commonwealth Fund, referrals for early intervention have doubled. In addition, Connecticut is the only state that provides universal access to an on-going child development monitoring system called *Ages & Stages*. Anyone in the state can access this free service.

**Other:** Child abuse and neglect is at the root of many of the problems children face. Children who are abused or neglected are at high risk for developmental and behavioral problems, health issues, learning disabilities and cognitive delays.

Abused or neglected children are more likely to become involved with the child protection and juvenile justice systems and to become involved with the departments of Social Services, Corrections and Mental Health as adults.

Children fare best when they are nurtured by parents who provide for their needs and help through difficult times growing up. And yet we find that most of the families who participate in Trust Fund programs are ripe for a crisis. More than half of the parents served were abused themselves as children, most are poor and have a limited education and more than half are teenagers – who are just growing up themselves.

As a result, many of the mothers are having difficulty bonding with their babies and meeting the needs of their infants. In Connecticut there are thousands more families who struggle with the demands of parenting and who are in the high range for abuse potential.

It is critical that families are reached before a crisis occurs. Child abuse and neglect must be prevented.

While prevention is a relatively new field, research demonstrates that the strategies employed by the Children's Trust Fund can help more families and more children have a better life. By preventing child abuse and neglect we have a better chance of keeping children safe in their homes, able to perform well in school and have a productive future.

## Department of Children and Families

**Program Name:** Positive Youth Development Initiative

**Program Description:** The Department funds 6 agencies, all using evidence-based or best practice models, to provide positive youth development and family strengthening programs. The Bureau of Prevention and External Affairs staffs bimonthly technical assistance meetings. An independent evaluator is assisting the Department, in partnership with the providers, to develop common outcomes for this initiative, gather data and monitor effectiveness.

**Number of children and families served:** A total of 896 children and 98 adults (representing 90 families) were served in SFY 2006-2007. The total number of persons served was 994.

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*The Division of Prevention at the Department of Children and Families is committed to applying the principles of performance-based standards and accountability into all contractual language and activities within our purview.*

**Long-Term Agency Goals:**

- An increase in the social-emotional skills of children through a universal prevention program/strategy;
- An increase in support and opportunities for young people through enrichment and/or recreation;
- An increase in bonding of children to their parents, school and peers; and
- An increase in the engagement of/and communication with families.

**Strategies:** The Positive Youth Development Initiative promotes approaches that help young people grow into competent, healthy adults by providing them with opportunities to build skills and form healthy relationships with others. The youth development approach defines goals or outcomes, based on the capacities, strengths, and developmental needs of youth.

**Performance Outcomes:** Increase student and parental life skills thereby reducing risk level and increasing the probability of youth success in school and future endeavors through the sustained implementation of universal and indicated evidence-based prevention programs for youth and families statewide. This initiative is only two and a half years old and possible outcomes are yet to be determined.

The possible outcomes under discussion within the agency include the following:

- Completion/graduation from program
- Decrease in drug use / delayed initiation of use
- Decrease in aggression/ violence
- Increase in positive peer network
- Increase in internal locus of control for youth and parents

- Increase in knowledge of & ability to identify and control moods including anger
  - Increase in young persons' self-efficacy
  - Increase in school bonding
  - Improvement in attendance
  - Improvement in graduation rate
  - Improvement in grades
  - Decrease in DCF involvement
  - Increase in youth involvement in their "passion"
  - Increase in parental skills (e.g., coping, monitoring, communication, discipline) and their application
  - Increase in parental involvement with school
  - Increase in help-seeking behavior by youth and parents
  - Decrease in perceived isolation by families
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**Program Name:** Youth Suicide Prevention

**Program Description:** The CT Youth Suicide Advisory Board (YSAB) was legislatively established in 1989 within the Department of Children & Families. The membership is comprised of volunteers, community and state agency representatives with the goal of preventing suicide among children & youth. This goal is accomplished through statewide awareness campaigns and training.

**Number of children and families served:** 864 people were trained in SFY 2006-2007.

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**Long-Term Agency Goals:**

- Increase public awareness of the existence of youth suicide and means of prevention;
- Make recommendations to the Commissioner of the Department of Children and Families for the development of state-wide training in the prevention of youth suicide;
- Develop a strategic youth suicide prevention plan;
- Recommend interagency policies and procedures for the coordination of services for youth and families in the area of suicide prevention;
- Make recommendations for the establishment and implementation of suicide prevention procedures in schools and communities;
- Establish a coordinated system for the utilization of data for the prevention of youth suicide;
- Make recommendations concerning the integration of suicide prevention and intervention strategies into other youth focused prevention and intervention programs

**Strategies:**

- Submit the recommendations outlined in the Comprehensive Suicide Prevention Plan to the Commissioner as prioritized by the Board.

- Combine funding with DMHAS and issue small community grants for youth suicide prevention in schools
- Continue training through United Way of CT and CT Clearinghouse
- Continue mailings to all schools, police, parents, mental health professionals, colleges, etc.
- Plan a statewide youth suicide prevention conference
- Through ongoing surveys conducted by DMHAS RACs, identify gaps in communities
- Reexamine the YSAB brochures to possibly insert protective factors - More resources are needed and better access to existing services – in particular, the DCF Emergency Mobile Psychiatric Services (EMPS) need to be more flexible and responsive –
- Identify and link resources in communities

**Outcomes:**

- Recommendations submitted to Commissioner
- Through blended funds from federal SAMSHA grant to DMHAS and DCF state prevention dollars, RFPs for mini-grants were issued in early Fall of 2007. These grants will fund 15-30 schools from \$1,000 - \$2,000 each. Another round is expected to occur in the spring of 2009.
- Training funded by DCF continues. These include training for college students, faculty and staff, DCF social workers and community providers. In addition, through combined dollars from federal SAMSHA grant to DMHAS with DCF state dollars, training is expanding in 2007/08 to include two evidence-based curricula, Assist (Applied Suicide Intervention Skills Training) and Assessing and Managing Suicide training. United Way will conduct 8 ASIST trainings (4 per year) and one Training for Trainer (TOT) session offered in the spring '09.
- Wheeler Clinic will conduct training on Assessing and Managing Suicide Risk (AMSR): Core Competencies for Mental Health Professionals clinical training for Masters and Ph.D. level clinicians. The first session was scheduled in the fall of 2007. Three additional sessions are intended for 2008 and 2009.
- Mailing to all schools, chiefs of police, Youth Service Bureaus and DCF Area Offices sent in August of 2006 and 2007.
- EMPS contracts examined and strengthened through DCF's Bureau of Behavioral Health.

**Measure of Effectiveness:** The number of public awareness campaigns conducted and the number of individuals and groups trained on strategies to recognize risk factors for youth suicide and tools to manage and prevent youth suicide. Schools, police, mental health professionals, parents, foster parents and community colleges are to be targeted.

**Methods:** Cultural competency is incorporated into the designing and implementation of all training and awareness campaigns. Target populations for training include high risk groups such as Gay, Lesbian, Bisexual and Transgender youth.

**Program Name:** Shaken Baby Prevention

**Program Description:** Public Awareness Campaign and training of DCF workers, other State workers and providers on strategies to calm crying babies and educate young people in the Department's facilities about the dangers of shaken baby syndrome.

**Number of children and families served:** Training was provided on baby calming strategies to over 400 providers and 100 parents. Technical assistance was provided and audio-visual materials were provided to the Department's four facilities in order to develop prevention education for young people in the Department's care.

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**Long-Term Agency Goals:**

- Reduce the incidence of shaken baby syndrome
- Increase the bonding of parents and young children.

**Strategies:** Since crying is a known trigger for shaken baby syndrome, the Department is leading an interagency planning effort to create a Training of Trainers to disseminate baby calming strategies to the general population, and in particular to parents who may be at greater risk for the perpetration of shaken baby syndrome across the State. Current partners include the Departments of Corrections; Public Health; Social Services; Department of Mental Health and Addiction Services; Corrections; Court Support Services Division; Office of the Child Advocate

**Methods:** Training of Trainers

**Measures of Effectiveness:** Currently, a subcommittee is investigating the possibility of funding in order to conduct an evaluation of this initiative.

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**Program Name:** DCF / Head Start Collaboration

**Program Description:** The original collaborative effort began in July 1999 in the DCF offices in Torrington, Waterbury and Danbury, and Head Start Programs in Litchfield County, Waterbury, Naugatuck and Danbury. The collaboration involved 150 staff from both agencies, developed new knowledge and understanding of the partner agency's program, improved communication, referral and collaboration; and had developed new services and resources. In February 2006, this collaborative partnership was revived and expanded to an additional five sites. The focus on this partnership is to develop strategies to promote family health and the stability of the child within the family.

**Service Level:** Potential number of children and families to be impacted: 1,500  
Number of staff involved from both agencies: 60

**Long Term Agency Goals:**

- Children and families experience coordinated services and continuity of care;
- Children's health, safety and development is monitored with increasing frequency and thoroughness;
- Families receive more frequent and comprehensive community based and in-home services;
- Children experience fewer placements;
- When placements out of home must occur children are placed with relatives and the agency works collaboratively to develop a plan of services and supports
- New strategies and resources are created for achieving child and family goals;
- Children and families increase strengths and resiliency; and
- Head Start and DCF have improved working relationship.

**Strategies:** The Collaboration promotes the strengthening of child and family relationships by developing a protocol for enhancing communication between each agency. As a result of the protocol, DCF and Head Start staff know more about one another's programs and services, thus they can use each others resources more effectively, and each agency can make and receive appropriate referrals to/from their partner agency. Head Start and DCF staff work collaboratively to identify mutual families served and participate in all aspects of service provision to children and families including: DCF referral, investigation, and treatment planning; and referral, enrollment and case management in Head Start. Through partnering both agencies build capacity in communities in the area of cross training and resource development.

**Outcomes:** This collaboration will promote family strengthening by reducing the risk of child neglect and abuse, out-of-home placements and placement disruptions, while monitoring the development, health and safety of young children. Families will be strengthened as they participate in identifying their strengths, needs, goals and resources. Communities and participating agencies will be developing new resources and collaborative innovative strategies for working with families.

The possible outcomes under discussion include the following:

- Decrease in isolation by families
- Increase child and family strength and resiliency
- Increase visibility of children within community
- Decrease in abuse and neglect
- Increase in child developmental screening and monitoring
- Increased ability to maintain children within their biological home or when necessary in relative care
- Increase in Head Start knowledge of DCF mission, locations, services
- Increase in DCF knowledge of Head Start mission, location, services
- Increase contacts with Head Start during DCF investigations, treatment planning conference and Area Case Reviews
- Increase in DCF participation in Head Start trainings and committees

**Measures of Effectiveness:** Measurements of effectiveness include monitoring the use of the protocol which documents the understanding and implementation of practices with respect to Head Start Policies including: Developing Family Partnership, Developing Community Partnerships, and Child Health and Safety; and with respect to DCF Policies including: Conducting Investigations, Case Dispositions, Treatment Planning, Foster Care, Administrative Review, Treatment Plan Monitoring, and Case Closure. Both quantitative and qualitative data are collected quarterly on cross agency communication regarding referrals, investigations, on-going services and joint treatment planning; and collaborative staff training, program planning and resource development within communities.

**Methods:** The protocol is designed to be child-centered, family focused and strength based. Data are collected from participating DCF area offices and Head Start and Early Head Start programs on a quarterly basis and include collaborative communications on case and program related activities, joint meeting minutes, cross-trainings and products developed and disseminated among Head Start/Early Head Start programs and within the DCF area office.

## Department of Developmental Services

**Program Name:** Birth to Three

**Program Description:** The Department of Developmental Services is the lead agency (17a-248 C.G.S.) for the Birth to Three program which is also operated under the provisions of Part C of the Individuals with Disabilities Education Act. This is the same federal law that governs special education for children ages 3-21.

The mission of the program is to strengthen the capacity of families to meet the developmental and health-related needs of their infants and toddlers who have delays or disabilities. The program ensures that all families have equal access to a coordinated program of comprehensive services and supports that:

- foster collaborative partnerships
- are family centered
- occur in natural settings
- recognize current best practices in early intervention
- are built upon mutual respect and choice

Birth to Three seeks to assist families to ameliorate delays in their infants' or toddlers' development that are identified early or to prevent secondary delays or disabilities. We work with families to ensure that their children are ready for Kindergarten at age five.

The federal law requires that two groups of children receive services 1) those with developmental delays and 2) those with diagnosed conditions expected to lead to a developmental delay without the benefit of early intervention. The State is given quite a bit of latitude in defining both of those groups.

Early intervention services must be delivered in natural environments, and for children of this age, that is typically the home, (although services can be delivered in any setting that the child and family typically frequent, such as at child care.) Most services are delivered by occupational, physical, and speech therapists along with early childhood special education teachers, although there are many other professionals and paraprofessionals who can be service providers as well.

**Number of children and families served:** In FY 2007, 8,687 children were newly referred for evaluation. 8,591 eligible children and their families received services during some portion of the fiscal year, with approximately 4,000 enrolled on any given day.

**Long-Term Agency Goals:** To ensure that children with developmental delays or who are at-risk for developmental delays are ready for Kindergarten.

**Strategies:** Family-centered early intervention services are delivered in natural environments as early as possible to all Connecticut infants and toddlers who have disabilities or significant developmental delays or who are at biological risk for significant developmental delays.

**Performance Based Standards:** There is a single statewide point of access, which is easily marketed to referral sources. Once children are referred, they are evaluated and, if eligible, family service plans are developed within 45 days of referral. All new services are delivered no later than 45 days from the writing of the plan. Plans are reviewed at least every six months and rewritten at least annually. School Districts are notified of all children receiving early intervention services unless parents opt out of that notification.

**Performance Based Outcomes:**

- All eligible children and their families are identified and offered services
- Children receive early intervention services as early as possible
- Children’s developmental trajectories are improved
- Families feel more confident and competent to foster their children’s development
- Fewer children need special education services by Kindergarten

**Performance Based Accountability:** Birth to Three has an in-depth process for assuring the quality of services and the performance of its contractors. All contractors are tied together in a real-time data system that enables the state to view performance on a daily basis. That allows us to monitor our data and produce monthly performance reports. The contractors have a “performance dashboard” as part of the data system which allows them to monitor their own performance. In addition, every two years, each contractor submits a “Biennial Performance Report” looking at their own performance over a wide variety of indicators, many of which require them to review child records and interview families. That report is submitted electronically. The state verifies the data and the contractor is required to prepare an improvement plan. Twice a year, the state ranks contractors on three specific performance indicators. Low-performing contractors receive an on-site monitoring visit by a team composed of state staff, a program director from a different agency, and parents. The team focuses on the indicator that was low but then digs much deeper into issues of quality. They review child records, interview staff, and interview parents. The monitoring report is issued and any items found to need improvement are added to the contractor’s existing improvement plan. The last check on performance is procedural safeguards for parents. Each written complaint received is investigated and may result in one or more findings that must be corrected by the contractor. The same is true for any administrative hearings, although they are held infrequently. All of these accountability processes are detailed in the Birth to Three Quality Assurance Manual found on [www.birth23.org](http://www.birth23.org) under “Publications.”

**Measures of Effectiveness: FY07 data:**

**Outcomes 1 & 2: All eligible children identified and offered services as early as possible**

- Percent of children under the age of three served - 3.4%. The national average for FY06 was 2.40%. Connecticut ranks 12<sup>th</sup> nationally.
- Percent of children under the age of 12 months served -1.2%. The national average for FY06 was 1.01%. Connecticut ranks 21<sup>st</sup> nationally.

**Outcome 3: Children's developmental trajectories are improved**

- Percent of infants and toddlers served who demonstrate:
- Improved positive social-emotional skills - 55% achieved or maintained age level and an additional 39% improved to a level closer to their age peers.
- Acquisition and use of knowledge and skills including early language and communication-58% achieved or maintained age level and an additional 38% improved to a level closer to their age peers.
- Use of appropriate behaviors to meet their needs - 60% achieved or maintained age level and an additional 35% improved to a level closer to their age peers.

**Outcome 4: Families feel more confident and competent**

- Percent of families served who report that early intervention services have helped the family help their children develop and learn. This includes better understanding their children's special needs - 97% of families agree, with 72% strongly or very strongly agreeing.

**Outcome 5: Fewer children need special education by Kindergarten**

- Percent of children served who have exited the program and who are not receiving special education services in Kindergarten as of October, 2007 - 64%.

**Methods:** All children that meet the eligibility criteria are eligible – irrespective of race, income level, gender, or town of residence. The program does not specifically target groups of children for services. However, by including all children with significant developmental delays, Birth to Three is working to teach families and other caregivers to facilitate the child's development so that they can “catch up” to their typical peers by Kindergarten. Therefore, we are actually concentrating on reducing disparities between children with developmental delays and their typically developing peers.

The focus of services is in teaching the family and caregiver(s) ways to intervene in the child's development during naturally-occurring routines and activities. Research tells us that very young children do not generalize and do not learn through what are called “massed” trials (repeated practice of a skill within a short period.) Birth to Three uses a coaching process to help the caregiver feel more confident and competent in intervening all during the day so that children get the opportunity to practice skills as they are functional and intermittently over a long period. Since each child's Individualized Family Service Plan is individualized for that child and that family, and since the focus of

the plan is on the family's priorities for their child and themselves, the family's ethnicity and income level will be addressed because it affects that family's priorities and need for services.

As services begin, children are assessed using any one of three curriculum-based assessments. This allows the Birth to Three providers to then summarize the child's development at entry which is then compared to the child's development at exit to track developmental progress. Use of this type of assessment also helps the family track their child's progress and be aware of the general order of development across all areas.

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### **Program Name: Family Supports**

**Program Description:** The Department of Developmental Services (DDS) provides Family Supports which assist families to care for their children who have mental retardation. Most families who have children with mental retardation need extra support to help them to care for their children at home. Family supports include goods, services, resources, and other forms of assistance that help families to successfully parent their children who have mental retardation. Family Supports help families to stay together and to maintain their children who have disabilities in the family home. When children grow up in a nurturing family home, they are more likely to live healthy, safe and productive lives.

**The department provides two primary Family Support programs, Individual and Family Grants and Respite at DDS Respite Centers.**

#### **Individual and Family Grants**

Individual and Family Grants are cash subsidies provided for the purpose of assisting individuals and families to defray extraordinary disability-related expenses. The provision of Individual and Family Grants acknowledges the extra effort and commitment of families who have children with disabilities that have an extraordinary financial impact on the family. The provision of Individual and Family Grants assists families to purchase items and services that are not otherwise reimbursable through insurance or available from other sources. The cash subsidies may be used to purchase supports that include, but are not limited to, in-home supports, behavioral supports, nursing, medical or clinical supports, temporary assistance, crisis support, skill training, family training, leisure services, transportation, support coordination, respite and assistance to access community supports. The maximum grant amount is \$5,000 per individual or family per fiscal year. For families who have children with mental retardation, Individual and Family Grants support the child to remain in the family home and help to prevent out of home placement. A total of 4,123 families received Individual and Family Grants in FY 2007. This number includes 1,859 families of children under age 18.

#### **Respite Services**

Respite is the temporary care of a person with mental retardation for the purpose of offering relief to the family. It is a service that allows the family to have time to reenergize, deal with emergency situations, or engage in personal, social, or routine activities and tasks that otherwise may be neglected, postponed, or curtailed due to the demands of caring for a child who has mental retardation. The goal of respite services is to support the continued presence and participation of individuals who have mental retardation within the family homes and to prevent out of home placement.

The Department of Developmental Services provides respite through eleven regional Respite Centers. DDS Respite Centers are specifically designed to provide planned and scheduled relief to families. The three DDS regions provide overnight respite throughout the year from Thursdays through Tuesdays and are open twenty-four hours a day, seven days a week for up to eight weeks during the year, including summer months or school vacations. Respite Centers are operated by DDS staff who have skills needed to work with children and adults who have mental retardation and their families.

In total, DDS Respite Centers served 1,114 persons who have mental retardation in FY 2007 including both children and adults. There were a total of 477 children served in DDS Respite Centers in FY 2007.

Number of children and families served: 2,211 served in fiscal year 2007.  
(Most children who received Respite Services also received Individual and Family Grants.)

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**Long-Term Agency Goals:** The Department of Developmental Services serves over 15,100 individuals who have mental retardation including 2,940 children under the age of 18. This number does not include children who do not have mental retardation and are served in the Birth to Three System. While most children live with their families, about 249 or eight percent of children served by DDS live in other residential settings. The department's long term prevention goal is to support families to care for their children in the family home and to prevent out of home placement.

**Strategies:** Most families who have children with mental retardation need extra support to help them to care for their children at home. DDS provides Family Supports to assist families to care for their children at home. Family Supports include goods, services, resources, and other forms of assistance that help families to successfully parent their children who have mental retardation. The Department of Developmental Services plans to continue to provide Individual and Family Grants and Respite to families. Within available resources, the department will expand the number of families served with these Family Supports.

During FY 2007, DDS also assigned Family Support Workers to provide temporary in-home and community support to individuals who live at home with their families. These supports are provided by DDS staff who have skills needed to work with children who have mental retardation and their families. The types of supports and services provided include in-home and community supports, respite, skill building, implementation of

behavior programs, activities to promote health and wellness, transportation to medical appointments, and support with transitions to adult programs. DDS plans to continue these supports.

In addition to the Family Support services offered by the department, DDS continues to implement Home and Community Based Services Waivers which offer services in the community as an alternative to institutional care. The department continues to expand the range and number of services available under the waivers that assist families to care for their children within the family home. These services include personal services, individualized supports, respite, home and vehicle modifications, family training and consultative services.

The department also has established the position of Lifespan Coordinator within the Central Office with an initial focus to coordinate children's services, including expanding the availability and ensuring the quality of supports provided to children and their families.

**Performance Based Standards:** The goal of DDS family supports is to support families of children with disabilities to stay together and to maintain their disabled children in the family home. DDS prioritizes family supports based on the support need of the children and family, for instance children who are high priority on the waiting list for residential services are high priority for services at respite centers. The standards are further described below in the Vision and Guiding Principles for Family Support.

**Performance Based Outcomes:** Specific outcomes to measure the success or effectiveness of the Family Supports provided by DDS include the number of children and families served and the number and percentage of children who live in family homes rather than in out of home placements.

**Performance Based Accountability:**

Family Supports are provided by DDS staff and programs and are not under contract. Respite Center and Individual and family Grant programs are operated based on DDS policies and procedures specific to those services. The procedures describe the eligibility criteria, priority for services, and service operational guidelines. DDS regions maintain data on the numbers of children and adults served. The department also has a goal of adding an additional respite center this year.

**Prevention Effectiveness:** The percentage of children served by DDS who lived in their family homes has remained consistent over the last six years. The percentage of out of home placements has not increased since October 2000 and has remained at eight percent.

**Methods:** DDS Family Support services are available to children and their families regardless of race, income level or gender.

**Other:** The Department of Developmental Services' vision and guiding principles for children with mental retardation are as follows:

**Vision:** All children with mental retardation grow up with the love and nurturing of their families. Families identify and receive the individually designed supports they need to raise their children in their local communities. Communities embrace children with mental retardation and their families and include them in all aspects of community life.

**Guiding Principles:** The following guiding principles were identified by focus team members as critical ingredients in providing supports to children and their families.

▪ **Children Grow Best in Families**

A “whatever it takes” approach should be adopted to keep children with their families. Families should receive the support they need to raise their children at home. When a family is not able to provide full time care for their child, arrangements should be made to share the care of their child with others who will provide a nurturing family home. When a child is unable to live with his or her family, even part-time, a permanent home should be provided for the child that balances the family’s wishes with the best interests of the child. It is essential that children maintain strong relationships with their families. Families’ bonds with their children should be maintained whenever possible.

▪ **Families Know their Children Best**

Families have primary responsibility for the well being of their children. Families should have information about available options, services, and resources that will enhance their abilities to make informed choices. Support staff should listen to families and respect their decisions.

▪ **Supports Are Responsive to the Needs of the Entire Family**

Families are the constant in their children’s lives. Children should be supported in the context of their families with services that are tailored to the unique family circumstance.

▪ **Supports Are Family-Directed**

Families should drive the planning process and have a strong voice in designing, selecting, and evaluating the supports and services they and their children receive. Families should have the tools and resources they need to be successful in directing their supports.

▪ **Supports Are Delivered in a Culturally Competent Manner**

The culture of the family influences the choices they make and will accept. Supports should be delivered in the family’s language and in ways that are consistent with a family’s cultural preferences. Supports should be provided by a culturally competent workforce that understands the diverse needs of families.

▪ **Services and Supports Are Individualized, Flexible, Far-reaching, and Responsive to Changing Needs**

No two families are alike in their strengths, challenges, or aspirations. Families should have access to a full range of options including in-home and community

supports that are uniquely tailored to their needs. Supports should be easily accessible and sufficiently available to make a difference. Supports should be available before a crisis arises, but if an emergency does arise, families want some sense of security that help will be there when they need it. Supports should be flexible to meet the changing needs of families in a timely way.

- **Families and Children Receive Supports and Services in Their Community of Choice**

Families want their children to be welcome participants in their own communities. They want their children to be able to access the same formal and informal supports available to children who do not have disabilities. Assistance should be available to help families to use and strengthen their natural supports, connect with their communities, and develop new resources. Families should be assisted to reach out to other families for networking, and to work on community building and workforce development issues. Supports should promote the integration and inclusion of children with mental retardation in the daily life of the community.

- **Supports Are Designed to Maximize Families' Competencies**

Families should be supported to make decisions about needed supports and services and to direct the provision of those services. Professionals and others should promote the competencies of families and provide any tools necessary to assist families including leadership, networking, and advocacy skill development that will prepare families to advocate for new or enhanced supports.

## Department of Education

**Program Name:** Even Start Family Literacy Program

**Program Purpose:** To break the cycle of poverty and illiteracy for low-income families.

**Program Description:** Even Start is a federally-funded program that provides intensive family literacy services that involve parents and children in a cooperative effort to help parents become full partners in the education of their children and assist children in reaching their full potential as learners. Even Start helps break the cycle of poverty and illiteracy by improving the education opportunities of families most in need in terms of poverty and illiteracy by integrating early childhood education, adult literacy or adult basic education, and parenting education into a unified family literacy program. Local programs are implemented through cooperative projects that build on high-quality existing community resources, creating a new range of services for low income children and parents.

Even Start helps children and families achieve the academic standards set forth by the state and uses instructional programs that are based on scientifically-based reading research to:

- enrich language development, extend learning, and support high levels of educational success for children birth to age seven and their parents;
- provide literacy services of sufficient hours and duration to make sustainable changes in a family;
- provide integrated instructional services for families, where children and their parents learn together to develop habits of life-long learning; and
- support families committed to education and to economic independence.

**Service Level:** During the 2006-07 period, Even Start in Connecticut operated with 6 programs serving high-need areas of Danbury, Middletown, Stamford, Windham, New London, Middletown and Shelton. Programs served 149 Even Start families (153 adults and 181 children) through early childhood education, adult education, and parenting classes. The number of programs supported has dropped significantly from a previous service level of 11 programs.

### **Performance Based Standards:**

1. It is expected that 50% to 65% of the Even Start children birth through age five will meet the reading readiness standards for their age group.
2. It is expected that 40% or more of the adults will meet adult literacy goals in ABE or ESL reading and 60% of the adults in a high school diploma or GED program will make progress toward attaining a diploma.
3. It is expected that 40% to 60% of the parents will meet standards for skill development in family literacy such as reading to child, borrowing books

from the library or other sources, encouraging children to read with them at home, etc.

**Performance-Based Accountability:** Even Start is required to contract for local program evaluation. All programs must report on quality, attendance and outcomes as well as meet state standards or performance indicators of success in early childhood, adult education and parenting education. Outcomes, attendance and quality assurance standards are reviewed on a monthly and an annual basis at the local and state level. Programs must also develop local objectives that are measurable and demonstrate the quality of their program and outcomes, monthly attendance of each child and adults. Local evaluation requires a visit 3-5 times per year to review early childhood records, lesson plans and observation of instruction, focus groups with staff and adults, etc.

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**Program Name:** Early Childhood Program (School Readiness)

**Program Purpose:** To enhance the quality of programs providing school readiness or child day care services

**Program Description:**

- To significantly increase the number of accredited and/or approved spaces for young children in order to provide greater access to high-quality programs for all children;
- To significantly increase the number of spaces for young children to receive full-day, full-year child care services to meet family needs and to enable parents to become employed;
- To establish a shared cost for such early care and education programs among the state and its various agencies, the communities and families and;

All programs must receive National Association for the Education of Young Children (NAEYC), Head Start, New England Association of Schools and Colleges (NEASC) or Montessori accreditation within three years of initial funding and must maintain such accreditation for continued funding to ensure high-quality programs for all children. Communities must offer a range of options regarding the length of program day and year in order to meet the needs of families. Families are offered a sliding fee scale as a means of providing affordable high-quality early education programming.

**Service Level:** During 2006/2007, a total of 58 towns/school districts in Connecticut served 8,732 children in 19 priority school districts and 39 competitive districts.

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**Performance Based Standards:**

1. Quality preschool services are available for 100% of eligible children in priority school districts.
2. By 2015 every School Readiness classroom will have a teacher with a bachelors degree or higher.
3. All of the School Readiness Programs are accredited or approved under the recognized systems.

**Performance-Based Accountability:** School readiness programs are based on ten (10) quality components and provide supports and services for collaboration with community agencies, health, nutrition, parent education and services, transition to kindergarten, professional development that includes training in emerging literacy and diversity, family literacy, child and program evaluation, a sliding fee scale and a non-discriminatory admissions process. The plan to implement these supports and services is described by each school readiness program in their RFP application. The program's adherence to the quality components is reported through the Connecticut School Readiness Preschool Program Evaluation System (CSRPE), as well as state monitoring visits and quarterly Community Liaison site visits. These reports focus on the program's implementation of the services and emphasize collaboration with outside service providers in order to support the individual needs of families in the context of their community.

*Agency goals as well as strategies, methods, outcomes and measures of effectiveness are referenced in the Connecticut State Board of Education's Five-year Comprehensive Plan for Education 2006-2011.*

### **Long-Term Agency Goal #1**

**Goal: High-quality preschool education for all students,** including preschool programs aligned with *Connecticut's Preschool Curriculum Framework and Preschool Assessment Framework* and linked to the *Connecticut Framework: K-12 Curricular Goals and Standards*. This will require alignment of research-based curriculum implemented by high-quality teachers in preschool through Grade 3, with a monitoring and assessment system aligned to the state standards.

**Strategies and Methods:** The State Board of Education will take the necessary steps to support the following state actions to address this priority:

- Provide funding for high-quality preschool education for all 3- and 4-year-old children living in high-need districts, as well as those children most in need throughout the state
- Provide incentives to districts to assume increased responsibility for high-quality preschool education
- Increase funds to existing state programs, such as School Readiness and Head Start, to support high-quality preschool education

- Revise current statute to increase funding for both school construction and the child-care facilities loan funds to expand capacity for preschool education
- Provide assistance to enable children of families most in need to receive a high-quality preschool education
- Collaborate with Connecticut higher education to establish a seamless system between two- and four-year programs to prepare high-quality early childhood educators
- Collaborate with Connecticut higher education institutions to provide incentives, such as scholarships, tuition waivers and forgivable loans, to candidates seeking an early childhood credential
- Expand early childhood educator preparation programs to allow alternate forms of obtaining a required credential, such as distance learning, off-campus and satellite learning centers, employment based and credit-granting courses, and supervised practicum; emphasis will be placed on increasing minority candidate participation
- Provide ongoing, systematic professional development in the use of *Connecticut's Preschool Curriculum Framework* and *Preschool Assessment Framework* to ensure that all early childhood educators have the knowledge and skills to prepare children for future school success
- Collaborate with the Department of Public Health to modify the role of the education consultant to support early childhood educators in effective instructional practices consistent with *Connecticut's Preschool Curriculum Framework* and *Preschool Assessment Framework*
- Establish a system of monitoring and technical assistance to support effective instructional practices consistent with *Connecticut's Preschool Curriculum Framework* and *Preschool Assessment Framework* and aligned with the *Connecticut Framework: K-12 Curricular Goals and Standards*
- Support the design and implementation of a developmentally appropriate measure of children's readiness for and progress in kindergarten

**Outcome and Measures of Effectiveness:** The expected outcome is a high-quality preschool education for all young children in Connecticut. The following indicators will serve as measures of success:

- More children will participate in high-quality, state-funded preschool programs, and there will be greater access to high-quality preschool programs statewide.

- More teachers will have specialized credentials in early childhood education and the skills and knowledge to provide a high-quality preschool education.
- All preschool programs will include a rigorous curriculum and an assessment system aligned to *Connecticut's Preschool Curriculum Framework* and *Preschool Assessment Framework*.
- Children who participate in all preschool programs will enter kindergarten fully prepared for further learning in literacy and numeracy.
- All children will have competencies in areas that support their learning and academic success, which include physical and motor development, creative and aesthetic expression, and personal, social and emotional skills.

## **Long-Term Agency Goal #2**

**Goal: High academic achievement of all students in reading, writing, mathematics and science**, with a focus on students in high-need schools and districts. High achievement will result only if all students are *expected* to achieve at high levels and have equal access to challenging curriculum and instruction, and adequate and equitable resources; and are taught by excellent educators who believe that all students, regardless of race, gender, ethnicity or socioeconomic status, can achieve at high levels.

**Strategies and Methods:** The State Board of Education will take the necessary steps to support the following state actions to address this priority:

- Develop model curriculums in reading, mathematics and science for prekindergarten through Grade 8
- Develop model curriculums for algebra and geometry
- Provide training and technical support for educators in the implementation of curriculums and monitor implementation in high-need districts
- Develop formative assessments, aligned to model curriculums, and provide training in the use of formative assessments
- Require low-performing districts to administer formative assessments in reading, writing, mathematics and science at all grade levels and use the information to improve instruction
- Establish incentives to attract, support and retain highly qualified and effective teachers in high-need districts, with priority given to attracting minority teachers
- Support “grow-your-own” programs in high-need districts by identifying (1) mentors for classroom-based support programs to increase teacher retention,

(2) outstanding paraprofessionals to become certified teachers and (3) teachers who exhibit strong leadership skills to become school leaders/administrators

- Provide communication and outreach to middle and high school students from high-need districts on incentives available after high school graduation to those who attend educator preparation programs in Connecticut
- Collaborate with higher education in Connecticut to provide tuition assistance to students most in need to pursue teaching careers in mathematics and science
- Conduct a comprehensive evaluation of all components of the BEST Program and implement appropriate changes based on evaluation findings to ensure that all beginning teachers provide high-quality, effective instruction
- Develop and provide an induction program for all new administrators, beginning in high-need districts
- Establish pilot programs for extended learning opportunities beyond the regular school day and year, such as before- and after-school programs, weekend programs, tutoring, homework help and summer school, with expansion to additional schools based on results of the pilot
- Align pre-service training with the National Council for Accreditation of Teacher Education (NCATE) standards on partnering with families and communities
- Provide professional development to school and district staff members in developing effective school-family- community/business partnerships based on State Board of Education standards
- Continue to expand the Connecticut Accountability for Learning Initiative (CALI) and support schools and districts identified by the No Child Left Behind Act (NCLB) in Year 3 of “in need of improvement” by:
  - requiring school-wide instructional assessment by an external evaluator;
  - requiring the review of reading and mathematics curriculums in these districts and, if not standards-based, requiring implementation of State Department of Education model curriculums;
  - requiring on-site coaching of superintendents and principals in these districts, using as coaches administrators with records of high student achievement;

- requiring leadership training for superintendents and principals in these districts in developing and implementing high-level instruction in reading and mathematics across all grade levels;
- requiring the use of formative assessments in each of these districts to improve instruction; and
- requiring the use of a longitudinal data system to track student indicators having direct impact on student achievement

**Outcome and Measures of Effectiveness:** The expected outcome for each of these actions is increased achievement of all students and a significant closing of the achievement gap in reading, writing, mathematics and science.

The following indicators, which are closely linked to student achievement, will serve as measures of success:

- Curriculums aligned to the *Connecticut Framework: K-12 Curricular Goals and Standards* implemented in every school.
- District implementation of the full range of assessment options available, including common grade-level or subject-area assessments, benchmark assessments and formative classroom assessments.
- Increased teacher retention rates and the number of minority teachers in high-need districts.
- Increased retention of high-quality, new administrators in high-need districts.
- Enhanced BEST Program so all beginning teachers are provided the necessary support for effective teaching of all students.
- Fewer districts and schools identified as “in need of improvement” and “in need of corrective action”.
- Implementation of a data system to measure student growth longitudinally.
- Significant increases in reading, writing, mathematics and science achievement within one year at schools with pilot programs for extended learning opportunities.
- Increased family participation in the planning and improvement of school programs.

- Increased support to families for supporting children’s learning at home.
- Improved district policies on school-family-community/ business involvement and consistent implementation of these policies.

### **Long-Term Agency Goal #3**

**Goal: High school reform,** so all students graduate and are prepared for lifelong learning and careers in a competitive, global economy. This will require all high schools to provide a rigorous, literacy-based curriculum linked to authentic, real-life experiences; performance-based assessments; a school climate in which personal and social responsibility is practiced; and school-business partnerships that offers students tangible knowledge and experience.

**Strategies and Methods:** The State Board of Education will take the necessary steps to support the following state actions to address this priority:

- Increase graduation requirements to reflect the skills needed to ensure success in a global society
- Establish competencies stating what students should know and be able to do upon graduation from Connecticut’s high schools in order to be successful in postsecondary activities, and require districts to align local graduation requirements with the established competencies
- Ensure that all districts develop and implement rigorous, standards-based curriculums to meet the changing needs of the workplace, technology and a global economy
- Allow standards-based alternatives for demonstrating knowledge, skills and understanding as a way to earn high school and/or college credits
- Require access to meaningful out-of-school learning experiences for all students
- Develop strategies to reduce the number of students who are suspended from and/or drop out of high school, including alternate programs for students most in need
- Create and sustain a data warehouse to track students’ performance from preschool through college
- Attract, support and retain highly effective secondary school administrators to meet the challenges and demands of redesigning Connecticut’s high schools

- Require that all students have a personal education plan that includes career development, in- and out-of-school coursework and/or activities, and transition to postsecondary education and/or the workplace

**Outcomes and Measures of Effectiveness:** All Connecticut high schools will be redefined using the research-based standards in the *Framework for Connecticut's High School: A Working Guide for High School Redesign*. The expected outcome from the preceding action is to have every student graduate from high school prepared for college and work.

Each high school will fully prepare students when the following are in place:

- a clear mission defining what it seeks to achieve;
- a rigorous, standards-based curriculum;
- a strong school community focused on the school's mission and high expectations for student learning;
- a small, safe, personalized and positive learning environment;
- embedded professional development with the single purpose of improving teaching and learning;
- a system using accurate data to inform and transform teaching, learning, leadership and management practices; and
- learning opportunities for all students that extend into the community.

## Department of Mental Health & Addiction Services

**Program Name:** Best Practices Initiative

**Program Description:** 14 statewide funded projects that apply science and research-based programs to populations across the life cycle. These science-based community prevention programs are designed to enhance the lives of adults and children and encourage family, peers, neighbors and others to become involved.

Utilizing multiple Substance Abuse and Mental Health Services Administration-Center for Substance Abuse Prevention (SAMHSA-CSAP) strategies, Best Practice programs focus on positive youth development; alcohol, tobacco and other drug education; healthy decision-making skills and recreation. Programming is varied and in many cases multi-pronged, but most target needy or otherwise at risk youth. Several programs incorporate academic support, peer leaders or mentors and many emphasize family development and parenting skills. Youth-led participatory research, training for professionals working in youth-serving organizations, and education, enrichment and respite services for grandparents and custodial relative caregivers are also represented.

The Best Practices engage youth, families, schools and communities in Danbury, Enfield, Hartford, Middletown, Milford, New Britain, New Haven, New London, Plainville, Torrington, Westport, Windham and surrounding municipalities in alternative activities, community-based processes, education, information dissemination, and problem identification and referral.

**Number of children and families served:** In SFY 07, 3,231 youngsters between 0-11 years old; 4,150 youth between 12 and 17 years-old; 21,497 young people between 18-24 years old; and 5,155 individuals 25 years and older were served by Best Practices programs

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**Program Name:** Local Prevention Council Programs

**Program Description:** The Local Alcohol, Tobacco and Other Drug Abuse Prevention Council Grant Program (LPCP) initiative supports the activities of local, municipal-based alcohol, tobacco, and other drug (ATOD) abuse prevention councils. The intent of this grant program is to facilitate the development of ATOD abuse prevention initiatives at the local level with the support of chief elected officials. The specific goal of this grant initiative is to increase public awareness focused on the prevention of ATOD abuse, and stimulate the development and implementation of local substance abuse prevention activities primarily focused on youth through 120 local municipal and town councils serving the 169 towns and cities in Connecticut.

Local Prevention Councils (LPCs) are advisory and coordinative in nature and reflective of each community's racial/ethnic, political, and economic diversity. Councils may include representation from professionals working in the prevention field in general and

ATOD abuse prevention in particular, including representation from volunteer groups whose activities focus on ATOD abuse prevention. Additionally, council membership may include a cross-section of the community which it will serve including city/town agencies, organizations, communities and ethnic groups, parents, media, business, senior citizens, health care sector, etc., concerned with prevention issues. The LPCP initiative is designed to: 1) support the on-going prevention activities of established councils; 2) support specific prevention projects of local councils; and 3) support activities that increase public awareness of the problem of ATOD use and abuse.

**Number of children and families served:** In SFY 07, 117,500 individuals were served including 49,500 between 0 and 11 years old; 51,500 between 12 and 17years old; 8,000 between 18 and 24 years old and 8,500 age 25 and older. These individuals included a mixture of children, family members, and community professionals.

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**Program Name:** Strategic Prevention Framework State Incentive Grant (SPF SIG)

**Program Description:** The SPF SIG program is designed to help grantees build a solid foundation for delivering and sustaining effective substance abuse services in order to: prevent the onset and reduce the progression of underage drinking and related problems in communities, and build prevention capacity and infrastructure at the state and community levels.

The overall purpose of the CT SPF Initiative is to develop a comprehensive Prevention Strategy for delivering and implementing effective substance abuse prevention services. The initiative serves as a blueprint for State and community partners to apply the federal Center for Substance Abuse Prevention's (CSAP) Strategic Prevention Framework towards creating healthy communities for everyone. Twenty eight communities throughout the state including campuses, municipalities and youth serving agencies utilize the SPF blueprint to conduct needs assessments, develop community capacity, develop strategic plans, implement programs, policies and practices identified in the plans and evaluate their outcomes.

**Number of children and families served:** A total of 13,529 children, family and community members, and prevention professionals were served in SFY 07. Of this number 150 were between 0-11 years old; 4,753 between 12 and 17years old; 1,897 between 18 and 24 years old; and 6,729 age 25 and older.

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**Program Name:** CT Youth Suicide Prevention Initiative

**Program Description:** Develop and implement comprehensive, evidence-based youth suicide prevention and early intervention strategies that may be maintained over time and expanded throughout Connecticut. This initiative builds on the recommendations of the Connecticut Interagency Suicide Prevention Network, the 2005 Connecticut

Comprehensive Suicide Prevention Plan, the Connecticut Youth Suicide Advisory Board, and the CT Mental Health Transformation Initiative. It specifically addresses Goal 1.2 of the President's New Freedom Commission on Mental Health, the need to advance and implement a national strategy for suicide prevention.

Key components of the project are to: 1) Support the use of the science-based "Signs of Suicide" (SOS) Program, the Question, Persuade and Refer Gatekeeper Model, and the College Response Model in selected middle and high schools and CT State Universities (CSU); 2) Expand the existing DCF-sponsored training program for foster and adoptive parents, school nurses, parent/teacher organizations, youth service bureaus, and juvenile justice personnel in recognizing the signs and symptoms of suicidality and depression; and 3) Design and pilot the implementation of a model program to increase the availability, accessibility, and linkages to mental health treatment by embedding services in school-based health and community-based hospital clinics.

**Number of children and families served:** Fiscal year 2007 was a start-up year for this initiative consequently, program services were not provided until July 2007.

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**Program Name:** Regional Action Councils

**Program Description:** 14 sub-regional planning and action councils that have responsibility for the planning, development and coordination of behavioral health services in their respective region.

Regional Substance Abuse Action Councils are public-private agencies comprised of community leaders. Its purpose is to establish and implement an action plan to develop and coordinate needed services across the behavioral health continuum. These services are generally described as a continuum of care which includes community awareness and education, prevention, intervention, treatment and aftercare. The members of the Regional Action Council serve as volunteers assisted by professional staff. Members include representatives of major community leadership constituencies: chief elected officials, chiefs of police, superintendents of schools, major business and professional persons, legislators, major substance abuse service providers, funders, minority communities, religious organizations and the media.

**Number of children and families served:** A total of 31,251 children, family and community members, and prevention professionals were served in SFY 07. Of this number 3,609 were between 0-11 years old; 9,866 between 12 and 17 years old; 2,000 between 18 and 24 years old; and 15,776 age 25 and older.

**Program Name:** Statewide Service Delivery Agents

**Program Description:** The Statewide Services Delivery Agents (SSDA), also known as the DMHAS Resource Links, are five entities funded by DMHAS to support prevention efforts across the state by building the capacity of individuals and communities to deliver prevention services. Their target populations include local communities, individuals, and agencies providing prevention programming; regional and statewide service agencies; societal organizations and institutions, e.g. corporate, medical, religious and recreational entities. The Statewide Service Delivery Agents utilize multiple strategies like information and public awareness, education, community development, capacity building and institutional change, and social policy to promote the health and well being of all Connecticut's residents across the life span. Within the last two years these SSDAs have provided distinct services to move Connecticut's prevention system to align with the Strategic Prevention Framework (SPF) five steps.

The Statewide Services Delivery Agents consists of the following entities:

1. Connecticut Assets Network - a network of individuals that promote the integration and successful use of strength-based strategies to build healthy communities and youth.
2. Connecticut Clearinghouse - is a comprehensive information resource center that makes available thousands of books, tapes and printed reports, and provides electronic access to the latest information on substance abuse, mental health and a variety of other issues.
3. Multicultural Leadership Institute, Inc. - is a coalition dedicated to promoting culturally and linguistically proficient services regarding the prevention of ATOD and other related problems among African origin and Latino populations.
4. Governor's Prevention Partnership - is a statewide organization comprised of public/private partnerships designed to change the attitudes and behaviors of Connecticut youths and adults toward substance abuse through its School, Campus, Workplace and Media Partnerships.
5. Prevention Training Collaborative - is to provide prevention practitioners and others in the field of prevention the training needed to obtain and maintain certification status and provide support to individuals looking to increase their knowledge and skills in the prevention area.

**Number of children and families served:** A total of 7,714 children, family and community members, and prevention professionals were served in SFY 07. Of this number 42 were between 0-11 years old; 191 between 12 and 17years old; 702 between 18 and 24 years old; and 6,779 age 25 and older.

**Program Name:** Tobacco Regulation & Compliance

**Program Description:** The federal government requires that states enforce and enact laws and implement strategies that reduce underage tobacco use. DMHAS employs a variety of strategies and activities to comply with the federal mandate.

These include:

1. Legislation & Law Enforcement: passing and enforcing youth tobacco access laws
2. Sampling Method & Survey Design: obtaining scientifically valid and reliable measure of tobacco retailer compliance with laws
3. Inspection Protocol & Implementation: following approved inspection protocols for conducting random, unannounced inspection of tobacco retailers
4. Merchant Education: producing and distributing educational and awareness materials for a merchant education program
5. Community Education & Media Advocacy: increasing public awareness on youth tobacco issues through youth forums and focus groups, community mini-grants and a statewide hotline for information and complaints.
6. Community Mobilization: forming coalitions to mobilize community support;

**Number of children and families served:** children and families will be served through merchant and community education activities in FY 2008. During FY 2007 3,733 retail inspections were completed and 5,905 pieces of materials distributed to the general public.

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**Long-Term Agency Goals:**

- Provide cost-effective, research based, developmentally appropriate prevention services that promote the health & well-being of children and families
- Increase partnerships with state and local agencies to develop, implement, evaluate and diffuse effective prevention programs and strategies that focus on youth and families
- Increase the cultural ability of prevention program providers to work effectively with youth and parents from culturally, economically and geographically diverse populations

**Strategies:**

- Fund programs based on needs identified by communities
- Implement program standards to monitor the service system
- Develop partnerships with state and local agencies by participating committees and advisory boards
- Increase funding of evidence-based programs that focus on families, early childhood and youth development

- Assess the prevention needs for youth and families across the state
- Explore resources to implement the prevention data infrastructure, policy and program recommendations
- Ensure quality prevention services and assess program effectiveness by providing training and technical assistance and monitoring and evaluating provider activities.

**Performance Standards:** DMHAS requires that prevention contractors adhere to Prevention Program Operating Standards. These standards establish a minimum level of program operation intended to reflect quality and articulate a service philosophy that promotes health and builds strengths. The purpose of the standards is to provide assurances to the public that alcohol and drug abuse prevention and early intervention programs are regulated under a set of minimum standards established by DMHAS. These standards are divided into 8 categories:

1. Human Relationships – require programs to build relationships among staff, families and communities in order to create strong effective programs
2. Program Planning – requires the development of a logical and systematic process for designing, implementing and evaluating services that fulfill the program’s mission
3. Program Activities – requires the provision of skills and knowledge to program participants so that they can make healthy lifestyle choices
4. Program Setting- requires that the physical environment is welcoming, comfortable, organized and well-equipped
5. Health & Safety – requires that the physical environment be healthy and safe
6. Program Implementation – requires organization, sufficient materials and effective communication to move planning into action
7. Program Administration – Requires sufficient resources and oversight to adequately manage the program
8. Evaluation – requires the systematic collection and analysis of data to make informed decisions.

**Performance Based Outcomes:**

- Increased number of evidence-based programs for youth, families and professionals that focus on youth suicide prevention, tobacco and alcohol use prevention
- A more refined quality assurance process that assesses effectiveness and fidelity of implementation of prevention programs
- An integrated state plan that supports families and communities in youth and early childhood development
- Increased partnerships with state and local agencies
- Increased number of providers trained and receiving technical assistance on cultural competency
- Increased cost-effectiveness

**Population Outcomes**

- Reduction in the drug/alcohol use
- Reduction in suicidal behavior among high school students

- Increased employment or school retention
- Decreased criminal justice involvement
- Increased social connectedness

**Program Outcomes**

- Increased enforcement of alcohol laws
- Reduction in retailer violation rates for tobacco sales to minors

**Performance Accountability:** Prevention program contractors complete program information and measures during the biannual contract renewal process. An action plan that identifies strategies to be used to meet objectives is also completed. Monthly process data are reviewed and monitored. Program changes are tracked via a fidelity tool. Quarterly telephone meetings are held to discuss progress and identify issues or technical assistance needs. Yearly site visits are made to validate activities and continued capacity and substantiate the need for continued funding. Agencies or programs not meeting objectives are placed on corrective action and closely monitored.

DMHAS will be receiving technical assistance to develop a process for collecting and reporting on program and community-level outcomes.

**Measure of Effectiveness:** In the last 3 years the DMHAS Prevention unit has increased by 50% the number of evidence-based programs that focus on youth and their families. With the increase in staff, there were also increases in the number of Prevention partnerships between DMHAS and other state and local agencies. Several plans have emerged from these partnerships, most notably the Early Childhood Partners, Strategic Prevention Framework, Tobacco Use and Prevention and a policy recommendation to align substance abuse prevention and social and academic development through school community and family partnerships. The DMHAS Prevention Training Collaborative has also increased the number of courses offered to providers.

**Methods:** DMHAS provides Prevention services aimed at increasing the health & wellness of children and their families through funding and assessing its pool of over 160 non-profit providers statewide. To address disparities, DMHAS contracts with the Multicultural Leadership Institute (MLI), a statewide resource in the provision of cultural competent mental health and substance abuse prevention services to assure that all products, activities and services are culturally competent.

**Other:** Where possible, the DMHAS Prevention unit shares lessons learned and program outcomes and accomplishments with the field at national meetings and conferences.

## Department of Public Health

**Program Name:** Asthma Program: Pediatric Easy Breathing Program

**Program Description:** The Connecticut Children's Medical Center (CCMC) Asthma Center is conducting *Easy Breathing*, a clinical management program that was conducted in five Connecticut communities. These communities include New Haven, Waterbury, New Britain, East Hartford/Manchester, and Bridgeport. The program is currently being expanded to provide statewide coverage. The *Easy Breathing* program is a professional education program that trains pediatric providers to administer a validated survey to determine whether a child has asthma, to conduct an assessment to determine asthma severity, to utilize treatment protocol guidelines for determining proper therapy, and to develop individual treatment plans. *Easy Breathing* is an asthma recognition and management program that is implemented by primary care providers that documents adherence to the National Asthma Education and Prevention Program Guidelines (NAEPP) standards for asthma care.

**Number of children and families served:** The Connecticut Children's Medical Center (CCMC) Asthma Center just completed five years of this *Easy Breathing* clinical management program in five Connecticut communities. Since the project began, 29,436 children have been surveyed, and 200 providers in 59 clinics/practices in five communities in CT have been trained. Of these children, 29% were newly diagnosed with asthma.

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### Long-Term Agency Goals:

- Health Goals: To ensure appropriate diagnosis and medical management of children with asthma
- Education Goals: To increase awareness that asthma is a controllable disease when properly managed

### Strategies:

- Expand the current program beyond the original five communities for Easy Breathing Program implementation across the state
- Identify, recruit and train pediatric healthcare practices/clinic sites to conduct the Easy Breathing Program
- Conduct surveillance activities to evaluate effectiveness and adherence to National Asthma Guidelines

**Performance-Based Standards:** The contractor conducts quarterly site visits with the Regional Program Coordinators to review and rectify data issues, training needs and/or implementation problems. Submits quarterly narrative and surveillance data to DPH.

**Performance-Based Outcomes:** Improved asthma diagnosis and medical management by primary care providers for better patient control and self-management based on the

National Asthma Education and Prevention Program (NAEPP) asthma diagnosis and treatment guidelines from the National Heart, Lung, and Blood Institute.

**Performance-Based Accountability:** Documentation of DPH oversight conducted under this contract with the contractor and subcontractors through audits, site visits, quarterly and annual aggregate reports as follows:

- Documentation of technical and professional assistance provided
- Description of the contractor-created, locally managed data quality control program and the actual assistance provided for the management of the Easy Breathing data system, generation of reports at each district
- Documentation of monitoring each participating district for adherence to required Program activities
- Documentation of review of all survey and treatment plan data from each district for consistency and appropriateness
- Documentation of the results of data analysis that include demographics of children surveyed in each community for asthma, by age, race/ethnicity, and number of newly diagnosed children by age, race/ethnicity
- Evaluation results of the effectiveness of the *Easy Breathing* Program in each participating community by analyzing the following process measures and outcome measures over time (quarterly)

**Measure of Effectiveness:**

- At least 95% of children surveyed to have a diagnosis of asthma have a written asthma treatment plan
- At least 95% of children surveyed to have a diagnosis of persistent asthma have an asthma treatment plan which includes anti-inflammatory therapy consistent with NAEPP guidelines.

**Methods:** Surveillance data of all participating children is reported for both Medicaid and non-Medicaid children including race and ethnicity. The program focuses on health care practices in urban areas where there is a higher proportion of asthma hospitalization and emergency department visits and Medicaid enrollment.

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**Program Name:** Child Day Care Licensing

**Program Description:** This Program regulates all licensed child day care programs in accordance with required standards established by state statutes and regulations. This is accomplished by providing technical assistance, application processing, facility monitoring, complaint investigation, and enforcement activities. The Program licenses over 1,603 Child Day Care Centers and Group Day Care Homes, and 2,714 Family Day Care Homes, and is committed to promoting the health, safety, and welfare of Connecticut's children in these licensed facilities.

**Number of children and families served:** 119,324 Licensed Capacity \*

\* This number does not reflect actual enrollment, as some slots may be under utilized or shared between part-time children.

**Long-Term Agency Goals:**

Program goal: To establish the baseline of quality below which it is illegal for licensed family day care homes, group day care homes, and child day care centers to operate.

Education goal: To provide technical assistance to license applicants and licensed child day care providers on regulatory issues to improve compliance.

**Strategies:**

- License and inspect child day care facilities.
- Provide resources and technical assistance to providers, upon request.
- Improve the quality of care children receive in licensed day care programs by revising Connecticut's licensing standards to be more in line with national standards and provide technical assistance to licensed programs.
- Collaborate with organizations such as the Departments of Social Services, Education, Children and Families, and the Early Childhood Education Cabinet, Child Day Care Council and the CT After School Network on issues that impact the Early Care and Education System and improve quality in child care settings.

**Performance-Based Standards:**

- Meet statutory requirements for inspections of licensed day care facilities: Inspect child day care centers and group day care homes every two years; inspect 1/3 of licensed family day care homes annually.
- Conduct complaint investigations.
- Take enforcement action against non-compliant facilities, as necessary.
- Meet statutory requirements for providing technical assistance on regulatory issues.

**Performance –Based Outcomes:**

- Continue the process to revise child day care regulations with improved health and safety standards.
- Technical assistance events conducted upon request of providers.
- The department consistently exceeds inspection goals for licensed child care facilities. From 7/1/06 – 6/30/07, 916 compliance monitoring inspections of family day care homes were required, 1435 inspections were completed; 802 compliance monitoring inspections of child day care centers and group day care homes were required, 1041 inspections were completed.

All complaints inspections include unannounced site visits. From 7/1/06 – 6/30/07, 1108 complaints were investigated involving licensed and illegally operating child day care facilities.

- From 7/1/06 – 6/30/07, 157 enforcements against licensed or illegally operating child day care facilities were taken.

**Performance-Based Accountability:** The Department of Public Health is the state agency responsible for the regulation and monitoring of licensed child day care facilities in accordance with the following statutes and regulations:

- C.G.S, Sec. 19a-80; Sec. 19a-87b
- Public Health Code, Sec. 19a-79-1a through 19a-79-13
- Public Health Code, Sec. 19a-87b-1 through 19a-87b-18

**Measure of Effectiveness:** The Child Day Care Licensing Quality Enhancement Unit coordinates enforcement actions for child day care programs. Regulatory actions are posted quarterly on the Department's website.

**Methods:**

- Application and license renewal reviews
- Unannounced compliance monitoring inspections
- Complaint investigation inspections
- Technical assistance activities, including on-site assistance during inspections, office meetings, workshops, web page updates, and articles on regulatory issues in *All Children Considered*, a newsletter funded by the Department of Social Services and Published by the UCONN Cooperative Extension Service that is distributed to licensed and license exempt child care providers.

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**Program Name:** Community Health Centers

**Program Description:** The purpose of the Community Health Center program is to assure access to comprehensive primary and preventive health care services and improve the health status of the underserved and vulnerable populations in CT. Thirteen health care corporations receive partial funding through the Department of Public Health to provide comprehensive preventive and primary health care services through Community Health Centers located in 30 towns throughout CT. As safety net providers, they deliver health care to individuals enrolled in Medicaid and Medicare as well as the underinsured and uninsured from birth through old age. Ten of the corporations are Federally Qualified Health Centers (FQHCs) that receive funding authorized by Section 330 of the Public Health Service Act. The other 3 meet FQHC program requirements but do not receive Section 330 funding.

Community Health Centers (CHCs) serve as the medical home and family physician for many of the poor, underserved, vulnerable, and at risk for poor health status people who live in communities throughout Connecticut. They offer comprehensive, community-based, primary and preventative health care including pediatric, adolescent, adult and geriatric health care, prenatal and postpartum care as well as supportive services such as translation, transportation, case management, health education, social services and culturally sensitive healthcare. Depending on the availability, many offer dental care, mental health and addiction services, school based health care and outreach programs.

**Number of children and families served:**

- In 2006, Connecticut Community Health Centers served over 225,000 patients with over 1 million visits.
  - 77% of health center patients had family incomes under 100% of the Federal Poverty Level. (\$19,350 per year for a family of four).
  - 31% were children <15 years and 28% were women between the ages of 15-44.
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**Long-Term Agency Goals:**

- **Health Goals:** To increase access to comprehensive, family-oriented community based health care to all who seek it, regardless of their ability to pay.
- **Education Goals:** To increase awareness of the mission of community health centers.

**Strategies:**

- Improve access to Primary and Preventive Care.
- Provide cost-effective and high-quality care.
- Assist in the reduction of health disparities.
- Provide effective management of chronic illness.
- Improve birth outcomes.

**Performance-Based Standards:** The contractor submits quarterly narrative and surveillance data to DPH.

**Performance-Based Outcomes:** Increase in unduplicated patient visits and medical management for low-income and uninsured clients.

**Performance-Based Accountability:** Documentation of DPH oversight conducted under this contract with the contractor through audits, site visits, quarterly and annual aggregate reports.

**Measure of Effectiveness:**

- At least 88% of children between the ages of 24 and 35 months were immunized in accordance with the AAP, AAP, and ACIP, and also have a record of receiving lead and nutritional assessments.
- At least 80% of adolescents between the ages of 12 and 19 years received a behavioral risk assessment regarding substance abuse, sexual activity, and nutrition assessment.
- At least 80% of women between the ages of 20 and 64 years of age receives a cardiovascular assessment and all appropriate cancer screenings for their age group.
- At least 80% of men between the ages of 20 and 64 years of age receives a cardiovascular assessment and all appropriate cancer screenings for their age group.
- At least 60% of adults aged 65 years and older received all of the following:
  - Cardiovascular and cerebrovascular risk assessments
  - All cancer screenings appropriate for their age and sex
  - Behavioral risk assessments
  - Nutrition assessment

- Flu Shot

**Methods:** Data of all unduplicated patients and patient visits is reported including age, sex, race/ethnicity, insurance status and federal poverty level.

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**Program Name:** Family Planning Program

**Program Description:** Twelve Family Planning Clinics (FPC) are funded by the Department of Public Health through a contract with Planned Parenthood of Connecticut, Inc. Total DPH funding to FPCs equals \$1,063,048. The purpose of the Department of Public Health Family Planning Program is to provide preventive and primary reproductive health care through health care services, information, and education to the uninsured or underserved individuals, both male and female, in CT.

**Program Services:** Family Planning Clinics serve to provide a broad range of effective and acceptable family planning methods and related preventive health services to low-income or uninsured persons. Family Planning Programs provide access to contraceptive services, supplies, and information to all who want and need them. In addition to contraceptive services and related counseling, the clinics provide related preventive health services such as patient education and counseling, breast and pelvic examinations, cervical cancer screening, sexually transmitted disease (STD) and Human Immunodeficiency Virus (HIV) prevention education, counseling, testing and referral, and pregnancy diagnosis and counseling. For many clients, the clinics provide the only continuing source of healthcare and/or education.

**Number of children and families served:** In 2006, the twelve DPH funded Family Planning Clinics served:

- 36,647 patients; 91% females, 9% males.
- Of the female patients served, 57% were White-non Hispanic, 17% Black- non-Hispanic, 23% Hispanic and 1% Asian/Pacific Islander.
- Of all clients served, 41% were Uninsured, 35% had private insurance, and 24% had public insurance.
- Of all clients served, 27% were between the ages of 15-19, 51% between ages 20-29, 14% between ages 30-39, and 8% 40 years or older.
- Of all clients served, 24% had incomes under 100% of the Federal Poverty Level (FPL), 65% had incomes 101% -200% FPL, and 11% had incomes over 201%FPL.
- Family Planning Clinics statewide provided 106,752 visits to 62,381 patients.

**Long-Term Agency Goals:**

- Health Goals: To increase access to comprehensive, family planning health care to all who seek it, regardless of their ability to pay.

**Strategies:**

- Improve access to Primary and Preventive Care.
- Provide cost-effective and high-quality care.
- Expand community education and outreach services.
- Assist in the reduction of health disparities.
- Improve birth outcomes.

**Performance-Based Standards:** The contractor submits quarterly narrative and surveillance data to DPH.

**Performance-Based Outcomes:** Increase in unduplicated patient visits and family planning services for low-income and uninsured clients.

**Performance-Based Accountability:** Documentation of DPH oversight conducted under this contract with the contractor through audits, site visits, quarterly and annual aggregate reports.

**Measure of Effectiveness:**

- At least 60% of eligible clients received reproductive health care services regardless of their ability to pay.
- At least 90% of female patients with a preventive reproductive health exam received a Pap test.
- At least 90% of female patients with a preventive reproductive health exam received a clinical breast exam.
- At least 85% of female patients with a preventive reproductive health exam received a screening for Chlamydia trachomatis and gonorrhea.
- At least 80% of clients with a preventive reproductive health exam received AIDS Education, behavioral counseling, and information on HIV testing sites.

**Methods:** Data of all unduplicated patients and patient visits is reported including age, sex, race/ethnicity, insurance status and federal poverty level.

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**Program Name:** Immunization Program

**Program Description:** The State of Connecticut Immunization Program's mission is to stop the spread of diseases that are vaccine preventable. The following means are used to achieve this goal: providing vaccine to the residents of Connecticut, educating the medical personnel and the public on the importance of vaccinations, working with providers using the immunization registry to assure that all children in their practice are fully immunized, assuring that children who are in day care, Head Start, and school are adequately immunized against diseases that are harmful and sometimes deadly, and

conducting surveillance for vaccine-preventable diseases to evaluate the impact of vaccination efforts and to identify groups that are still at risk of vaccine-preventable disease.

**Number of children and families served:** According to the latest National Immunization Survey (fiscal year 2006) 82 % of the states' two year olds were up to date on their immunizations comprised of a series of 4 doses of DTP, 3 doses of Polio, 1 dose of MMR, 3 doses of HiB, 3 doses of Hepatitis B, and 1 dose of varicella vaccines (4:3:1:3:3:1). This rate is the second highest in the country. Connecticut's childhood immunization has remained among the top five nationally since the 1990's, was ranked third in 2005, and has a projected rate of 85% for 2007

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**Program Name:** Injury Prevention Program-Unintentional Childhood Injury Prevention

**Program Description:** The Program's goal is to reduce death and disability among children and adults from unintentional injury including motor vehicle crashes, falls, fire/burns, drowning and poisoning. The Program provides technical assistance and resources to providers and community agencies on injury prevention issues. The Program works closely with other agencies, and injury related coalitions to raise awareness, and develop and implement injury prevention programs and policies. Through the Maternal and Child Health Block Grant, the Program collaborates with Safe Kids Connecticut to provide child passenger safety training to health care, childcare and other community service providers.

**Number of children and families served:** N/A

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**Long-Term Agency Goals:** Reduce deaths and disabilities due to unintentional injuries among children in Connecticut.

**Strategies:**

- Contract with Safe Kids Connecticut for child passenger and transportation safety training to health care, childcare and community service providers
- Collaborate with other State Agencies, including the Department of Transportation, Department of Consumer Protection, Department of Social Services, Department of Education, and coalitions such as Safe Kids Connecticut to raise awareness and develop injury prevention policies and programs.
- Develop and disseminate surveillance data on fatal and non fatal injuries in CT.

**Performance-Based Standards:** Training programs are based on national safety curricula developed by child passenger safety experts, and are regularly reviewed to ensure that they meet current "best practice." Nationally certified child passenger safety instructors deliver training.

**Performance –Based Outcomes:** Health care, child care and community service providers report increased awareness of measures to prevention injuries to children in motor vehicle crashes.

**Performance-Based Accountability:** Contractor is required to submit periodic reports on program activities and outcome measures.

**Measures of Effectiveness:** Pre-Post evaluation surveys are used to measure increases in provider knowledge.

**Methods:** The Injury Prevention Program works closely with the contractor for Safe Kids Connecticut and other partners to identify and insure that providers serving low-income families receive child passenger safety training.

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**Program Name:** Lead Poisoning Prevention and Control Program

**Program Description:** To protect the health and safety of the people of Connecticut and to prevent lead poisoning and promote wellness through education and a wide range of program activities that relate to lead poisoning prevention and in particular, childhood lead poisoning prevention.

**Number of children and families served:** 270,187 children under the age of six years old.

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**Long-Term Agency Goals:**

**Health Goals:** The Connecticut Lead Poisoning Prevention Control Program (LPPCP) is committed to reducing and eliminating lead poisoning in Connecticut children less than six years of age by 2010. The LPPCP will increase the monitoring of demographic and socioeconomic status of the high-risk populations being tested in Connecticut in order to evaluate the screening rates among these high-risk populations.

**Education Goals:** The LPPCP will increase the awareness of lead poisoning prevention by providing educational messages to the community (private and professional) about lead poisoning and lead poisoning prevention through monthly newsletters, two (2) educational conferences, and six (6) outreach and education opportunities.

**Health Strategies:**

- **Annual Activity 1:** The LPPCP will integrate the Connecticut birth record information into the current surveillance system.
- **Annual Activity 2:** The LPPCP will integrate Medicaid socioeconomic information into the current surveillance system.
- **Annual Activity 3:** The LPPCP will integrate the refugee resettlement information into the current surveillance system.

- **Annual Activity 4:** The LPPCP will evaluate the screening rate among these high-risk populations. Information will be placed in the LPPCP Annual Surveillance Report.

#### **Education Strategies:**

- **Annual Activity 1:** The LPPCP will publish monthly newsletters that will provide current prevention and regulatory information to the lead poisoning prevention community.
- **Annual Activity 2:** The LPPCP will conduct two educational conferences with targeted specialty sessions for local health department personnel, health care partners and regulatory authorities so that current information on childhood lead poisoning prevention may be disseminated on a widespread basis.
- **Annual Activity 3:** The LPPCP will develop six (6) outreach and education opportunities with elementary and preschools, Family Resource Centers, School Readiness programs, Head Start, Parent Teacher Organizations, School Nurse Organizations, and high schools with teen parents.

#### **Performance-Based Standards:**

- Elimination of lead poisoning - to decrease the rate of children under six years old residing in CT with blood lead levels of 10 µg/dL or above to less than 1%
- Screening of all children at ages 1 and 2 years
- Retesting of children (of any age) with blood lead levels greater than or equal to 10 µg/dL

#### **Performance –Based Outcomes:**

- The screening rates of children will increase.
- The prevalence of children with elevated blood lead levels greater than or equal to 10 µg/dL will decrease.
- The total number of elevated blood lead level cases greater than or equal to 10 µg/dL will decrease.

#### **Performance-Based Accountability:**

Evidence based guidelines for the LPPCP's intervention guidance includes:

- CDC documents
  - 1) *Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials*, November 1997
  - 2) *Managing Elevated Blood Lead Levels Among Young Children: Recommendations from the Advisory Committee on Childhood Lead Poisoning Prevention*, March 2002
- Connecticut Department of Public Health Lead Poisoning Prevention and Control Regulations
- Principal Connecticut General Statutes related to lead poisoning prevention
- Findings from audits of local health department lead poisoning prevention programs.
- Findings from oversight of the local health department case management activities (child and environmental) using the Lead Surveillance System.

**Measure of Effectiveness:**

- Increase in the screening rate of all one and two year olds due to newly passed legislation
- Decrease of the incidence and prevalence of children with elevated blood lead levels greater than or equal to 10 µg/dL

**Methods:** Education/outreach and intense screening efforts are targeted toward urban settings where low income, minority children between 1 and 2-years of age live. Children in this age group are at highest risk for lead poisoning for reasons including lower socioeconomic status, deteriorated lead-based paint in and around their homes, and common toddler behavior (e.g., crawling on floors and putting things in their mouths).

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**Program Name:** Newborn Screening Program (Tracking)

**Program Description:** Connecticut State Law mandates that all newborns delivered in Connecticut be screened for selected genetic and metabolic disorders. The aim of this program is to screen all babies in CT prior to discharge from birthing facilities or within the first 4 days of life for early identification of newborns risk for these diseases so that medical treatment can be promptly initiated to avert complications and prevent irreversible problems and death. Infants with abnormal screening results are referred to regional treatment centers for comprehensive testing, counseling, education, and treatment services. This program also aims to educate and counsel the families about their child's genetic disorder and about the potential of having other or future children with this disorder.

**Service Level (Number of Infants Served):**

Over 1.8 million newborns have been tested since the program began. Blood specimens on infants born in Connecticut are received from 30 birthing facilities. Nurse mid-wife sites were identified that will increase the numbers of infant screening for genetic disease/disorders. In 2006 there were 42,180 births by occurrence resulting in 43,279 infants receiving at least one screen. There were 42 confirmed cases, all of which needed and received treatment.

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**Long Term Program Goals:** The Newborn Tracking System (NBTS) database will continue to be modified to accommodate further explanation of potential additional disorders and to improve report output capability. A linkage will be developed between the Newborn Screening Program (NBS) and the electronic vital records system database to assure that each child born receives a laboratory screen. DPH will continue to enhance the website with additional information. NBS staff will continue to participate and collaborate on the implementation of the CT Genomic Action Plan and regional workgroups.

Quality improvement reviews will continue to assure that all newborns are screened in a timely and accurate manner to enable prompt identification of disorders and referrals to

State designated Regional Treatment Centers for confirmation testing, treatment, education, counseling, and follow-up services.

Connecticut currently mandates testing for all of the recommended disorders except Cystic Fibrosis (CF). Testing is currently provided by the two medical centers Yale and UCONN on a voluntary basis. The CT Public Health Laboratory would perform initial screening, and both hospitals would provide follow-up confirmation laboratory and physical testing in addition to care plans and family counseling. The two CF treatment centers will handle all referrals from their catchment area. Approximately 2,200 newborns a year will screen positive and will need further confirmation testing.

**Strategies:** The CT Legislative Appropriations Committee Initiative applied the Results Based Accountability (RBA) to the budget process for early childhood programs. The framework includes: 1) the population results to which such program makes a significant contribution; 2) indicators for such population results; and 3) measures of program quality and client outcomes. Designated programs will be required to report through the RBA process.

The NBS program will use the RBA process to reintroduce the legislation for including CF on the NBS screening panel for legislative consideration of expanding the screening mandate to include CF screening and to provide the funding to implement an efficient screening component.

- Hire one chemist to perform the testing. Newborn screening would require additional personnel to assure the referral, tracking/surveillance and confirmatory testing/treatment/follow-up components of the program are adequately addressed. Hire an additional Nurse consultant and a Health Program Associate to assume the additional CF screening responsibilities.
- Develop a contractual agreement with established Cystic Fibrosis Treatment Centers to ensure confirmation testing and treatment for suspect positive and confirmed cases of CF.
- Maintain the Newborn Screening Program's Web-Based Training.
- Procure and disseminate information for parents, hospitals, primary care providers etc. (Brochures, website, fact sheets, etc.).
- Prepare the Newborn Screening Program to be moved to the new laboratory facility in Rocky Hill ~2011.
- Work with State Laboratory Architects to assist in the development of an efficient workspace for the Testing and Tracking Units.
- Develop linkage between Laboratory NBS LIMS system and the electronic Vital Records birth certificate database to assure that each child born in CT has received the laboratory NB screening.
- Enable the Primary Care Provider (PCP) to access Laboratory newborn Screening results for their patients. The NBTS database will continue to be modified to accommodate further expansion of potential additional disorders and to improve report output capability.

- Ensure confidentiality through the regulatory standards and provisions of CT State General Statutes Sec. 19a-55, clinical Laboratory Improvement amendments of 1988, 42 U.S.C. 263a (CLIA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Outcomes:**

- 1.8 million newborns have been screened prior to hospital discharge and 941 identified with genetic disorders to allow treatment to be promptly initiated to avert complications and prevent irreversible problems.
- Relocation of Newborn Screening Tracking Unit to the Lab resulted in more efficient testing, tracking and referral process for newborn disease/disorder results.
- Coordinated prevention and intervention efforts with parents and health professionals as partners lead to improved health and school readiness.
- Revision of child day care regulations with improved health and safety standards, staff training opportunities, number of technical assistance opportunities conducted, and the number of inspections and investigations completed.
- Data Integration among agency programs will allow for seamless retrieval of information. Linkage developed between the NBS and the electronic vital records system database assures that each child born receives a laboratory screen.
- Treatment center referrals to the Children with Special Health Care Needs Program for establishing a medical home for the infants with a confirmed diagnosis.

**Performance Accountability – Measures of Effectiveness:**

***Connecticut State Statute Sec. 19a-55:***

Connecticut State Law mandates that all newborns delivered in Connecticut be screened for selected genetic and metabolic disorders. The aim of this program is to screen all babies born in CT prior to discharge from birthing facilities or within the first 4 days of life for early identification of newborns at risk for these diseases so that medical treatment can be promptly initiated to avert complications and prevent irreversible problems and death. Infants with abnormal screening results are referred to regional treatment centers for comprehensive testing, counseling, education and treatment services.

- Over 1.8 million newborns have been tested since the program began.
- In 2006, 42,180 births by occurrence resulting in 43,279 infants receiving at least one screen. There were 42 confirmed cases, all of which needed and received treatment.

**Maternal and Child Health Bureau Federal Performance Measure for States:**

***National Performance Measure #01:***

The percent of newborns that received timely follow-up to definitive diagnosis and clinical management for condition(s) mandated by their state-sponsored newborn screening programs.

Numerator: the number of newborns screened and confirmed with condition(s) mandated by the State sponsored newborn screening program that received timely follow-up to definitive diagnosis and clinical management.

Denominator: The number of newborns screened and confirmed with condition(s) mandated by the State sponsored newborn screening program.

Objectives were met by assuring that 100% of infants screened as positive with condition(s) received follow-up to definitive diagnosis and clinical management. Of 42,180 infants born in CT in 2006, 99% received newborn screening prior to discharge or within first weeks of life. All 2,630 suspect positive results were reported to Regional Treatment Centers and/or primary care physicians for further testing and follow-up. Of these, 60 were confirmed as disease cases and 894 Hemoglobin traits were identified.

***Healthy People 2010 Objectives:***

(Developmental) Ensure appropriate newborn bloodspot screening, follow-up testing, and referral to services.

Ensure that all newborns are screened at birth for conditions mandated by their state sponsored newborn screening programs, for example, PKU and hemoglobinopathies.

Ensure that follow-up diagnosis testing for screening positives is performed within an appropriate time period.

Ensure that infants with diagnosed disorders are enrolled in appropriate service interventions within an appropriate time period.

(Developmental) Reduce hospitalization for life-threatening sepsis among children aged 4 years and under with sickling hemoglobinopathies.

(Developmental) Increase the proportion of children with special health care needs who have access to a medical home.

**Methods to Reduce Health Disparities:** NBS program contracts with providers who [in part] will deliver culturally competent services in the following manner:

- The program or institutional mission and goal statement of contractor shall explicitly incorporate a commitment to cultural diversity;
- Policies and procedures for the provision of interpreter/translator services;
- Readily available bilingual staff who can communicate directly with clients in their preferred language, and who are assessed for their ability to convey information accurately in both languages;
- The development of non-English client related materials that are appropriate for the population served by the program;
- Signage (in commonly encountered languages) that provide notices and directions to services within the facility;
- Policies and procedures to address the needs of the patient population, taking into account factors such as race and ethnicity, age, gender, hearing impairment, visual impairment, physically challenged, mental illness, developmental challenged, and sexual orientation;
- Strategies in place to actively recruit and retain a culturally diverse staff (e.g. if the patient population is mainly from minority populations, applicants who are of related

minority groups with equivalent clinical expertise as the majority applicants could be assigned more value on the cultural competency scale);

- Institutional policies and procedures to accommodate the ethnic and cultural practices of patients, families and staff;
  - An organized way to collect data on the ethnic and cultural characteristics of patients and families served by the program;
  - Surveys and their methods of assessing the satisfaction of patients and their families related to cultural diversity.
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**Program Name:** Nutrition, Physical Activity and Obesity Prevention Program

**Program Description:** The Nutrition, Physical Activity and Obesity Prevention Program is partnering with School Readiness and Head Start programs in Connecticut to support young children's social, emotional, physical, cognitive, and language development. While nutrition efforts have typically focused on young children's physical development, the Nutrition, Physical Activity and Obesity Prevention Program provides training for and promotes an approach to classroom learning and mealtime environments at preschools and with families that support young children's social, emotional, cognitive, and language development. We achieve this expanded outcome by equipping School Readiness teachers and parents to use classroom learning experiences and mealtimes to better support young children's capability for self-regulation, experience emotionally connected relationships, and build healthy eating capabilities and life skills.

The Nutrition, Physical Activity and Obesity Prevention Program focuses on three areas:

- Developing and supporting School Readiness teachers' capability and motivation to provide nutrition and physical activity experiences in their classrooms that support young children's learning achievement in the areas of math, science, and language.
- Increasing young children's exposure to healthy foods, increasing the variety of healthy foods offered to them, and increasing young children's ability to eat and enjoy healthy foods and physical activity.
- Building teachers and parents' capability to create and maintain healthy mealtime environments. This step was taken to equip and motivate teachers and parents to use mealtimes to build ten healthy eating capabilities and life skills in young children.

The Nutrition, Physical Activity and Obesity Prevention Program supports young children's enjoyment of and capability to learn.

The Nutrition, Physical Activity and Obesity Prevention Program uses a developmentally savvy approach to achieve a positive impact on young children's healthy eating and physical activity. The program achieves its results by focusing on teachers and parents who then use behaviors and strategies that have an impact on young children's eating and physical activity.

**Number of children and families served:** In the 2005-2006 fiscal year the Nutrition, Physical Activity and Obesity Prevention Program:

- An average of 70 School Readiness teachers serving a total of 1,050 preschoolers indicated they were using The Adventures of Captain 5 A Day curriculum and were using mealtimes to promote preschoolers' healthy development. Since this data is only being collected from Bridgeport, Hartford, New Haven, and Waterbury School Readiness programs, it does not reflect the use of the curriculum by many other preschools and licensed child care providers in Connecticut.
- 2,424 teachers, parents, and providers and 1,890 children who attended training offered by the Food Stamp Nutrition Education Program.
- 2,570 adults and children who received nutrition education at community media events, health fairs and health expos.
- Additionally, over 200,000 people who were reached with targeted messages through the Community Health Network newsletters.

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**Education Goals:**

Increase the number of children who are ready for school at an appropriate age, learn to read by third grade, and succeed in school.

**Measures of Effectiveness:**

**Performance Measure 1:** Increase children's willingness to taste and consume targeted fruits and vegetables.

- The 15-week intervention resulted in an increase from one in two children to three in four children willing to taste spinach. The control group had a decrease from one in two children to one in three children willing to taste spinach.
- The 15-week intervention resulted in an increase from one in four children to one in three children eating a full portion of spinach. The control group had a decrease from one in four children to one in five children eating a full portion of spinach.

**Performance Measure 2:** Increase the number of programs and classrooms using the Captain 5 A Day preschool nutrition curriculum and documenting time spent on nutrition education in the four-targeted cities – Hartford, New Haven, Bridgeport, and Waterbury.

- 30% (77 of 255 classrooms) are submitting monthly logs of time spent on nutrition activities in the classroom and at mealtimes.

**Performance Measure 3:** Increase the number of School Readiness and Head Start programs and the number of parent groups from School Readiness and Head Start programs receiving introductory training about building healthy mealtime environments.

- 13 School Readiness and Head Start programs have received the introductory training about building healthy mealtime environments. Nine of the thirteen training requests were unsolicited and resulted from word-of-mouth promotion of the training.
- 2 parent groups from School Readiness and Head Start programs have received the introductory training about building healthy mealtime environments.

Teachers routinely report that the Captain 5 A Day preschool nutrition curriculum activities and lessons are fun and enjoyable for the teachers and kids. Teachers also report using the activities throughout the school year and using them more than once. Nearly all

teachers attending training about building healthy mealtime environments report having frustrations and concerns about kids' eating and communicate a desire to have strategies to help improve kids eating and to build more pleasant mealtime environments.

Based on the comments from the evaluations of the building healthy mealtime environments training, teachers appreciate the mealtime environment approach and the strategies for supporting young children's healthy development at mealtimes. Evaluation comments from parents have also been quite positive about the mealtime environment approach and the strategies for supporting young children's healthy development at mealtimes.

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**Program Name:** Office of Oral Health

**Program Description:** The mission of the Office is to promote health and reduce disease and health disparities in Connecticut through enhanced oral health and oral health care access. The Office works to build the public health infrastructure for oral health within the Department of Public Health and throughout Connecticut. The Office is staffed by the State Dental Director (a dentist) and a Health Program Associate (a dental hygienist).

**Number of children and families served:** 9,364 (Every Smile Counts Survey)

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**Long-Term Agency Goals:** Goals of the office include implementing effective, culturally appropriate oral health promotion and disease prevention programs that adopt, adapt and enhance best practices. The office also works to centralize, coordinate, enhance and integrate oral health data, information and monitoring systems to detect disease, inform policy, and evaluate programs.

**Strategies:**

- Develop a Statewide Oral Health Plan
- Provide ongoing surveillance of the oral health status of children and adults in Connecticut
- Educate the public and providers on the importance of oral health
- Improve and provide oral health preventive services throughout Connecticut

**Performance-Based Standards:**

- American State and Territorial Dental Directors (ASTDD) Best Practices Approach for State Oral Health Programs
- Development of a State Oral Health Plan based on a collaborative approach
- Mandating an Office of Oral Health by state statute
- Develop a statewide oral health surveillance system
- Develop a description of the state's oral health overview/assessment or identify oral health problems of the state with supporting data

- The National Oral Health Objectives for the Year 2010 (Healthy People 2010 Objectives)

**For six- to eight-year-old children there are three primary oral health status objectives:**

1. To decrease the proportion of children who have experienced dental caries in permanent or primary teeth to 42 percent.
2. To decrease the proportion of children with untreated dental caries in permanent or primary teeth to 21 percent.
3. To increase the proportion of eight-year-olds receiving protective sealing of the occlusal surfaces of permanent molar teeth to 50 percent.

**Performance –Based Outcomes:**

- Office of Oral Health mandated by Connecticut statute
- Development of a *Statewide Oral Health Improvement Plan 2007-2012*. This plan was developed in collaboration with the CT Coalition for Oral Health Planning to improve the oral health of children and adults in Connecticut.
- The first statewide open-mouth survey to collect data on the oral health status of children in Connecticut was conducted during the 2006-2007 school year. This survey called “*Every Smiles Counts*,” targeted Head Start, kindergarten and third grade children.
- Development of a *Report of the Oral Health Status in Connecticut*. This is a comprehensive report on the status of oral health in Connecticut based on currently available data.

**Performance-Based Accountability:**

ASTDD Basic Screening Survey Tool

Centers for Disease Control (CDC) *The Burden of Oral Disease: A Tool for Creating State Documents*

**Measure of Effectiveness:**

- Connecticut has met the Healthy People 2010 objectives for reducing the prevalence of decay experience among elementary school children – 34%
- Connecticut has met the Healthy People 2010 objectives for reducing untreated dental caries in permanent or primary teeth – 17%
- Connecticut has not met the Healthy People 2010 objectives to increase the proportion of eight-year-olds receiving protective sealing of the occlusal surfaces of permanent molar teeth – 38%
- There are significant oral health disparities in Connecticut with minority and low-income children having the highest level of dental disease and the lowest level of dental sealants.

**Methods:** The Office of Oral Health conducted an oral health survey during 2006-2007, called “Every Smile Counts,” and as a result the department now has baseline data

available on the oral health status of Head Start, Kindergarten and 3<sup>rd</sup> grade students in Connecticut by race and ethnicity.

**Program Name:** Rape Crisis and Prevention Services

**Program Description:** Make available to sexual assault victims and their families free and confidential services such as crisis intervention, support and advocacy, survivor groups, 24-hour hotline, and emergency transportation. Services also include community education, training, primary prevention activities, and coordination of services.

**Number of children and families served:**

- 2,872 primary victims and 1,373 secondary victims
  - Primary prevention curricula were provided as single sessions to 19,262 children and youth and as multi sessions to 14,365 children and youth.
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**Long-Term Agency Goals:**

- Develop a State of Connecticut Sexual Violence Prevention Plan.
- Enhance decision-making and program planning by assessment and utilization of data, resources, tools, and evaluation methods.
- Utilize training and technical assistance to build state and local capacity for primary prevention.
- Enhance sexual violence prevention efforts in targeted populations.
- Increase the numbers of children and youth exposed to primary prevention curricula focused on building healthy relationships.
- Evaluate the cultural relevance and effectiveness of informational material and interventions reflecting primary prevention messages reaching targeted populations.

**Strategies:**

- DPH will collaborate with key partners to convene a Sexual Violence Prevention Planning Committee (SVPPC) with representation by key stakeholders and organizations.
- The SVPPC will assess current data capacity tools and resources, prevention programming, capacity for training, and level of evaluation activities for primary prevention at the state and local levels and make recommendations for implementation.
- The SVPPC will assess technical assistance needs and begin to identify and provide technical assistance and training to targeted populations and organizations.

**Performance-Based Standards:** The SVPPC will establish standards of accountability related to sexual violence prevention.

**Performance –Based Outcomes:** The SVPPC will establish outcomes related to sexual violence prevention. The CDC has provided tools to utilize to help in this process.

**Performance-Based Accountability:** The contractor submits quarterly and annual reports. The contractor performs pre and post-test surveys within primary prevention curricula.

**Measure of Effectiveness:** Over the past several years, the contractor has moved from a risk reduction approach to primary prevention activities. There has also been a shift from single-session to multi-session primary prevention educational sessions. The SVPPC will help evaluate measures of effectiveness of sexual violence prevention efforts.

**Methods:** The SVPPC will help perform a needs assessment of sexual violence prevention methods in the state and move toward establishing methods to reduce disparities across race, income level, and gender.

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**Program Name:** Tobacco Use Prevention and Control Program

**Program Description:** The Tobacco Use Prevention and Control Program follows the guidelines and recommendations put forward by the Centers for Disease Control and Prevention (CDC) via Best Practices documentation for state-based comprehensive tobacco control and prevention programs. Address all risks associated with the use of tobacco products and exposure to environmental tobacco smoke (ETS), focusing on youth, pregnant women, and disparate populations.

**Number of children and families served:** During 2006-2007, local prevention programs served 4,537 individuals, which included 137 low-income pregnant and parenting women.

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**Long-Term Agency Goals:** To reduce exposure to secondhand smoke and prevent youth initiation of tobacco use.

**Strategies:** To educate parents and children about the hazards of tobacco use and exposure to secondhand smoke by providing examples and statistics on their health effects.

**Performance-Based Standards:** The goal of the prevention programs is to prevent or delay smoking initiation and to reduce participant's exposure to second-hand smoke. More specifically, the objective of the program is to prevent 50% of the non-smoking participants from starting to smoke through the implementation of a model curriculum taught by qualified instructors. The curriculum must adhere to CDC's best practices guidelines and incorporate education regarding the prevention of smoking initiation and the harmful effects of second hand smoke.

**Performance –Based Outcomes:**

- Average age participants smoked first whole cigarette.
- Proportion of participants that never tried a cigarette, not even 1 or 2 puffs.

**Performance-Based Accountability:** Contractors are required to submit periodic progress reports detailing their program activities, and submit deliverables as dictated by their contract. In addition, contractors must submit the results of their outcome measures.

**Measure of Effectiveness:** Contractors will be implementing pre- and post-surveys for determining program effectiveness.

**Methods:** Smoking and smoking-related diseases are higher in certain disparate populations. Through surveillance efforts, we can identify some of them and target services appropriately.

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**Program Name:** The Supplemental Nutrition Program for Women, Infant and Children (WIC)

**Program Description:** The Connecticut WIC Program serves pregnant, postpartum, and breastfeeding women; infants; and children up to five years of age. The program provides nutritious food and education during critical times of growth and development, in an effort to improve birth outcomes and child health. Eligibility is based on both income (up to 185% of the federal poverty level) and nutritional need based on an assessment of health and dietary information. An analysis of linked birth, WIC and Medicaid records has revealed that participation in the CT WIC Program was responsible for preventing the occurrence of more than 300 low birth weights in the year 2000 among infants of women who participated in the program for at least 12 weeks of their pregnancy. The estimated savings in averted medical costs is \$11.8 million. The WIC Program's promotion and support of breastfeeding, and efforts to prevent childhood anemia also contribute to childhood health and school readiness.

**Number of children and families served:** 42,139 children (as of 8/07) - number of families served is unavailable

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**Strategies:** Provide nutrition and breastfeeding education, supplemental food, and referrals for health and social services to eligible women, infants and children through the WIC Program.

**Performance-Based Standards:** Federal and state regulations include a number of prevention related standards that the local agencies must meet, including timeframes for enrolling program applicants; requirements regarding the early and continuous enrollment of pregnant women; policies to ensure that all pregnant women are encouraged to breastfeed, unless medically contraindicated, and provided information and support; and requirements to provide information regarding the risks associated with drug, alcohol and tobacco use during pregnancy, and to ensure that children are screened for anemia and lead poisoning by their health care provider.

**Performance-Based Outcomes:** The incidence of low birth weight (LBW) among infants whose mothers were on the WIC Program for at least 6 months during pregnancy does not exceed 6%.

- At least 50% of infants whose mothers were enrolled in the WIC Program during pregnancy breastfeed.
- The prevalence of anemia among children enrolled in the WIC Program for at least one year does not exceed 10%.

**Performance-Based Accountability:**

- Local agencies that sponsor WIC Programs must submit an annual program plan that identifies measurable outcome and process objectives, and specifies action plans and evaluation methods.
- The State WIC office tabulates and provides outcome data to the local agencies twice per year for their use in program evaluation. The State WIC office conducts on-site performance evaluations of each local agency at least once every two years.

**Measure of Effectiveness:**

- An analysis of linked birth, WIC and Medicaid records has revealed that participation in the CT WIC Program was responsible for preventing the occurrence of more than 300 low birth weights in the year 2000 among infants of women who participated in the program for at least 12 weeks of their pregnancy. The estimated savings in averted medical costs is \$11.8 million.
- Between 2001 and 2005 the rates of low birth weight among women who participated in the WIC Program for at least 6 months during their pregnancies was lower than the rates among non-WIC mothers in Connecticut. Among Hispanic and Black (non-Hispanic) mothers, WIC versus non-WIC differences in LBW percents are significantly different for each year from 2001-2005.
- The WIC Program's promotion and support of breastfeeding, and efforts to prevent childhood anemia also contribute to childhood health and school readiness. The breastfeeding initiation rate among infants whose mothers were enrolled in the WIC Program is lower than the rate among all infants born in the state (57.7% and 79.5%, respectively for 2004 births), but it is increasing. The anemia rate among children enrolled in WIC Program for at least a year is lower than the national WIC anemia rate and decreasing (8.9% and 10.1%, respectively, in 2004)

**Methods:** WIC Program benefits and services are provided to all eligible applicants. Each applicant's nutritional needs are assessed and education is provided based on the individual's needs, and the WIC "food package" is tailored to the participant's preferences and needs, within regulatory limits. The birth outcomes reported above attest to the program's success in reducing disparities. Pending the availability of funding, the WIC Program is prepared to replicate a successful breastfeeding peer counseling program in New Haven, targeting African American women, whose breastfeeding rates are lower than White and Hispanic women enrolled in WIC. A statewide effort to further improve nutrition counseling techniques is underway and is anticipated to reduce disparities in the childhood anemia rates.

**Program Name:** Youth Violence / Suicide Prevention

**Program Description:**

Youth violence prevention programs contracted by the Connecticut Department of Public Health (DPH) focus upon increasing knowledge and changing behaviors that are manageable within the limited scope and influence of the programs. Program goals include recognizing and dealing appropriately with anger, conflicts, peer-to-peer relationships; increasing knowledge regarding the impact of, and risk factors, for violent behavior; decreasing arguments and fighting and providing knowledge of appropriate resources for help. Suicide prevention programs focus on increasing information and awareness of suicide, suicide risk and protective factors and places to go for help.

**Number of children and families served:** 1,510

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**Long-Term Agency Goals:** To reduce youth violence.

**Strategies:** Youth violence prevention programs funded under the local health allocation are dependent upon local health departments and districts deciding to use Preventive Health and Health Services Block Grant (PHHSBG) funding for youth violence prevention. Programs are required to follow the program template, which recommends Federal sources and other resources for program development, and are required to report on the outcome measure. The Injury Prevention Program provides technical assistance and contract monitoring.

**Performance-Based Standards:** Programs are required to report on a specific youth violence prevention outcome measure.

**Performance –Based Outcomes:** Ninety-five percent of program participants are able to identify nonviolent alternatives to fighting.

**Performance-Based Accountability:** Programs are required to report on activities and outcomes.

**Measure of Effectiveness:** Observation and program specific evaluation tools assess outcome measure.

**Methods:** Programs report demographic information- localities decide program participants.

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**Overall Agency Prevention Goals:**

**Long Term Agency Goals:** The Department of Public Health (DPH) works proactively to protect the health and safety of the people of Connecticut and to prevent disease and promote wellness through education and programs such as prenatal care, newborn

screenings, immunizations, nutrition and supplemental foods, AIDS and sexually transmitted disease awareness. Reducing health disparities in maternal and child health remains one of the agency's highest priorities. DPH selected its prevention programs for inclusion in this report based on a focus on children birth to age eighteen. These initiatives also impact the families of these children, either directly or indirectly. The selected programs are preventive in nature, provide education and information to families that promote healthy behaviors, attempt to reduce crime and violence, promote academic success, and discourage socially destructive behaviors.

**Strategies:**

- Implement disease prevention and health promotion of women, infants and children including children and youth with special health care needs
- Identify and nurture community-based health and prevention initiatives through public and private partnerships
- Provide funding to community-based providers to implement prevention programs at the local level, including school-based and community health centers
- Through Community-Based Health Centers, assure the availability and accessibility of comprehensive primary and preventative health care and other essential public health services for low-income uninsured and vulnerable children and families in underserved areas
- Conduct surveillance activities to continuously monitor the effectiveness of the agency's prevention initiatives
- Collaborate with other state agencies to cut across agency boundaries and combine programmatic and funding efforts to improve outcomes
- Establish and coordinate the DPH's Virtual Children's Health Bureau to capture the overarching programs and initiatives throughout the agency
- Promote the use of asthma management plans by health care providers and parents of asthmatic children, address the early identification of children with asthma and work to develop a state asthma plan and enhance asthma surveillance activities
- Provide nutrition education to parents, pre-school children, and teachers in Head Start and School Readiness programs, and provide workshops to enable teachers to integrate nutrition education into their lesson plans and curriculum, and to educate parents on feeding healthy food to their children
- License and regulate child day care facilities and offer resources and technical assistance to providers
- Improve the quality of care children receive in licensed child day care programs by revising Connecticut's licensing standards to be more in line with national standards and provide technical assistance to licensed programs
- Work with organizations such as the Child Day Care Council and the CT After School Network to develop draft regulations, staff training, and assure inspection goals are met in accordance with state statutes
- Ensure that state-of-the-art emergency medical care is available for all ill or injured children or adolescents, and that pediatric services are well integrated into an emergency medical service system
- Prevent disease, disability and death from vaccine preventable diseases in infants, children and adolescents through surveillance, case investigation and outbreak

control, vaccination, monitoring of immunization levels, provision of vaccine, and professional and public education

- Conduct comprehensive lead poisoning prevention programs to reduce the risk of lead exposure
- Screen all newborns for genetic and hearing disorders prior to hospital discharge or within seven days of birth to help prevent severe health and developmental consequences
- Through Oral Health initiatives, increase entry into long-term comprehensive dental services for Medicaid, SCHIP, and other underserved children and develop a best practice model for sealant programs
- Make available to sexual assault victims and their families free and confidential services such as crisis intervention, support and advocacy, survivor groups, 24-hour hotline, and emergency transportation
- Through collaborative effort between Injury Prevention Program and CT Safe Kids, provide child passenger safety workshops to health care and childcare professionals to increase provider capacity as effective educators on child passenger safety
- Provide a variety of services to adolescents to reduce the transmission and incidence of selected sexually transmitted diseases
- Address all risks associated with the use of tobacco products focusing on youth, pregnant women, disparate populations and environmental tobacco smoke
- Provide nutrition education and supplemental food to eligible women, infants, and children through the WIC and Nutrition Programs
- Provide professional education, technical assistance and program development targeted toward youth violence prevention
- Identify where our pockets of under immunized children continue to exist in our major urban centers by utilizing our state immunization registry data.
- Improve the quality and comprehensiveness of care by promoting co-located care coordinators at community-based home for children and youth with special health care needs

The role of DPH is to address prioritized needs and gaps in services for the target populations. Services provided by community-based programs include case management, outreach, disease prevention, education, and the empowering of maternal and child health populations about health and health-related issues. The combination of ongoing assessments, quarterly reporting data, technical assistance meetings and site visits assist DPH in determining priorities.

**Outcomes:**

- 1.8 million newborns have been screened prior to hospital discharge and 941 identified with genetic disorders to allow treatment to be promptly initiated to avert complications and prevent irreversible problems
- Inception of newborn hearing screenings at birth in 2000 has identified 360 babies with hearing loss, with the average age of diagnosis dropping from 2 ½ years to 2 months, and in 2005, Connecticut conducted hearing screenings on 99% of newborns
- Coordinated prevention and intervention efforts with parents and health professionals as partners lead to improved health and school readiness

- Revision of child day care regulations with improved health and safety standards, staff training opportunities, number of technical assistance opportunities conducted, and the number of inspections and investigations completed
- Every child, their parents, and all pregnant women in Connecticut will have access to comprehensive, preventive, continuous health care
- All children will have access to affordable, healthy, safe, and developmentally-appropriate early care and education with comprehensive support services that facilitate effective transitions from birth to Kindergarten
- All families will have access to the information and resources they need to raise healthy children, and parents will be involved as partners in the planning of early childhood services
- Effective local or regional early childhood collaborative structures will ensure the provision of integrated services
- A state level infrastructure with community representation will guide, support, and monitor implementation of a comprehensive, integrated system of services for children and families
- Data integration among agency programs will allow for seamless retrieval of information

**Measure of Effectiveness:** Infant Mortality – programming within DPH to reduce infant mortality is aimed at the period before conception, along with the prenatal and postnatal periods.

- From 1981 to 2003, Connecticut’s infant death rate fell from 12.0 to 5.3 deaths per 1,000 live births

Births to Teens – State programs serve pregnant and parenting teens and provide intensive case management services with emphasis on promoting positive pregnancy outcomes, positive parenting and breastfeeding.

- In Connecticut from 1993-2003, the birth rate for teens dropped from 38.8 to 25.8 infants born per 1,000 female teens

Prenatal Care – DPH strives to improve access to prenatal care through several strategies, such as supporting sites for primary care and free pregnancy testing at family planning clinics.

- In Connecticut in 2004, 87.5% of infants were born to women who began receiving prenatal care in the first trimester

Title V programs Comadrona, Healthy Start, Healthy Choices for Women and Children, Fetal Infant Mortality Review and Right From the Start provided outreach to and identification of pregnant women to promote early entry into prenatal care

Breastfeeding – DPH promotes breastfeeding as a social norm in the state due to the positive maternal and infant health effects

- The estimated rate for breastfeeding in Connecticut has improved from 68.7% to 69.3%

**Methods to Reduce Health Disparities:** Reducing disparities in maternal and child health indicators remains one of the major challenges facing the public health community, and DPH utilizes multi-level strategies that include:

- Addressing health disparities by targeting low-income families and encouraging them to participate in screenings, prevention activities such as immunizations and oral health, and HUSKY
- Improving the number and capacity of providers in underserved communities by functioning as liaison in the recruitment and retention of primary health care professionals through a collaboration with the DPH Primary Care Office and the Connecticut Primary Care Association
- Increasing the knowledge base on causes and intervention to reduce disparities by analyzing data on health care practices and use across racial and ethnic groups
- Utilizing the DPH Office of Multicultural Health to raise public and provider awareness of racial/ethnic disparities in health care
- Increase vaccination coverage rates in underserved populations for children living in poverty by utilizing immunization registry data to determine where our pockets of under immunized children continue to exist and develop intervention strategies targeting these children to improve vaccination coverage.
- Increase HPV vaccination coverage in underserved adolescent populations by measuring HPV vaccine uptake among high-risk underserved female adolescent population to reduce cervical cancer incidence among low-income women. This includes developing HPV educational messages for health care providers to address cultural barriers and increase sensitivity to specific ethnic groups that will impact vaccine acceptance.
- As resources permit, consider addressing the recommendations of the Connecticut Health Foundation's Policy Panel on Racial and Ethnic Disparities which include:
  - Collect and integrate racial and ethnic data to its statewide planning efforts and publish a report on the key findings
  - The Office of Health Care Access and DPH should require health care organizations, including providers and payers, to collect data on each patient's primary language in health records and information systems, and post signage in the languages of the patients they serve
  - Establish a certification program for all medical interpreters to ensure cultural competence and quality service
  - Establish a system for monitoring and enforcing PA 00-119 regarding linguistic access in acute care hospitals

## Department of Social Services

**Program Name:** Emergency Shelter for Victims of Domestic Violence

**Program Description:** Program participants who are victims of domestic or family violence are provided safe and supportive services in emergency shelters and/or host homes. Generally, the adult, usually the female parent, is the primary contact for the receipt of services. However, primary prevention occurs with the children, who are sheltered with the parent, through mandated shelter based children's programs. These programs address emotional and social health issues that are found among child witnesses; many of whom may also have been victimized. Based on the best data available, children who witness domestic violence are more likely to repeat the behavior as adults as either a batterer (mainly males) or victim (mainly females). The shelter based programs for children helps them to address their anger, fear, and other issues in ways that reduce the likelihood of intergenerational transmission of family/domestic violence. The primary goal of the shelter's children's program is to provide services to child witnesses/victims of family/domestic violence that address their health and safety needs. Poor people are disproportionately represented as victims/child witnesses of domestic/family violence. Most of the families who use State funded shelters do not have other alternatives. Case management and other shelter-based programs can lead to improved economic circumstances for these families and children.

**Service Level:**

- |                              |       |
|------------------------------|-------|
| • Women                      | 1,042 |
| • Young Children (birth -12) | 881   |
| • Teenagers                  | 109   |
- 

**Long-Term Agency Goals:**

1. Provide emergency shelter/host homes for victims of domestic/family violence;
2. Provide 24 hour hotline access for victims of domestic/family violence;
3. Provide shelter based programs that address the health and safety needs of adults/child witnesses/victims of family/domestic violence; and
4. Provide programs and services for child witnesses that help to reduce the likelihood of intergenerational transmission of domestic violence.

**Strategies:** Case Management, hotline services, educative counseling, client assessment, crisis intervention, support groups, housing referrals and safety planning.

**Performance-Based Standards:** Standards for the delivery of services and the circumstances and conditions under which those services are provided to clients are clearly delineated in the contract. In addition to client/program participant based services, each contract specifies that providers must provide outreach and awareness education about family/domestic violence through collaborations, community education, and house meetings within shelters. Each of these activities must be documented by

listing organizations with which the activity has occurred and, for house meetings, by recording attendance lists and meeting dates.

**Performance –Based Outcomes:** Actual numbers for the following must be reported: bed occupancy; number of clients with a separate count for children; number of hotline calls, number of house meetings/dates; number and type of activities for children; and outcomes for clients.

**Performance-Based Accountability:** Site visits, quarterly and annual reports of activities and accomplishments are submitted to the Department’s staff.

**Measure of Effectiveness:** Measuring the effectiveness of intervention strategies used with child witnesses/victims of family violence requires a level of sophistication in research and resources that make this type of finding impossible. Parents awareness and access to resources aid in their ability to become more self-sufficient. This acquisition of skill and knowledge ameliorate factors related to child poverty.

**Methods:** Not available at this time.

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**Program Name:** Fatherhood Initiative

**Program Description:** The purpose of the Fatherhood Initiative Program is to promote and facilitate positive interaction between fathers and their children thereby increasing the parent child bond that contributes to optimal growth and development for children. The Initiative also facilitates and supports social and emotional connections between fathers and their children, which has been shown to increase financial support for children of non-custodial, separated, and divorced fathers.

This Initiative is operationalized through contracts with five geographically dispersed agencies. Intervention strategies and tactics used by Fatherhood Initiative providers aim to prevent child poverty, child abuse and neglect, absentee fathers, intergenerational poverty, and youth violence among children of program participants. The agencies provide a range of services including preparation for employment, job search, life skills training, case management, parenting skills and education for parenting. Program participants are multi-ethnic, multicultural, working income, no income, and marginal income men, many of whom have had some involvement with the criminal justice system, DCF, and DSS.

**Number of children and families served:** Approximately 400 fathers will be served annually.

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**Specific long term goals for the Department are:**

- To provide structured ongoing programs and activities that support the development and retention of parenting (fathering) skills among non-custodial, divorced, and fathers with shared custody;

- To reduce the level of poverty among children living in households in which the father is absent;
- To support and facilitate healthy child development by providing programs and services for Fatherhood Initiative program participants that contribute to healthy father-child relationships;
- To promote and support co-parenting, regardless of marital status;
- To foster and facilitate, through various community based programs and services, economic self-sufficiency for Fatherhood program participants and their children;
- To provide programs and services that increase the vocational skills and employability of program participants; and
- To provide community based programs and services that sustain co-parenting and successful father-child relationships.

**Specific intended outcomes of DSS' prevention efforts include but are not limited to:**

- Among Fatherhood program participants, a decrease in the number of unemployed and underemployed program participants;
- Increase in the number of children who have healthy relationships with their fathers;
- Increase in the number of gainfully employed non-custodial fathers who contribute to the financial support of their children;
- Decrease in the number of single female headed households who are totally dependent on entitlements;
- Among non-custodial fathers and single mothers, increased awareness of the pivotal role that men play in normal healthy child development and positive psycho-social/educational outcomes for children;
- Increase in voluntary child support payments; and
- Increase in the number and rate of voluntary paternity acknowledgement by unmarried fathers.

**Strategies:** Strategies developed to achieve the goals and intended outcomes are:

- Contract with five geographically dispersed agencies with expertise and knowledge about fatherhood, non-custodial parenting, co-parenting, cultural and ethnic factors in parenting, and proven ability to work with low/no income men;
- In collaboration and partnership with contracted agencies, identify best practices for developing, supporting, and/or improving father-child relationships and parent to parent relationships;
- Provide non-custodial fathers and other Fatherhood program participants with life skills training;
- Provide non-custodial fathers and other Fatherhood program participants with employment training and job placement;
- In partnership with contracted agencies, support and facilitate job development and job retention among Fatherhood program participants;
- Develop and provide knowledge and skill driven father-child activities that foster and support healthy father-child relationships;

- Educate fathers and mothers about the importance of male parent involvement in the lives of children; and
- Develop strategies and practices that, whenever possible, connect unmarried fathers to the gestation/birth process, parenting roles and responsibilities prior to the birth of the child.

**Outcomes:** Specific outcomes that may be used to measure the success or strategic effectiveness of the Fatherhood Initiative may consist of:

- Longitudinal comparison of changes in parent-child relationships, rate and extent of co-parenting (regardless of marital status), and rate of job retention among Fatherhood program participants from ethnic/cultural minority communities;
- Increase in the actual number of early pre-post birth paternity acknowledgements; and
- Positive changes in the rate of voluntary child support payments.

**Measure of Effectiveness:**

- Rate and extent of voluntary and involuntary child support payments among program participants;
- Consistent ongoing employment;
- Reduction in the rate of unemployment and underemployment among program participants;
- Reported rate of co-parenting among program participants;
- Rate of voluntary paternity establishment and acknowledgement among unmarried fathers;
- Actual rate of pre-post birth involvement of unmarried fathers;
- Changes in pay rates/income among program participants; and
- Number of households evidencing an increase in income, resulting in a reduction in child poverty, as a result of the receipt of financial support from non-custodial, divorced, separated, and/or co-parenting fathers.
- Other measures of effectiveness will result from the completion of the grant related evaluation, currently under development.

**Methods:** In progress, however, greater emphasis is being placed on addressing the impact of ethnicity, income, and gender on performance outcomes.

**Program Name:** Promoting Responsible Fatherhood is under the auspices of the Fatherhood Initiative.

**Program Description:** The Department was awarded a five year five (5) million dollar grant (one million dollars per year) from the Department of Health and Human Services (DHHS)/Administration for Children and Families (ACF) in October, 2006. This grant funds the implementation of the Department’s “Promoting Responsible Fatherhood” demonstration project. Grant strategies and activities include the three ACF authorized

activity areas: healthy marriage, responsible parenting, and economic stability. In partnership with the five state-certified fatherhood programs, the Department has targeted, primarily, low-income fathers, new fathers, fathers-to-be, and young fathers who may be single/unmarried, non-custodial, or co-habiting. In addition, couples interested in marriage and/or those who indicate that they are engaged are included in the target population.

The overall goal of the Responsible Fatherhood Project is to provide members of the target populations with a cohesive continuum of services that connects them to programs, resources, and services. Father involvement in the lives of children results in improved economic circumstances, better academic outcomes for children leading to better futures as self sufficient earners, and reduces the likelihood of childhood poverty. The same gains, for children, can also be seen in successful marriages.

**Service Level:** 500 Fathers and 40 Couples

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**Long-Term Agency Goals:**

1. Increase the earning capacity of program participants thereby increasing economic supports for children.
2. Increase fathers' knowledge about responsible parenting.
3. Increase the level of effectiveness of communication between parents.
4. Increase commitment to healthy co-parenting.
5. Optimize employability and employment of program participants through training and supportive services.

**Strategies:**

Project services include:

- Enhanced prevention and intervention strategies that promote healthy marriage; and
- Responsible parenting and economic stability.

Program providers/partners will offer standard curricula: "*Exploring Relationships and Marriage with Fragile Families*, *Inside Out Dad* (for incarcerated men), and *24/7 Dad*, for program participants, as an activity in the Healthy Marriage and Responsible Parenting program component.

Other strategic Project activities include:

- Development of a curriculum to train DSS and community partners to enhance knowledge and skills in assessing domestic violence, cognitive limitations, and case management (connecting program participants to appropriate services).
- Collaboration with multi-disciplinary partners, statewide, to effectuate change in the conditions and situations that have a negative impact on low-income fathers and couples.
- Partnering with the Connecticut Coalition Against Domestic Violence, the Department's Bureau of Rehabilitation Services, and multiple community based

stakeholders in order to ensure the development and provision of programs and services that are ecologically based.

- Contracting with the Consultation Center at Yale University to evaluate the Project.

**Performance-Based Standards:** For this program, the number of participants and the type of services to be provided are specified in each provider contract. In addition, program staff makes site visits, receive and review quarterly reports, and review client based outcome measures in determining providers' programmatic performance.

**Performance-Based Outcomes:** Clients complete before and after surveys related to knowledge about healthy marriage and responsible parenting. An objective assessment of each client's economic condition, educational level, and employment skills is also included. Changes in these factors, positive or negative, determines the extent to which program strategies and interventions are effective. Negative or lack of individual or situational change creates opportunities to review and modify strategies/interventions when indicated.

**Performance-Based Accountability:** This program relies on specific performance based language in the written contracts, reports, site visits, and evaluative outcomes to ensure compliance and accuracy of deliverables.

**Measure of Effectiveness:** The extent to which the effectiveness of *prevention* is evidenced in Promoting Responsible Fatherhood is directly related to participant outcomes including increased child support, improved co-parenting, increased employment among program participants, and increased involvement of fathers with their children.

**Methods:** Not applicable for this program.

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**Program Name:** Teen Pregnancy Prevention

**Program Description:** The primary purpose of the Teen Pregnancy Prevention Program is to provide information and enrichment activities to youths between ages 11 and 17 who are at risk for teen pregnancy. Contractors/service providers must use either the Children's Aid Society Carrera Adolescent Pregnancy Prevention Program the Reach for Health (RFH) or the Teen Outreach Program (TOP) service learning model. There are two major components of RFH and TOP: volunteerism (teen program participants must volunteer in the community, performing tasks such as tutoring, public beautification, clean-up, etc.) and a structured curriculum that allows the teens to reflect on the volunteer experience and to address adolescent life issues. Based on available research (Furstenberg and others), teen parents are more likely to depend on public welfare to meet their subsistence needs; children born to teen parents are more likely to become teen parents themselves; children of teen parents are more likely to be impoverished; and marriage rates among teen parents are very low. The poorest children in Connecticut

tend to be members of single parent female headed households. This program (1) reduces dependency on public welfare and (2) reduces the incidence of single parent female-headed households. Both of these factors are positively correlated with child poverty.

**Service Level:** 799 youth

**Long-Term Agency Goals:**

1. The primary goal is to prevent teen pregnancy.
2. Secondly, the Program provides experiences and activities that support the development of life skills, among program participants, that lead to making responsible choices in their lives.

**Strategies:**

1. Planned supervised community service projects;
2. Individual and small group discussions;
3. Assistance with access to health care;
4. Assistance with personal development through guided interaction;
5. Education about the legal, personal, and social responsibilities of responsible parenthood and bearing a child;
6. Information and referral;
7. Information about reduced risk sexual behavior including postponing sexual involvement, contraception, reproductive health education, life skills and social competency training; and
8. Information about personal safety and dysfunctional family patterns.

**Performance-Based Standards:** Contractors/service providers are required to use any of the three standardized curriculums in addition to other services. They are also required to provide case management and individual youth assessments. Contracts clearly specify outcomes and how those outcomes are to be demonstrated or documented. Providers must also report on participation rates and outcome based data, on a quarterly and annual basis.

**Performance –Based Outcomes:**

1. Percentage of participants who do not experience a pregnancy;
2. Percentage of program participants who evidence understanding of risky sexual behavior based on three program measures of risky sexual behavior; and
3. Percentage of program participants who attend school on a regular basis as documented by rate of absenteeism, dropout and academic performance.

**Performance-Based Accountability:** Field visits, provider reports, and participant feedback are used to ensure contract benchmarks and deliverables are aligned with the contractual agreement.

**Measure of Effectiveness:** Program participants who evidence consistent participation in Teen Pregnancy Prevention Programs have a much lower rate of teen pregnancy than their non-Program participant peers.

**Methods:** This data is not available at this time.

## Office of Policy and Management

**Program Name:** Title V Delinquency Prevention Program

**Program Description:** The Title V Delinquency Prevention Program provides grants to cities and towns (units of local government) in Connecticut for delinquency prevention and early intervention projects based upon a risk and protective factor approach. This approach calls on communities to identify and reduce risk factors to which their children are exposed and to identify and increase/enhance protective factors which mitigate risk. Risk-focused delinquency prevention provides communities with a conceptual framework for prioritizing the risk and protective factors in their own community, assessing how their current resources are being used, identifying resources which are needed, and choosing specific programs and strategies that directly address those factors.

**Service Level:** 250 children

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**Long-Term Goal:** The goal of this program is for communities to develop and implement a comprehensive delinquency prevention plan that coordinates and uses existing programs and resources for the purpose of specifically addressing those risk and protective factors which are known to be associated with delinquent behavior within the individual communities. The program seeks to address these factors at the earliest appropriate stage in each child's development. The target population is all, or any group of, at-risk children in a given program community.

**Strategies:** Program communities are to develop a comprehensive delinquency prevention plan that specifically addresses those risk and protective factors which are known to be associated with delinquent behavior within the communities. The strategies must inventory available federal, state, local and private resources and also develop vehicles for making these resources and programs readily accessible to children and families in need.

**Performance Strategies:** Program communities must develop and implement a local delinquency prevention plan that:

- Assesses the prevalence in the community of specific, identified risk and protective factors, including the establishment of baseline data for the factors and a list of priority factors to be addressed;
- Identifies all available resources in the community;
- Assesses gaps in the needed resources and how to address them;
- Establishes goals and objectives along with an implementation timeline; and
- Insures the collection of data for the measurement of performance and outcome of planned program activities.

**Performance Based Accountability:** Program grantees prepare quarterly progress reports and collect evaluation data for the measurement of performance and outcome of planned program activities.

**Performance Based Outcomes:** Program grantees are required to collect the following data elements:

Outputs:

- Number of full time equivalent employees funded with grant funds;
- Number of planning activities conducted; and
- Number of program youth served.

Outcomes:

- Number and percent of program youth exhibiting an increase in school attendance;
- Number and percent of program youth completing program requirements;
- Number and percent of program youth satisfied with the program; and
- Number and percent of program staff with increased knowledge of program area.

**Prevention Effectiveness:** The findings from the past outcome program evaluation suggest that involvement with the Title V Delinquency Prevention Program has a positive influence on youth's attitude towards school. It also appears that the staff and directors of the program derived information of value from their participation in the process evaluation. The collection and interpretation of youth perception data and the development of implementation plans with expert consultation resulted in tangible and positive changes in youth's experiences of the programs.

**Methods:** These programs are required to provide services that are appropriate to the populations they serve.

# Appendix E

## Prevention Measures

The data provided below for the Council's prevention goals represents baseline data that was included in the Council's 2007 report and the comparable data available to-date. This data may be supplemented in coming years as other ongoing prevention-based data collection initiatives get underway, including the state's Mental Health Transformation Initiative, the Youth Futures Committee, and the Early Childhood Research and Policy Council.

Each prevention goal is followed by: 1) baseline indicators; and 2) data available to provide a sense of where the state stands with regard to the goal. This data will be updated for the 2009 Progress Report.

**Goal: Increase access to health care.**

### **Indicators:**

- **Health care insurance coverage.** The percentage of people without health insurance coverage was 6.4% in 2006.<sup>1</sup>
- **Health care insurance coverage for children.** The percentage of children under age 19 who do not have health insurance was 2.7% in 2006.<sup>1</sup>
- **Well-baby visits.** In the fourth quarter of 2001, 55.8% of 4- to 24-month-olds and 29.6% of 3 to 5-year-olds enrolled in HUSKY A had the recommended number of well-baby visits.<sup>2</sup>
- **Well-child care.** In 2004, 56% of children enrolled in HUSKY A received well-child care.<sup>3</sup> In 2006, 65% of children enrolled in HUSKY A received well-child care.<sup>4</sup>

**Goal: Increase access to stable and adequate housing.**

### **Indicators:**

- **Affordability of home purchase.** An average price single-family home cost 5.2 times the state per capita personal income in 2003.<sup>5</sup>
- **Affordability of home rental.** The hourly wage that a full-time worker would have to earn in order to afford an average two-bedroom apartment at fair market rent was 2.5 times the state minimum wage in 2003.<sup>6</sup>
- **Number of homeless persons.** The number of children and individuals who experienced homelessness over a twelve month period was 33,000, of whom 13,000 were children, in 1999.<sup>7</sup>
- **Long term or repeated homelessness.** The number of households that have been homeless at least a year or more, or experience repeated episodes of homelessness was approximately 3,000 in 1999.<sup>8</sup>

**Goal: Increase the percentage of pregnant women and newborns who are healthy.**

**Indicators:**

- **Late or no prenatal care.** In SFY 2004, 12.9% of mothers obtained prenatal care after the first trimester of their pregnancy or did not obtain prenatal care.<sup>9</sup> In SFY 2005, 13.2% of mothers obtained prenatal care after the first trimester of their pregnancy or did not obtain prenatal care.<sup>10</sup>
- **Low birthweight.** In SFY 2004, 8% of births were considered low birthweight (less than 2,500 grams)<sup>11</sup>
- **Infant mortality.** In SFYs 2002-2004, the infant mortality rate was 5.8 infant deaths in the first year of life per 1,000 live births.<sup>12</sup>
- **Immunization.** In 2005, 81.5% of children 19-35 months of age were fully immunized (for 4:3:1:3:3:1 vaccination series)<sup>13</sup> In 2006, 82% of children 19-35 months of age were fully immunized (for 4:3:1:3:3:1 vaccination series).<sup>14</sup>
- **Lead screening.** In 2004, 45.3% of children from one to two years of age received a blood lead screening during that year.<sup>15</sup> In 2005, 48.8% of children from one to two years of age received a blood lead screening during that year.<sup>16</sup>

**Goal: Decrease the rate of child neglect and abuse.**

**Indicators:**

- **Substantiated abuse or neglect.** In SFY 2004, there were 14 substantiated cases of child abuse or neglect per 1,000 children.<sup>17</sup>
- **Children removed from home.** In 2004, 10.9% of victims of child maltreatment were removed from their homes and placed in the custody of the Department of Children and Families.<sup>18</sup> In 2005, 10.4% of victims of child maltreatment were removed from their homes and placed in the custody of the Department of Children and Families.<sup>19</sup>

**Goal: Increase the percentage of children who are ready for school at an appropriate age.**

**Indicators:**

- **Preschool experience.** In SFY 2005, 77% of kindergartners statewide had preschool experience and in SFY 2004, 56% of kindergartners in ERG I had preschool experience.<sup>20</sup>
- **Kindergarten Assessment.** The SDE is charged with developing a kindergarten assessment which is scheduled to be in place in Fall 2009.

**Goal: Increase the percentage of children who: learn to read by third grade, succeed in school, graduate from high school, enter post-secondary education, and successfully obtain and maintain employment as adults.**

**Indicators:**

- **CMT score in 3<sup>rd</sup> grade reading.** In 2006, 54.4% of 3<sup>rd</sup> graders reached the goal in reading on the Spring 2006 Connecticut Mastery Test (CMT). In 2007, 52.3% of 3<sup>rd</sup> graders reached the goal in reading on the Spring 2007 Connecticut Mastery Test (CMT).<sup>21</sup>
- **CMT score in 4<sup>th</sup> grade reading.** In 2006, 57.8 % of 4<sup>th</sup> graders overall and 27.5% of 4<sup>th</sup> graders receiving free or reduced-price lunch met the 4<sup>th</sup> grade Connecticut Mastery Test (CMT) goal in reading.<sup>22</sup> In 2007, 57% of 4<sup>th</sup> graders overall and 28.2% of 4<sup>th</sup> graders receiving free or reduced price lunch met the 4<sup>th</sup> grade CMT goal in reading.<sup>23</sup>

- **School districts in need of improvement under NCLB.** In SFY 2006, 22 public school districts were “in need of improvement” under NCLB (i.e. failing to meet Adequate Yearly Progress for two consecutive years).<sup>24</sup> In SFY 2007, 25 public school districts were “in need of improvement” under NCLB (i.e. failing to meet Adequate Yearly Progress for two consecutive years).<sup>25</sup>
- **Out-of-school suspension or expulsion.** In SFY 2004, 28,035 incidents resulted in out-of-school suspension and 1,002 incidents resulted in expulsion.<sup>26</sup>
- **Graduate from high school.** In 2004, the four-year cumulative high school dropout rate (i.e. the percentage of students in the graduating class who have dropped out between grades 9 and 12), was 8.8% statewide and 20.9% in ERG I for the Class of 2004.<sup>27</sup>

**Goal: Decrease the percentage of children who are unsupervised after school.**

**Indicators:**

- **After school and other activities: self-reports.** In 2005, the percentage of students who reported that they took part in organized after school, evening, or weekend activities (such as school clubs, sports, community center groups, music/art/dance lessons, drama, church, or other supervised activities) on one or more of the past seven days was 58.5% for one or more days and 22.7% for five or more days.<sup>28</sup>

**Goal: Reduce unhealthy behaviors among youth (e.g. teen pregnancy, smoking, auto accidents).**

- **Teenage births.** The teenage birth rate was 13.8 births per 1,000 females ages 15-17 in SFY 2004.<sup>29</sup>
- **Self-reports of cigarette usage.** The percentage of high school students who reported that they smoked cigarettes during the past 30 days was 18.1% in 2005 survey year.<sup>30</sup>
- **Self-reports of marijuana usage.** The percentage of high school students who reported that they used marijuana during the past 30 days was 23.1% in 2005 survey year.<sup>31</sup>

- **Self-reports of alcohol usage.** The percentage of high school students who reported that they smoked cigarettes during the past 30 days was 45.3% in 2005 survey year.<sup>32</sup>
- **Self-reports of riding with driver who had been drinking alcohol.** The percentage of high school students who report that they did not ride with a driver who had been drinking alcohol during the past 30 days (70.3% in 2005 survey year)<sup>33</sup>

**Goal: Decrease the incidence of child and youth suicide.**

**Indicators:**

- **Suicide rate.** The suicide rate among young people, ages 15-24, was 5.3 deaths per 100,000 in 2003.<sup>34</sup>
- **Self-reports of suicide attempts.** The percentage of high school students who reported that they attempted suicide during the past 12 months was 12.1% in 2005 survey year.<sup>35</sup>

**Goal: Decrease the incidence of juvenile crime.**

**Indicators:**

- **Juvenile violent crime arrests.** The juvenile arrest rate for offenses included in the Violent Crime Index (VCI) was 290 VCI crime arrests of persons under age 18 for every 100,000 persons ages 10-17 in 2003.<sup>36</sup>
- **Juvenile arrests for drug violations.** The juvenile arrest rate for drug violations was 479 drug arrests of persons under age 18 for every 100,000 persons ages 10-17 in 2003.<sup>37</sup>

**Goal: Increase the positive involvement of fathers with their children.**

**Indicators:**

- **Marriage rates among low income families.** In 2005, 3.5% of married couple families with children had income below the federal poverty level while 28.3% of female-headed families with children and no husband present had income below the federal poverty level.<sup>38</sup> In 2006, 2.7% of

married couple families with children had income below the federal poverty level while 28.4% of female-headed families with children and no husband present had income below the federal poverty level.<sup>39</sup>

**Goal: Encourage ongoing future leadership on child poverty and prevention issues.**

**Indicators:**

- **To be determined.**

# Appendix F

## Report of the Grid Working Group

THE CHILD POVERTY AND PREVENTION COUNCIL (CPPC), AT THEIR JANUARY 4, 2008 SPECIAL MEETING, ADOPTED THE FOLLOWING RESOLUTION WHICH IDENTIFIED PRIORITY ISSUES TO BE FURTHER RESEARCHED AND DEVELOPED.

ADOPTION OF THESE RECOMMENDATIONS BY THE CPPC IS A FIRST STEP. The intent is to identify issues that are ready to be moved forward in the near future. There was insufficient time to discuss in depth all thirteen recommendations made by the expert panel. Some proposals will require additional evaluation before the CPPC can make specific recommendations.

### 1) FAMILY INCOME AND EARNINGS POTENTIAL:

- a. FEDERAL EITC: It was recommended that CPPC explore how to increase usage of federal EITC.
- b. HOMELESSNESS: It was recommended that CPPC look into expanding homeless diversion programs for families. This could include expanding transitional housing to keep children out of homeless shelters.
- c. The target group for both proposals would be working poor families.

### 2) EDUCATION:

- a. EARLY CHILDHOOD EDUCATION: It was agreed that the CPPC should review the Early Childhood Cabinet proposals. The target group for those proposals would be birth to five.
- b. YOUTH DROPOUT PREVENTION: It was recommended that the CPPC support enhancing efforts to reduce the number of students who drop out of high school.
- c. POST-SECONDARY EDUCATION: The CPPC supported the proposal to expand access to our state colleges, particularly our community colleges, and to expand programs intended to encourage high school students to pursue a college education. The target population for these latter two proposals would be late teen and young adult.

- d. **WORKFORCE DEVELOPMENT:** The expert panel identified workforce development as a key strategy for reducing poverty. It was recommended that the CPPC look into how to enhance the existing GED program for families receiving TFA and literacy. It was also recommended that CPPC look at how youths who drop out of high school can obtain a GED. The target population would be working poor families.

### 3) INCOME SAFETY NET:

- a. **SUPPORT FOR YOUNG MOTHERS ON TFA:** It was recommended that case management services be available to some young mothers on TFA so that they and their children would have access to family support services, particularly during the twelve months after having a child. The target population would be late teen and young adult.
- b. **ABRUPT TERMINATION OF BENEFITS:** It was suggested this issue be re-examined.
- c. **ENHANCE ACCESS TO FEDERAL PROGRAMS:** It was suggested that the CPPC look into how to increase access to food stamp and other similar federally funded programs. The target population would be working poor families.

### 4) FAMILY STRUCTURE AND SUPPORT:

- a. **REDUCE TEEN PREGNANCY:** It was recommended that efforts be intensified to reduce teen pregnancy. The target population would be late teen and young adult.
- b. **CASE MANAGEMENT FOR EMPLOYMENT RELATED SERVICES:** There was general agreement that providing case management services was critical to overcoming barriers to employment.
- c. **FATHERHOOD INITIATIVE:** It was recommended that the fatherhood initiative be supported. Both of these latter two suggestions would benefit the working poor families target group.

- 5) **IMPROVED MEASURE OF POVERTY:** It was agreed that the review of alternative measures of poverty could be addressed during the RBA process, by the Economic Modeling consultant and that the Council should monitor how the federal government and other states address this issue.

- 6) CHARTER OAK GROUP'S RESULTS BASED ACCOUNTABILITY INITIATIVE. The CPPC discussed the Charter Oak Group's recommendations concerning coordination with the RBA initiative.



<b>working poor families</b>	2008: (1) increase usage of federal EITC  (2) homeless diversion program for families (transitional housing and eviction prevention)  2009/2010:	2008: workforce development education, particularly adult literacy and GED for families receiving TFA  2009/2010:	2008: increase access to federal programs such as food stamps, etc.  2009/2010:	2008: (1) case management and employment-related services  (2) Fatherhood Initiative  2009/2010: Study of “cliff” issues including info from DSS	2008:   2009/2010: (addressed by RBA and Economic Modeling initiatives)
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# Appendix G

## Endnotes

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