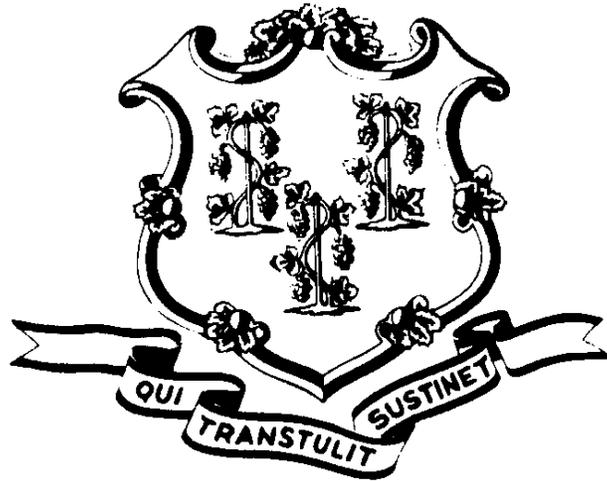


STATE OF CONNECTICUT
AGENCY PREVENTION REPORT



A REPORT TO THE
CHILD POVERTY AND PREVENTION
COUNCIL

November 2010

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NOVEMBER 2010

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REPORT TO THE CHILD POVERTY AND PREVENTION COUNCIL

I. State Agency Report

This report implements C.G.S. Section 4-67x (g) which requires each state agency with membership on the Council that provides prevention services to children to submit an agency prevention report to the Council by November 1st of each year through 2014. This report must also be included in the Council's annual progress report to the Governor and legislature. This report represents the fifth annual State Agency Prevention Report.

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.

Prevention programs and services highlighted in this report serve children aged 0-18 and their families. Primary prevention refers to programs designed to prevent or eliminate at-risk behavior before a problem occurs and promote the health and well-being of children.

Each report includes the following:

- long-term agency 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
- a brief description of the purpose of the prevention program;
- the number of children and families served; and
- state and federal funding for fiscal year 2009-2010.

This Prevention Report is comprised of reports from:

- Department of Children and Families
- Department of Developmental Services
- Department of Education
- Department of Labor
- Department of Mental Health and Addiction Services
- Department of Public Health
- Department of Social Services
- Judicial Branch Court Support Services Division
- Office of Policy and Management

The Departments of Transportation, Higher Education, Economic and Community Development, Office of Health Care Access, Commission on Children, and the Commission on Human Rights and Opportunities 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.

State Agency Prevention Programs - SUMMARY

State Agency Prevention Programs

This section of the report provides a summary on state agency primary prevention services that provide intensive, comprehensive and family-centered resources and support which reduces or eliminates high-risk behavior and promotes the health and well-being of children and families.

In Fiscal Year (FY) 2010, these agencies expended over \$296,276,261 to administer 48 comprehensive primary prevention programs and services that positively impact Connecticut's children and families. The chart below provides a snapshot of the state agency primary prevention programs included in this report.

Summary

Department of Children and Families			
Program	FY10 Funding	Service Level	Description
DCF/Head Start Partnership	\$10,800	8,728 children (0-5 yrs old); 44 pregnant women; 14 DCF area offices; 75 DCF staff and 100 Head Start staff. For the mental health clinician work with children and consultation provided to the Head Start programs in Enfield and Manchester, a total of 202 children, 6 parents and 64 teachers were served.	A partnership to develop strategies to promote young children's healthy development and the stability of the child within the family.
Early Childhood Consultation Partnership	\$1,685,996	2,460 children and 1,193 teachers were served.	Prevent children birth to age 6 from being suspended or expelled from their early care and education setting due to challenging behaviors.
Early Childhood Services	\$520,512	77- 112 families served in Parents in Partnerships and 70 families in Child First	Promotes the development of positive parenting skills and the development of healthy children.
Positive Youth Development	\$558,975	545 children and 147 adults.	Funds six agencies to provide positive youth development and family strengthening programs.
Shaken Baby Prevention	\$8,064	36 providers trained	Support public awareness strategies about the dangers of shaken baby syndrome.
Youth Suicide Prevention	\$39,379	636 individuals trained	Statewide awareness campaigns and training.
Total	\$2,823,726		

Department of Developmental Services			
Program	FY 10 Funding	Service Level	Description
Birth to Three	\$53,471,358	9,591 children and families	Early intervention services to all infants and toddlers who have developmental delays or disabilities.
Family Support Services	\$3,557,216	747 individuals and children-Respite Care and 630 individuals statewide-Family Support Services	Services, resources and other forms of assistance to help families raise their children who have intellectual disabilities.
Total	\$57,028,574		

Department of Education			
Program	FY10 Funding	Service Level	Description
Early Childhood Program (School Readiness)	\$74,820,544	10,516 children in 19 priority school districts and 45 competitive districts.	Expands and enhance access to and availability of school readiness and child-day care programs.
Even Start Family Literacy	\$442,556	78 even start families	Intensive family literacy services to low-income parents and children.
Total	\$75,263,100		

Department of Labor			
Program	FY 10 Funding	Service Level	Description
Jobs First Employment Services	\$17,555,803	11,713	Provides employment services to families in receipt of time- limited state cash assistance.
Youth Employment Program	\$1,425,000	779	Provides employment services for youth aged 14 through 24.
Total	\$21,055,803		

Department of Mental Health and Addiction Services			
Program	FY 10 Funding	Service Level	Description
Best Practices Initiative	\$2,034,178	13,484 children, family members, prevention and treatment professionals, as well as older adults were served.	Positive youth development programs including academic support, peer leaders, mentors, family development and parenting skills.
Local Prevention Council Programs	\$547,065	11,181 children, adults, family and professionals	Alcohol, tobacco, and other drug abuse prevention initiatives at the local level.
Partnership for Success	\$945,519	Services to implement program objectives are planned for October 1, 2010.	The Partnership for Success (PFS) Initiative uses a public health approach in over 30 municipalities and statewide across college campuses to decrease alcohol consumption in youth ages 12 to 20.
Strategic Prevention Framework State Incentive Grant	\$2,245,023	421,280 children, family, community members and professionals	Develop comprehensive strategies for delivering and implementing effective substance abuse prevention services.
Youth Suicide Prevention Initiative	\$243,518	730 students, adults and professionals	Youth suicide prevention and early intervention strategies.
Regional Action Councils	\$2,099,198	136,308 children, family, community members and professionals	Community awareness, education, prevention, intervention, treatment and aftercare for substance abuse.
Statewide Service Delivery Agents	\$1,947,408	11,181 children, family, community members and professionals	Supports prevention efforts locally and statewide by building the capacity of individuals and communities to deliver prevention services.
Tobacco Regulation & Compliance	\$618,984	1,997 retail inspections and 39,530 audio and printed material	Enforcement and strategies to reduce underage tobacco use.
Total	\$10,680,893		

Department of Public Health			
Program	FY10 Funding	Service Level	Description
Asthma Program: Easy Breathing	No contracts for Adult Easy or Asthma were executed for 2009-2010).	N/A	Statewide training of pediatric providers on determining whether a child has asthma, asthma severity, proper therapy, and developing treatment plans.
Child Day Care Licensing	\$2,529,946	114,151 Licensed Capacity	Regulates child day care programs through technical assistance, application processing, facility monitoring, complaint investigation, and enforcement activities.
Community Health Centers	\$5,102,912	289,395 clients	Provides comprehensive, community-based, primary and preventive health care.
Emergency Medical Services for Children	\$130,000	All CT children	Reduce child and youth disabilities and death due to illness or injury by providing providers with resources to meet children's needs.
Family Planning	\$1,073,557	35,015 participants	Provides preventive and primary reproductive health care through health care services, information, and education to the uninsured or underserved.
Immunization Program	\$41,284,219	76% of the state's children aged 2	Prevent disease, disability and death from vaccine preventable diseases in infants, children adolescents and adults.
Unintentional Childhood	\$45,250	350 parents/caregivers and 500 children	Technical assistance and resources to providers and community agencies on injury prevention issues.
Intentional Youth Violence	\$31,512	11,089 youth	Raises awareness, increase knowledge and changes manageable behaviors.
Lead Poisoning Prevention and Control	\$3,302,411	270,187 children	Education, outreach, and screening e targeted toward urban settings.
Newborn Laboratory Screening and Tracking	\$1,049,397	39,589 infants screened	Screening for inborn genetic disorders which have the potential for severe health consequences.
Nutrition, Physical, Activity and Obesity	\$559,231	112,000 children and families	Develops school readiness teachers' capability and motivation to provide nutrition and physical activity experiences, increases young children's exposure to healthy foods and physical activity; and builds teachers' and parents' capability to create and maintain healthy mealtime environments.
Oral Health-Home by One	\$160,000	26,840 children	Provides training and education of physicians, dental professionals, WIC staff, early childhood providers and parents to support age one dental visits for at-risk children.
Rape Crisis and Prevention Services	\$1,146,368	28,239 children, youth, adolescents, patients, clients, primary and secondary victims	Makes 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.
Tobacco Use Prevention and Control	\$2,209,525	3,728 individuals	Provides local cessation and prevention programs.
Women, Infant and Children	\$48,078,732	73,238 children and 28,766 women	Provides nutrition and breastfeeding education, supplemental food, and referrals for health and social services to eligible women, infants and children.
Total	\$106,703,060		

Department of Social Services			
Program	FY 10 Funding	Service Level	Description
Family Development Training and Credentialing Program	\$20,000	70 students received credentials.	Training human services staff to better engage and support families in prevention efforts.
Family Empowerment Initiative	\$200,000	700 participants through home and group based services.	Seven nationally recognized prevention programs that assist high risk group of parents and other involved in the lives of children.
Family School Connection	\$930,000	175 families	Provides intensive services to families whose children are at risk of school failure.
Healthy Start	\$1,600,000	5,000 mothers	Ensures maternal and child health outcomes through enrollment in Husky.
Help Me Grow	\$380,000	3,000 children and families	Ensures that children and their families have access to a system of early identification, prevention and intervention services.
Kinship and Respite Fund	\$1,050,000	1,266 children and 822 adults	Probate court administered program awards small grants to aid children living with relatives who are court appointed guardians.
Nurturing Families Network	\$10,000,000	2,000 families – intensive home visits 600 families-parenting groups, 7,200 screened and connection services to 1,700 individuals.	Provides intensive home visits; nurturing parenting groups; nurturing connection; home visits tailored to fathers; and home cognitive behavioral therapy.
Fatherhood Initiative	\$2,500,000	932 participants	Outreach and awareness education and training for parents related to parenting, healthy relationships and healthy marriages.
Teen Pregnancy Prevention	\$2,427,547	500 youth	Prevents teen pregnancy and welfare dependence through awareness education and support services.
Total	\$19,107,547		

Judicial Branch Court Support Services			
Program	FY 10 Funding	Service Level	Description
Educational Support Services	\$679,600	312 participants	Supports families to ensures that children’s educational needs are identified and free and appropriate educational services are accessible.
Family Support Centers	\$2,236,489	490 participants	A multi-service “one-stop” service for children and families referred to juvenile court.
Total	\$2,916,089		

Office of Policy and Management			
Program	FY 10 Funding	Service Level	Description
Title V Delinquency Prevention	\$117,481	113 youth (10-18 years old)	Provides grants to cities and towns for delinquency prevention and early intervention projects.
Governor's Urban Youth Violence Prevention	\$575,988	1,965 youth (12-18 years old)	Provides grants to municipalities and nonprofits that serve youth in urban neighborhoods who are at-risk of exposure to or involvement with violent behaviors.
Total	\$693,469		

Department of Children and Families

- **DCF/Head Start Collaboration**
- **Early Childhood Consultation**
- **Early Childhood Services**
- **Positive Youth and Family Strengthening Development Initiative**
- **Shaken Baby Prevention**
- **Youth Suicide Prevention**

Long-Term Agency Goals: The Department of Children & Families applies a generalized knowledge of prevention in the design and implementation of all its prevention programs and activities. The programs use existing data and national research as the foundation for designing and implementing appropriate evidence-based programs and practices. Similar to other state and federal agencies, risk and protective factors play an important role in the Department's planning process. For example, the federal Children's Bureau has outlined five protective factors that may diminish the likelihood of maltreatment: nurturing and attachment between family members; knowledge of parenting and child development; parental emotional resilience; social connections for parents; and concrete supports such as food, clothing, housing, transportation, and services. The theory is that parents and caregivers who better understand how to care for their children, have access to more and better resources and feel safe and connected to their community will thrive and be less likely to abuse or neglect their children. The programs described here have been shown through research and evaluation to be effective at addressing at least one of these important factors. Knowing that prevention resources are limited, the Department works diligently to collaborate with other state and community based agencies as well as internally to maximize existing prevention dollars. All of the programs listed are examples of collaborations and partnerships.

Goals:

- Prevention/Less Need for DCF Services
- Children to Remain Safely at Home
- Achieve More Timely Permanency
- Improved Child Well-Being
- Transitioning Youth Better Prepared for Adulthood

Strategies: Meeting the desired outcomes is best achieved through building agency and local capacity, public awareness, programs and services, and integrating prevention principles, strategies and resources throughout the department.

Performance-Based Outcomes: The Department is working diligently to meet the Exit Outcomes for its Consent Decree. Therefore, the following outcomes are aimed at meeting these court defined measures. A complete list of Outcome Measures can be found at http://www.ct.gov/dcf/LIB/dcf/positive_outcomes/pdf/Two_Page_Summary_Outcomes_1_22.pdf

1. Prevention/Less Need for DCF Services

- Fewer investigations
- Fewer open cases
- Fewer delinquency petitions
- Fewer Families with Service Needs (FWSN) petitions
- Increase numbers of families receiving appropriate and effective services
- Fewer re-entries into child welfare system

2. Children to Remain Safely at Home

- Fewer removals from home
- Fewer re-entries into care
- Fewer delinquency commitments
- Lower recidivism
- Fewer disrupted adoptions
- Fewer FWSN commitments

3. Achieve More Timely Permanency

- Fewer youth aging out with APPLA goal
- Reduce average Length of Stay (LOS) for reunification & Meet Outcome Measure (OM) 7 re: Reunification
- Reduce average LOS for Transfer of Guardianship (T Of G) & Meet OM 9 re: T/G
- Reduce average LOS for adoption & Meet OM 8 re: Adoption

4. Improved Child Well-Being

- Fewer school changes
- Improved school achievement

- Fewer placement changes
- Meet OM 14 re: Placements within License Capacity
- Increase of placement with siblings
- Meet OM 6 re: Child maltreatment in Out of Home (OOH) care
- Increase percentage of children placed with relatives
- Timely medical/dental care
- Lower percentage of children in congregate care
- Reduction of children on discharge delay
- Improved performance on OM 15 re: Needs Met

5. Transitioning Youth Better Prepared for Adulthood

- Increased percentage with family/adult connection
- Increased percentage of high school graduates
- Increased percentage engaged in treatment if needed
- Increased percentage with financial literacy
- Increase percentage with sustainable housing
- Meet OM 20 re: Discharge
- Meet OM 21 re: Discharge to DMHAS/DDS

Measure of Effectiveness: The findings thus far indicate that programs targeting and strengthening families have been the most effective. Research tells us that the earlier interventions are introduced into children's lives the greater the chance for positive results now and later. National research studies show that very young children are especially vulnerable. The Adverse Childhood Experience Study (ACES) found that adverse childhood experiences are strongly related to the development and prevalence of risk factors for disease and health and social well-being throughout the lifespan. This emphasizes the need for prevention and early intervention programs for very young children and the need to target children in the context of their families and the communities in which they live.

Methods: At the ground level, programs such as The Breakthrough Series (a program implemented in Waterbury to look at the issue of overrepresentation of minorities in the child welfare system) and Better

Together (a program to engage families in our work to inform the Department's ongoing efforts) work to concretely address the issue of disparities in outcomes by race, income and gender. At the systems level, two new DCF initiatives, the Differential Response System and the Best Practice Model, work to support the mission of the Department to protect children, improve child and family well-being and support and preserve families. The goal is to provide a framework for how the agency as a whole will work internally and partner with families, service providers, and others to put our mission and guiding principles into action in daily practice and operations. The Department's workforce reflects the populations it serves. In addition, DCF requires all contractors to administer, manage and deliver a culturally responsive and competent program with specifics clearly articulated in every contract.

Other: Prevention is just one of the Department of Children and Families' many mandates but it is one of its most important. The Bureau of Prevention defines prevention as the promotion of wellbeing for all children and families. This is accomplished by building local and agency capacity, public awareness and funding prevention and early intervention programs and services.

Building capacity is done primarily through training. Since 2005, thousands have been trained in a variety of workshops and conferences on early childhood specific topics, youth substance abuse, depression, suicide prevention, Strengthening Families 10-14 (a nationally recognized evidence-based curriculum), working with parents with cognitive limitations and shaken baby prevention - to name just a few.

Knowledge is power. It is this belief that drives the Department's Public Awareness campaigns. Getting important and timely information to families, providers and DCF personnel requires constant contacts. Along with the dissemination of letters and brochures to schools, superintendents, police, youth service bureaus, and DCF Area Offices and the information regularly distributed electronically through the Prevention list serve, the new CT Parenting website <http://www.ctparenting.com/> offers parents and other individuals a user friendly internet site for information on a multitude of topics for parents and caregivers.

The Department's prevention programs and services are designed to strengthen children and families and the communities in which they live. This report highlights six such programs.

DCF / HEAD START PARTNERSHIP: The focus of this partnership is to develop strategies to promote young children's healthy development and the stability of the child within the family. All fourteen DCF Area Offices have formed partnerships with the Head Start programs in their area affording more young children in DCF placement and DCF involvement the opportunity to receive a high quality preschool experience and more support and resources for their parents.

Number Served: 8,728 children (0-5 yr); 44 pregnant women; 14 DCF area offices; 75 DCF staff; 100 Head Start staff. For the mental health clinician work with children and consultation provided to the Head Start programs in Enfield and Manchester, a total of 202 children, 6 parents and 64 teachers were served.

Program Cost: FY 2009 – 2010: \$10,800

Performance-Based Standards: This is a statewide collaboration and does not currently have any contracts. Through Mental Health Block Grant money, a small, time-limited contract was awarded in the Manchester area to provide clinical mental health work and consultation to the Head Start programs in Enfield and Manchester.

Performance-Based Outcomes: This is a still a relatively new initiative and performance based outcomes are being developed. Possible outcomes include the number of children involved with DCF who are enrolled in Head Start, the number of Head Start programs with a DCF social worker on their policy council, the number of area offices conducting joint treatment planning, the number of DCF area offices that have a collaboration with the Head Start programs in their area, the number of Head Start programs utilizing the Early Childhood Consultation Partnership consultant, the number of Head Start programs with an Early Childhood Behavioral Consultation program the number of Head Start programs conducting joint home visits with their DCF area office. The enrollment rate for each Head Start program, the number of Head Start programs working with their DCF area office to recruit foster parents, the number of DCF area offices with an organized system for referring children to Head Start for enrollment.

Performance-Based Vendor Accountability: Aside from the one completed grant to provide clinical mental health work and consultation to Head Start Programs in Enfield and Manchester, this is a statewide collaboration without contracts.

Early Childhood Consultation Partnership (ECCP): The goal of ECCP is to prevent children birth to age 6 from being suspended or expelled from their early care and education setting due to challenging behaviors. ECCP promotes and facilitates the early identification of children in daycare education settings with mental health needs. The focus of this service is the provision of consultation and training to staff in Early Care and Education Settings in order to promote young children's social and emotional wellness in order to prevent behaviors that could result in the child being suspended or expelled from the early care and education setting. The program also provides service to DCF foster homes, safe homes, childcare homes, and parent child residential facilities.

Number Served: Since its inception in 2002 the program has served over 12,800 children and over 4,400 teachers and assistant teachers within an estimated 750 (nearly 60%) of Connecticut's licensed early care or education centers. In 2009-2010, 2,460 children and 1,193 teachers were served.

Program Cost: FY 2009 – 2010 \$1,685,996

Performance-Based Standards: ECCP is a data driven program demonstrating its effectiveness through the internal quality assurance and program improvement measures it employs and through external research evaluations and national studies. ECCP is further backed by a 2007 rigorous randomized control evaluation conducted by Walter S. Gilliam, PhD, of Yale Child Study Center. A randomized study compared outcomes for children who were/ were not enrolled in classrooms that received ECCP services. Results indicated significant effectiveness in reducing classroom behavior problems in children, demonstrating changes such as decreased oppositional behaviors and hyperactivity. Program measures such as 6 month follow up data show that 99 percent of children in programs that received consultations were neither suspended nor expelled from their early care or education settings, and that 92 percent of classrooms served demonstrated improvement in the overall quality of classrooms environments.

Performance-Based Outcomes:

- Increased number of early childhood education centers and staff who have access to education and support services related to social and emotional wellness.
- Increased the number of caregivers and teachers that are implementing practices supportive of social and emotional
- Improved ability of educators to observe and document children's behavior and identify behaviors that may be clinically significant
- Improved ability of educators to deliver classroom strategies and interventions targeted to specific children
- Improved ability of educators to initiate discussions with parents regarding children's behavioral difficulties, and to work in partnership with families, in helping to address children's individual needs
- Reduced incidence of suspension and expulsion in young children due to behavioral problem
- Increase coordination between parent /guardians, providers, DCF workers
- Increased capacity of parent /guardians, providers, DCF workers and early educators in the areas of healthy social/emotional development and attachment
- Increased support for children in foster care and for DCF staff

Performance-Based Vendor Accountability: ECCP is funded through Connecticut's State Department of Children and Families and is managed by Advanced Behavioral Health (ABH®), a non-profit behavioral health care management company. ABH has been responsible for the development and administration of the ECCP program. ABH subcontracts with 10 non profit behavioral health clinics for 20 Early Childhood Mental Health Consultants to provide statewide coverage. ECCP is backed by a rigorous research evaluation and features a fully manualized service approach, customized central Information System, and an integrated and competency based workforce development and training program.

EARLY CHILDHOOD SERVICES: Parent in Partnership (PIP) strengthens parenting through the use of a standardized parenting curriculum for an in-home and community-based support and intervention for high risk families. Child FIRST provides home based assessment, family plan development, parenting education, parent-child therapeutic intervention, and care coordination/case management for high-risk families.

Number Served: Parents in Partnership 77-112 families /yr and Child FIRST 70 families/yr

Program Cost: FY 2009 – 2010 \$520,512

Performance-Based Standards: Promotes the development of positive parenting skills, school readiness skills and healthy development for children, ages birth to six who may be identified as at risk for abuse and/or neglect and having developmental delays in order to increase their ability to function optimally in social and learning environments.

Performance-Based Outcomes:

- Families will have less or no DCF Involvement - measured at enrollment and at the end of the program
- Parents/caregivers will show less stress as evidenced by the Parenting Stress Index (PSI)
- Caregiver-parent relationships will be strengthened as evidenced by the Observation of Caregiver-Child Relationship (OCCR)
- The home environment will demonstrate improvement as evidenced by the Home Observation - Physical Environment (HOPE)
- Families will gain a better understanding of stages of childhood development including social and emotional development and children will show improvement in this area as measured by the Ages and Stages-Social Emotional Questionnaires
- Parents will be screened for depression and will show improvement
- Clients will be satisfied with the program

Performance-Based Vendor Accountability: Quarterly and Annual reports. Site visit review tool are being developed.

POSITIVE YOUTH AND FAMILY STRENGTHENING DEVELOPMENT INITIATIVE: The Department funds six (6) agencies, all using evidence-based or best practice models, to provide positive youth development (ages 6-13) and family strengthening programs. The Bureau of Prevention staffs bimonthly technical assistance meetings. Long-Term Goals include: (1) an increase in the social-emotional skills of children through a universal prevention program/strategy, (2) an increase in support and opportunities for young people and their families through enrichment and/or recreation, (3) an increase in bonding of children to their parents, school and peers, (4) an increase in the engagement of/and communication with families, and (5) an increase in youth and families' ability to seek help when needed. The programs are located in Enfield, Torrington, Hartford, New Haven, West Haven and Willimantic.

Number Served: 545 children and 147 adults

Program Cost: FY 2009 - 2010 \$558,975

Performance-Based Standards: Designed to teach social skills, promote positive mental health and support the role of parents of children ages 6 through 12. They teach children effective communication, understanding feelings, coping with anger and criticism, stress management, social skills, problem solving, resisting peer pressure, consequences of substance use, and compliance with parental rules. Families taught skills to strengthen communication and bonds within their family by providing feedback to families, modeling desired outcomes and providing opportunities for families to practice their new skills.

Performance-Based Outcomes: For parents: Better parent child communication, learning key parenting skills such as self-regulation, boundary setting, and commitment to family time. For youth: Increased knowledge about drug, alcohol and other risky behavior. Learning conflict resolution skills and other key life skills such as self-regulation, communication, and goals/life planning.

Performance-Based Vendor Accountability: An independent evaluator assists the Department, in partnership with the providers, to develop common outcomes for this initiative, gather data and monitor effectiveness. The purpose of the evaluation of PYDI is to understand and document the process and effect of replicable, evidence-based prevention models (e.g. Second Step, Strengthening Families, SPF 10-14, and All Stars) and two promising practices (Better Horizons and Farnam House) in CT communities. The outcome evaluation involves the analysis/synthesis of program specific surveys and common outcome surveys.

SHAKEN BABY PREVENTION: Supports public awareness strategies about the dangers of shaken baby syndrome. A pilot was implemented in 2008-2009 evaluating two best practice programs, Dr. Harvey Karp's "Happiest Baby on the Block" and Dr. Ronald Barr's "Period of Purple Crying" Program, to evaluate what elements of each works best with DCF, DOC, DMHAS targeted populations and in DPH's contracted WIC programs and community based health centers. A statewide collaborative has been formed to address shaken baby prevention. The Massachusetts Children's Trust Fund will conduct training of trainers to use, Babies Cry, Have a Plan in the DCF facilities.

Number Served: Trained 36 providers of services to parents, the majority of whom were providers of services to dads in the model developed by the Massachusetts Trust Fund, "Babies Cry Have A Plan."

Program Cost: FY 2009 - 2010 \$8,064

Performance-Based Standards: Plans are being developed to develop a training of trainers to distribute this program throughout the State. The USDII School District is currently implementing this program to an age appropriate audience. Purple Crying DVDs were replenished to programs that participated in last years' pilot.

Performance-Based Outcomes: An increased awareness of the dangers of shaking a baby among caregivers, particularly male caregivers. An increased knowledge of soothing techniques for calming a crying baby.

Performance-Based Vendor Accountability: An evaluation component will be developed after the training of trainers and distribution plan is completed.

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

Number Served: 636 individuals trained. Information emailed and posted statewide.

Program Cost: FY 2009 - 2010 \$39,379

Performance-Based Standards: Numbers and types of populations trained (e.g. police, parents, school social workers, and youth). Number and types of information and public awareness efforts.

Performance-Based Outcomes: Parents, foster parents, caregivers, youth workers, police, first responders and schools will be better able to identify and appropriately respond to suicidal youth. Public awareness will be raised.

Performance-Based Vendor Accountability: All contractors are monitored and held accountable to their contracts. Satisfaction type surveys are conducted at the end of each training session.

Department of Developmental Services

- **Birth to Three**
- **Family Support Services**

Long-Term Agency Goals: The Department of Developmental Services (DDS) serves over 15,000 individuals who have mental retardation in Connecticut including 2,825 children under the age of 18. This number does not include children who are served in the Birth to Three System. While most children live with their families, approximately 215 children served by DDS live in other residential settings. The department's long term prevention goal is to:(1) provide early intervention to families of very young children with disabilities or delays to ameliorate the delay or to at least prevent secondary disabilities; (2) support families to care for their children in the family home and (3) to prevent out-of-home placement.

Strategies: For children enrolled in Birth to Three, family-centered early intervention services are delivered in natural environments as early as possible. Most families who have children with intellectual disabilities over the age of three need extra support to care for their children at home. DDS provides Family Supports to assist families caring for their children at home. Family Supports include goods, services, resources, and other forms of assistance that help families to successfully raise their children who have mental retardation. The Department of Developmental Services plans to continue to provide Individual and Family Grants, Respite and Family Support Workers to families. Within available resources, the department serves as many families as possible with these Family 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 for children over the age of three. 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. All children who receive Medicaid fee for services are provided with a DDS case manager. A referral service or help line is being put in place in all regions this fall to assist families who do not have a case manager to access appropriate family support services.

Performance-Based Outcomes: For children enrolled in Birth to Three, children are identified as early as possible, children's developmental trajectories are improved, parents feel more confident and competent to foster their children's development, and fewer children need special education services by Kindergarten. For children over the age of three, children are able to live at home longer with their families, receiving appropriate supports and avoiding more costly residential or out-of-home care.

Measures of Effectiveness: Other than in the Birth to Three Program, DDS is unique among state agencies that provide services, in that individuals eligible for DDS supports and services have a diagnosis of mental retardation and will likely require lifetime services. While mental retardation in and of itself is not "preventable", strategies are pursued to lessen or delay the need for more comprehensive services throughout a consumer's lifetime and to provide support and services that build skills and independence. The provision of in-home services often delays the need for more comprehensive and thus more expensive residential or out-of-home services. In Birth to Three, the data supports that the stated outcomes are being achieved to a great degree.

Methods: All children that meet the DDS eligibility criteria for all programs are eligible, irrespective of race, income level, gender or town of residence. Birth to Three is an entitlement program and all eligible children receive services. The focus of services is in teaching the family and other caregivers to intervene in the child's development during naturally occurring routines and activities. Resources for other programs are allocated to consumers and families based upon an individual's level of need and available appropriations.

BIRTH TO THREE: 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 to 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 developmental 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. States are given quite a bit of latitude in defining both of those groups.

Early intervention services must be delivered in natural environments, and for children at 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 Served: In FY 2010, 8,571 referrals were accepted for evaluation. 9,591 eligible children and their families received services during some portion of the fiscal year, with an average of 5,000 enrolled on any given day. Data back to children born in 2000, shows that the Birth to Three System has consistently served 10%-11% of children in each birth cohort.

Program Cost: FY 2009 - 2010 \$53,471,358

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. Individualized Family Service Plans (IFSPs) 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 Vendor Accountability: Birth to Three has an in-depth, multi-layered process for assuring the quality of services and the performance of its contractors.

Data System - All contractors are part of a real-time data system that enables the state to view their performance on a daily basis. As part of that data system, the contractors have a "performance dashboard" that allows them to monitor their own performance.

State Performance Plan/Annual Performance Report - The department submitted a five-year State Performance Plan to the U.S. Department of Education and then submits an Annual Performance Plan each year reporting on progress. Each indicator of performance in the annual plan is also reported for each contractor. Any contractor not in 100% compliance with the Individual with Disability Education Act (IDEA) for any indicator receives a finding of non-

compliance which must be corrected as soon as possible but no later than twelve (12) months from written identification.

Self Review- In addition, every two years, each Birth to Three contractors submits self-review looking at their performance over a wide variety of indicators. That review is submitted electronically to DDS central office staff who verifies the data and the contractor is required to prepare an improvement plan for any items that are either not in compliance with the law or performance items that need improvement. Once a year, the state ranks contractors on one or more specific indicators chosen by a stakeholders group. 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 delves much deeper into issues of quality. The team reviews child records, interviews staff, and interviews parents. The monitoring report is issued and any findings of non-compliance are made. Corrections of non-compliance findings or items needing improvement are added to the contractor's existing improvement plan. Any finding of non-compliance must be corrected as soon as possible, but no later than twelve (12) months from written identification.

Dispute Resolution. The last check on contractor 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 have been held infrequently. All of these components of the Birth to Three accountability and monitoring system can be found in greater detail on www.birth23.org under "How Are We Doing".

FAMILY SUPPORT SERVICES: The Department of Developmental Services (DDS) provides Family Supports that assist families to care for their children who have intellectual disabilities in their homes. Most families who have children with intellectual disabilities need extra support to help them keep their children at home. Family Supports include goods, services, resources, and other forms of assistance that help families successfully raise their children who have intellectual disabilities. Family Supports include Respite Services provided by DDS and DDS Family Support Workers. Family Supports help children grow up in a nurturing family home where they are more likely to live healthy, safe and productive lives. DDS Respite Centers provide 24-hour care for extended weekends in comfortable home-like environments.

Family Support Workers provide temporary in-home and community support to DDS consumers 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.

Number Served: The department has 11 Respite Centers which served a total of 747 individuals statewide in FY 10, including 304 children. During FY 10, DDS family support workers provided services to more than 630 individuals statewide, including 196 children.

Program Cost: FY 2009 - 2010 \$ 3,557,216

Performance-Based Standards: The goal of DDS Family Supports is to provide a range of supports for families of children with intellectual disabilities so they can stay together and keep their children in the family home. DDS prioritizes family supports based upon the level of need of the child and the family; for instance, a child who is a high priority on the waiting list for residential services is also a high priority for services at respite centers.

Performance-Based Outcomes: Specific outcomes in measuring the success and effectiveness of 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 compared to children in out-of-home placements.

Performance-Based Vendor Accountability: Family Supports are provided by DDS staff through the department's programs and are not contracted services. Family Support programs are operated based upon DDS policies and procedures specific to those services. The procedures are described in the eligibility criteria, priority for services, and

service operational guidelines. DDS regional offices maintain data on the numbers of children and adults served.

DDS has a
centralized
process to

Connecticut State Department of Education

review requests for out-of-home placement for children. The department's Children's Services committee meets monthly to review any requests to place a child under age 18 out of the family home. The committee reviews alternative supports that have been put in place, makes recommendations for additional supports that may be successful in keeping families together and makes recommendations to the Commissioner regarding the appropriateness of placements.

- **Even Start Family Literacy Program**
- **Early Childhood Program (School Readiness)**

Long-Term Agency Goal #1:

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*¹; and

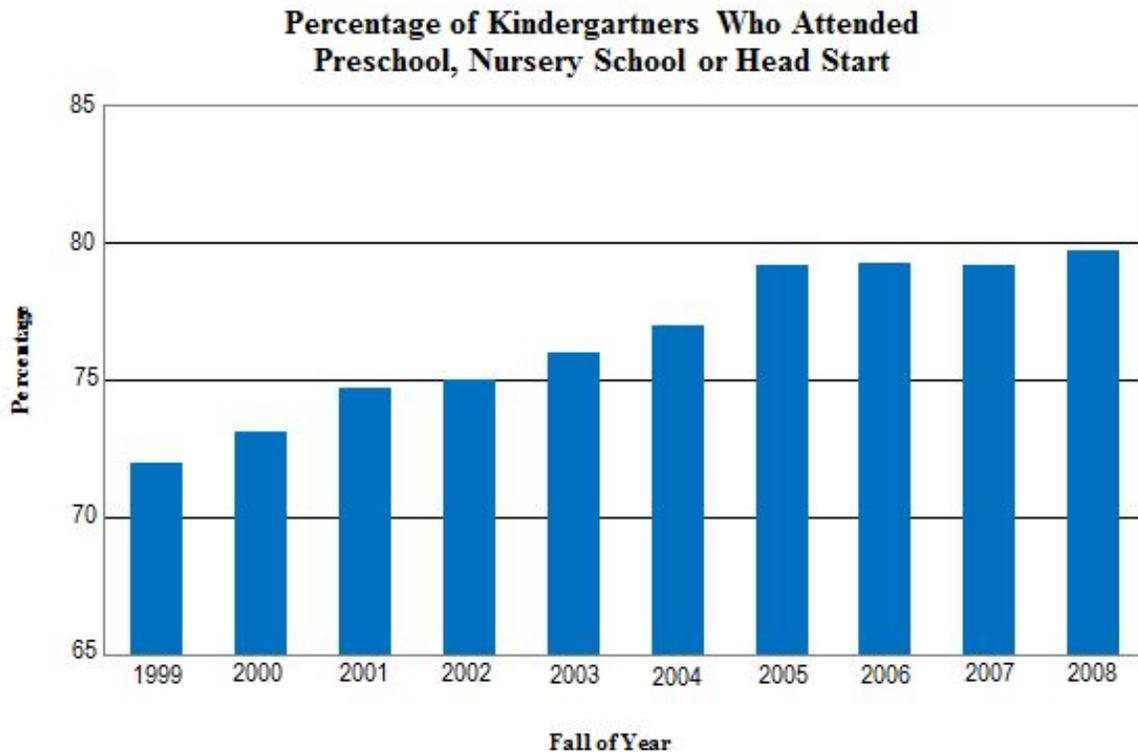
¹ *The Connecticut Framework: K-12 Curricular Goals and Standards has been modified through adoption of national standards and is now referred to as the Connecticut Common Core State Standards (CCSS).*

- 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. Due to the current economic climate, many of the material and staffing supports necessary to accomplish the aforementioned strategies are no longer available within the state department of education, nor the local district partners. However, where funding and other resources are available to support this work, 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; and
- 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.

Overall Findings on Effectiveness: After increasing by 9 percentage points from 1998 to 2005, the percentage of kindergarteners with prekindergarten experience has remained stable at 79 percent for the last four years. The high rate of kindergarteners with a prekindergarten experience means that the vast majority of kindergarteners enter kindergarten having some preparation for school. There is continuing need for improvement. In 2009-10, approximately 8,000 students entered kindergarten without prekindergarten educational experience. (Source: *The Condition of Education in Connecticut*, Connecticut State Department of Education, 2010).



Long-Term Agency Goal #2:

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 Program² 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; and
- 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;

² With passage of Connecticut Public Act 08-107, the Beginning Educator Support and Training (BEST) program has been reconfigured and has been renamed the Teacher Educator And Mentoring (TEAM) Program.

- 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. Due to the current economic climate, many of the material and staffing supports necessary to accomplish the aforementioned strategies are no longer available within the state department of education, nor the local district partners. However, where funding and other resources are available to support this work, the following indicators will serve as measures of success:

- curricula aligned to the *Connecticut Framework: K-12 Curricular Goals and Standards*³ 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; and
- improved district policies on school-family-community/business involvement and consistent implementation of these policies.

Overall Findings on Effectiveness: *Connecticut Mastery Test (CMT) – Grades 3 through 8*

For the CMT, five levels of student performance are reported: Below Basic, Basic, Proficient, Goal and Advanced. The proficient level is used to identify schools and districts that are making Adequate Yearly Progress (AYP) under the federal No Child Left Behind (NCLB) Act. The goal level is more challenging than the proficient level and is the state target for student performance. In September, parents receive CMT score reports that provide individual student performance data for their children.

Compared with the results from the first administration of the Generation 4 CMT in 2006, Connecticut’s elementary and middle school students improved their performance at the goal level in all content areas and at all grade levels tested, except for Grade 3 Writing in 2010. Performance at the proficient level also showed marked gains over the base year at all grade levels and in all subject areas except writing at Grades 3, 7 and 8 which dropped by approximately 1 percentage point from the first administration of Generation 4. Grades 6 and 7 posted the greatest gains over the base year at the goal level in both reading and mathematics, with an increase of 12.4 percentage points in mathematics and 11.3 percentage points for reading in Grade 6 and an increase of 11.8 percentage points in mathematics and 10.8 percentage points for reading in Grade 7.

Compared with the 2009 administration, most content areas were up across all grades at both the proficient and goal levels with the following exceptions: reading at Grades 4 and 5 both at the proficient and goal levels and writing at Grades 3, 7 and 8 at both the proficient and goal levels. Grade 4 increased at the proficient level, but dropped by less

³ *The Connecticut Framework: K-12 Curricular Goals and Standards has been modified through adoption of national standards and is now referred to as the Connecticut Common Core Standards (CCSS).*

than one percentage point at the goal level. Grade 3 mathematics remained unchanged at the proficient level (i.e., there was less than a .5 percent change over last year). In science at Grades 5 and 8, results increased at the goal level, but decreased by less than one percentage point at the proficient level.

This year's test results show that from 2006 to 2010, there is a positive trend of improved student achievement across all six grades and academic disciplines, which is encouraging.

**CMT Performance, by Year and Grade, Percent At/Above Proficient
and Percent At/Above Goal 2006-2010**

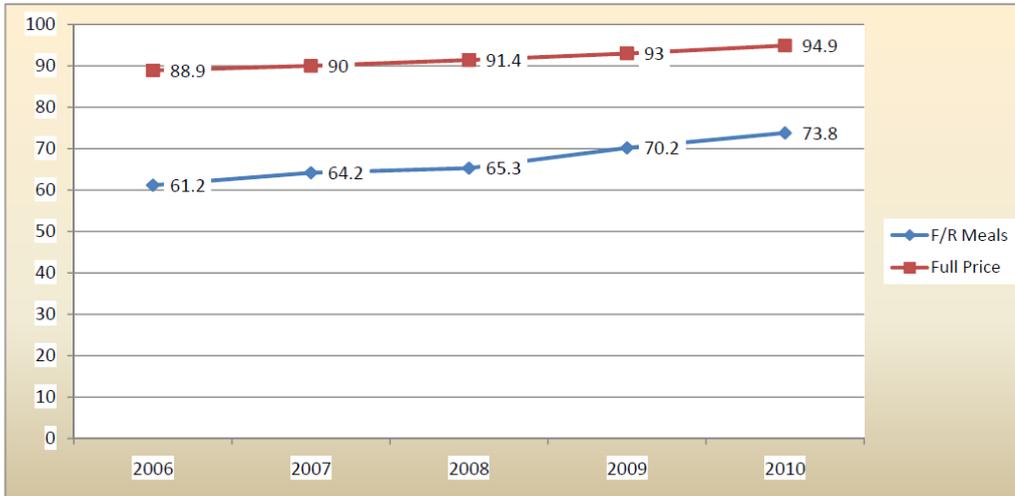
Grade	Year	Mathematics		Reading		Writing		Science	
		% Goal	% Prof	% Goal	% Prof	% Goal	% Prof	% Goal	% Prof
3	2006	56.3	78.3	54.4	69.2	61.1	81.7		
3	2007	59.4	80.1	52.3	69.3	60.8	82.4		
3	2008	60.2	80.7	52.1	68.4	63.5	82.9		
3	2009	63.0	82.8	54.6	71.1	62.6	83.2		
3	2010	62.6	83.6	57.1	72.3	58.3	80.3		
4	2006	58.8	80.3	57.8	71.8	62.8	84.2		
4	2007	62.3	80.9	57.0	70.6	65.1	84.1		
4	2008	60.5	81.5	56.0	69.7	62.9	84.8		
4	2009	63.8	84.6	60.7	74.4	64.2	85.0		
4	2010	67.2	85.2	60.0	72.9	63.6	86.5		
5	2006	60.7	80.8	60.9	72.8	65.0	85.3	NA	NA
5	2007	66.0	82.5	61.5	73.4	64.6	85.7	NA	NA
5	2008	66.2	83.1	62.2	74.0	64.6	85.7	55.2	81.1
5	2009	69.0	85.9	66.0	77.7	66.6	86.5	58.3	82.9
5	2010	72.6	87.8	61.8	75.4	68.2	87.3	59.7	82.5
6	2006	58.6	79.8	63.6	75.4	62.2	82.7		
6	2007	63.9	82.7	64.3	75.7	63.0	83.8		
6	2008	66.6	84.3	66.4	77.6	61.9	82.9		
6	2009	69.0	86.8	69.0	80.3	62.2	83.1		
6	2010	71.0	88.2	74.9	85.5	65.9	85.5		
7	2006	57.0	77.8	66.7	76.4	60.0	80.9		
7	2007	60.3	80.2	65.9	75.5	60.4	81.1		
7	2008	63.3	82.6	71.2	79.7	62.0	80.1		
7	2009	66.3	85.7	74.9	83.4	62.9	80.9		
7	2010	68.8	87.4	77.5	85.3	61.3	79.7		
8	2006	58.3	78.9	66.7	76.6	62.4	81.9	NA	NA
8	2007	60.8	80.8	66.6	76.4	64.0	82.5	NA	NA
8	2008	61.0	81.2	64.9	77.0	63.4	82.7	58.9	75.2
8	2009	64.7	84.5	68.5	80.5	66.5	83.7	60.9	76.6
8	2010	67.5	86.6	73.4	82.6	62.7	80.6	63.1	76.0

Eligibility for Free/Reduced Priced Meal Subgroup: While the 2010 CMT results demonstrated improvement over the base year for all students in all content areas except writing, students who were eligible to receive free/reduced priced meals posted much higher gains than their peers who pay full price, thus indicating that the achievement gap based upon economic need or poverty is narrowing. Eligibility for free/reduced-priced meals is used as a proxy for a family's social-economic status or level of economic need. Students who were economically disadvantaged posted higher average gains across all grades, performance levels and content areas except for writing at the goal level. An

example of gains made among students who are eligible for free and reduced price meals can be seen in the following two graphs that illustrate proficiency among grade 5 students.

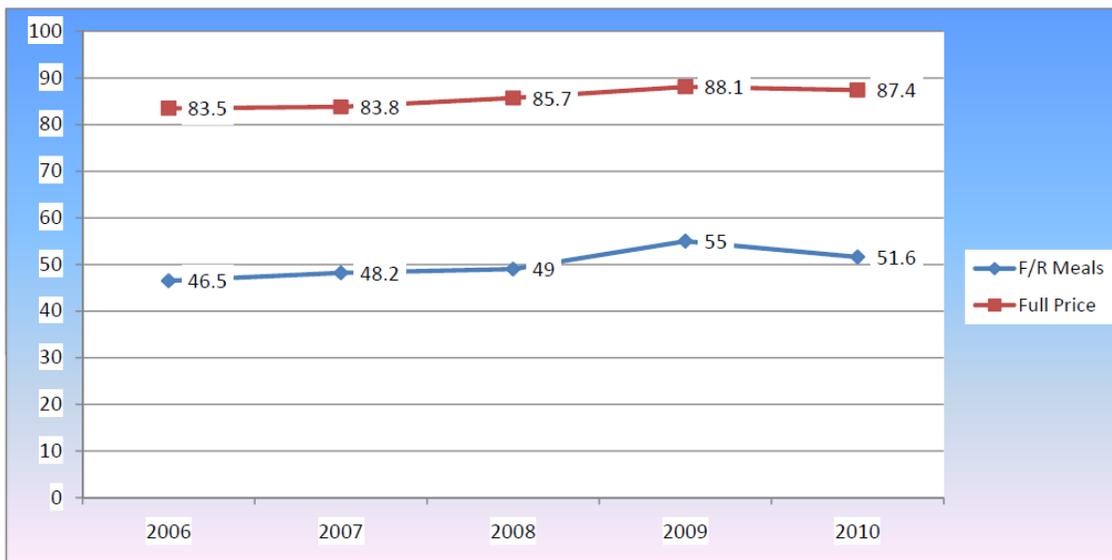
CMT MATH
GRADE 5
Free Reduce Meals (F/R Meals) / Full Price

Proficient or Above



CMT READING
GRADE 5
Free Reduce Meals (F/R Meals) / Full Price

Proficient or Above



For additional comparisons of students eligible for free and reduced price meals, along with other student subgroups, please see the News Bulletin from July 15, 2010 at <http://www.sde.ct.gov/sde/lib/sde/pdf/pressroom/cmt2010pressrelease.pdf>.

Connecticut Academic Performance Test (CAPT) – Grade 10

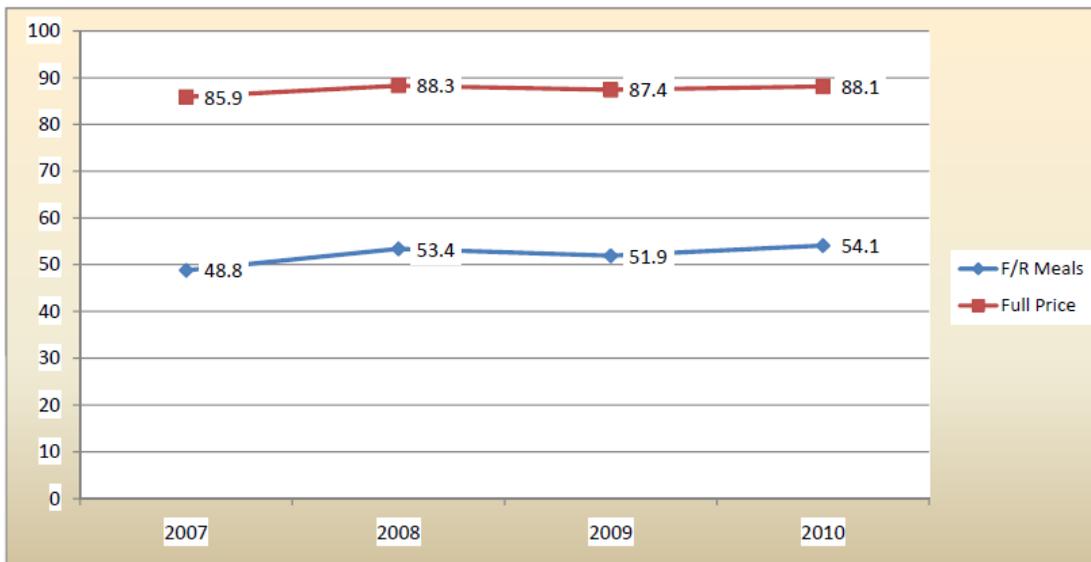
Grade 10 students take the CAPT in the spring of each year. This test assesses student performance in mathematics, science, reading and writing. The CAPT is aligned with Connecticut’s curriculum frameworks and provides information on how well students are performing with respect to the critical skills required in the four content areas. As on the CMT, CAPT scores are reported at five achievement levels (Below Basic, Basic, Proficient, Goal and Advanced). While Connecticut uses the Proficient level for NCLB purposes, the state continues to use the higher standard of Goal or above as its benchmark for achievement.

2007-2010 CAPT Performance for Percent At/Above Proficient and At/Above Goal

Year	Mathematics		Science		Reading Across the Disciplines		Writing Across the Disciplines	
	% at/above Proficient	% at/above Goal	% at/above Proficient	% at/above Goal	% at/above Proficient	% at/above Goal	% at/above Proficient	% at/above Goal
2007	77.3	45.3	81.4	44.5	79.7	45.5	82.3	53.0
2008	79.7	50.2	80.5	46.5	82.7	45.5	88.2	57.9
2009	78.4	48.0	78.4	43.0	81.8	47.5	86.5	55.1
2010	78.8	48.9	81.5	45.5	82.9	45.9	86.2	59.6

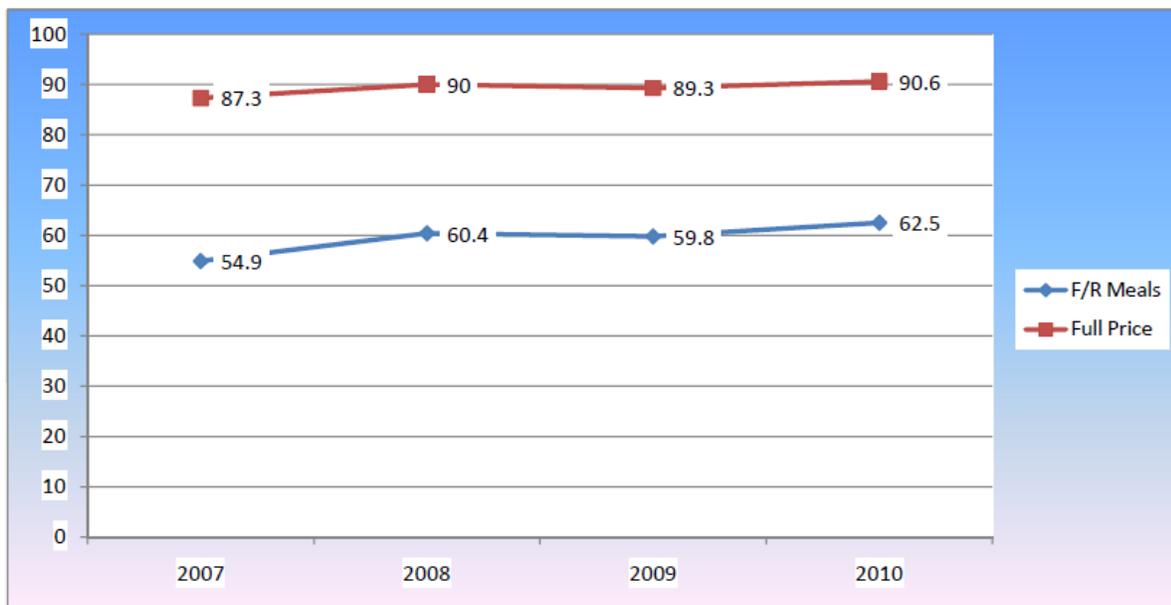
Students who receive free or reduced-priced meals have made impressive gains in all four content areas compared to last year and to the baseline year of 2007. For example, the percentage of these students reaching Proficient or above has increased by 7.6 percentage points in reading and 8.6 percentage points in writing over the last four years. The graphs below show the trends for students who receive free or reduced-priced meals compared to student not eligible for mathematics and reading over the past four years.

CAPT MATH
GRADE 10
Free Reduce Meals (F/R Meals) / Full Price
Proficient or Above



CAPT READING
GRADE 10
Free Reduce Meals (F/R Meals) / Full Price

Proficient or Above



Results of the 2010 Connecticut Academic Performance Test (CAPT) show Grade 10 students generally improved their performance when compared to 2009 at the Proficient and Goal levels across content areas. Student performance on the CAPT has also improved in all areas when compared to the baseline year of 2007. Results also show a closing of the achievement gap between white students and their black and Hispanic counterparts from the baseline year of 2007.

For additional information concerning student performance on the Connecticut Academic Performance Test, please view the July 16, 2010 News Bulletin online at <http://www.sde.ct.gov/sde/lib/sde/pdf/pressroom/2010captpressrelease.pdf>.

Long-Term Agency Goal #3:

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 offer 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; and
- 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. Due to the current economic climate, many of the material and staffing supports necessary to accomplish the aforementioned strategies are no longer available within the state department of education, nor the local district partners. However, where funding and other resources are available to support this work, the following indicators will serve as measures of success:

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.

Overall Findings on Effectiveness: During the 2009-10 school year, the Connecticut Department of Education, in an effort to use formulas consistent with the U.S. Department of Education began to measure 4-year graduation rates based upon a cohort model. This new formula defines the 4-year graduation rate as the number of high school students who receive a standard diploma within four years out of the students who were first time freshman four years ago. Along with this formula, three additional elements are defined, including those students *Still Enrolled*, who are students who are part of the cohort but have not graduated and are repeating a year; *Non-completers*, including students who earned a certificate of attendance; and *Other*, which includes students who have dropped out, enrolled in an GED program, transferred to postsecondary education and those whose status is unknown.

As these data provide a more accurate view of student completion rates, the actual graduation rate for the 2009 cohort was 79.3 percent, with 6.7 percent still enrolled, 0.3 percent non-completers and 13.7 percent other. The largest disparities within this these data are for Income, English Proficiency and Special Education Status. Those students eligible for free/reduced price lunch had a 4-year graduation rate of 59.9 percent, while those not eligible had a graduation rate of 85.6 percent. Students with Limited English Proficiency (LEP) had a graduation rate of 53.4 percent, while students who were non-LEP had a graduation rate of 80.6 percent. Students who were enrolled in special education programs and had an Individual Education Program (IEP) had a graduation rate of 61.3 percent, while students who were non-IEP had a graduation rate of 81.7 percent. (Source: Connecticut State Department of Education News Bulletin, March 23, 2010).

2009 Connecticut Adjusted Cohort Graduation Rates

	2009 Cohort #	4-year	Still Enrolled	Non-completers	Other
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		Graduation Rate			
All	43,648	79.3%	6.7%	0.3%	13.7%
Ethnicity					
Hispanic	6,688	58.1%	9.4%	0.5%	32.0%
Non Hispanic	36,960	83.2%	6.2%	0.2%	10.4%
Race					
African - American	6,174	66.2%	10.2%	0.9%	22.7%
Native American	107	73.8%	7.6%	0.0%	18.6%
Asian/Pacific Islander	1,526	82.4%	4.2%	0.0%	13.4%
White/Caucasian	29,153	86.8%	5.4%	0.1%	7.7%
Gender					
Male	22,405	75.9%	8.2%	0.5%	15.4%
Female	21,243	82.9%	4.9%	0.1%	12.1%
Income					
Eligible for free/reduced lunch	11,074	59.9%	11.0%	0.9%	28.1%
Not eligible for free/reduced lunch	32,574	85.6%	5.5%	0.1%	8.8%
English Proficiency					
LEP ^a	2,122	53.4%	7.5%	0.0%	39.1%
Non-LEP	41,526	80.6%	6.6%	0.4%	12.4%
Special Education Status					
IEP ^b	5,071	61.3%	19.7%	0.5%	18.5%
Non-IEP	38,577	81.7%	4.9%	0.3%	13.1%

Connecticut State Department of Education News Bulletin, March 23, 2010

^aLimited English Proficiency

^bIndividual Education Plan

Row and column percentages may not total 100 percent due to round-offs

Among the requirements set forth in P.A. 10-111, schools are now required to expand the availability of Advanced Placement and online course offerings and that all school districts exceeding the state average for student dropouts must provide access to online credit recovery. In the previous year, 21 school districts were identified as having particularly high dropout rates. Each of these schools has identified specific staff members to monitor progress in attaining increased graduation and decreased dropout rates in their district/schools. The Dropout Prevention Steering Committee, formed for the purpose of identifying and providing oversight of improvement activities continues to meet to monitor the efforts of continuing districts. To assist with tracking students from preschool through college the Connecticut State Department of Education is collaborating with the Department of Higher Education to provide for tracking mechanisms that will be consistent with CSDE's efforts through the State Assigned Student Identification number (SASID). To further assist students in achieving sufficiently to meet college ready standards the CSDE will publish in this current academic year *Guidelines for Student Support Plans (SSP)* and provide support for schools implementing these new standards.

Early Childhood Program – School Readiness: 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; and to establish a shared cost for such early care and education programs among the state and its various agencies, the communities and families. All programs must receive National Association for the Education of Young Children (NAEYC) or Head Start 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. The program serves resident children in priority school districts and competitive grant municipalities who are ages 3 and 4 years of age and children age 5 years of age who are not eligible to enroll in school.

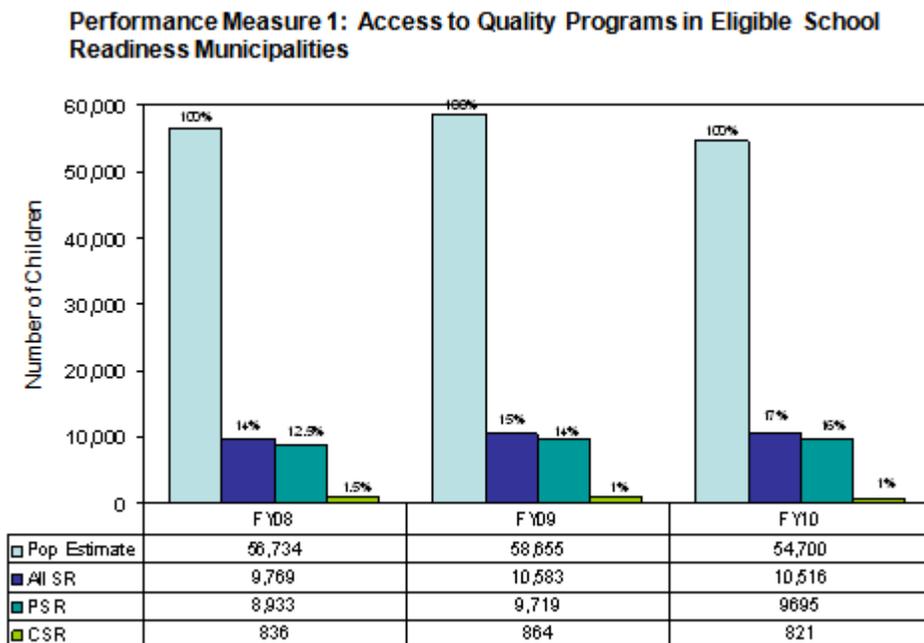
Number Served: A total of 64 towns/school districts in Connecticut served 10,516 children in 19 priority school districts and 45 competitive districts.

Program Cost FY 2009-2010: \$78,821

Performance-Based Standards: Quality preschool services are available for 100 percent of eligible children in priority school districts. By 2015 every School Readiness classroom will have a teacher with a bachelor’s degree or higher. All of the School Readiness Programs are accredited or approved under the recognized systems.

Performance-Based Outcomes: Quality early childhood programs ameliorate the risk factors that lead to achievement gaps. Two components that contribute to program quality are: teachers with early childhood specific training; and systematic monitoring across multiple program components.

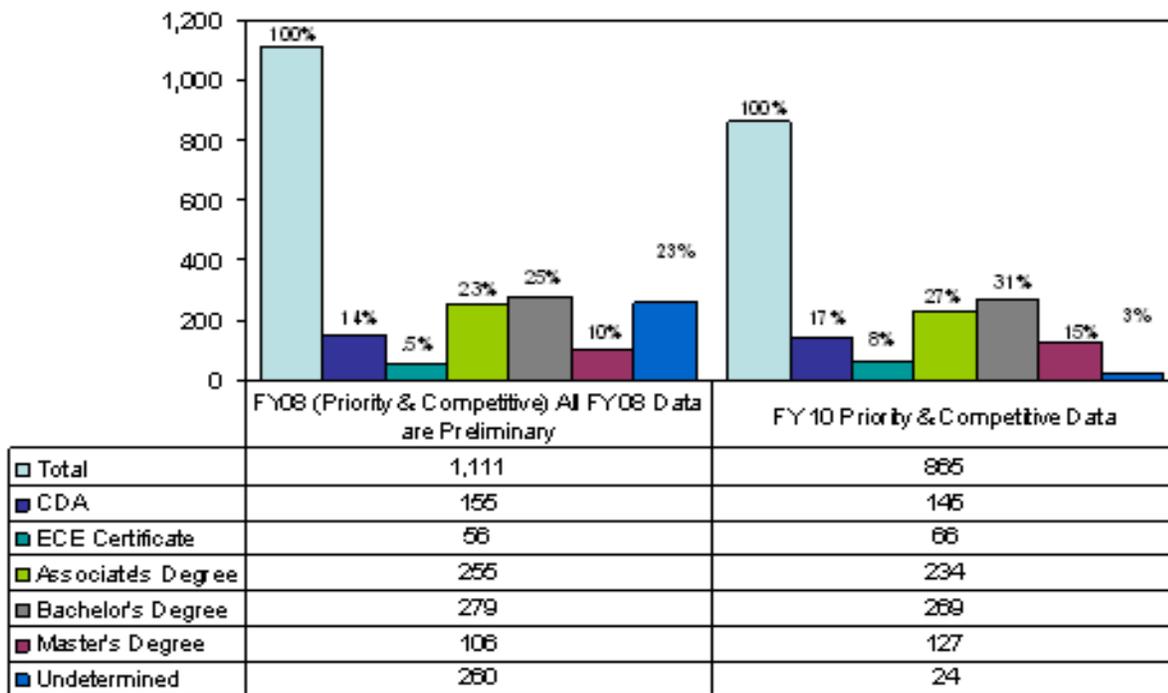
Performance Measure 1: Access to quality early childhood programs in eligible municipalities.



This graph shows a comparison of the School Readiness-funded space capacity over the past three years in relation to the preschool population estimates, for eligible 3-4 year olds, in the 64 School Readiness Municipalities. The School Readiness municipalities show a slight decrease by .6 percent in capacity to serve more preschool children. Level funding prohibited any increase in capacity. In addition, the community and public school programs were cautious in decisions to commit to School Readiness due to the reduction of parent fees and Care4Kids subsidies as these sources complete the funding needed to operate quality programs. The unstable economic environment has impacted the ability to increase School Readiness capacity. School Readiness programs shifted children’s spaces from the lower reimbursement slots to higher reimbursement slots which caused a lower overall number of available spaces.

Performance Measure 2: Progress toward teacher qualifications.

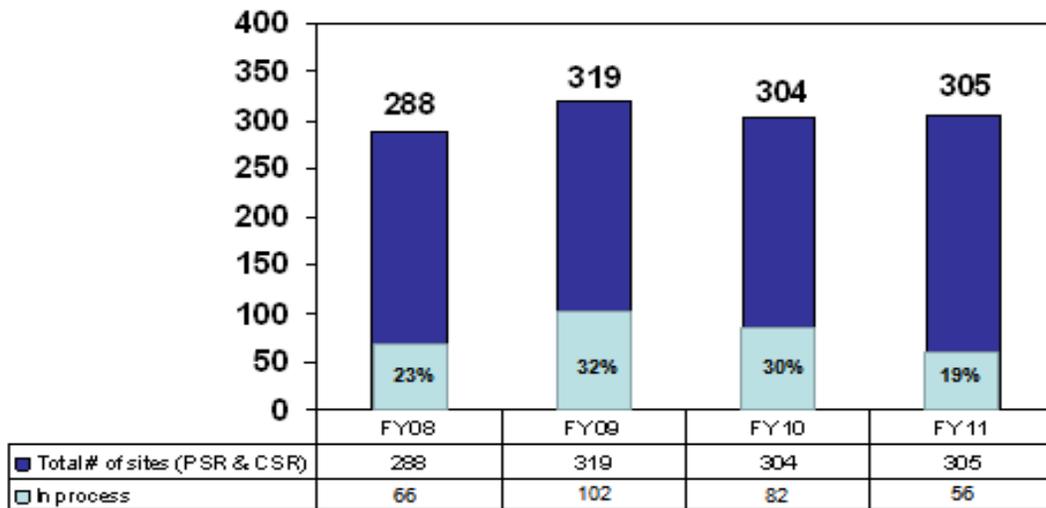
Performance Measure 2: Progress of Teacher Qualifications Toward Baccalaureate Degree in School Readiness Programs



Working collaboratively with the Early Childhood Professional Development Registry, the State Department of Education (SDE) can now report real-time data for this measure. Therefore, FY 10 data is available for this report. Since the Registry is unable to report teacher data at the classroom level, the SDE further disaggregated teacher information from the Registry to provide an accurate picture, matching teacher to classroom. SDE found 616 School Readiness classrooms with 865 teachers. There does not seem to be significant progress toward attaining higher level teacher qualifications. However, there has been a major reduction in the number of teachers in the “undetermined” category due to more accurate credential verification.

Performance Measure 3: Monitoring progress toward quality standards.

Performance Measure 3: Progress Toward Quality Standards



There are 305 School Readiness sites in Connecticut, 294 of these programs are participating in the NAEYC accreditation system; 81 percent of which hold accreditation and 19 percent are in process of achieving such status. There are 11 programs that hold Head Start status not pursuing NAEYC accreditation. The NAEYC and Head Start systems align with the School Readiness quality components and are therefore adopted as the School Readiness quality monitoring system. These systems address multiple program quality components such as health, curriculum, family, assessment, physical environment, teaching, leadership, and community partnerships.

Performance-Based Vendor Accountability:

School readiness programs are based on ten 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 application. The program’s adherence to the quality components is reported through the Connecticut School Readiness Preschool Program Evaluation System (CSRRPES), as well as state monitoring visits and 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.

Even Start Family Literacy Program: To break the cycle of poverty and illiteracy for low-income families. 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.

Number Served: Even Start in Connecticut operated with four programs serving high-need areas of Danbury, Middletown, New London, and Shelton. Programs served 78 Even Start families (81 adults and 89 children) through early childhood education, adult education, and parenting classes. The number of programs supported has dropped significantly each year from a previous service level of 10 programs in FY 2003.

Program Cost FY 2009-2010: \$442,556

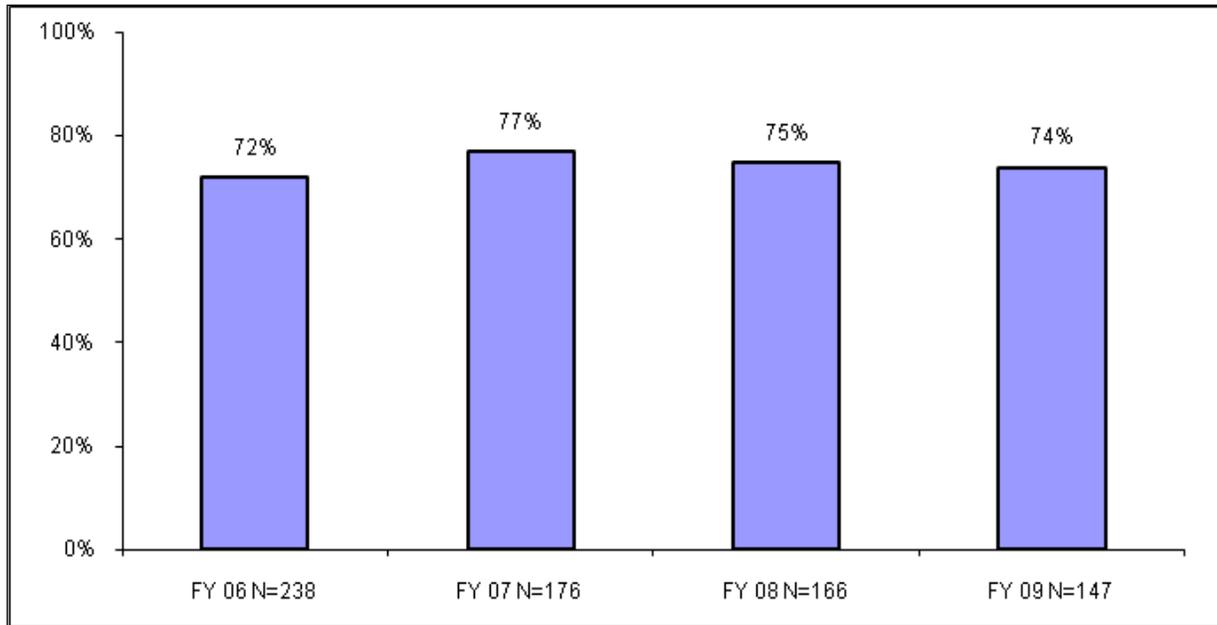
Performance Based Standards:

1. It is expected that 50 to 65 percent of the Even Start children birth through age 5 will meet the reading readiness standards for their age group.
2. It is expected that 40 percent or more of the adults will meet adult literacy goals in Adult Basic Education or English as a Second Language reading and 60 percent of the adults in a high school diploma or General Educational Development program will make progress toward attaining a diploma.
3. It is expected that 40 to 60 percent 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 Outcomes:

Although we see solid gains in Even Start, the number of participants continues to decrease due to federal budget cuts. The state's federal allocation has decreased over 70 percent from \$1,615,000 in 2005-06 to \$442,556 in 2009-10.

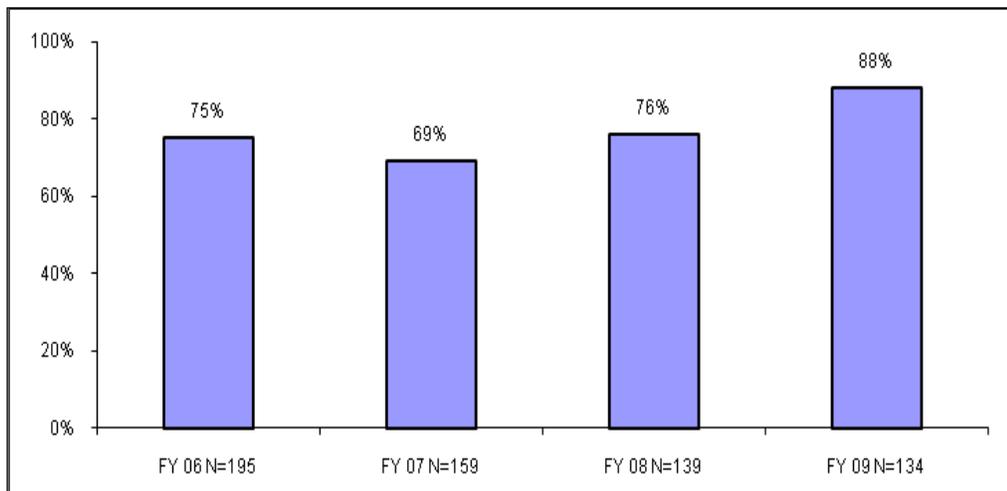
Performance Measure 1: Percent of Even Start children meeting standards in reading/reading readiness skills.



Even Start program performance data show that between 65 percent and 77 percent of the children met or exceeded standards in reading readiness for their age group (birth to 6). Children participate in early childhood classrooms an average of 69 hours per month. While there was a slight decrease in the number of children meeting or exceeding standards in reading/ reading readiness, the program saw a decrease in the number of children served and an increase in the number of children with special needs. The trend in program performance is considered stable. Reading/ reading readiness skills are assessed with the following measures, depending on the child’s age: the Ages and Stages Questionnaire, the CT Preschool Assessment Framework, the Phonological Awareness Literacy Screening (PALS), the Peabody Picture Vocabulary Test (PPVT), grade promotion, Concepts About Print, and the Developmental Reading Assessment.

Although research data are not available for Connecticut, research from other states indicates that children who receive Even Start services outperform children who do not participate in Even Start. These studies suggest that Even Start children score significantly higher on measures of reading readiness and are twice as likely as non-Even Start children to be reading at or above grade level.¹

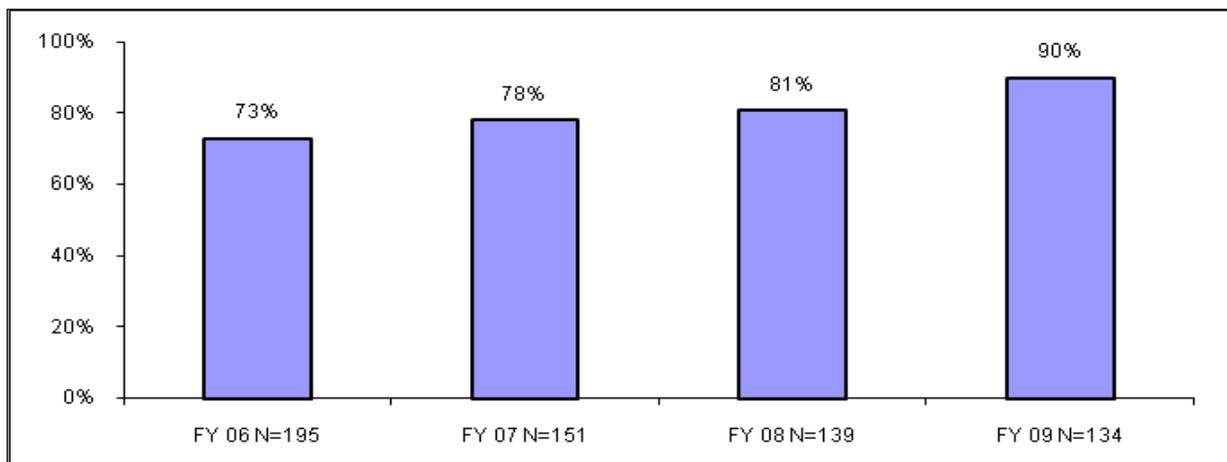
Performance Measure 2: Percent of Even Start parents showing significant learning gains or earning a high school diploma.



Over the past four years, adults in Even Start have consistently made significant gains. Even Start adults average 39 hours of adult education per month.

Compared to the entire population of adult education students, Even Start participants make impressive gains on measures of high school completion and English language acquisition. The percent of Even Start parents attaining a measurable educational outcome has been significantly greater than that of all adult education participants statewide by about 25 percentage points annually.ⁱⁱ

Performance Measure 3: Percent of Even Start parents demonstrating gains in family literacy skills.



Results show that in the past four years, three-quarters to 90 percent of the parents were observed to learn and apply parenting skills related to family literacy. The trend is improving showing an increase of 9 percent from FY 08 to FY 09. Parents participate in parenting education classes, interactive literacy activities (with their child), and home visits 17 hours per month. Evaluation in FY 09 focused on parenting classes and interactive literacy activities. Results show that programs demonstrate planned and purposeful lessons and activities in book reading, language development, and reading readiness. Parents are guided by staff and encouraged to apply language and literacy skills regularly with their children in the classroom and at home; thereby, preparing their child with the skills that support reading and learning and setting a strong foundation to link home to school. Feedback on the each program's classes was provided. Additionally, Even Start staff participated in an SDE sponsored professional development workshop, 'Let's Talk' to develop and reinforce language and literacy instruction in working with parents.

Performance-Based Vendor 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, as well as monthly attendance of each child and adult. Local evaluation requires a visit 3-5 times per year to review early childhood records and lesson plans, observe instruction and conduct focus groups with staff and adults.

¹ Link, D. E. and Weirauch, D. M. (2005). Questioning the validity of the evidence against family literacy programming: A critical

Department of Labor

- **Jobs First Employment Service**
- **Connecticut Youth Employment Program**

Long-Term Agency Goals: The Department Labor (DOL) is committed to protecting and promoting the interests of Connecticut workers. In order to accomplish this in an ever-changing environment, the DOL assists workers and employers to become competitive in the global economy using a comprehensive approach to meeting the needs of workers and employers, and the other agencies that serve them.

Within the context of DOL's long term agency goals, the DOL has two programs that target families and children: Jobs First Employment Services (JFES) and CT Youth Employment Program. The goals of the JFES program are to enable all families who receive time-limited state cash assistance to become and remain independent of welfare through employment by the end of the 21-month durational limit on cash assistance. The goal of the CT Youth Employment Program (CYEP) is to provide low-income youth aged 14 through 24 years with meaningful paid work experiences.

Strategies: To meet the goals of the JFES program, parents on cash assistance are provided with employment-related assessments, job counseling, case management, vocational education, adult basic education, subsidized employment and support

services to enable them to become employed before their cash assistance ends. TFA recipients often have multiple and/or severe barriers to participating in the program and obtaining and retaining employment. The program offers intensive, home-based case management which provides in depth assessments and assistance obtaining the services necessary to overcome the barriers to employment.

To meet the goals of the CYEP program, low-income youth are provided with job-readiness training, career exploration and guidance, exposure to the world of work and paid work experience.

Measure of Effectiveness: The DOL measures the effectiveness of these programs by collecting and reporting on obtained employment information on these two groups. The JFES program issues monthly figures on the number of JFES participants who are employed by vendor and statewide. The number of participants with earnings higher than the TFA payment standard and the Federal Poverty Level are also issued monthly. JFES contracts with vendors contain performance standards and contractors' performance are measured and issued once the wage file information is available.

CYEP measures effectiveness by collecting data on the number of youth to participate in a paid work

experience and compare these numbers to the vendors' goals as stated in their contracts. DOL also collects data on the number of youth to participate in job-readiness training and to receive support services. Compliance monitoring is conducted at all five regional Workforce Investment Boards (WIBs). This includes a review of financial management, consisting

of financial reporting, cost allocation methodology, cash management, allowable costs, payroll controls, audit requirements, procurement and property controls. Also, WIA eligibility verification for youth is reviewed by sampling client files throughout the state.

Jobs First Employment Services: Provides employment services to families in receipt of time-limited state cash assistance. These services assist TFA recipients to prepare for, find and keep employment so that they can become independent from welfare.

Number Served: 11,713 (based on 9 mos. instead of 12 due to budget crisis) 17,000 is the approximation of current annual caseload with 9,000 monthly caseload.

Program Cost: FY 2009 - 2010 \$17,555,803

Performance-Based Standards:

- Number of participants to obtain employment during the State Fiscal Year
- Number of participants and percentage of JFES caseload to obtain employment with wages higher than the cash benefit that they receive during the State Fiscal Year
- Number of participants and percentage of JFES caseload to obtain employment with wages higher than the federal poverty level for their family size during the State Fiscal Year

Performance-Based Outcomes: SFY10 complete employment data will not be available until January 2011. SFY09 data is: total caseload (16,704) 7,047 or 42% of the caseload obtained employment; 5,194 or 31% of the caseload earned wages above temporary family assistance benefits; and 1,961 or 12% of the caseload earned wages above the federal poverty level.

Performance-Based Vendor Accountability: Indicators of performance toward achieving these standards at contractor and statewide levels are determined and issued monthly. Contracts with program vendors and subcontractors include these performance base standards. Standards are measured using the DOL wage data when it is available (normally six months after the end of a program period). Until the recent recession, all vendors consistently met these standards.

Connecticut Youth Employment Program: State funded subsidized employment program for low-income youth aged 14 through 24 years. The Youth Employment Program prepares the target population for succeeding in employment through the provision of support services including adult mentoring, follow-up services and comprehensive guidance and counseling.

Number Served: 799 participants

Program Cost: FY 2009 - 2010 \$1,425,000

Performance-Based Standards: As established in the contract, the number enrolled and successfully completed the program and the wages paid.

Performance-Based Outcomes: PY 2009 –779 participants served and 744 successful completions.

Performance-Based Vendor Accountability: Workforce Investment Boards review their procedures for worksite development to ensure that they include a review of the wage and workplace standards applicable to youth under the age of 18. Workforce Investment Boards ensure that all vendors hired to run summer programs are aware of and are knowledgeable about these regulations, and take care to ensure that worksites developed meet the standards applicable

to the youth that will be placed there. Monitoring is conducted to ensure program objectives are being met; and proper and timely payment of wages. Worksites and working conditions are examined for compliance with applicable health and safety laws and laws governing the employment of minors.

Department of Mental Health and Addiction Services

- **Best Practices Initiative**
- **Local Prevention Council Programs**
- **Strategic Prevention Framework State Incentive Grant**
- **Connecticut Youth Suicide Prevention Initiative**
- **Partnership for Success**
- **Regional Action Councils**
- **Statewide Service Delivery Agents**
- **Tobacco Regulation & Compliance**

Long-Term Agency Goals: The goals of the Department of Mental Health and Addiction Services (DMHAS) include:

- Reduce the incidence of problem behavior and improve the health and well-being of Connecticut's citizens.
- Achieve quantifiable decreases in substance abuse rates across the state.
- Establish a quality care management system to achieve defined goals, service outcomes and the continued improvement of the integrated DMHAS health care system.
- Maintain a broad array of programs and practices that are data informed and will respond to changing needs as the prevention system grows.
- Increase workforce capacity to provide culturally competent and integrated services to persons whose needs are challenging or not well met.
- Create a resource base to support DMHAS' prevention services goals, expansions, and fiscally sound system investments

Strategies: The Departments' strategies include:

- Assess the prevention needs for youth, families and communities across the state
- Provide cost-effective, research based, developmentally appropriate prevention services that promote the health & well-being of children and families
- Develop, maintain and increase partnerships with state and local agencies to implement, evaluate and diffuse effective prevention programs and strategies that focus on youth and families
- Implement program standards to monitor the service system

- Increase funding of evidence-based programs that focus on families, early childhood and youth development
- Explore resources to implement the prevention data infrastructure, policy and program recommendations
- Provide training and technical assistance to increase the cultural ability of prevention program providers to work effectively with youth and parents from culturally, economically and geographically diverse populations

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, tobacco and other drug laws
- Reduction in retailer violation rates for tobacco sales to minors
- Reduction in access to alcohol, tobacco and illegal drugs by minors

Measure of Effectiveness. DMHAS continues to document gains in the federal health outcome measures, namely:

- A reduction in cigarette and other tobacco use rates among 12-17 year-olds, as well as

recent use of illicit drugs across all ages (2008 NSDUH report)

- Although alcohol and marijuana use remains above the national average, the state has seen a reduction in alcohol use rates over the past year among ages 12-20 and 21 and over
- The number of tobacco merchants selling tobacco products to minors has decreased to 13.3% in 2010 from a high of 70% in 1996
- The percentage of funded prevention programs that are evidence-based has increased to 73% in 2009 from 65.5% in 2008. The percentage of expenditures spent

on evidence-based programs and strategies has also increased.

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 several statewide and regional technical assistance resources to ensure that all products, activities and services are culturally competent and developed and implemented with fidelity.

BEST PRACTICES INITIATIVE: 14 statewide funded projects that employ a population-based public health approach to address demonstrated substance abuse prevention needs. Contractors conduct activities focusing on the prevention of community problem substance use utilizing the five-step Strategic Prevention Framework. Approximately 50% of their overall funding for the initiative is used to reduce underage drinking and related consequences in youth ages 12-20 with the remaining funds used to reduce other problem substance use identified through a regional needs assessment process.

Program Cost FY 2009 - 2010: \$ 2,034,178

Number Served: A total of 13,484 children, family members, prevention and treatment professionals, as well as older adults were served in SFY 10.

Performance-Based Standards: DMHAS requires programs under the Best Practices Initiative to 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 programs 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: Contractors under this initiative are expected to:

- Assess the risk and protective factors associated with problem substance use and related consequences in targeted communities using relevant epidemiological and other data
- Build community capacity to understand and implement prevention strategies utilizing existing substance use prevention coalitions of community leaders, key stakeholders and representatives of underserved populations
- Update DMHAS-approved prevention plans for problem substance use and related consequences that describes evidence-based environmental interventions/strategies to reduce problem substance use consumption
- Implement evidence-based interventions/strategies to reduce problem substance use consumption, and

- Evaluate changes in problem substance use consumption and consequences in the target population.

Performance-Based Vendor Accountability: Program contractors for this initiative complete a strategic plan of community needs and resources, evidence-based programs and strategies to address them and evaluation information and measures. An action plan that sets the stage for the collection of process measures necessary for federal reporting is also completed. It identifies and codes the action steps for implementing goals and objectives, the staff hours required to implement activities and the numbers to be served by each activity. Contractors are required to use the federal guidance document for identifying and selecting evidence-based programs which assures program fidelity and fit. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an opportunity to discuss any program changes and challenges. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

LOCAL PREVENTION COUNCIL PROGRAMS: 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 include representation from professionals working in the prevention field in general and ATOD abuse prevention in particular. Additionally, council membership includes a cross-section of the community which it serves 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 Served: A total of 11,181 elementary and high school students, parents and family members were served in SFY 10.

Program Cost: FY 2009 - 2010 \$547,065

PARTNERSHIP FOR SUCCESS: The Partnership for Success (PFS) Initiative uses a public health approach in over 30 municipalities and statewide across college campuses to decrease alcohol consumption in youth ages 12 to 20. Programs under this initiative build on existing resources to implement environmental strategies known to be effective in reducing youth alcohol use rates, such as curtailing retail and social access, policy change, enforcement, media advocacy, and parental and merchant education. The initiative is intended to measure changes in underage drinking utilizing student survey and social indicator data.

The program serves school aged children 12 to 17 years old, college students 18 to 20, and those people who influence these youth including parents, family members, care-givers, schools, communities at large and the agencies, organizations and institutions within those communities

Number of children and families served: Funding for PFS coalitions began in January 2010. At that time they were intended to enhance their structures, identify risk and protective factors relevant to underage alcohol in their communities and develop a plan to mitigate risk factors and enhance the protective factors. Services to implement this objective are planned for October 1, 2010.

Program Cost: FY 2009 - 2010 \$945,519

Performance-Based Standards: DMHAS requires programs under the PFS Initiative to 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 programs 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:

Contractors under this initiative are expected to:

- Assess risk and protective factors associated with underage alcohol consumption and related consequences in the target community using relevant epidemiological and other data.
- Build community capacity to understand and implement prevention strategies utilizing existing alcohol prevention coalitions of community leaders, key stakeholders and representatives of underserved populations
- Develop a community strategic plan that describes community methods to address the underage alcohol consumption using environmental strategies
- Implement evidence-based or innovative environmental intervention(s)/strategies to reduce underage alcohol consumption, and
- Evaluate reductions in past 30 day use of alcohol by the target population. Evaluate community changes in underage alcohol consumption risk and protective factors through changing data and new information on alcohol-related problems in the community.

Performance-Based Contractor Accountability: Program contractors for this initiative complete a five-step planning process to guide their prevention activities. The steps include: (1) assessing population needs; (2) building capacity to address the needs; (3) developing a comprehensive strategic plan that articulates a vision for organizing programs, policies and practices to address the needs;(4) implementing evidence-based programs, practices and policies identified in step 3; and (5) monitoring implementation and evaluating effectiveness. Contractors also complete an action plan which identifies and codes the action steps for implementing their plan, the staff hours required to implement activities and the numbers to be served by each activity. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an opportunity to discuss any program changes. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

STRATEGIC PREVENTION FRAMEWORK STATE INCENTIVE GRANT: 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 strategy for delivering and implementing effective substance abuse prevention services. The initiative brings together 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 address underage drinking in 54 towns by conducting needs assessments, developing community capacity, developing strategic plans, implementing programs, policies and practices identified in the plans, and evaluating their outcomes.

Number Served: Services performed by SPF Coalitions ended on June 30, 2010. A total of 421,280 children, family and community members, and prevention professionals were served.

Program Cost: FY 2009 - 2010 \$2,245,023

Performance-Based Standards: DMHAS requires programs under the SPF Initiative to 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 programs 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: The Government Performance and Results Act of 1993 require agencies to link their performance to their budgets. To meet these requirements, the federal funder must collect performance data from the state grantees. The performance measures in each of the domains relevant to the Strategic Prevention Framework are listed below and DMHAS is expected to collect and aggregate these data from the target communities for the SPF SIG.

Abstinence from Drug Use/Alcohol Abuse

- 30-day substance use (non-use/reduction in use)
- Availability of alcohol, tobacco and other drugs
- Perception of drug use as harmful
- Attitude toward use (Perception of drug use as wrong)

Increased/Retained Employment or Return to/Stay in School

- School attendance
- ATOD-related suspensions/expulsions
- Drug-related workplace injuries

Decreased Criminal Justice Involvement

- Drug-related crime

Increased Stability in Family and Living Conditions

- Parent participation in prevention activities

Increased Access to Services (Service Capacity)

- Number of persons served by age, gender, race, and ethnicity

Increased Social Supports/Social Connectedness

- Under development

OMB Required Outcome/Domain

Cost Effectiveness

- Increase services provided within cost bands

Use of Evidence-Based Practices

- Total number of evidence-based programs and strategies funded by SPF SIG

Performance-Based Vendor Accountability: Program contractors for this initiative complete a five-step planning process to guide their prevention activities. The steps include: (1) assessing population needs; (2) building capacity to address the needs; (3) developing a comprehensive strategic plan that articulates a vision for organizing programs, policies and practices to address the needs; (4) implementing evidence-based programs, practices and policies identified in step 3; and (5) monitoring implementation and evaluating effectiveness. Contractors also complete an action plan which identifies and codes the action steps for implementing their plan, the staff hours required to implement activities and the numbers to be served by each activity. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an opportunity to discuss any program changes. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

CT YOUTH SUICIDE PREVENTION INITIATIVE: 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; 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; and 4) Develop a mini-grant program that serves communities statewide through the use of a youth driven, positive community youth development approaches .

Number Served: Funding for the CYSPI ended on May 31 2010. During the fiscal year 380 college students were trained, 12 middle school students were assessed for depression and suicide risk and where appropriate referred for therapeutic counseling, and 338 adults and professionals were trained in various model programs.

Program Cost: FY 2009 - 2010 \$ 243,518

Performance-Based Outcomes:

- Reduction in suicidal behavior among high school students
 - Improvement in treatment outcomes for students who screen positive for depression symptoms at school health clinics
 - Improve suicide knowledge of parents and community health care personnel
 - Increase in the number of students accessing college counseling services
-

REGIONAL ACTION COUNCILS: 13 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 (RACs) 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 Served: A total of 136,308 children, family and community members, and prevention professionals were served directly in SFY 10.

Program Cost: FY 2009 - 2010 \$2,099,198

Performance-Based Standards: DMHAS requires all contractors to 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 programs 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:

- 100% of towns in sub regions are funded through Local Prevention Councils
- 25% of funding efforts are focused toward underage alcohol initiatives resulting in a reduction in use across sub regions
- 25% of funding efforts are directed towards the prevention of underage tobacco use resulting in a violation rate of less than 20% among tobacco retailers in the sub region
- The development of a Priority Needs Assessment on the substance abuse continuum of care from prevention through treatment and recovery in the sub region
- The development of SPF Sub-Regional Profiles to include alcohol, prescription drugs, heroin, cocaine, marijuana and other substances of note

Performance-Based Vendor Accountability: Program contractors for this initiative complete program information and measures during the biannual contract renewal process. An action plan that sets the stage for the collection of process measures necessary for federal reporting is also completed. It identifies and codes the action steps for implementing goals and objectives, the staff hours required to implement activities and the numbers to be served by each activity. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an opportunity to discuss any program changes. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

STATEWIDE SERVICE DELIVERY AGENTS: 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 blueprint of the Strategic Prevention Framework (SPF).

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 comprising of public/private partnerships designed to change the attitudes and behaviors of Connecticut youths and adults toward substance 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 Served: A total of 11,181 children, family and community members, and prevention professionals were served directly in SFY 10.

Program Cost: FY 2009-2010: \$1,947,408

Performance-Based Standards: DMHAS requires contractors to 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 programs 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:

- Improvement in the health and wellness of gay, lesbian, bisexual, trans-gendered and questioning clients
- Increase in the number of DMHAS providers with approved cultural competency plans
- Increase in the number of Hispanic and African American staff in substance abuse agencies across the state
- Increase in the number of school and community based mentoring programs
- Reduction in the state rate for underage drinking
- Increase in the number of resources aimed at alcohol, tobacco and other drug prevention
- Increase in the capacity of prevention contractors to implement evidence-based programs, policies and practices

Performance-Based Vendor Accountability: Program contractors for this initiative complete program information and measures during the biannual contract renewal process. An action plan that sets the stage for the collection of process measures necessary for federal reporting is also completed. It identifies and codes the action steps for implementing goals and objectives, the staff hours required to implement activities and the numbers to be served by each activity. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an opportunity to discuss any program changes. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

TOBACCO REGULATION & COMPLIANCE: 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 Served: During FY 2010, 1,997 retail inspections were completed and 39,530 audio and print materials were developed and distributed to tobacco merchants.

Program Cost: FY 2009 – 2010: \$618,984

Performance-Based Outcomes:

- Increase in age of first use for tobacco products
- Decrease in tobacco use rates among youths ages 12-17
- A rate of no more than 10% of merchants across the state who sell tobacco products to minors

Performance-Based Vendor Accountability: Tobacco merchant inspections are completed in strict adherence with federal Substance Abuse Mental Health Services Administration (SAMHSA) guidelines. Annual reports on these inspections and their results, changes in the state’s tobacco laws, coordination and collaboration activities are submitted and available for public review and comment on the DMHAS website.

Department of Public Health

- **Asthma Program: Easy Breathing**
- **Child Day Care Licensing**
- **Community Health Centers**
- **Emergency Medical Services for Children**
- **Family Planning**
- **Immunization Program**
- **Injury Prevention – Unintentional Childhood**
- **Injury Prevention- Intentional Youth Violence**
- **Lead Poisoning Prevention and Control**
- **Newborn Laboratory Screening and Tracking**
- **Nutrition, Physical Activity and Obesity**
- **Oral Health-Home by One**
- **Rape Crisis and Prevention Services**
- **Tobacco Use Prevention and Control**
- **Women, Infant and Children**

ASTHMA PROGRAM: PEDIATRIC EASY BREATHING PROGRAM: The Connecticut Children’s Medical Center (CCMC) Asthma Center is conducting *Easy Breathing*, an asthma clinical management program. The program has successfully expanded beyond the original five communities 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 Served: There were no children served for this budget year. Circumstances related to delayed state budget adoption, approval and implementation for year one 2009 – 2010 led to disbanding of the program and staff layoffs. The year one contract was executed on March 11, 2010 and upon execution the Connecticut Children’s Medical Center (CCMC) Asthma Center began to rebuild the program by identifying contractors and staff to hire to again provide Easy Breathing using a Regional approach. Reduced funding by fifty percent from the previous year necessitated using a regional approach instead of statewide coverage that had showed such promising results in the last two-year contract period. Since the Easy Breathing Program is in a contract and rebuilding phase, services were not available to individuals in fiscal year 2010. A total of 14,639 children were surveyed to identify symptoms that needed to be assessed to determine if the child had asthma for the two-year period 7/1/08 – 6/30/09.

Program Cost: FY 2009-2010: \$441,517 (CCMC Pediatric Easy Breathing is the only contract executed from CHI state funds for SFY 2009 – 2010. No contracts for Adult Easy Breathing (2 planned) or Asthma Awareness by CCEJ were executed for 2009-2010).

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. Indicators are guideline adherence for prescribing inhaled corticosteroids for those with persistent asthma and patient education and provision of patient written treatment plans to enable patients to effectively manage their asthma symptoms before they become acute.

Performance-Based Outcomes: Improved asthma diagnosis and medical management by primary care providers for better patient control and self-management based on the National Institute of Health’s Asthma Guidelines

Performance-Based Vendor 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).

CHILD DAY CARE LICENSING: This Program regulates all licensed child day care programs throughout the state of Connecticut 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 1579 Child Day Care Centers and Group Day Care Homes, and 2,688 Family Day Care Homes, and is committed to promoting the health, safety, and welfare of Connecticut's children in these licensed facilities.

Number Served: 114,151 Licensed Capacity.*

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

Program Cost FY 2009-2010 \$2,529,946

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.
- 39 technical assistance activities conducted from 7/1/09 – 6/30/10 served 974 child care providers and applicants.
- The department consistently exceeds inspection goals for licensed child care facilities. From 7/1/09 – 6/30/10, 896 compliance-monitoring inspections of family day care homes were required, 1234 inspections were completed; 790 compliance-monitoring inspections of child day care centers and group day care homes were required, 923 inspections were completed.
- All complaints investigations include unannounced site visits. From 7/1/09 – 6/30/10 there were 1368 complaint investigation inspections involving licensed and illegally operating child day care facilities.
- From 7/1/09 – 6/30/10, 105 enforcements against licensed or illegally operating child day care facilities were taken.

Performance-Based Vendor 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

COMMUNITY HEALTH CENTERS: 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 Connecticut Department of Public Health to provide comprehensive preventive and primary health care services through Community Health Centers located in over 150 satellites 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. Twelve of the 13 corporations are Federally Qualified Health Centers (FQHCs) that receive funding authorized by Section 330 of the Public Health Service Act and one does

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 the 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 Served: 289,395. This number includes those clients seen for primary and preventive care, oral health care, and health care access. The Uniform Data System (UDS) data from the federal government is not yet available for the calendar year 2008. This UDS data is what is utilized for most reporting.

Program Cost FY 2009-2010: \$5,102,912

Performance-Based Standards: All 13 CHCs submit quarterly and annual reports to DPH. The Uniform Data System or UDS submitted to the federal government annually by section 330 funded health centers is utilized for data for 12 of the 13 CHCs. The one other CHC utilizes a modified form of reporting to the federal government that is also utilized by DPH for reporting.

Performance-Based Outcomes:

- Number of pregnant women beginning prenatal care in the first trimester.
- Number of children with second birthday during the measurement year with appropriate immunizations.
- Number of women 21-64 years of age who received one or more Pap tests during the measurement year or during the two years prior to the measurement year.
- Number of diabetic patients whose HbA1c levels are less than or equal to 9 percent.
- Number of adult patients 18 years and older with diagnosed hypertension whose most recent blood pressure was less than 140/90.
- Number of births less than 2,500 grams to health center patients.

Performance-Based Vendor Accountability: Review of reports including reports the CHCs submit to the federal government; periodic site visits to the contractor; medical record audits on site visits; communication and collaboration with CHC contractors and CHC Association of CT.

EMERGENCY MEDICAL SERVICES FOR CHILDREN: EMSC strives to reduce child and youth disability and death to due illness or injury by providing health care providers with the education, products, and resources necessary to address the unique medical needs of children and adolescents.

Number Served: We serve all children and families in Connecticut

Program Cost FY 2009-2010: \$130,000

Performance-Based Standards: We work under Federal performance measures and are required to survey hospitals on transfer agreements and guidelines of children and EMS providers on medial control, and equipment. Our program provides training each year for nurses and EMS providers to better prepare them to care for children.

Performance-Based Outcomes: We are currently getting a national list of equipment recommended for ambulances vetted within the state. We are working on a pediatric medical designation system for hospitals. We just finished surveying hospitals on pediatric transfer guidelines and agreements and are currently surveying EMS providers on medical control, protocols and equipment.

Performance-Based Vender Accountability: When we contract for training classes we ask for copies of the people certified in the pediatric classes. Final course rosters are obtained for non-certification classes.

FAMILY PLANNING: Twelve Family Planning Clinics (FPC) are funded by the Connecticut Department of Public Health (DPH) through a contract with Planned Parenthood of Connecticut, Inc. The purpose of the DPH 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 Connecticut.

Number served: A total of 35,015 participants served.

Program Cost FY 2009-2010 \$1,073,557

Performance-Based Standards: Planned Parenthood of Southern New England, Inc. (PPSNE) CT's Family Planning program met or exceeded all outcome measure goals and improved over the previous year. Seventy five percent of the program's clients received services regardless of ability to pay (this includes patients paying according to their sliding fee scale and those covered by Medicaid). Based on sample chart reviews, 98% of female patients receiving a preventive reproductive health exam received a Pap test; 99% of female patients with a reproductive health exam received a clinical breast exam; 79% of female patients with a reproductive health exam received screening for Chlamydia trachomatis; and 87% of clients with a reproductive health exam received AIDS education, non-specific behavioral counseling and, upon request, information on testing sites.

Performance-Based Outcomes:

- Number of clients receiving services this period regardless of ability to pay (were unable to pay all or part of cost). Goal: 60%-Actual: 75%
- Number of patients receiving a comprehensive annual preventive reproductive health exam during this reporting period
- Number of female patients with a preventive reproductive health exam who received a Pap test. Goal: 90% Actual: 98%
- Number of clients with a preventive reproductive health exam who received a clinical breast exam. Goal: 90%-Actual: 99%
- Number of clients receiving a comprehensive initial preventive reproductive health exam during this reporting period
- Number of female patients receiving a preventive reproductive health exam during this reporting period who received a screening for Chlamydia trachomatis and gonorrhoea. Goal: 85% -Actual: 79% The goal for the number of female patients receiving screening for chlamydia is 85%; PPSNE fell short of this goal due primarily to the fact that more women who are married or in long-term monogamous relationships are declining an annual chlamydia test
- Number of clients with a preventive reproductive health exam who received AIDS education, non-specific behavioral counseling and, upon request, information on testing sites. Goal: 80%-Actual: 87%
- Number of clients surveyed who reported overall satisfaction with visit and satisfaction with key areas (friendliness of staff, comfort of waiting, skills of medical personnel). Goal: 90%; actual: 96.1%

Performance-Based Vendor Accountability: Performance based vendor accountability is monitored through site visits with random medical record reviews, observations and staff interviews, review of quarterly and annual report data, and contractor participation and updates on various Maternal and Child Health Committees and Advisory Boards. PPSNE conducts ongoing community outreach activities.

IMMUNIZATION: The State of Connecticut Immunization Program's mission is to prevent disease, disability and death from vaccine-preventable diseases. The following means are used to accomplish this goal: provide vaccine for

Connecticut children; educate medical personnel and the general public on the importance of vaccination; work with providers using the immunization registry to assure that all children in their practice are fully immunized; assure that children who are in day care, school and college are adequately immunized; and conduct surveillance and outbreak control activities for vaccine-preventable diseases.

Number served 2010-2011: According to the 2009 National Immunization Survey (NIS), 76% of the states' two year olds were up to date on their immunizations based on the following vaccine series that includes 4 doses of DTaP, 3 doses of Polio, 1 dose of MMR, 3 doses of Hepatitis B, 1 dose of varicella vaccines and 4 doses of pneumococcal conjugate vaccine (PCV). The 4:3:1:0:3:1:4* vaccine series is based on NIS data that excludes Hib vaccine altogether to allow comparisons over time for a series measure not affected by the Hib shortage. Coverage for individual antigens is as follows: 4+ DTaP at 87.6%; 3+ Polio at 96.6%; 1+ MMR at 93.7%; 3+ Hep B at 98.4%; 1+Varivella at 92.1% and 4+PCV at 90.7%.. The coverage rates for the individual antigens are all above the national rates. The 2009 NIS survey included children born January 2006 through July 2008.

*(The Hib vaccine shortage during which ACIP recommended deferral of the booster dose (December 2007 – September 2009) for most children was reflected in the 2009 data. As a result, estimates for the 4:3:1:3:3:1:4 series measure dropped nationally and in all states, and these drops reflect mostly the deferral of the Hib booster dose, and thus not useful for assessing changes in coverage for the series.)

Program Cost FY 2009-2010: \$41,284,219

Performance-Based Standards: Immunization coverage is one of our principal performance-based standards. The National Immunization Survey (NIS) conducted annually by CDC estimates vaccination coverage among children aged 19-35 months old nationally and for each state.

Performance-Based Outcomes: Connecticut's 2009 NIS coverage (excluding Hib vaccine) for 4 doses of DTaP, 3 polio, 1 MMR, 3 hepatitis B, 1 varicella and 4 PCV (4:3:1:0:3:1:4) was 76%. Based on this information, CT was ranked 6th with Massachusetts among all 50 states with highest immunization coverage rates. Last year's NIS survey results for CT based on 4:3:1:3:3:1:4 series which showed a significant drop in our coverage rate is not relevant for comparison because of the Hib vaccine shortage. It is likely that the estimates for this series will continue to drop over the next couple of years before we have a leveling off of the effects of the shortage on children born through September 2009. CDC will include the 4:3:1:0:3:1:4 measure in the next two NIS annual reports for comparison purposes across years.

According to our CIRTS immunization registry data which looked at the records of 35,309 two-year-olds born in 2007, 4:3:1:3:3:1* coverage is 65% and 4:3:1:2:3:1* coverage is 85%. Eighty five % of our 2007 birth cohort (35,309 out of 41,413) is enrolled in our registry.

*Please note the vaccine series that include Hib reflect the Hib supply shortage and the February 2008 to July 2009 deferment of the Hib booster dose.

Performance-Based Accountability: The Immunization Program has contracts with 11 Immunization Action Plan Coordinators (IAPs) working at local health departments in areas of greatest need. IAPs are required to submit quarterly reports and they are evaluated on their outreach efforts (number and percentage of children behind on their immunizations who are brought back into medical care) and the immunization coverage rates of the providers with whom they work.

INJURY PREVENTION – UNINTENTIONAL CHILDHOOD: The Program's overall 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, organizations and coalitions to raise awareness, and develop and implement injury prevention programs and policies. Through Maternal and Child Health Block Grant funding the Program contracts with Safe Kids Connecticut to provide child transportation safety

training to health care, childcare and other service providers and to provide education, child safety seats and booster seats to low-income families. The geographic service area is statewide.

Number served: Through Maternal and Child Health Block Grant funding the program provided 21 child passenger safety workshops serving 350 parents/caregivers and 500 children.

Program Cost FY 2009-2010: \$45,250

Performance-Based Standards: Training programs are based on national safety curricula developed by child passenger safety experts, and are regularly reviewed to insure that they meet current “best practice” Standards. Nationally certified child passenger safety instructors or technicians deliver the training and educational programs and work with families to ensure that child safety seats and booster seats are correctly installed and used.

Performance-Based Outcomes: Percentage of parents/family members and service providers reporting increased awareness of effective measures to prevention injuries to children in motor vehicle crashes including selection and use appropriate occupant protection systems.

Performance-Based Vender Accountability: Contractor is required to submit periodic reports on program activities and outcome measures. The Injury Prevention Program monitors selected training programs and closely with the Contractor and other partners to identify providers organizations and to insure that low-income families receive program services.

INJURY PREVENTION – INTENTIONAL YOUTH VIOLENCE: 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 increasing awareness; 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.

Number Served: Through 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. A total number of 11,089 youths were served.

Program Cost FY 2009-2010: \$31,512

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 Vender Accountability: Contracted programs are required to report on program activities, process and outcome measures. Programs use questionnaires, surveys and/or observation to assess outcome measures including violence prevention related survey instruments from *Measuring Violence-Related Attitudes, Behaviors and Influences Among Youths*- Centers for Disease Control and Prevention publication.

LEAD POISONING PREVENTION AND CONTROL: 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 Served: 270,187 children under the age of six years old.

Program Cost FY 2009-2010: \$3,302,411

Performance-Based Standards:

- 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 0.8%
- 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 Vendor Accountability: Development of specific contract deliverables focusing on items listed in the scope of work along with submission of required case management (child and environmental) documents, which will also be reviewed by program staff.

NEWBORN LABORATORY SCREENING TRACKING: CT Statute 19a-55 mandates that “the administrative officer or other person in charge of each institution caring for newborn infants shall cause to have administered to every such infant in its care an HIV-related test, as defined in section 19a-581, a test for phenylketonuria and other metabolic diseases, hypothyroidism, galactosemia, sickle cell disease, maple syrup urine disease, homocystinuria, biotinidase deficiency, congenital adrenal hyperplasia and such other tests for inborn errors of metabolism as shall be prescribed by the Department of Public Health.” The goal of newborn screening is early identification of infants at increased risk for selected metabolic or genetic diseases, so that medical treatment can be promptly initiated to avert complications, prevent irreversible problems, and death. The Newborn Screening Program consists of three components: Testing, Tracking, and Treatment. Specimens are collected at birthing facilities and sent to the CT State Public Health Laboratory for testing. The Program’s Tracking Unit staff report all abnormal results to primary care providers and assure that referrals are made to the appropriate state-designated regional treatment centers or that repeat specimens are obtained. The treatment centers provide comprehensive care services that include confirmation testing, counseling, education, on-going treatment, and follow-up.

Number Served: Over 2 million newborns have been tested since the program began in 1964 and 1,214 babies have been identified with one of the diseases screened for. In 2009, there were 39,481 occurrent births and the CT Public Health Laboratory screened 39,589 1st blood specimens. There were 68 confirmed cases, all of which continue to receive treatment and follow-up genetic and nutritional counseling at one of the state Regional Treatment Centers.

Program Cost FY 2009-2010: \$1,049,397

Performance-Based Standards:

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

Performance-Based Outcomes:

- TESTING: The CT Public Health Laboratory screened 40,568 specimens in 2009. Of the 39,481 occurrent births in CT for 2009, 99% received newborn screening (NBS)
- TRACKING: Assure that 100% of infants who screen positive with metabolic & genetic condition(s) receive follow-up to definitive diagnosis and clinical management.
 - All 2100 suspect positive results were reported to Regional Treatment Centers and/or primary care physicians for further testing and follow-up.
 - There were 710 unsatisfactory NBS specimens; all but 3 were resolved with receipt of a 2nd specimen.
 - There were 11 CT State Waivers submitted to the lab for refusal of screening due to conflicts with religious tenets. Of these, 4 newborns had specimens obtained later by their PCP.

- There were a total of 839 missed scan specimens (specimens that were not received by the Laboratory by the 7th day of life), of these over 130 specimens needed tracking and follow-up.
- Tracking staff follow infants who are transfused prior to the NBS blood test until a 90-day post-transfusion specimen is collected and tested for Hemoglobinopathies and Galactosemia.
- TREATMENT: 77 of the referrals were confirmed as disease cases and 874 hemoglobin trait cases were identified. These babies continue to be followed by the treatment centers comprehensive care, education, and counseling.

Performance-Based Vendor Accountability:

- Laboratory Newborn Screening Guidelines for Birthing Facilities (effective 12.01.08);
- Connecticut Public Health Statutes and Public Health Code – 19a-55, 19a-55-1 & 19a-55-3;
- Maternal and Child Health Bureau Federal Performance Measures;
- Healthy People 2010 Objectives;
- CT’s methods to Reduce Health Disparities;
- CT Dept. of Public Health Statistical Report of Contract Activities (Quarterly Reporting form used by designated regional contractors providing treatment services);
- Newborn Screening Program Advisory Committee (NSPAC) formerly the Genetics Advisory Committee (GAC);
- Clinical Laboratory Standards Institute Guidelines (CLSI);
- CT Electronic Reporting-Newborn Screening Data System (NSS);
- Health Insurance Portability and Accountability Act of 1996 (HIPAA); and
- Department of Public Health, Newborn Screening Tracking Program Business Associate Agreement.

NUTRITION, PHYSICAL ACTIVITY AND OBESITY: The NPAO program receives federal funds to provide nutrition education to low-income individuals in Connecticut, and many projects focus specifically on children and parents. The successful, evidence-based “Adventures of Captain 5 A Day” curriculum is utilized in over 93 Head Start and School Readiness programs across the state. The curriculum supports social, emotional, cognitive, and language development in young children while encouraging healthy eating and physical activity. The program trains and motivates teachers, provides materials, and serves as an ongoing resource to promote the implementation of nutrition education and physical activity in the preschool classroom.

In addition, the program uses “Supermarket Smarts” parent workshops to inform parents on how to make healthy food choices within a limited budget and to promote a positive mealtime environment. This developmentally savvy approach achieves results by focusing on teachers and parents who then display behaviors and strategies that impact young children. Further, the program participates in statewide health fairs and community events, and supports a website and seasonal newsletters; these activities extend and reinforce the healthy eating and physical activity messages.

The NPAO program also awarded federal funds to 21 Local Health Departments/Districts (LHD) who carry out various activities to reduce the consumption of excess dietary fats through multi-session educational programs. These sessions are intended to provide needed information on dietary fats and offer practical skills to establish healthy eating patterns. Other initiatives are for the promotion of physical activity and prevention of obesity through multi-session programs to assist individuals to establish a minimum level of wellness into their lifestyles. Each LHD hire qualified personnel and submit a “Service and Evaluation Plan” that details: activities, indicators for evaluation, staff responsible for oversight, and target date for completion for all services in the fiscal year funded.

Number Served: 112,000 children and families

Program Cost FY 2009-2010 \$559,231

Performance-Based Standards:

Nutrition Education:

- Healthy Food – After completion of SNAP-Ed interventions, participants will increase their intake of healthy foods by 5%.

- Physical Activity – After completion of SNAP-Ed interventions, participants will increase physical activity to balance their individual dietary intake needs.
- Fruit & Vegetable Consumption – After completion of SNAP-Ed interventions, participants will increase their average daily consumption of vegetables by ½ cup per day.
- Resource Management – After completion of SNAP-Ed interventions, participants will increase their purchasing power by 5%.

Reduce Excess Dietary Fats:

- Program participants can accurately identify at least three dietary practices to reduce fat intake and promote heart health.
- Program participants report at program end, taking action to reduce dietary fat intake.

Block Grant Physical Activity:

- Program participants are able to correctly identify the recommended levels of physical activity to promote heart health.
- Program participants report at program end that they plan to engage in at least light to moderate physical activity three to five days a week.

Policy and/or environmental changes:

- Participants are aware of risk factors that contribute to obesity.
- Participants will participate in activities to reduce obesity.
- Participants will participate in activities to reduce obesity.

Testing of Curricula:

- Needs Assessment
- Process and Outcomes Evaluation
- System for Observing Fitness Instruction (SOFIT)
- Healthy Living Questionnaire
- Sustainability Assessment

Performance-Based Outcomes:

- Eight LHDs conducted 29 nutrition education programs.
- Seven LHDs conducted 31 physical activity programs.
- Six LHDs implemented 14 policy and/or environmental changes increasing physical activity, and improved nutritional practices at the community level.
- Pre- and post-tests; oral assessments; interactive game questions; program staff and teacher observations.
- Individual teachers and parents responses; group activity responses; interactive activities; discussions.
- Children task response to stated objectives, skill demonstration and informal feedback.
- Teachers and parents task response to stated objectives, skill demonstration (e.g. meal planning and food purchasing), informal feedback and perceived change in skills.
- Children’s perceived ability to change; reported change (e.g. reported change in children’s intake of vegetables by teachers); food records; food frequency instruments; physical activity questions.
- Teachers and parents’ perceived ability to change; reported change.

Performance-Based Vendor Accountability:

- Number of SNAP-eligible children and parents reached through direct nutrition education.
- Number of Head Start and School Readiness programs participating in the program.
- Number of “train-the-trainer” workshops delivered to Head Start and School Readiness teachers.
- Time Head Start and School Readiness teachers provide nutrition education in the classroom and at mealtime.
- Time of technical assistance delivered to ensure fidelity of the nutrition education program.
- Number of materials and resources prepared and delivered.
- Number of Supermarket Smarts workshops delivered to Head Start and School Readiness parents.
- Number of community partnerships/collaborations formed and enhanced to reach SNAP-eligible children and parents.
- Number of collaborations with agencies to prevent duplication of services, gain updated knowledge of new programs and tools, and facilitate effective management of the programs.
- Service and Evaluation Plans submitted.
- Quality Assurance Plans submitted.

- Quarterly narrative and expenditure reports.
 - Participate in site visits as appropriate.
 - Staffing plans, including responsibilities of funded or in-kind staff to meet proposal objectives.
 - Number of community wellness coalitions that demonstrate community support, mobilization, and buy-in.
 - Number of agencies, organizations and municipalities that serve in a leadership capacity.
 - Documentation of community inventory/assessment, and report or recommendations completed.
 - Submission of comprehensive evaluation plans to include defined outcome and process measures.
 - Demonstration of plans implementation and project sustainability.
-

ORAL HEALTH-HOME BY ONE: The purpose of the Home by One Program is to build integrated partnerships with the early childhood community at the state and local levels that focus on oral health as essential to the overall health and well-being of children in the state of Connecticut through the achievement of the following goals: increase the coordination and exchange of oral health information as it relates to overall health among state agencies and community organizations that address early childhood services; increase the number of parents trained as oral health advocates for children and families; increase the number of non-oral-health professionals who are competent in preventive oral health strategies to enhance access to oral health services for at-risk children; expand the number of dental practices and clinics providing dental homes for children, including those with special health care needs.

Number Served: 26,840 children

Program Cost FY 2008-2009: \$160,000

Performance-Based Standards: The National Oral Health Objectives for the Year 2010 (Healthy People 2010 Objectives)

For two to four year old children there are two primary oral health objectives:*

- Reduce the proportion of young children with untreated dental decay in their primary teeth to 9 percent.
- Reduce the proportion of young children with dental caries experience in their primary teeth to 11 percent.

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

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

*Note: the 2007 oral health assessment of preschool (2-4 years old), kindergarten and third grade (6-8 years old) students in Connecticut determined the following:

- 31 percent of preschool children have experienced dental decay.
- Of those with decay experience, 20 percent have untreated decay.
- 41 percent of third grade children have experienced dental decay.
- Of those with decay experience, 18 percent have untreated decay.
- 38 percent of third graders have dental sealants.

Performance-Based Outcomes:

- Advisory Group for the Home by One Program continues to meet twice per year.
- Health Program Associate continues to attend the MCH Advisory meetings and other oral health members have been included on the advisory. Oral health was included in the needs assessment of the MCH Block Grant application.
- Home by One Program was accepted as an emerging best practice and is on the *AMCHP Innovation Station*. Home by One program was presented as a poster presentation at 2010 annual session of AMCHP.

- Home by One Program was highlighted at 2010 National Oral Health Conference as part of an oral presentation: *WIC: Building Collaboration to Improve Oral Health*.
- Home by One collaborated with The Nurturing Family Network to provide oral health presentations to their community networks in Bridgeport, Norwalk, Killingly, Hartford, New Haven and Waterbury.
- The completed curriculum for advocacy was incorporated into 17 advocacy and oral health workshops that were given in the following WIC sites, Torrington (3), Willimantic, East Hartford (2), Meriden, Norwich, Waterbury, Bridgeport (Separate English and Spanish Workshops), Stamford (Separate English and Spanish workshops), Norwalk, Putnam, Danbury, and Fair Haven. The Project Coordinator has met with the WIC coordinators, nutritionists and dietitians to request their guidance and assistance in identifying parents who may be interested in becoming oral health advocates.
- The 73 parents who attended Advocacy & Oral Health trainings March 2010-September 2010 received training certificates developed March 2010, recognizing them as dental parent advocates.
- Dental Parent Advocates received invitations to attend June 2, 2010 workshop Supporting Children with Special Health Care Needs in a Dental Home; June 11, 2010 Statewide Oral health Conference; and an opportunity to participate in fluoride varnish demonstrations by Medical and Dental Providers in Meriden October 20, 2010.
- A total of 191 parents completed advocacy oral health training to date.
- 24 of the 24 Local WIC sites with full time staff completed oral health training and an orientation to the *Home by One* Program. WIC staff are provided with tools to facilitate the incorporation and integration of oral health into existing WIC risk assessment and nutritional guidance. WIC sites include Waterbury (3), Hartford (2), East Hartford (2), New Haven (4), Norwich, New London, Torrington, Danbury, Stamford, Norwalk, Bridgeport, Meriden, Middletown, Bristol, New Britain, Willimantic and Putnam.
- 170 WIC professionals have received oral health training to date through Home by One program.
- 303 additional Medical providers: Physicians, APRNs, RNs, and Pas, have trained in oral health concepts and fluoride varnish for this reporting year. The total number of medical providers credentialed to bill DSS for oral risk assessment and fluoride varnish application is 262. A total of twenty-eight training sessions have been provided to date to 935 physicians/APRNs/Pas/RNs. The contract between Home by One Program and University of Connecticut Health Center is completed. Medical provider oral health trainings will be available online through CT TRAIN beginning November 2010.
- A core medical-dental home group has been established and outlined the essential components of the medical-dental home model. A plan for implementation has been developed and medical-dental home sites have been identified. An evaluation consultant has been hired for the medical-dental home model development and measures have been drafted.
- March 2009-September 2010, an additional 22 dental home sites received an orientation to the Home by One Program, partnering with the program to offer age one dental visits and accept referrals from WIC, bringing the total number of dental homes to 35. The training consultant provided trainings and the Program Coordinator provided the resources for coordination of WIC referrals. Individual referral programs were developed for each dental home. Five dental home partners trained through the Course # 1018656 *The Dental Providers Perspective on the Age One Dental Visit*, which is offered on CT TRAIN. 58 Dental Professionals have taken the online training since it was launched in September 2009. All future dental provider trainings will be provided through online course.
- The Home by One Coordinator presented Home by One trainings to dental hygiene students in University of Bridgeport, University of New Haven, and Lincoln College dental hygiene programs.
- A Contract between Home by One Program and Child Health and Development Institute is expanded to support a dental coordinator for children and youth with special healthcare needs. The dental coordinator will organize six oral health & advocacy trainings in the CT Family Support Network regions. Medical Home coordinators will be provided with oral health training opportunities as well as oral health educational resources from the Home by one program, and dental home resources.
- A media campaign promoting the well baby dental message of first visit by age one ran in English and Spanish on busses in New London, Waterbury and Middletown October 2010.
- A banner promoting the well baby dental message of first visit by age one was displayed for one week near Capitol Building in Hartford in February 2010.
- The webpage for the Home by One Program has received 545 hits since launch in August 2009. It is linked with the Early Childhood Partners webpage.

Performance-Based Accountability:

Evaluation process for *Home by One* grant including:

- Assessing number of early childhood organizations that expand their agenda to include oral health as a result of Home By One activities.
- Evaluate the number of families who report having engaged in oral health advocacy for themselves, their children or their families.
- Determine the number of *Home By One* presentations completed in pediatric practices, family medicine practices.
- Assess the impact of *Home by One* trainings by:
 - Interview a sample of staff in practices receiving *Home by One* training to determine impressions of changes in access to dental services.
 - Assess the impact of training by perform chart audit in a sample of *Home by One* trained practices to ascertain evidence of early preventive dental services delivered by pediatric or family medicine provider, fluoride varnish application and successful referral to dental provider.
 - Determining the number of dental providers receiving training on treating young children, age one dental visits and serving as a dental home.

RAPE CRISIS AND PREVENTION SERVICES: 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, primary prevention activities, training to health care providers, schools, law enforcement, social services providers and the community regarding sexual violence prevention, and coordination of services. The program goal is to end sexual violence and ensure high quality, comprehensive and culturally competent sexual assault victim services by offering primary prevention and victim crisis intervention services statewide through the following member service areas: Bridgeport, Danbury, Meriden/Middletown/New Haven, Milford, New Britain/Hartford, Stamford, Torrington, Waterbury, Willimantic/New London.

Number Served: Between the period of July 1, 2009 and June 30, 2010, a total of 28,239 children, youth, adolescents and young adults in the school settings participated in rape prevention and educational sessions. A total of 3,845 clients were served based on their town of residence, and 81 professional trainings were offered to 1638 professionals. 2,624 primary victims and 1,221 secondary victims were also served during that time period.

Program Cost FY 2009-2010: \$1,146,368

Performance-Based Standards: Standards of accountability are measured based on the following outcomes: clients are able to access the needed and appropriate services from a choice of service options, clients are provided acute care and safety at time of contact, clients are able to access long-term support services. The Rape Crisis Prevention Services met and/or exceeded all outcome measure goals.

Performance-Based Outcomes:

- Clients are able to access the needed and appropriate services from a choice of service options. 90% or more of clients requesting referrals will receive them within 3 days (72 hours). Goal: 90% -Actual: 99.99%
- Clients are provided acute care and safety at time of contact. 90% or more of clients requesting immediate emotional assistance will receive such assistance by phone or in person. Goal: 90% -Actual: 99.97%; 90% or more clients who request that an advocate meet them at the hospital will be met by an advocate. Goal: 90% -Actual: 99.64%
- Clients are able to access long-term support services. 90% or more of clients requesting individual counseling will receive an appointment within three days (72 hours). Goal: 90% -Actual: 100%; 70% of clients requesting group counseling will receive an appointment within thirty days. Goal: 70%: Actual: 99.64%

Performance-Based Vendor Accountability: Performance-based vendor accountability is monitored through review of quarterly and annual report data. The contractor also performs pre and post-test surveys within primary prevention curricula.

TOBACCO USE PREVENTION AND CONTROL: The Tobacco Use Prevention and Control Program follows the guidelines and recommendations put forward by the Centers for Disease Control and Prevention (CDC) in their document “Best Practices for Comprehensive Tobacco Control Programs”. The Tobacco Program works toward addressing all areas in tobacco control including educating the public about the risks associated with the use of tobacco products and exposure to environmental tobacco smoke (ETS). Areas of focus include youth prevention, pregnant women, those of low-socioeconomic status, individuals with mental illness and other disparate populations who are affected by tobacco use.

Number served 2009-2010: Community cessation programs funded during the period along with the telephone-based tobacco quitline served at least 3,728 individuals with most of those services targeted to low socio-economic status participants and pregnant women.

Program Cost 2009-2010: \$2,209,525

Performance-Based Standards:

Our standards include the reduction and elimination of use of all forms of tobacco, to prevent or delay smoking initiation, and to reduce participant’s exposure to second-hand smoke. All funded programs must adhere to CDC’s best practices guidelines and use evidenced-based curriculums. All programs include education regarding the prevention of smoking initiation and the harmful effects of second hand smoke.

Performance-Based Outcomes:

- At least 75% of program participants will reduce their tobacco use;
- At least 75% of program participants will make changes to protect the health of non-smokers.

Performance-Based Vendor Accountability:

Contractors are required to collect data at several intervals during the program to assess program effectiveness, including pre-and post-program surveys. Contracts must submit periodic progress reports detailing their program activities including their self-evaluation and the results of their outcome measures. In addition, an independent evaluator is on contract to evaluate these programs.

WOMEN INFANTS AND CHILDREN (WIC): The Connecticut WIC Program serves pregnant, postpartum, and breastfeeding women; infants; and children up to five years of age. The program provides services in four major areas during critical times of growth and development, in an effort to improve birth outcomes and child health: 1) Nutrition Education and Counseling; 2) Breastfeeding Promotion and Support; 3) Referral to outside medical and social services; and 4) Vouchers for healthy foods prescribed by the WIC Nutritionists (WIC food packages). 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. Active enrollment in Medicaid (HUSKY A) qualifies applicants for categorical eligibility in the WIC Program. 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 was \$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 served 2009-2010: 73,238 children and 28,766 women

Program Cost 2009-2010: \$48,078,732

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 breastfeeding information and support; 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:

- At least 70% of pregnant women participating in the WIC Program for a minimum of 6 months gain appropriate weight.
- 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 60% of infants whose mothers were enrolled in the WIC Program during pregnancy breastfeed.
- At least 25% of infants enrolled in the WIC Program breastfeed for at least 6 months.
- The prevalence of anemia among children enrolled in the WIC Program for at least one year does not exceed 9%.

Performance-Based Accountability:

- Local agencies that sponsor WIC Programs must submit annual program plans that identify measurable outcome and process objectives, and specify 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.

- **Children’s Trust Fund**
- **Fatherhood Initiative**
- **Teenage Pregnancy Prevention**

Long Term Agency Goals: The Department of Social Service (DSS) is informed by relevant data, partner and/or contract with other agencies and organizations to create and implement programs and services that address the *root causes of poverty and the concomitants of poverty*, in order to effectively promote/facilitate the health and well being of children and families. Goals include:

- Increase access to affordable sound housing stock for income eligible children and families.
- Increase awareness about availability and access to food/good nutrition for income eligible children and families.
- Increase awareness about and access to preventive and curative health care for income eligible children and families.
- Increase the number of children, from infancy to three, who are “ready to learn” by providing child care/parenting education that help infants and toddlers develop characteristics and skills confidence, risk taking, how to socialize and get along with others, trust that are essential in school success.

Strategies:

- Program and contract staff will have the most up to date local, regional, and national data related to clients’ needs, poverty and its concomitants as well as knowledge and awareness of objectively determined effective program/service outcomes for targeted low income/income eligible children and families that will be used to inform/plan, develop, and contract for services for clients, with external agencies/organizations.
- In addition to actually enumerating level of program participation, contractees will be required to provide objective outcome measures that demonstrate effectiveness of programs/services based on documented client progress and client feedback.

- Quarterly reviews/evaluations of client outcome data will be provided by contractees.
- Make information about the Department’s programs and services for low income children and families available through many access points public libraries, doctors’ offices, health care centers, neighborhood markets and stores, malls, schools, hospitals, other agencies/organizations, child care/day care, etc., in order to increase awareness and program participation.
- Engage in ongoing recruitment of health care providers/physicians in order to increase access to health care for income eligible children and families.
- Continue the contractual relationships with community action agencies to ensure awareness and supportive access to programs/services provided by DSS.
- Whenever possible, dispatch staff to provide information about the Department’s programs/services such as speaking at community events, participating in community fairs, and convening focus groups for purposes of providing, collecting program/service related information.
- Introduce a formal mechanism to collect program participant/service recipients’ feedback related to the receipt and use/usefulness of services provided.
- In DSS funded child care settings, place greater emphasis on helping parents understand the relationship between child rearing practices and “readiness/ability” to learn as well as the value of good nutrition for optimal growth, development, and learning.
- Train and support staff in modifying contracts based on objectively determined clients/program participants’ outcome data.
- Take advantage of funding opportunities that can be used to increase the number of sound adequate housing for income eligible children and families.

Measure of Effectiveness: The effectiveness of prevention is best measured longitudinally; the Department is in the process of formalizing a data collection and analysis approach that addresses this issue.

Methods: Current data collection processes do not lend themselves to performance measures and outcomes based on race, income level, and gender.

The Department plans to rectify this as soon as possible.

Other: As the Medicaid, housing, TANF agency, lead agency for persons with disabilities, subsidizer of child care, and the administrator/manager of the Supplemental Nutritional Assistance Program, the

Department provides programs and services that by their very nature address the health and safety needs of children and families. There is no doubt that it succeeds in doing so; however, in the coming months and years, DSS will collect data in ways that clearly demonstrate the extent to which current programs are succeeding in prevention.

The Department's Children's Trust Fund provides an excellent example of research based programs that are primary prevention.

Long-Term Children's Trust Fund Program

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 goals 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 effect the well being of children including improving parent-child bonding and interaction, parenting skills and family relationships, 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. Sites are encouraged to achieve the outcomes of the highest performing sites.

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

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

Highlights of the 2010 report on the Nurturing Families Network follow:

- The annual rate of abuse and neglect is 2%. This rate is very low when compared with rates of 20-25% reported in studies with

similarly high-risk mothers who did not receive home visitation services.

- Mothers were more likely to have graduated from high school and be employed and live independently.
- Mothers made significant improvement on the Community Life Skills scale, indicating they were more connected to others in the community and were adept at accessing available resources.
- Rates of preterm and low birth weight babies for the high risk mothers compared favorably with the state and national rates for the general population.
- 96% of participating children were fully immunized and 98% had a pediatric care physician.
- The domestic violence rate dropped significantly from 2.4% at program entry to 1% at the end of the year. All of the mothers who reported domestic violence at program entry were not in violent relationships 1 year later.

The evaluation demonstrates that the NFN program is effective in reducing the incidence of child abuse and neglect and improving the well being of both the parents and children who participate in the program.

Performance-Based Accountability: A continuous quality improvement team has been established to review practice guidelines, training needs and program protocols for the larger Trust Fund programs. The policies are written into a manual that guides program implementation efforts at each site. The Trust Fund staff monitors site 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. 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, parenting groups 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 performance 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 outperformed a comparison group of children from wealthier and more stable families not considered at risk for poor outcomes.

Family Development Training and Credentialing Program (FDC): Training human services staff to better engage and support families in prevention efforts. Course are offered for front-line and management staff. Six college course credits and a credential are available for participants that successfully complete the course for frontline staff. The FDC program is providing training for all of the staff at 3 anti-poverty agencies. An evaluation is underway to assess the results.

Number Served: 70 students received credentials through the FDC program in 2009

Program Cost: FY 2009 – 2010: \$20,000

Performance- Based Standards: Students must complete 75% of a 90-hour course, a comprehensive portfolio and pass a written exam.

Performance-Based Outcomes: Students who complete these requirements are awarded a credential from the University of Connecticut.

Performance –Based Vendor Accountability: Sites offering the training must follow a syllabus established by the program leaders and follow program requirements.

Family Empowerment Initiatives: Family Empowerment Initiatives include seven nationally recognized prevention programs that assist high-risk groups of parents and others involved in the lives of children.

Number Served: In 2009 Family Empowerment Initiatives provided home and group based services to roughly 700 parents.

Program Cost: FY 2009 – 2010: \$200,000

Performance- Based Standards: Follow model replication standards. Use the AAPI 2 or other tool to assess changes in parenting attitudes and behaviors.

Performance-Based Outcomes: Program sites have developed within recognized standards of best practice. Parents reports gains in knowledge and less stress caring for their children.

Performance –Based Vendor Accountability: Providers submit quarterly reports.

Family School Connection: Provides intensive home visiting services to families whose children are frequently truant or tardy or otherwise at risk of school failure. These children are often not getting their needs met at home and are at greater risk for child abuse and neglect, developmental, behavioral and health issues. The program is offered in grades K -12 at five elementary schools.

Number Served: In 2009 Family School Connection provided intensive home visiting services to 175 families.

Program Cost: FY 2009 – 2010: \$930,000

Performance- Based Standards:

- Improvement in parenting skills
- Increased parent involvement with their child’s educational experience

Performance-Based Outcomes: The participants showed a significant increase in their involvement with their child’s school. In addition, they found that parents were spending more time listening to their child read and helping them with their homework. Participants also showed a significant increase in life skills, specifically in the areas of budgeting and getting support from others.

Performance –Based Vendor Accountability: Vendors submit monthly data and quarterly reports.

Healthy Start: Ensures maternal and child health outcomes through Husky enrollment and by connecting pregnant and parenting new mothers to health care and other services.

Number Served: Services are provided in 15 locations across the state. Approximately 5,000 mothers received services in 2009. The program is provided in collaboration with DPH.

Program Cost: FY 2009 – 2010: \$1,600,000

Performance- Based Standards:

- Successful enrollment of prenatal and pregnant women in Husky.
- Improve maternal and infant birth outcomes

Performance-Based Outcomes: 5,000 women successfully enrolled in Husky. A study by Yale University found that participants and better maternal and infant birth outcomes.

Performance –Based Vendor Accountability: Data collected on a weekly basis.

Help Me Grow: Ensures that children and their families have access to a system of early identification, prevention and intervention services. Links child health providers, parents and service providers with existing community resources through a toll-free telephone number.

Number Served: In 2009 Help Me Grow connected 3,000 children and families to community based services. It also provided the Ages and Stages Child Monitoring program to 3,000 families.

Program Cost: FY 2009 – 2010: \$380,000

Performance- Based Standards:

- Successfully connecting children and families to services.
- Monitoring child development and informing parents

Performance-Based Outcomes:

- Help Me Grow successfully connected 86% of callers to services.
- Tracked the development of 3,000 children and provided feedback, activities and referrals for families with need.

Performance –Based Vendor Accountability: Maintains extensive database including assessment, attempts and connections to services.

The Kinship and Respite Fund: This probate court-administered program awards small grants to aid children living with relatives who are court-appointed guardians. The grants provide for a range of activities including tutoring, camp, extra-curricular experiences and program fees, and respite for grandparents.

Number Served: In 2009 the Kinship and Respite Funds provided grants to 1266 children and 822 adults.

Program Cost: FY 2009 – 2010: \$1,050,000

Performance- Based Standards: Identify impoverished guardians and provide appropriate grant support

Performance-Based Outcomes: On a case-by-case basis probate courts identified guardians and children in their care who would benefit from a kinship or respite grant.

Performance –Based Vendor Accountability: Maintain case files and provide quarterly reports.

Nurturing Families Network (NFN): NFN has 5 components: Intensive home visiting for new parents who are at high risk for child abuse and neglect. The program focuses on nurturing parenting, child development, and maternal and child health and community resources. Nurturing parenting groups that assist parents in developing appropriate expectations of their children and enhance their parenting skills. Nurturing Connections that brings new parents together with volunteers and others in the community who can help them adjust to the demands of having a baby. Two new components have been added to the NFN including home visiting tailored to the needs of fathers and men. Also the program is offering in-home cognitive behavioral therapy to treat maternal depression. Evaluation data on these new efforts is not available at this time.

Number Served: Services are provided at 42 community locations throughout the state. In 2009 NFN served about 2,000 families in intensive home visiting and 600 families in Nurturing Parenting groups. The program screened 7,200 and provided Connections services to 1,700.

Program Cost: FY 2009 – 2010: \$10,000,000

Performance- Based Standards:

- Maternal Health/Behavioral Outcomes
- Infant and Child Health and Mortality
- Child Development
- Parenting Skills and Stress
- School Readiness
- Crime and Domestic Violence
- Child Abuse and Neglect
- Economic and family well being

Performance-Based Outcomes: The annual rate of abuse and neglect is 2%. This rate is very low when compared with rates of 20-25% reported in studies with similarly high-risk mothers who did not receive home visitation services.

- NFN mothers made statistically significant gains in life course outcomes during their participation in the program.
- Mothers were more likely to have graduated from high school and be employed
- Mothers were more likely to live independently.
- Mothers made significant improvement on the Community Life Skills scale, indicating they were more connected to others in the community and were adept at accessing available resources.
- Rates of preterm and low birth weight babies for the high-risk mothers compared favorably with the state and national rates for the general population.
- 96% of participating children were fully immunized and 98% had a pediatric care physician.
- The domestic violence rate dropped significantly from 2.4% at program entry to 1% at the end of the year. All of the mothers who reported domestic violence at program entry were not in violent relationships 1 year later.
- Parents participating in groups are significantly less stressed and have more realistic attitudes of their children.

Performance- Based Vendor Accountability: Vendors must agree to participate in an evaluation. Submit monthly data, review results and develop a written plan to address areas needing improvements.

Fatherhood Initiative: Outreach /awareness education and training for parents related to parenting, healthy relationships, and healthy marriages. Also, support services that connect parents/program participants to programs and services that address their emotional and socio-economic needs.

Number Served: 932 participants

Program Cost: FY 2009 – 2010: \$2,500,000

Performance- Based Standards:

- Increase in effective communication skills (between partners/parents)
- Increase in knowledge about responsible parenting
- Increase in the ability to secure and retain employment
- Decrease in the potential for child abuse and neglect
- Increase in responsible parenting
- Identify and assess potential for spouse/partner/child abuse
- Targeted intervention strategies for parents with cognitive limitations

Performance-Based Outcomes:

- Results of pre and post-test of training offered for each program participant
- Decrease in child/partner/spousal abuse
- Improved communication between parents/partners
- Improved parent-child relationships
- Increase in marriage between partners (couples)

Primary Prevention Outcomes:

- Decrease in child poverty
- Prevention of child abuse and/or neglect

Performance –Based Vendor Accountability: Grant access to Yale researchers who are evaluating the program; evidence of dissemination and collection of pre-pos test of curricula; observable use of the 24/7 Curriculum developed by the National Fatherhood Initiative and approved/required by the federal government; report number of program participants; evidence of recruiting and retaining program participants; attend and participate in mastering curricula related to assessing domestic violence and working with parents with cognitive limitations; and evidence of a program plan for each participant in which all services and rationale for the service/referral is included.

TEEN PREGNANCY PREVENTION: This program aims to prevent teen pregnancy and welfare dependency through the provision of awareness education (delay in sexual activity, safe sex practices, personal growth and development, etc.) and supportive programs and services.

Number Served: 500 program participants

Program Cost FY 2009 – 2010: \$2,427,547

Performance-Based Standards: Ongoing documented participation in either the Carrera or Service Learning Teen Pregnancy Prevention Model. Absence of reported and/or lack of observable pregnancies.

Performance-Based Outcomes: Absence of pregnancies among male and female program participants.

Performance-Based Vendor Accountability: Demonstrated implementation and use of either the Carrera or Service Learning model; participants' attendance; and evidence of participants' involvement in program activities, both personal and community based.

Judicial Branch, Support Court Services Division

- Educational Support Services
- Family Support Centers

Long Term Goals: The prevention goal of the Judicial Branch, Court Support Services Division (CSSD) is to divert children from juvenile court involvement and penetration into the criminal justice system.

Strategies:

- Divert children from the judicial process through non-judicial supervision services and referrals to appropriate community-based agencies and diversion programs.
- Identify needs and risk factors of children and families through the use of valid risk/need screening and assessment instruments, and refer children and families to programs and services that address their needs in order to prevent further juvenile court involvement or penetration into the criminal justice system.
- Collaborate with schools, community partners, provider agencies, and other state agencies to support local and state efforts designed to prevent or eliminate at-risk behaviors and to promote the health, well-being, and success of children.

Performance-Based Outcomes:

- Reduction in juvenile court intake (Families with Service Needs-FWSN and Delinquency referrals)
- Juveniles engaged in criminogenic need-based treatment
- Reduction in 24-month re-arrest rates for juveniles on probation or supervision
- Fewer delinquency commitments

Measures of Effectiveness: CSSD has adopted a results-based accountability framework to measure the effectiveness of its strategies. Data is collected on outcome measures and reported quarterly to management, line staff, judges, attorneys, and contracted service providers as part of a continuous quality improvement effort. In addition, CSSD conducts, through both internal and contracted resources, evaluations of targeted strategies and/or programs. They include:

- Performance Measure 1 – Juvenile Court Intake: Intake fell 29% from 15,857 in FY 2007 to 11,333 in FY 2009, and rose to

11,944 (+5%) in FY 10. The increase is likely due to the legislation that raised the age of juvenile jurisdiction to include 16-year olds.

- Performance Measure 2 – Juveniles Engaged in Criminogenic Need-based Treatment: Research suggests that completion of targeted treatment is connected to lower recidivism rates. The starting treatment rate in 2009 was 67% and rose to 95%, as of the end of quarter three of 2010. The treatment completion rate in 2009 was 20% and has risen to 68%, as of the end of quarter three for 2010.
- Performance Measure 3 – Reduction in 24-month Re-arrest Rates: The rate of re-arrest (recidivism) at 24-months after the start of a period of probation or supervision has remained consistent over the last three years. For example, 66 percent of the juveniles placed on probation or supervision in 2005 were re-arrested by the time their 24-month follow up period ended in 2007. This trend has been steady over the past four years.
- Performance Measure 4 – Juveniles Committed to the Department of Children and Families: Juveniles committed to either long-term residential placement or to incarceration at the Connecticut Juvenile Training School have decreased by 69 percent over the past 11 years and by nearly 50 percent in the past six years, from 401 juveniles committed in 2004 to 206 juveniles committed in 2009.

Methods: A core goal of the CSSD strategic plan is to engage in activities that provide a diverse, gender responsive and culturally competent environment for staff and clients that are sensitive to values and responsive to needs. CSSD established a Cultural Competency Advisory Committee which guides the implementation of this strategic goal. CSSD employees a diverse staff that is representative of the population served, including in key management positions within the agency. The Training Academy has embarked on an organization-wide cultural competency training initiative. CSSD provides culturally competent, research- and evidence-based programming, interventions and supervision services through the use of race- and gender-neutral screening

and risk/need assessment tools, and a network of contracted providers. CSSD requires all contractors to meet cultural competence expectations in hiring and service delivery. CSSD routinely reviews operation and program performance measures for any disparities based on gender or race/ethnicity. In addition, no race/ethnicity disparity was found in case handling, adjudication rates, court outcomes and placement rates in an independent report, *A Reassessment of Disproportionate Minority Contact in the Connecticut Juvenile Justice System* (May 2009), funded by the OPM Juvenile Justice Advisory Committee study.

Other: CSSD has implemented several programs directed at improving the parenting skills of court involved families. Parent engagement training for probation staff will assist officers in teaching parents

strategies to manage at home behaviors and provide parents with alternatives to calling police during domestic disagreements, and reduce the likelihood of siblings entering the juvenile justice system. Juvenile Probation also has begun outreach efforts to better coordinate with schools to manage the in-school behaviors of court involved juveniles. This effort should reduce the number of in-school arrests, which has shown to have a significant impact on a juvenile's successful completion of probation. CSSD, in conjunction with DCF and through its partnership with other stakeholders of the Executive Implementation Team of the Joint Juvenile Justice Strategic Plan, has established a local interagency services team (LIST) for each juvenile court district to increase local awareness and support for the needs of children at risk for juvenile justice involvement.

Educational Support Services: The goal of Education Support Services is to support families in ensuring that their children's educational needs are properly identified and that children have access to a free and appropriate education as required by law. Education Support Services include legal case consultation, advocacy, and training by contracted special education attorneys serving families and probation officers of children referred to juvenile court due to status offending or delinquent behaviors, and who exhibit school difficulties and/or performance challenges. Services were available at all thirteen (13) juvenile courts for FY10, and will be available for the twelve (12) existing juvenile courts in FY11.

Number Served: 312 participants

Program Cost: FY2009-2010 \$679,600

Performance-Based Standards:

- Percentage of clients that obtained/modified/preserved special education services
- Percentage of clients that overcame proposed suspension or expulsion
- Percentage of clients that obtained education-related benefits
- Percentage of clients that obtained procedural protections

Performance-Based Outcomes:

- 37% of clients obtained/modified/preserved special education services
- 11% of clients overcame proposed suspension or expulsion
- 34% of clients obtained education-related benefits
- 33% of clients obtained procedural protections

Performance-Based Vendor Accountability: CSSD has established a continuous quality improvement team for each contracted service. Each team includes best practices staff, who develop program models based on the best practice literature and oversee program implementation; contract compliance specialists, who ensure that providers are adhering to the program model and the contract requirements; data collection support staff, who ensure that providers are inputting data into the CSSD "contractor data collection system" (CDCS) and the data meets quality standards; and program analysis staff, who analyze the data to ensure that programs are meeting benchmarks. Provider performance is reviewed by CSSD management staff on a quarterly basis, and the CQI team works with the provider to ensure quality service.

Family Support Centers: Since 2005, legislative change impacting the treatment and handling of status offenders (Families with Service Needs, FWSN) resulted in the development of distinct services for FWSN children and their

families. Beginning with the prohibition on a court's placing an adjudicated child in detention for a violation of a court order, changes in the law also called for statewide process modification for the handling of FWSN referrals. Public Act 05-250 established that "no child that is found to be in violation of any such FWSN order may be punished for such violation by commitment to any juvenile detention center". In 2006, the legislature authorized an amendment to this legislation, Public Act 06-188, which established the Families with Service Needs Advisory Board to oversee the implementation of services in response to 05-250. The most recent legislative change came in an amendment of 46b-149 which changed the FWSN statute substantially, resulting in the development and funding of Family Support Centers.

A Family Support Center (FSC) is a multi-service "one-stop" service center for children and families referred to juvenile court due to status offenses (e.g., truancy, beyond control, runaway) and serves as a diversion to formal court processing. There were four (4) FSCs servicing the Bridgeport, Hartford, New Haven, and Waterbury juvenile courts. FSCs services will be made available to the eight (8) remaining juvenile courts in FY 10-11. The purpose of the FSC is to quickly assess service and/or treatment needs for the children and families and then provide and/or access the needed services in a timely fashion. Services offered include assessment, crisis intervention, family mediation, educational advocacy, case planning and management, psycho-educational groups, and flexible funds for pro-social supports.

Number Served: 490 participants

Program Cost: FY 2009-2010 \$2,236,489

Performance-Based Standards:

- Program completion rate: completion of the FSC program means that the client satisfied 80 percent of the goals identified on the collaborative plan. The goal through June 2011 is for 65% of clients under age 16, and 55% of 16 and 17 year olds to successfully complete the program.
- Client engagement: juvenile and family participate in the program intake process post referral. The goal is for 80% of clients under age 16, and 65% of clients age 16 and 17.
- Arrest rate for completers: percentage of program completers arrested within 12 months of program discharge. The goal is improved program performance by at least one percentage point each year.
- Re-referral rate for completers: percentage of program completers who have a new status offending court referral within 12 months of program discharge. The goal is improved program performance by at least one percentage point each year.

Performance-Based Outcomes: Based on data from January 2009-June 2010:

- Program completion rate: 75% for clients under age 16, and 51% for clients ages 16 and 17.
- Client engagement: 89% for clients under age 16, and 69% for clients ages 16 and 17.
- Arrest rate for completers: 33% for clients under age 16, and 31% for clients ages 16 and 17.
- FWSN referral rate for completers: 16% for clients under age 16, and 10% for clients ages 16 and 17.

Performance-Based Vendor Accountability: CSSD has established a continuous quality improvement team for each contracted service. Each team includes best practices staff, who develop program models based on the best practice literature and oversee program implementation; contract compliance specialists, who ensure that providers are adhering to the program model and the contract requirements; data collection support staff, who ensure that providers are inputting data into the CSSD "contractor data collection system (CDCS) and the data meets quality standards; and program analysis staff, who analyze the data to ensure that programs are meeting benchmarks. Provider performance is reviewed by CSSD management staff on a quarterly basis, and the CQI team works with the provider to ensure quality service.

- **Title V Delinquency Prevention Program**
 - **Governor's Urban Youth Violence Prevention Program**
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TITLE V DELINQUENCY PREVENTION PROGRAM: 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.

Number Served: 113 at-risk youth who are between the ages of 10 and 18.

Program Cost: FY 2009-2010 \$117,481

Performance-Based Standards: Program communities must develop and implement a local delinquency prevention plan that:

- Assess 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;
- Identify all available resources in the community;
- Assess gaps in the needed resources and how to address them;
- Establish goals and objectives along with an implementation timeline; and
- Insure the collection of 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.

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

GOVERNOR'S URBAN YOUTH VIOLENCE PREVENTION PROGRAM: The Governor's Urban Youth Violence Prevention Program is a competitive program for municipalities and nonprofit agencies that propose to serve youth ages 12 to 18 in urban neighborhoods. The purpose of the Governor's Urban Youth Violence Prevention Program is to reduce urban youth violence by providing grants for programs to serve youth ages 12 to 18 years in

urban centers. Funding for this program (\$1,500,000) comes from the U. S. Department of Education to the Office of Policy and Management under the federal Safe and Drug-Free Schools and Communities Act, Governor's Portion.

Number of Served: 1,965 youth residing in urban communities who are between the ages of 12 and 18

Program Cost: FY 2009-10 \$575,988

Performance-Based Standards: On a regular basis, the selected agencies receiving funding under the Governor's Urban Youth Violence Prevention Program must collect data on program youth as well as the involvement of their parents. This data includes:

1. Attendance and Participation (Youth Sign-In/Sign-Out);
2. Youth Demographic Data
3. Parent Permission Forms
4. Parent Involvement Data

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

Outputs

- Number of youth registered;
- Number of different youth who attend;
- Number of days the center is open;
- Average number of days youth attend monthly;
- Average number of youth served daily; and
- Number of parents participating.

Outcomes

- Number and percent of program youth exhibiting a decrease in anti-social behavior
- Number and percent of program youth completing program requirements
- Number and percent of program youth satisfied with the program
- Number and percent of program staff with increased knowledge of program area

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

C.G.S. Section 4-67x (g)

(g) (1) On or before 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 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 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.
