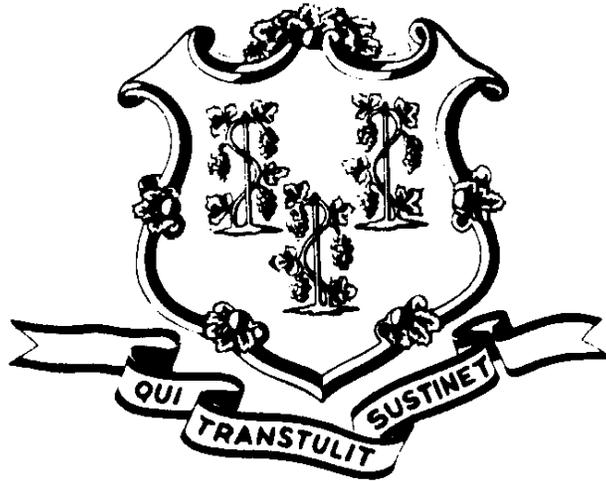


STATE OF CONNECTICUT
AGENCY PREVENTION REPORT



A REPORT TO THE
CHILD POVERTY AND PREVENTION
COUNCIL

November 2011

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NOVEMBER 2011

Table of Contents

I.	State Agency Prevention Reports.....	2
	A. Program Summary.....	3
	B. Department of Children and Families.....	8
	C. Department of Developmental Services.....	14
	D. Department of Education.....	18
	E. Department of Labor.....	34
	F. Department of Mental Health and Addiction Services.....	36
	G. Department of Public Health.....	39
	H. Department of Social Services.....	53
	I. Judicial Branch Court Support Division.....	60
	J. Office of Policy and Management	65
II.	Appendix	
	C.G.S. Section 4-67x (g).....	67

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 sixth 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 2010-2011.

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) 2011, these agencies expended \$293,354,191 to administer 40 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	FY11 Funding	Service Level	Description
DCF/Head Start Partnership	No cost	8,728 children (0-5 yrs old); 44 pregnant women; 14 DCF area offices; 75 DCF staff and 100 Head Start staff	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	\$2,347,995	3,035 children and 1,192 teachers	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 program \$90,000 evaluation	434 children and 73 adults	Funds six agencies to provide positive youth development and family strengthening programs.
Shaken Baby Prevention and Safe Sleep Public Awareness Campaign	\$500	Over 100 private and state leaders	Support public awareness strategies about the dangers of shaken baby syndrome.
Youth Suicide Prevention	\$ 41,500	1,090 individuals trained	Statewide awareness campaigns and training.
Total	\$ 3,559,483		

Department of Developmental Services			
Program	FY 11 Funding	Service Level	Description
Birth to Three	\$50,287,770	9,468 children and families	Early intervention services to all infants and toddlers who have developmental delays or disabilities.
Family Support Services	\$ 5,314,883	1,328 individuals and children-Respite Centers, and 813 individuals and children - Family Support Services	Services, resources and other forms of assistance to help families raise their children who have intellectual disabilities.
Total	\$ 55,602,653		

Department of Education			
Program	FY11 Funding	Service Level	Description
Early Childhood Program (School Readiness)	\$74,820,544	10,430 children in priority and competitive school readiness programs	Expands and enhance access to and availability of school readiness and child-day care programs.
Even Start Family Literacy	\$479,919	61 even start families	Intensive family literacy services to low-income parents and children.
Total	\$75,300,463		

Department of Labor			
Program	FY 11 Funding	Service Level	Description
Jobs First Employment Services	\$17,557,963	16,490 annual caseload	Provides employment services to families in receipt of time- limited state cash assistance.
Youth Employment Program	\$3,500,000	1,853 youth	Provides employment services for youth aged 14 through 24.
Total	\$21,057,963		

Department of Mental Health and Addiction Services			
Program	FY 11 Funding	Service Level	Description
Partnership for Success	\$2,300,000	95,408 clients served by PFS coalition, including 37,077 individuals between 5 and 17 years old.	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.
Tobacco Prevention and Enforcement	\$100,000	2,101 retail inspections and 65,563 audio and printed material	Enforcement and strategies to reduce underage tobacco use.
Total	\$ 2,400,000		

Department of Public Health			
Program	FY11 Funding	Service Level	Description
Asthma Program: Pediatric Easy Breathing Program	\$500,000	4,689 children surveyed and 1,078 or 23% with asthma	A professional education program that trains pediatric providers to administer a validated survey to determine whether a child has asthma.
Child Day Care Licensing	\$4,869,368	112,506 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	298,268 clients	Provides comprehensive, community-based, primary and preventive health care.
Family Planning	\$1,073,559	31,466 people with reproductive health services over 54,000 visits, conducted outreach and education to 1,911 people, provided educational presentations to 1,231 at-risk teens and 230 incarcerated and/or women in domestic violence shelters and distributed 400,000 free condoms.	Provides preventive and primary reproductive health care through health care services, information, and education to low-income women of reproductive age.
Immunization Program	\$43,995,538	79% of the state's children aged 2	Prevent disease, disability and death from vaccine preventable diseases in infants, children adolescents and adults.
Injury Prevention - Childhood Motor Vehicle	\$30,000	250 parents/caregivers and 693 children	Child passenger safety education and child booster seats provided to parents and caregivers.
Intentional Youth Violence	\$69,167	6,303 youth	Raises awareness, increase knowledge and changes manageable behaviors.
Lead Poisoning Prevention and Control	\$3,085,246	245,428 children	Prevents lead poisoning and promotes wellness through primary and secondary prevention activities.
Newborn Laboratory Screening and Tracking	\$1,858,366	39,585 infants screened	Screening for inborn genetic disorders which have the potential for severe health consequences.
Nutrition, Physical, Activity and Obesity	\$764,342	105,000 children and families –SNAP-Ed; 12,660 Preventive Health Services	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.
Oral Health-Home by One	\$160,000	25,000 children	Builds 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.

Rape Crisis and Prevention Services	\$ 1,064,978	19,029 children, youth, adolescents and young adults; 48 professional training offered to 923 professionals; 2,570 primary victims and 1,207 secondary victims served.	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	\$2,247,399	10,384 individuals	Provides local cessation and prevention programs.
Special Supplemental Nutrition Program for Women, Infant and Children	\$48,078,732	13,722 infants, 30,166 children and 11,789 women	Provides nutrition and breastfeeding education, supplemental food, and referrals for health and social services to eligible women, infants and children.
Total	\$112,899,607		

Department of Social Services			
Program	FY 11 Funding	Service Level	Description
Family Development Training and Credentialing Program	\$40,000	45 students received credentials.	Training human services staff to better engage and support families in prevention efforts.
Family Empowerment Initiative	\$200,000	690 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	217 families	Provides intensive services to families whose children are at risk of school failure.
Healthy Start	\$1,600,000	5,103 mothers	Ensures maternal and child health outcomes through enrollment in Husky.
Help Me Grow	\$380,000	2,401 children and families and 2,588 families through the Ages and Stages Child Monitoring program	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	3,117 grants to 1,201 children and 1,911 adults	Probate court administered program awards small grants to aid children living with relatives who are court appointed guardians.
Nurturing Families Network	\$10,389,000	1,950 families – intensive home visits 500 families-parenting groups, 5,868 screened and connection services to 1,820 individuals.	Provides intensive home visits; nurturing parenting groups; nurturing connection; home visits tailored to fathers; and home cognitive behavioral therapy.
Shaken Baby Syndrome	\$ 20,000	1,230 parents	Provides education programs on this topic to parents with young children.
Fatherhood Initiative	\$1,195,000	844 participants	Outreach and awareness education and training for parents related to parenting, healthy relationships and healthy marriages.
Teen Pregnancy Prevention	\$ 1,936,074	690 participants	Prevents teen pregnancy and welfare dependence through awareness education and support services.
Total	\$ 17,740,074		

Judicial Branch Court Support Services			
Program	FY 11 Funding	Service Level	Description
Educational Support Services	\$657,600	346 participants	Supports families to ensure that children's educational needs are identified and free and appropriate educational services are accessible.
Family Support Centers	\$3,372,805	1,117 participants	A multi-service "one-stop" service for children and families referred to juvenile court.
Total	\$ 4,030,405		

Office of Policy and Management			
Program	FY 11 Funding	Service Level	Description
Title V Delinquency Prevention Program	No funding for FY 2010-2011	N/A	Provides grants to cities and towns for delinquency prevention and early intervention projects.
Governor's Urban Youth Violence Prevention	\$763,544	1,286 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	\$763,544		

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 tell us that the earlier interventions are introduced into children’s lives the greater the chance for positive results now and later. National research studies shows 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 combine 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. DCF 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.

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. The partnership has expanded and now includes Early Childhood Consultation Partnership, DCF Supportive Housing and Child FIRST.

Number Served: 8,728 children (0-5 yr); 44 pregnant women; 14 DCF area offices; 75 DCF staff; 100 Head Start staff.

Program Cost: FY 2010 -2011: No cost.

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: 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 15,466 children and over 5,428 teachers and assistant teachers within an estimated 832 (nearly 67%) of Connecticut's licensed early care or education centers. In 2010-2011, 3,035 children and 1,192 teachers were served.

Program Cost: FY 2010-2011: \$2,347,995

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 health
- 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. ECCP is now an evidence –based effective practice and nationally recognized as an evidence-based model for other states to follow.

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 2010 – 2011: \$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: 434 children and 73 adults

Program Cost: FY 2010-2011: Programming \$558,975; Evaluation \$90,000

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 and SAFE SLEEP PUBLIC AWARENESS CAMPAIGN: A statewide collaborative mission was expanded to address shaken baby prevention and promote public awareness regarding safe sleep for infants and young children. The Massachusetts Children's Trust Funds conducted several trainings of trainers on the curriculum they developed, Babies Cry, Have a Plan. This curriculum is in the process of being incorporated in programming with partners of the Fatherhood Initiative, the young adult programs in DMHAS, and the DCF facilities.

Number Served: Over 1000 leaders from private sector and state agencies attended a Symposium on Safe Sleep.

Program Cost: FY 2010-2011: DCF- \$500. However, the Symposium would not be possible without the financial contributions of the Department of Social Services and the Department of Public Health.

Performance-Based Standards: This is a statewide collaborative and currently does not have any contracts.

Performance-Based Outcomes: An increased awareness of the dangers of shaking a baby among caregivers, particularly male caregivers. An increased knowledge of the current research on safe sleep practices among community based providers and state agencies. Over 100 leaders from the private sector and state agencies attended a Symposium on Safe Sleep. The Connecticut Safe Sleep Committee, now known as KISS (Keep Infants Safe and Secure) developed the symposium. National and state experts presented and the participants gave input to assist in the development of statewide public awareness campaign regarding this issue

Performance-Based Vendor Accountability: An evaluation component was conducted.

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: 1,090 individuals trained

Program Cost: FY 2010-2011: \$41,500

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) provides services and support to more than 15,600 individuals who have a diagnosis of intellectual disability in Connecticut including 2,592 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 181 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 intellectual disability. 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 help line exists in each of the three DDS regions 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 intellectual disability or autism spectrum disorder and will likely require lifetime services. While intellectual disability or autism spectrum disorder 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 (DDS) 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 2011 8,603 referrals were accepted for evaluation. 9,468 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 on children born in 2000 through 2007, shows that the Birth to Three System has consistently served 10%-11% of children in each birth cohort. Data on those children born in 2007 shows that 1 out of every 95 children born that year received autism services sometime before their third birthday.

Program Cost: FY 2010 -2011: \$50,287,770

In addition to state and federal funding, the state netted \$1,090,272 from parent fees and \$3,986,381 from commercial insurance in FY 11. (Medicaid billing resulted in \$9,651,913 federal reimbursement for the state's general fund).

Performance-Based Standards: There is a single statewide point of access, which is easily marketed to health care providers and other 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 shortly before the child turns three, if the children have not already been referred to the districts. Parents are encouraged to refer their children no later than age 2 ½.

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. Connecticut’s Annual Performance Report for IDEA Part C has resulted in a determination of “meets requirements” for the past five consecutive years.

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. Twice 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 accountability processes are detailed in the Birth to Three Quality Assurance Manual on www.birth23.org under “Publications”.

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 intellectual disability 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 1,328 individuals statewide in FY 11, including 346 children. During FY 11, DDS family support workers provided services to more than 813 individuals statewide, including 293 children.

Program Cost: FY – 2010-2011: \$5,314,883

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 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.

Connecticut State Department of Education

- **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

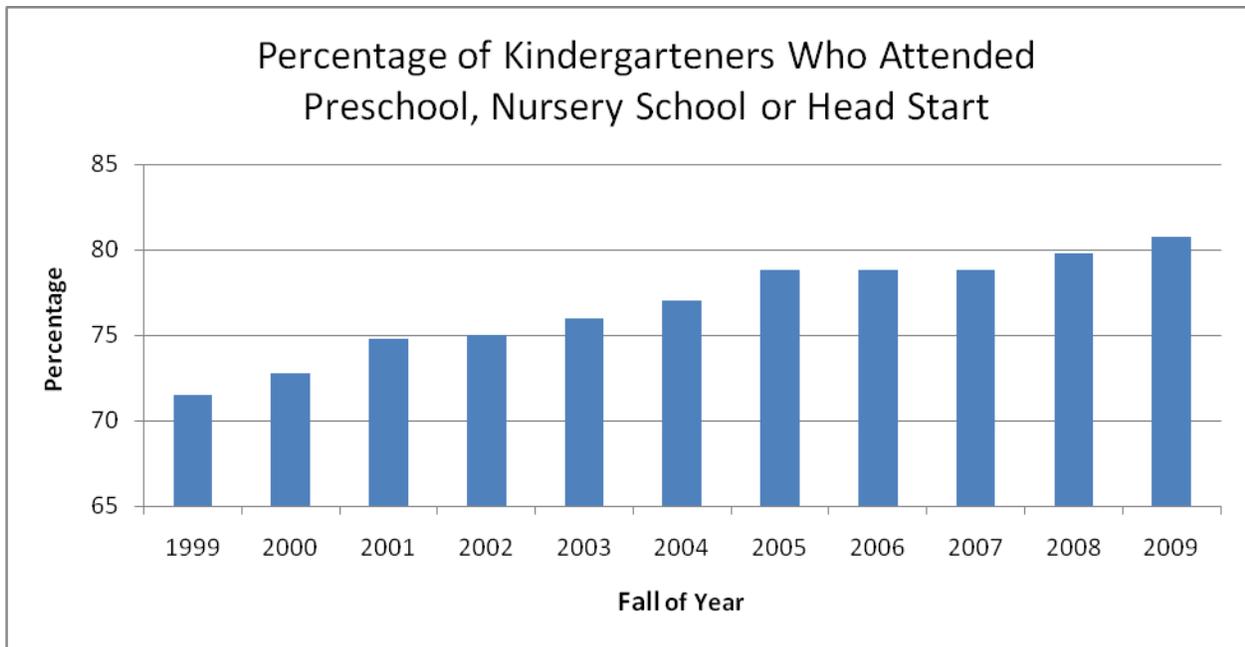
¹ *The Connecticut Framework: K-12 Curricular Goals and Standards has been modified through adoption of national standards and is now referred to as the Connecticut Common Core State Standards (CCSS).*

- 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 Connecticut State Department of Education (CSDE), 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 10.5 percentage points from 1998 to 2005, the percentage of kindergarteners with prekindergarten experience has remained stable at 80 percent for the last five 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;
 - 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;

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 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 CSDE, nor the local district partners. Despite these challenges, on July 7, 2010, with a unanimous vote, the State Board of Education adopted new national academic standards, known as the Common Core State Standards (CCSS) in English language arts and mathematics that will establish what Connecticut’s public school students should know and be able to do as they progress through Grades K–12. The newly adopted national standards will provide guidance to local curriculum committees as they develop grade-by-grade and course level expectations and as they engage in secondary school reform. The following indicators will serve as measures of success:

- district adoption and implementation of the Common Core State Standards and Assessments which include full range of assessment options available, such as 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 TEAM 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.

This year’s test results show that the positive trends of improved student achievement continue. 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 2011. 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 and 8. The increase in mathematics performance at the goal level was particular strong in Grades 5 through 8 and in reading in Grades 6 and 7. Writing performance was relatively flat at the goal level over the course of generation 4 CMT and science increased modestly in Grades 5 and 8.

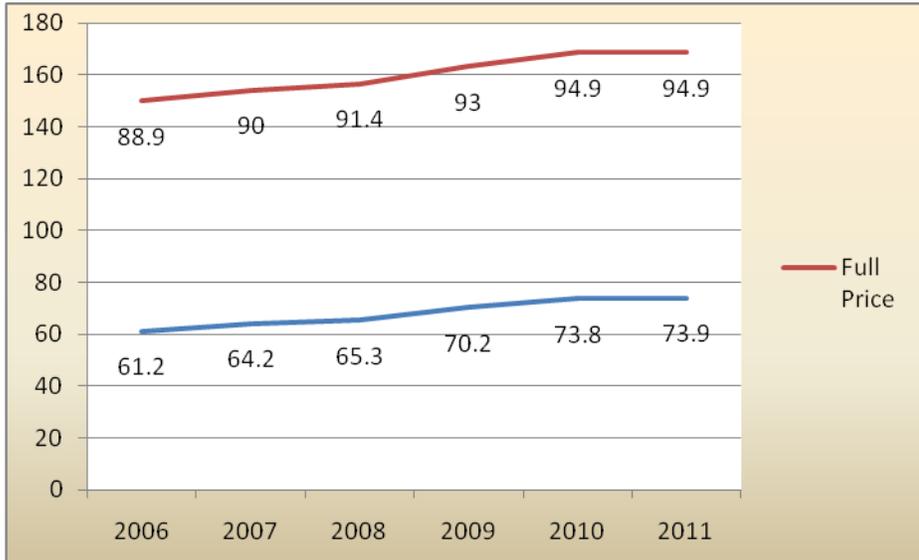
**CMT Performance, by Year and Grade, Percent At/Above Proficient
and Percent At/Above Goal 2006--2011**

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		
3	2011	63.3	84.3	58.4	74.0	61.1	81.1		
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		
4	2011	67.3	85.2	62.5	74.7	65.5	85.4		
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
5	2011	72.7	87.6	61.4	75.1	66.8	88.0	60.2	82.4
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		
6	2011	71.6	88.5	76.0	86.5	65.3	86.1		
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		
7	2011	68.7	87.2	77.8	85.7	58.9	79.8		
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
8	2011	66.8	86.0	74.7	83.4	64.8	81.6	63.3	75.9

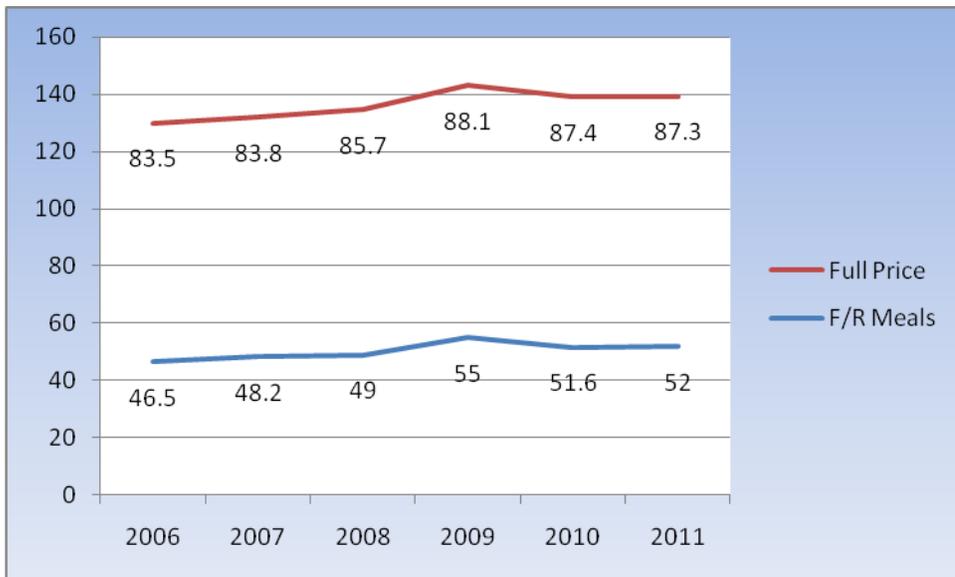
Eligibility for Free/Reduced Priced Meal Subgroup: While the 2010 CMT results demonstrated improvement over the base year for all students in all content areas except writing, students who were eligible to receive free/reduced priced meals posted much higher gains than their peers who pay full price, 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



For additional comparisons of students eligible for free and reduced price meals, along with other student subgroups, please see the News Bulletin from July 13, 2011 at <http://www.sde.ct.gov/sde/lib/sde/pdf/pressroom/cmt2010pressrelease.pdf>.

Connecticut Academic Performance Test (CAPT) – Grade 10

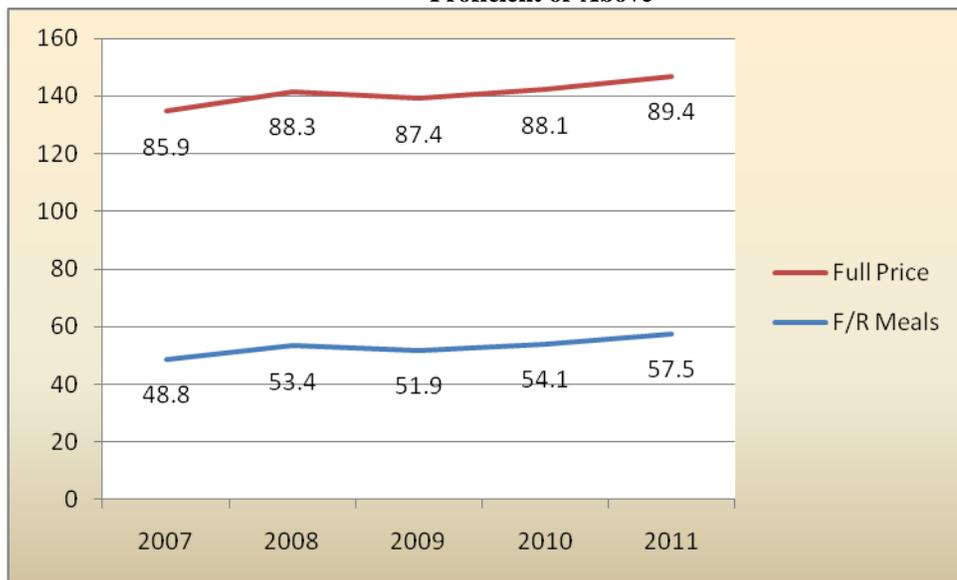
Grade 10 students take the CAPT in the spring of each year. This test assesses student performance in mathematics, science, reading and writing. The CAPT is aligned with Connecticut’s curriculum frameworks and provides information on how well students are performing with respect to the critical skills 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- 2011 CAPT Performance for Percent At/Above Proficient and At/Above Goal

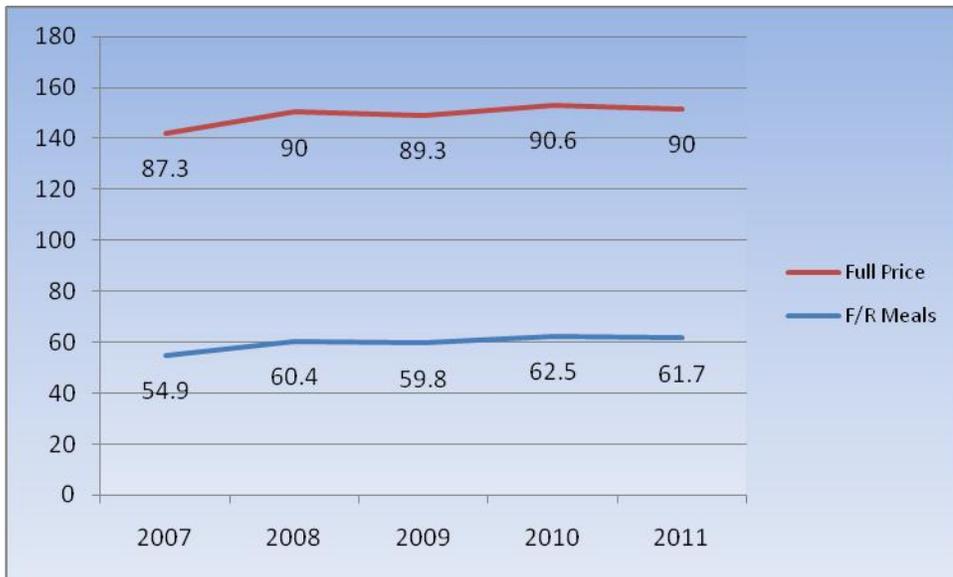
Year	Mathematics		Science		Reading Across the Disciplines		Writing Across the Disciplines	
	% at/above Proficient	% at/above Goal	% at/above Proficient	% at/above Goal	% at/above Proficient	% at/above Goal	% at/above Proficient	% at/above Goal
2007	77.3	45.3	81.4	44.5	79.7	45.5	82.3	53.0
2008	79.7	50.2	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
2011	80.3	49.6	81.9	44.8	88.6	61.3	81.7	47.2

Students who receive free or reduced-priced meals have made steady gains in all four content areas compared to the baseline year of 2007. For example, the percentage of these students reaching Proficient or above has increased by 8.7 percentage points in mathematics and 6.8 percentage points in reading over the last five years. The graphs below show the trends in the areas of mathematics and reading over the past four years for students who receive free or reduced-priced meals compared to student not eligible for free or reduced price meals.

**CAPT Math
Grade 10
Free Reduce Meals (F/R Meals) / Full Price
Proficient or Above**



CAPT Math
Grade 10
Free Reduce Meals (F/R Meals) / Full Price
Proficient or Above



Results of the 2011 Connecticut Academic Performance Test (CAPT) show Grade 10 students generally improved their performance when compared to 2010 at the Proficient and Goal levels across content areas except for Reading. 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 12 2011 News Bulletin online at <http://www.sde.ct.gov/sde/lib/sde/pdf/pressroom/2010captpressrelease.pdf>.

Long-Term Agency Goal #3:

High school reform, to ensure 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. Although the current economic climate has limited the availability of the material and staffing supports necessary to accomplish the aforementioned strategies, there has been legislative support in pushing High School Reform in Connecticut. 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 Graduation Rate	Still Enrolled	Non-completers	Other
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 CSDE 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 10,430 children in priority and competitive school readiness programs.

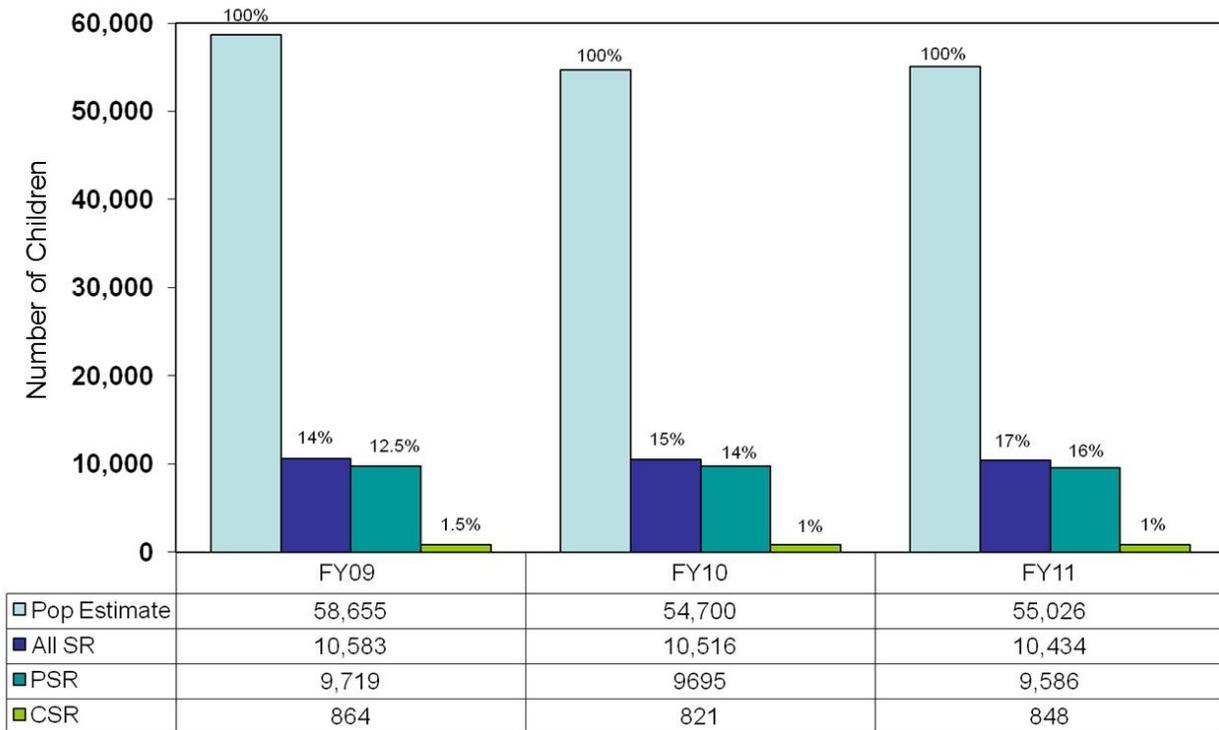
Program Cost FY 2010-2011: \$74,820,544

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.

Performance Measure 1: Access to Quality Programs in Eligible School Readiness Municipalities

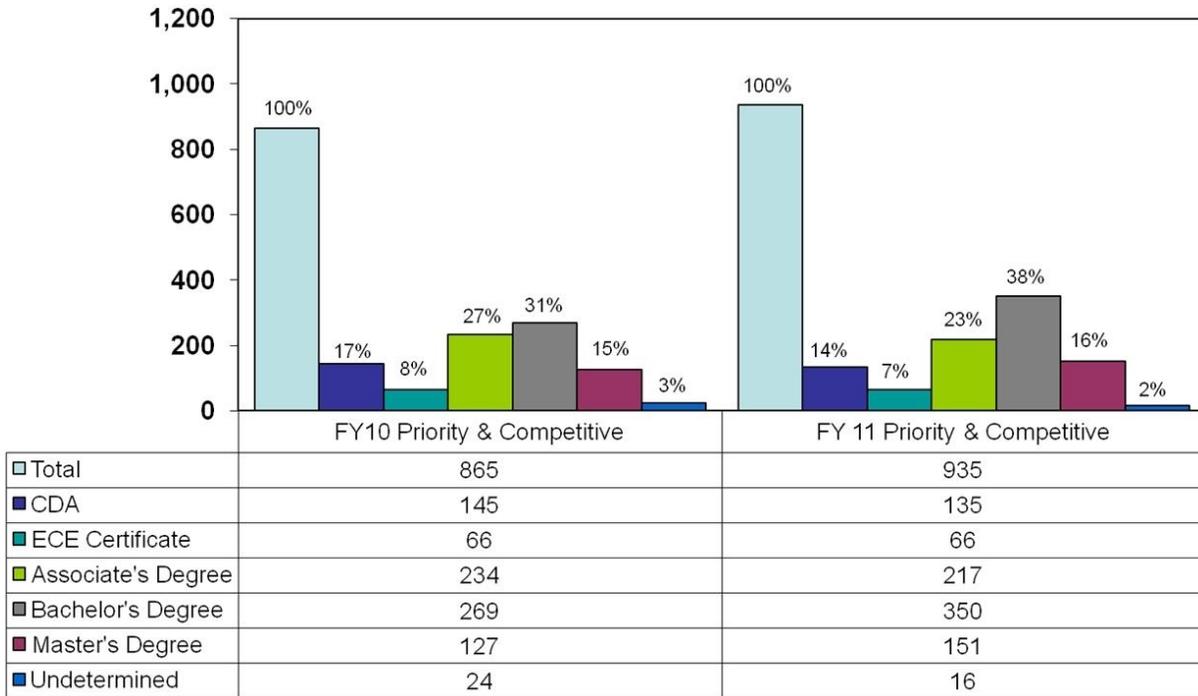


This graph shows a comparison of the School Readiness-funded space capacity over the past three years in relation to the preschool population estimates, for eligible 3-4 year olds, in the 64 School Readiness Municipalities. The School Readiness municipalities show a slight decrease by .6 percent in capacity 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.

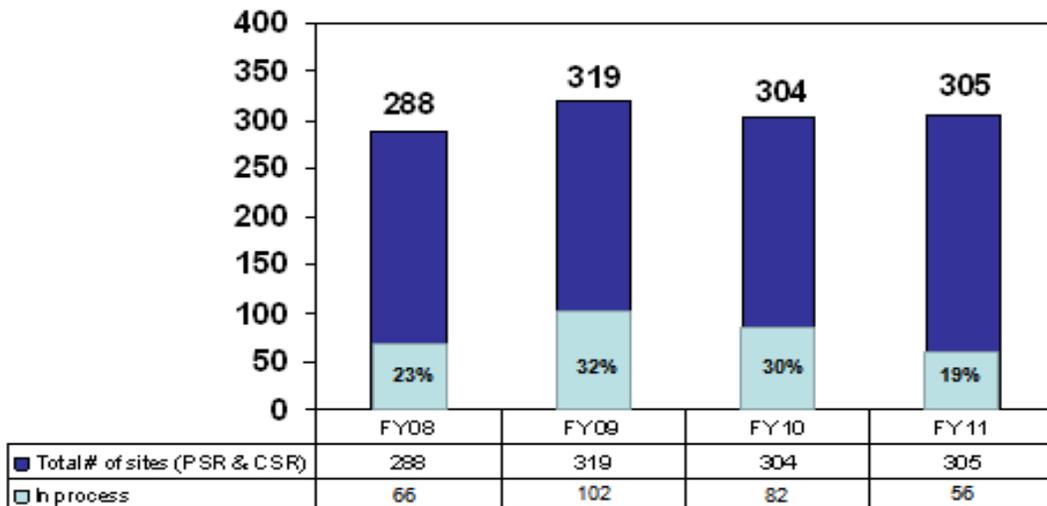
Performance Measure 2: Progress of Teacher Qualifications Toward Baccalaureate Degree in School Readiness Programs



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 and FY 11 data are available for this report. Since the Registry is unable to report teacher data at the classroom level, the CSDE further disaggregated teacher information from the Registry to provide an accurate picture, matching teacher to classroom. The CSDE found 305 School Readiness sites with 935 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 61 Even Start families (65 adults and 70 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 2010-2011: \$ 479,919

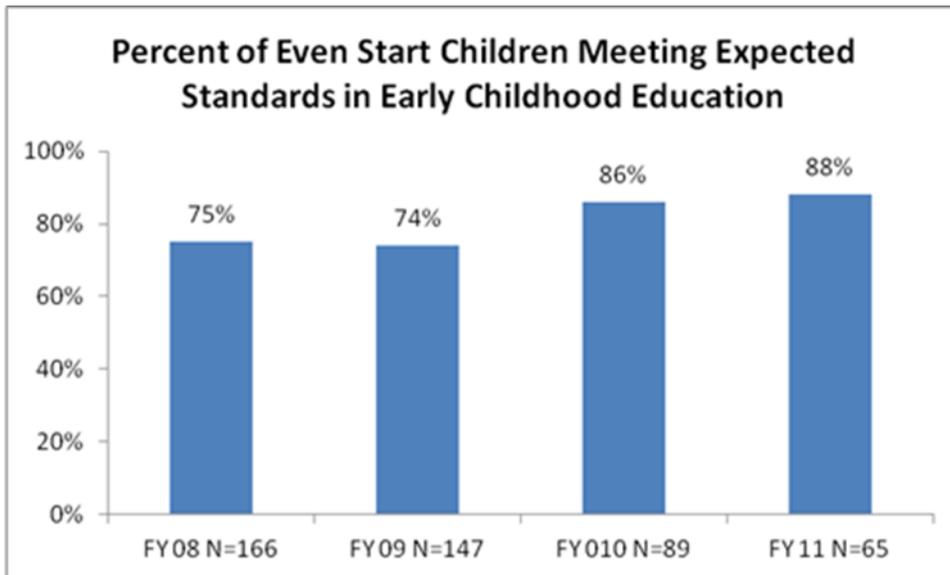
Performance Based Standards:

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 \$479,919 in 2009-11

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

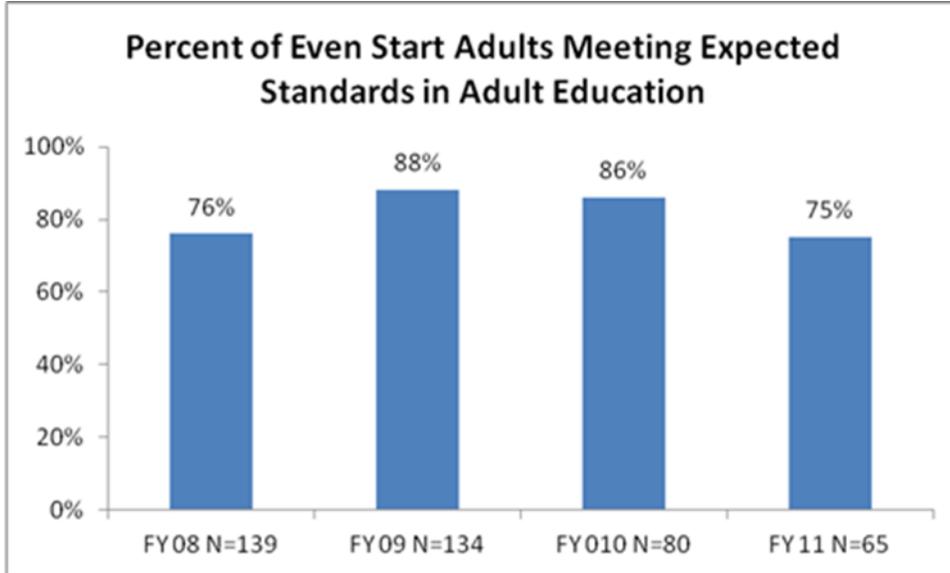


Even Start program performance data over four years show that on average, 81percent of the children met or exceeded standards in reading readiness for their age group (birth to 6). Children participate an average of 64 hours per month in early childhood classrooms, interactive literacy activities and during home based instruction. 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.ⁱ

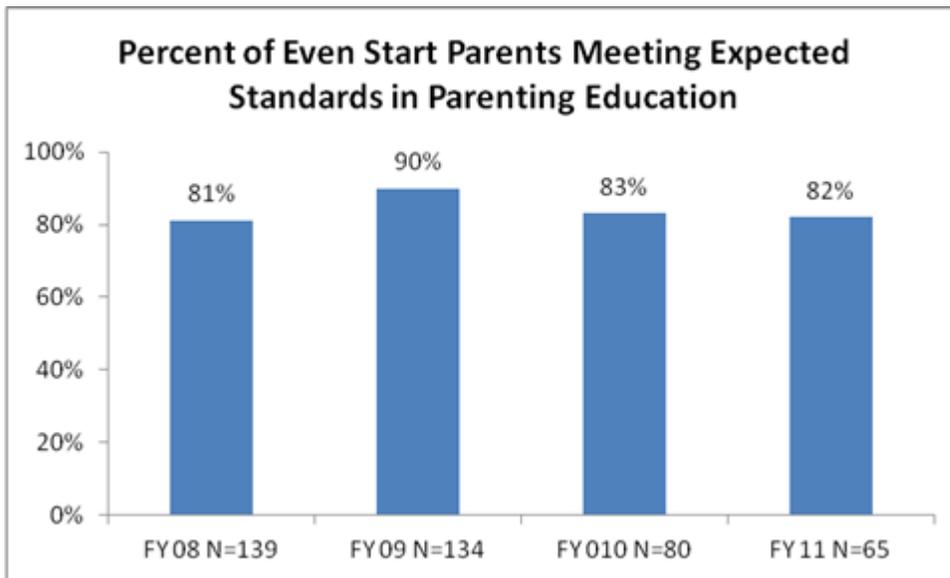
Performance Measure 2: Percent of Even Start parents showing significant learning gains or earning a high school diploma.



Over the past four years, adults in Even Start have consistently made significant gains and on average, 81% of the adults have met one or more of the performance measures in adult education. Even Start adults average 36 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, on average, 84 percent of the parents were observed to learn and apply parenting skills related to family literacy. Parents participate in parenting education classes, interactive literacy activities (with their child), and home visits 15 hours per month. Evaluation in FY 11 focused on the home based instruction component. Results show that home visitors demonstrate planned and purposeful lessons and activities in book reading, language development, and reading readiness. Parents are encouraged to work directly with the child while the home-based visitor guides the parent. Home based instruction aligns with parenting education classes and with what children are learning in their preschool/ compulsory school classrooms.

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, monthly attendance of each child and adults. 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 analysis of the National Even Start Evaluations. Literacy Harvest/Family Literacy Forum, 12, 33-38. New York: Literacy Assistance Center.

¹ Source: Connecticut Adult Reporting System (CARS)

Department of Labor

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

Long-Term Agency Goals: The Department of 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: 16,490 annual caseload

Program Cost: FY: 2010-2011 \$17,557,963

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: SFY 11 complete employment data will not be available until January 2012. SFY 10 data is: total caseload (11,713 based on 9 months instead of 12 months due to budget crisis), 3,985 or 34% of the caseload obtained employment; 3,254 or 28% of the caseload earned wages above temporary family assistance benefits; and 1,961 or 17% 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 provides employment opportunities, work-readiness training and supportive services. In some instances, academic remediation is also provided. In FY 10-11, state funds were leveraged with federal funds resulting in employment opportunities for an additional 4,499 youth.

Number Served: 1,853 youth

Program Cost: FY – 2010-2011: \$3,500,000

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

Performance-Based Outcomes: FY 2010 – 1,853 youth s served and 1,661 successful completions.

Performance-Based Vendor Accountability: Workforce Investment Boards (WIBs) solicit employers and worksites either directly or through subcontracts with municipalities and community-based organizations. WIBs ensure employers comply with applicable wage and workplace standards. The Department of Labor monitors program operations for proper and timely payment of wages, to ensure funds are spent primarily on wages, and program objectives are met.

- **Partnership for Success**
- **Tobacco Prevention and Enforcement**

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 and community readiness to implement prevention programs

Population Outcomes

- Reduction in the drug/alcohol use
- Reduction in suicidal behavior among youth and young adults
- 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 11.3% in 2011 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.

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 target populations are: 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: 95,408 clients were served by the PFS coalition between July 2010 and June 30, 2011. This includes 37,077 individuals between 5 and 17 years old.

Program Cost: FY –2010-2011 \$ 2,300,000

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.

TOBACCO PREVENTION and ENFORCEMENT: 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 2010-2011, 2101 retail inspections were completed and 65,563 audio and print materials were developed and distributed to tobacco merchants.

Program Cost: FY 2010-2011: \$ 100,000

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 – Childhood Motor Vehicle**
- **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**
- **Special Supplemental Nutrition Program for 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 4,689 children surveyed and 1,078 or 23% had asthma

Program Cost: FY 2010-2011: \$500,000

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. The contractor 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. The contractor trained 10 new practices in Easy Breathing and retrained 6 other practices. There were 44 private practices and 14 clinics that participated in Easy Breathing. None of the practices met the weekly goal of 25 patients per week being surveyed.

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 was reported as follows: for patients with persistent asthma, 97% were prescribed inhaled corticosteroids. This is an excellent measure of adherence to NAEPP treatment guidelines. In addition, 79% received a written treatment plan per the NAEPP 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 1,548 Child Day Care Centers and Group Day Care Homes, and 2,693 Family Day Care Homes, and is committed to promoting the health, safety, and welfare of Connecticut's children in these licensed facilities.

Number Served: 112,506 Licensed Capacity.*

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

Program Cost FY 2010-2011: \$ 4,869,368

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:

- 15 technical assistance activities conducted from 7/1/10-6/30/11 served 182 child care providers and applicants.
- 7/1/10-6/30/11, 896 compliance –monitoring inspections of family day care homes were required, 1294 inspections were completed; 782 compliance-monitoring inspections of child day care centers and group day care homes were required, 1275 inspections were completed.
- From 7/1/10-6/30/11 there were 1044 complaint investigation inspections
- From 7/1/10-6/30/11, 80 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 Connecticut. 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 the state. 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. The remaining community health center (CHC), referred to as an FQHC “look-alike,” meets all the requirements to be considered a FQHC, but does not receive Section 330 funding.

Specifically, CHCs are the medical home and family physician for many of the poor, underserved, vulnerable, and those at risk for poor health status who live in communities throughout Connecticut. They offer comprehensive, community-based, primary and preventative health care that includes: pediatric, adolescent, adult and geriatric health care; prenatal and postpartum care; supportive services, such as translation, transportation, case management, health education, social services and culturally sensitive healthcare. Depending on availability, many offer dental care; mental health and addiction services; school based health care; and outreach programs. These services are available to individuals regardless of their ability to pay.

Number Served: 298,268. 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 what is utilized for most reporting.

Program Cost FY 2010-2011: \$5,102,912

Performance-Based Standards: All 13 CHCs submit quarterly and annual reports to DPH. The UDS report, which section 330 funded health centers submit annually to the federal government, is utilized for data for 12 of the 13 CHC’s. The “look-alike” utilizes a modified form of reporting to the federal government that is also used 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.
- At least 80% of children served between the ages of 24 and 35 months will be immunized.
- At least 80% of adolescents will receive a behavioral risk assessment for substance abuse and sexual activity, and a nutrition assessment.
- At least 80% of men and women between the ages of 20 and 64 years will receive a cardiovascular risk assessment, and appropriate cancer screenings.
- At least 60% of adults aged 65 and older will receive a cardiovascular and cerebrovascular risk assessment, cancer screenings, a behavioral health risk and a nutrition assessment, and a flu shot.

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 Community Health Center Association of Connecticut (CHCACT).

FAMILY PLANNING: Twelve Family Planning Centers are funded by the Connecticut Department of Public Health (DPH) through a contract with Planned Parenthood of Southern New England, Inc. The purpose is to provide a Family Planning Program for primary prevention through comprehensive reproductive health care services in those areas of

Connecticut with a high concentration of low-income women of reproductive age and with a high rate of teen pregnancy. The health care services include clinic services, cancer screenings, outreach activities, health education programs, pregnancy testing, distribution of condoms, HIV counseling and testing, and referrals and follow-up.

Number served: The program provided 31,466 people with reproductive health services over 54,000 visits, conducted outreach and education to 1,911 people, provided educational presentations to 1,231 at-risk teens and 230 incarcerated and/or women in domestic violence shelters and distributed 400,000 free condoms.

Program Cost FY 2010-2011: \$1,073,559

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-nine 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, 96% of female patients receiving a preventive reproductive health exam received a Pap test (Goal 90%); 99% of female patients with a reproductive health exam received a clinical breast exam; 80% of female patients with a reproductive health exam received screening for Chlamydia trachomatis; and 86% of clients with a reproductive health exam received AIDS education, non-specific behavioral counseling and, upon request, information on testing sites (goal of 80%).

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: 79%
- Number of patients receiving a comprehensive annual preventive reproductive health exam during this reporting period-676
- Number of female patients with a preventive reproductive health exam who received a Pap test. Goal: 90% Actual: 96%
- 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-532
- Number of female patients receiving a preventive reproductive health exam during this reporting period who received a screening for Chlamydia trachomatis and gonorrhea. Goal: 85% -Actual: 80% 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: 86%
- 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: 96.8%

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 multiple related 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 2010 National Immunization Survey (NIS), Connecticut reported statistically significant increases in several individual vaccines (1+MMR, 3+Hib, Hepatitis B birth dose, 3+rotavirus), and the 4:3:1:3:3:1:4 vaccine series. 79% 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 the Haemophilus influenzae type b (Hib) vaccine. The coverage for MMR increased 4.1 percentage points from 93.7% \pm 3.3 in 2009 to 97.8% \pm 1.5 in 2010. Larger increases were observed for the full series of Hib (24.2 percentage points), Hepatitis B birth dose (13.2 percentage points), and rotavirus vaccines (15.4 percentage points). Coverage for the 4:3:1:3:3:1:4 series that includes the full series of Hib vaccine increased 23.5 percentage points from 34.4% \pm 9.6 in 2009 to 57.9% \pm 8.0 in 2010. These increases were statistically significant (S). Coverage for the 4:3:1:3:3:1:4 vaccine series, referred to as the modified vaccine series in the upcoming MMWR release, increased 3.4 percentage points, but this increase was not statistically significant (NS). The coverage rates for the individual antigens are all above the national rates. The 2010 NIS survey included children born January 2007 through July 2009.

As a reminder, coverage estimates for Hib are based on a more accurate measure of Hib coverage that considers the vaccine product type and the number of recommended doses. The Hib shortage, temporary suspension of the Hib booster dose at 12-15 months, and this new method for measuring Hib coverage had a major effect on coverage estimates in most states in 2010 compared to 2009.

Program Cost FY 2009-2010: \$43,995,538

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 2010 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 79%. Based on this information, CT was ranked 6th among all 50 states with highest immunization coverage rates.

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 – Childhood Motor Vehicle Injury Prevention:

Child passenger safety education and child safety and booster seats are provided to parent/caregivers with a special emphasis on low-income families. The geographic service area is statewide. The Maternal and Child Health Block Grant funds the services through a contract with Safe Kids Connecticut.

Number served: Through Maternal and Child Health Block Grant funding, the program provided 18 child passenger safety workshops, serving 250 parents/caregivers and 693 children during SFY2010.

Program Cost FY 2010-2011: \$30,000

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/caregivers aware of correct use of 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 provider 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 on increasing knowledge and changing behaviors that are manageable within the limited resources available to the programs. Program goals include increasing awareness of issues associated with youth violence; recognizing and appropriately dealing 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: 6,303

Program Cost FY 2010-2011: \$69,167

Performance-Based Standards: Youth violence prevention program participants are able to identify nonviolent alternatives to fighting.

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 primary and secondary prevention activities including: education, early detection and disease management, environmental interventions, compliance monitoring and regulatory response, and a wide range of program activities that relate to lead poisoning prevention and in particular, childhood lead poisoning prevention.

Number Served: 245,428 children under the age of six years old (disease surveillance system data).

Program Cost FY 2010-2011: \$3,085,246

Performance-Based Standards:

- Education of medical providers on the need for the screening of children at ages 1 and 2 for lead poisoning.
- 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 10µg/dL.
- Decrease the rate of children under six years old residing in Connecticut with blood lead levels of 10 µg/dL or above to less than 0.9%.
- Perform comprehensive lead inspection in homes where children are lead poisoned.
- Ensure lead abatement work is completed according to state statutes and regulations.

Performance-Based Outcomes:

- The screening rates of children will increase.

- The prevalence of children with elevated blood lead levels greater than or equal to 10µg/dL will decrease.
- The total number of elevated blood lead level cases greater than or equal to 10µg/dL will decrease.
- The level of awareness about lead poisoning will increase.
- The number of children (school age and younger) identified that may need special services due to lead poisoning will increase.
- The number of painting and home improvement projects that are done in a lead safe manner will increase.

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: CT General 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.”

As of October 1, 2010 Cystic Fibrosis testing was mandated however; testing is performed at Yale and UCHC. The Newborn Screening Program consists of three components: Testing, Tracking, and Treatment. Specimens are collected at birthing facilities, by midwives and primary care providers and sent to the 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: confirmation testing, counseling, education, treatment, and comprehensive follow-up services.

The Newborn Screening Tracking Unit coordinates and provides educational programs, guidelines, protocols, materials, technical assistance for birthing facilities staff, primary care providers, and health professionals and provides telephone technical assistance for families, and the general public.

The aim of this program is to screen all babies born in Connecticut prior to hospital discharge or within the first 4 days of life and the goal 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.

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 calendar year 2010, there were 38,519 occurrent births in the state. The Public Health Laboratory screened 39,585 1st blood specimens. Babies confirmed with diseases, continue to receive treatment and follow-up genetic and nutritional counseling services at one of the State Regional Treatment Centers.

Program Cost FY 2010-2011: \$1,858,366

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 Public Health Laboratory screened 39,585 1st specimens in 2010. Of the 38,519 Connecticut births in 2010, 98.8% received newborn screening (NBS). A total of 2,628 initial suspect positives; 1,883 suspect positive results reported and 1,244 babies were referred to state regional treatment centers and/or primary care providers for further testing and follow-up. Of these, 99 newborns were confirmed with diseases; 38 carriers confirmed; and 933 hemoglobin traits identified.
- **TRACKING:** Assure that 100% of infants who screen positive with metabolic & genetic condition(s) receive follow-up to definitive diagnosis and clinical management.

- All 2,628 suspect positive results were reported to Regional Treatment Centers and/or primary care physicians for further testing and follow-up.
- There were 390 unsatisfactory NBS specimens; all but 3 were resolved (lost to follow-up) with receipt of a 2nd specimen.
- There were 7 State Waivers submitted to the lab for refusal of screening due to conflicts with religious tenets. Of these, 3 newborns had specimens obtained later by their PCP.
- There were a total of 846 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. Of the 846 missed scan specimens only 2 were lost to follow-up.
- Tracking staff provide follow-up for infants who are transfused prior to the NBS blood test until a 120-day post-transfusion specimen is collected and tested for Hemoglobinopathies and Galactosemia.
- TREATMENT: 99 of the referrals were confirmed as disease cases and 933 hemoglobin trait cases were identified. These babies continue to be followed by the treatment centers comprehensive care, education, and counseling.
- With limited funding support from the MCHBG, the UCHC Genetics Program continued to provide the Pregnancy Exposure Information Services (PEIS) toll-free telephone line. Referrals are made to UCHC Genetics for follow-up. During 2010, this line provided information to 841 pregnant women who were concerned about exposure to toxic substances during pregnancy and the possible effect(s) to their baby.

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: NPAO): 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 120 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. The program also conducts interactive classroom events for preschool children to reinforce the messages taught by teachers. Further, the program participates in statewide health fairs and community events, and supports seasonal newsletters and recipe cards; 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: SNAP-Ed (105,000 children and families)

Program Cost FY 2010-2011: SNAP-Ed \$499,028

Performance-Based Standards:

Nutrition Education:

- By September 30, 2011, 50% of Head Start/School Readiness preschoolers who participate in *Captain 5 A Day* will increase their fruit & vegetable preference by 25%.
- By September 30, 2011, 50% of Head Start/School Readiness preschoolers who participate in *Captain 5 A Day* will engage in at least 60 minutes of physical activity per week.
- By September 30, 2011, 50% of teachers who attend a *Captain 5 A Day* teacher training will plan to increase their fruit & vegetable consumption by ½ cup daily.
- By September 30, 2011, 50% of parents who attend a *Supermarket Smarts* workshop will be able to identify 3 tips to save money at the supermarket.
- By September 30, 2011, 50% of parents who attend a *Supermarket Smarts* workshop will report a willingness to prepare fruit & vegetable recipes at home.

Number Served: Preventive Health and Health Services (PHHS) Block Grant (12,660)

Program Cost FY 2010-2011: Preventive Health and Health Services (PHHS) Block Grant (\$265,314)

Reduce Excess Dietary Fats:

- By September 30, 2011, at least 50-75% of program participants can accurately identify at least three dietary practices to reduce fat intake and promote heart health.
- By September 30, 2011, at least 25-40% of program participants report, at program end, taking action to reduce dietary fat intake.

Block Grant Physical Activity:

- By September 30, 2011, at least 70-85% participants report, at program end, can correctly identify recommended levels of physical activity to promote heart health.
- By September 30, 2011, at least 60-75% the participants report, at program end, their intent to continue exercising three or more days per week, 30 minutes per day.

Policy and/or environmental changes:

- By September 30, 2011, each participating Health Department/District shall implement two to four policy and/or environmental changes to promote healthy nutrition habits.
- By September 30, 2011, each participating Health Department/District shall implement two to four policy and/or environmental changes to increase access to, or the availability of, areas in which people can engage in physical activity.

Testing of Curricula:

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

Performance-Based Outcomes:

- Six LHDs conducted 40 nutrition education programs.
- Six LHDs conducted 24 physical activity programs.
- Nine LHDs implemented 18 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 *Captain 5 A Day* “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 nutrition education materials and resources disseminated.
- 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 facilitates 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: 25,000 children

Program Cost FY 2010-2011: \$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 presented as a poster presentation at 2011 National Oral Health Conference.
- Home by One continues to collaborate with The Nurturing Family Network
- 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 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 staffs 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 is available online through CT TRAIN.
- 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.
- To date 41 dental home sites have received an orientation to the Home by One Program, partnering with the program to offer age one dental visits and accept referrals from WIC. 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 *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 the 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 Connecticut 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 buses 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 the Capitol Building in Hartford in February 2010 and continues to be displayed for one week every February in observance of “Children’s Dental Health Month.”
- The webpage for the Home by One Program has received 1,870 hits since its 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:
 - Interviewing a sample of staff in practices receiving *Home by One* training to determine impressions of changes in access to dental services.
 - Assessing 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, and Willimantic/New London.

Number Served: Between the period of July 1, 2010 and June 30, 2011, a total of 19,029 children, youth, adolescents and young adults in school settings participated in rape prevention and educational sessions. A total of 3,784 clients were served based on their town of residence, and 48 professional trainings were offered to 923 professionals. 2,570 primary victims and 1,207 secondary victims were also served during that time period.

Program Cost FY 2010-2011: \$1,064,978

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: 100%
- 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: 99.92%; 90% or more clients who request that an advocate meet them at the hospital will be met by an advocate. Goal: 90%-Actual: 99.76%
- 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: 100%

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 guidelines and recommendations put forward by the Centers for Disease Control and Prevention (CDC) in their document “Best Practices for Comprehensive Tobacco Control Programs.” This program works to address all areas in tobacco control including educating the public about the risks associated with the use of tobacco products and the hazards of exposure to secondhand smoke. Areas of focus include preventing initiation among youth and young adults, promoting quitting among all tobacco users, eliminating exposure to both second- and third-hand smoke for all residents, and identifying and eliminating tobacco-related disparities among population groups including those of low socioeconomic status, individuals with mental illness, gay/lesbian/bisexual/transgender, and pregnant women; all of whom are disproportionately affected by tobacco use.

Number served 2010-2011: Community-based tobacco use cessation and prevention programs funded during the period along with the telephone-based tobacco use cessation quitline served at least 10,384 Connecticut residents, with many of those services being targeted to individuals with low socio-economic status.

Program Cost 2010-2011: \$2,247,399

Performance-Based Standards:

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

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN INFANTS AND CHILDREN (WIC):

The Connecticut Special Supplemental Nutrition Program for Women, Infants and Children (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. 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 2010-2011: Average monthly participation: 55,677 (11,789 women, 13,722 infants and 30,166 children).

Program Cost 2010-2011: \$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:

- **Maternal Weight Gain (MWG).** Pregnant women participating in the WIC Program for a minimum of 6 months gain appropriate weight: Target: $\geq 70\%$. Current statewide average: 67.2%; range (12 WIC regions): 54.5% – 83.9%.
- **Low Birth Weight (LBW).** Incidence of low birth weight among infants whose mothers were on the WIC Program for at least 6 months during pregnancy: Target: $\leq 6\%$. Current statewide average: 6.0%; range (12 WIC regions): 2.4% – 8.6%.
- **Breastfeeding Initiation.** Infants whose mothers were enrolled in the WIC Program during pregnancy breastfeed: Target: $\geq 60\%$. Current statewide average: 65.6%; range (12 WIC regions): 48.1% – 91.2%.
- **Breastfeeding Duration.** Infants enrolled in the WIC Program breastfeed for at least 6 months: Target: $\geq 25\%$. Current statewide average: 27.0%.
- **Childhood Anemia.** Prevalence of anemia among children enrolled in the WIC Program for at least one year: Target: $\leq 9\%$. Current statewide average: 6.6%; range (12 WIC regions): 3.5% – 8.6%.

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 on a quarterly basis for their use in program planning and 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 Services' (DSS) goals are informed by relevant data secured from a variety of sources. The data that is collected facilitate the creation and implementation of programs and services that address the *root causes of poverty and the concomitants of poverty*. The Department's 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, individuals and families.
- Increase awareness about and access to preventive and curative health care for income eligible children, individuals 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 in 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, within the next 12 months 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, individuals and families.
- Enhance contractual relationships with community action agencies to ensure awareness and supportive access for clients to programs/services provided by DSS, via various community based locations.
- 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.
- Develop and implement a person-created intake and support system that optimizes access and program information for clients twenty-four hours a day seven days per week.

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, language proficiency, and gender. The Department plans to rectify this within the next 18 months.

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, individuals, 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 preventing intergenerational poverty, the concomitants of poverty, and poor health conditions.

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. Courses 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: 45 students received credentials through the FDC program in 2010

Program Cost: FY: 2010-2011: \$40,000

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 2010 Family Empowerment Initiatives provided home and group based services to roughly 690 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 2010 Family School Connection provided intensive home visiting services to 217 families.

Program Cost: FY: 2010-2011: \$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 5,103 mothers received services in 2010. The program is provided in collaboration with DPH.

Program Cost: FY: 2010-2011: \$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 2010 Help Me Grow connected 2,401 children and families to community based services. It also provided the Ages and Stages Child Monitoring program to 2,588 families.

Program Cost: FY: 2010-2011: \$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 2010 the Kinship and Respite Funds provided 3,117 grants to 1,201 children and 1,911 adults.

Program Cost: FY 2010-2011: \$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 2010 NFN served about 1,950 families in intensive home visiting and 500 families in Nurturing Parenting groups. The program screened 5,868 and provided Connections services to 1,820.

Program Cost: FY 2010-2011: \$10,389,000

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.

Shaken Baby Syndrome: Provides the *Period of Purple Crying* parent education program to parents with young children. The program works in collaboration with DCF, hospitals, health care providers, prisons and others to reach vulnerable populations.

Number served: The program was offered to 1,230 parents.

Program Cost: FY 2010-2011: \$20,000

Performance Based Standards: Use and maintain fidelity to the evidenced shaken baby prevention program.

Performance-Based Outcomes: Parent are more knowledgeable about shaken baby syndrome, the circumstances that create risk, and strategies the can sue to prevent it.

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: 844 participants

Program Cost: FY 2010-2011: \$1,195,000

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
- Collaboration with DCF to prevent the occurrence/reoccurrence of child abuse/neglect among parents referred to DCF for services.

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: 690 program participants

Program Cost FY 2010-2011: \$1,936,074

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, Youth in Crisis-YIC 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 reportedly 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. Performance measures include:

- Performance Measure 1 – Juvenile Court Intake: Intake fell 30% from 15,857 in FY 2007 to 11,140 in FY2011, even with the increase in juvenile jurisdiction to include 16-year olds beginning on January 1, 2010.
- 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 97%, as of the end of quarter three of 2011. The treatment completion rate in 2009 was 20% and has risen to 76%, as of the end of quarter three for 2011.
- 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 several 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 five years.
- Performance Measure 4 – Juveniles Committed to the Department of Children and Families: Juveniles committed to either long-term residential placement or for incarceration at the Connecticut Juvenile Training School have decreased by 62 percent over the past 12 years and by nearly 52 percent in the past seven years, from 401 juveniles committed in 2004 to 263 juveniles committed in 2010.

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. CSSD also participates in the Judicial Branch's Limited English-Proficiency and Translation of Court Documents Initiatives to assess and develop strategies to meet the needs of clients. 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 (DMC) in the Connecticut Juvenile Justice System* (May 2009), funded by the OPM Juvenile Justice Advisory Committee (JJAC). CSSD is also partnering with the Center for Children's Advocacy, Inc. and the Center for Children's Law and Policy to support local DMC reduction pilots in Hartford and Bridgeport.

Other: CSSD has implemented several strategies to support the prevention or diversion of children and youth from court referral, including a focus on increasing family engagement, decreasing school arrests, and building local partnerships. Both Detention and Probation staff are engaged in creating better partnerships with families. Detention clinicians are meeting with families of newly detained juveniles to engage the family in the child's care while in detention and to help prepare the family for working with the Court and treatment providers to support the child's success and limit further court involvement. Probation staff is being trained in parent engagement to assist officers in working with families to support them in managing at home behaviors and providing parents with alternatives to calling police during domestic disagreements. Juvenile Probation also engages in outreach efforts to better coordinate with schools to manage the in-school behaviors of court involved juveniles. In addition, CSSD recently revised the Probation Intake policy to allow probation supervisors to return any referral that does not warrant court intervention. These efforts, in addition to the expansion of the School-based Diversion Initiative highlighted below, should reduce the number of court referrals for in-school arrests, which may be better managed by local schools and service providers. 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. The LIST initiative is increasing community attention and local-state partnerships in addressing the contributing factors to juvenile delinquency.

A model intervention that holds great promise in diverting school-based arrests is the School-based Diversion Initiative (SBDI), jointly developed and piloted by CSSD, DCF and CHDI, and funded by the MacArthur Foundation. SBDI seeks to bridge existing behavioral health services and supports to children and youth with mental health needs to prevent juvenile justice involvement. The creation of SBDI was based on three areas of concern in Connecticut, and nationally. First, although juvenile arrest rates have trended downward in the last 5 to 10 years, there remain high rates of *in-school* arrests, as well as expulsions and out of school suspensions, particularly among students with mental health needs. Exclusionary discipline results in more arrests, leading to academic failure and eventually to school drop-out. Youth with unmet behavioral health needs are disproportionality represented among students arrested in schools and approximately 65-70% of youth in detention have a diagnosable behavioral health condition. Second, students who are arrested or expelled are disproportionately to be students of color, particularly African-American and Hispanic males. Even when the behaviors are the same, too often school responses to behaviors are more severe for students of color. Third, to meet the needs of students at-risk of arrest or expulsion, schools report a need for better linkage to community-based mental health resources, particularly crisis response.

The SBDI model was designed to address these concerns and attends to the underlying needs of school professionals, which in turn allows schools to more effectively meet the needs of at-risk students. SBDI incorporates a Graduated Response model for disciplinary intervention, which seeks to ensure that school policies and procedures are fair and equitable, do not rely excessively on juvenile justice system interventions, and effectively meet students' needs.

The primary goals and objectives of SBDI include:

Goal 1: Enhance knowledge and capacity of school professionals for early identification of mental health needs, diversion from arrest and expulsion, and referral to community-based services

Objective 1: Coordinate delivery of expert training to school professionals in key content areas

Objective 2: Facilitate staff skill development and attitude change regarding key competencies

Goal 2: Reduce number of in-school arrests and expulsions and associated racial/ethnic disparities

Objective 3: Develop individualized school policies and procedures to build capacity for reducing arrests and expulsions

Objective 4: Enhance awareness of racial/ethnic disparities in arrests and expulsions

Goal 3: Increase utilization of community-based resources as alternatives to arrest or expulsion for youth with mental health needs

Objective 5: Enhance collaboration between participating schools, local law enforcement, and service providers to improve service referrals

Objective 6: Improve early identification and referral of youth with mental health needs to effective diversionary services such as Emergency Mobile Psychiatric Services (EMPS)

Students in SBDI-participating schools are diverted from arrest whenever possible, and instead linked to appropriate community-based resources. SBDI emphasizes use of each community's local EMPS team. EMPS is a statewide mobile crisis response program that deploys teams of specially trained mental health professionals to respond immediately to requests for crisis stabilization, provide brief treatment, and ensure appropriate linkage to ongoing care. EMPS providers respond directly to homes, schools, and emergency departments and services are intended to reduce inappropriate service referrals to correctional and inpatient settings. EMPS is available to every school in the state; however, existing data suggests that schools have historically underutilized this resource due to a lack of awareness and in some cases, a history of poor collaboration with the broader mental health provider community. SBDI seeks to

strengthen relationships between schools and EMPS as a key community resource.

Outcomes: SBDI was piloted in four school districts (2 in SY 09-10, 2 in SY 10-11), and is currently being implemented in three districts (SY 11-12). Results of school and student-level data collected from participating SBDI schools indicate:

- In-school arrests of students decreased 50-69% per school, particularly among youth with behavioral health needs
- On average, suspensions dropped 9% in-school and 8% out-of-school
- EMPS utilization tripled, while ambulance calls decreased up to 22%

A 2011 evaluation by Yale University compared EMPS utilization rates and arrest data for communities with SBDI compared to similar communities without SBDI using survival analyses with the following results:

- Youth first served by EMPS had less subsequent juvenile justice involvement compared to those initially referred to CSSD (47% re-arrest rate for EMPS vs. 66% for CSSD).
- Among youth with previous CSSD involvement, rates of subsequent juvenile justice referrals were significantly lower in SBDI communities (31%), even after controlling for race, age, gender, and previous delinquency, compared to non-SBDI communities (43%)
- Youth with previous CSSD involvement in SBDI communities experienced lower risk and delayed onset of recidivism (398 days to re-arrest), compared to non-SBDI communities (258 days).

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 twelve (12) existing juvenile courts in FY11.

Number Served: 346 participants

Program Cost: FY 2010-2011 \$657,600

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:

- 44% of clients obtained/modified/preserved special education services
- 16% of clients overcame proposed suspension or expulsion
- 38% of clients obtained education-related benefits
- 28% 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 were 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: 1,117 participants

Program Cost: FY 2010-2011 \$3,372,805

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 December 2011 is for 85% of clients under age 16, and 78% of 16 and 17 year olds to successfully complete the program.
- 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: 80% for clients under age 16, and 78% for clients ages 16 and 17.
- Arrest rate for completers: 36% for clients under age 16, and 20% for clients ages 16 and 17.
- FWSN referral rate for completers: 19% for clients under age 16, and 16% 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: No program activity for FY 2010-2011. Grants will be awarded in FY 2011-2012.

Program Cost: FY: 2010-2011 No available funds

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 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: 1,286 youth residing in urban communities who are between the ages of 12 and 18

Program Cost: FY: 2010-2011 \$763,544

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.
