

# **DCF Family Engagement and Kinship Care Activities in Child Protection**



**FY 2008-2009**

## **INTRODUCTION**

Knowledge of family and its meaning in the lives of children, as well as social work practice, require that children are protected in the context of their family, culture, and community. A major challenge for the child welfare system has been striking the right balance between a time-sensitive, child-protective approach and the efforts to engage families in problem-solving. Research has documented that most of the time and resources in the child welfare system are directed toward the children, with less investment in efforts to engage families in building their own capacity to protect their children. Among the social costs of these policies and practices are long stays in out-of-home and no permanent attachments.

In Connecticut, sincere efforts have been taken, and are underway, to expand the role families play in addressing the risk and safety concerns that brought the family to the attention of the Department in the first place. These efforts in combination with some promising outcomes provide evidence that a shift in child welfare practice is taking place. Still, too often methods of engagement are not being conducted early, broadly, or consistently enough.

The Department intends to move forward in this direction because:

- 1) Family connections are critical for healthy child development;
- 2) Familiar settings at a time of crisis in a family matter;
- 3) Relative searches should begin the moment a child is at risk of placement;
- 4) Father's extended family networks matter, and;
- 5) Family members have a right to know.

This shift in practice has inspired child welfare professionals to focus on the appropriateness and relevance of policies, services and supports children and their kinship families. The purpose of this report is to offer some insight into Connecticut kinship practice and take stock of efforts aimed at improving this practice. It contains three sections:

- 1) Key Indicators of Kinship Practice
- 2) Methods of Measurement and Current Findings
- 3) Programs and Initiatives

## 1) KEY INDICATORS OF OUR KINSHIP PRACTICE

- **Fewer Children In State Care, More Intact Families Served**--The number of children in care as the result of abuse or neglect has declined by 1,064 children or 16.7 percent since January 2004 and by 1,724 children or 24.6 percent since January 2000. This reflects a number of positive developments including a reduction in the number of children entering care and an accompanying increase in the number of families served with their children at home. Whereas 2,930 children entered care in 2002, the three-year average for 2005 through 2007 was 2,515.7, and the total for 2007 was 2,137. In-home cases have increased 41 percent from July 2002 when there were 2,849 in-home cases to September 2008 when there were 4,010 in-home cases.
- **More Out-of-Home Children in Family-Based Care**--Another important trend is that family care is growing as measured by the percentage of children first entering care being placed into a foster home, relative home or special study home. Whereas 57 percent of children first entering care were placed in a family setting in 2002, this has grown to 72 percent in both 2006 and 2007. Importantly, this increase is in part driven by a greater reliance on kinship care with first-time placements in these settings growing from 9% in 2002 to 17% in 2007.
- **Meeting Goals For Timely Permanency**--Over the past eight quarters, all three measures of timely permanency, which include adoption, subsidized guardianship, and reunification, have met the goal in 20 of the 25 possible occasions. Timely adoptions, which represented just 10.7 percent of all adoptions in the first quarter of the Exit Plan, has been at or over 33 percent in each of the last seven quarters.
- **More Permanent Homes**--During state fiscal years 1997 to 2005, an average of 615 permanent homes (both adoptions and subsidized guardianships) were found annually for children in foster care -- more than four times the number in 1996. In FY2008, 634 adoptions were finalized and 234 subsidized guardianships granted for a total of 868 new permanent homes.
- **Reducing Reliance on Residential Care**--The movement away from congregate settings for children in care is one that has been underway since the inception of the Exit Plan in 2004. The outcome measure for reducing reliance on residential care reached its best levels in the final two quarters of FY2008 and has met the goal for nine consecutive quarters. As of September, 2008, the number of children in residential care has declined by 340 children or more than 38 percent since April 2004. The number of children in residential care, 549 as of September, 2008, is at its lowest level on record. There are 160 fewer children (32.6%) in an out of state residential program: 491 in September 2004 compared to 331 in September 2008. Of those out-of-state, 74% are in New England.
- **In Home and Community Based Services**--The reduction in children in residential care overall is attributable to a number of factors. One clear improvement is that Connecticut now has the capacity to serve nearly 2,300 children a year in intensive home-based programs, which largely did not exist only a few years ago. Community based behavioral health funding totaled \$69 Million in SFY 08 or more than double the amount spent in SFY 02 (\$32 M).

## 2) METHODS OF MEASUREMENT AND CURRENT FINDINGS

The focus of the federal Child and Family Service Review (CFSR) process is on a State's capacity to create positive outcomes for children and families and on the results achieved by the provision of appropriate services. In this process, states are assessed for substantial conformity with certain federal requirements for child protective, foster care, adoption, family preservation and family support, and independent living services. The Children's Bureau, part of the Department of Health and Human Services, administers this review system.

The purpose of the CFSR is to: (1) ensure conformity with federal child welfare requirements; (2) determine what is actually happening to children and families as they are engaged in child welfare services; and (3) assist states to enhance their capacity to help children and families achieve positive outcomes. Ultimately, the goal of the reviews is to help states improve child welfare services and achieve the below outcomes for families and children who receive services

States that do not achieve their required improvements sustain penalties as prescribed in the federal regulations. All 50 states, the District of Columbia, and Puerto Rico completed their first review by 2004. No state was found to be in substantial conformity in all of the seven outcome areas or seven systemic factors. Since that time, states have been implementing their Program Improvement Plans (PIP) to correct those outcome areas not found in substantial conformity.

Connecticut successfully exited its 2002 PIP on August 3, 2007. The second round of reviews began nationwide in the spring of 2007, and Connecticut's review was conducted in September 2008.

In addition to the above, the Department created its own case review tool called the Connecticut Comprehensive Outcomes Reviews (CCOR). The CCOR is modeled on the federal CFSR, which looks at the agency's performance across seven outcomes in the areas of safety, permanency and well-being. The CCOR, like the CFSR, is comprised of two phases:

1. Area Office Self Assessment - The area office completes a self-assessment document that describes their performance across the seven CFSR outcomes. This self-assessment is shared with the review team and serves to inform the reviewers of local strengths, areas needing improvement and practice issues identified by the local management team.
2. On-Site Review - A week-long case review is conducted by a team of reviewers on randomly selected cases. In addition to reviews of the case record and interviews with case participants conducted by reviewers, CCOR Team Leaders conduct focus groups with local stakeholders and providers to identify strengths and areas needed improvement.

Cases are randomly selected for review from the universe of eligible cases from the area office during a specific sampling period. Case ratings are determined from information gathered from the case record and interviews about the case practice during a specific Period Under Review (PUR).

Each review team is comprised of 5 review pairs. Each review pair reviews 2 to 3 cases, including a review of the case record and interviews with key case participants. Review pairs use the federal On-Site Review Instrument (OSRI) to conduct their review. Completed OSRIs are submitted for quality assurance to the Team Leaders.

**These on-site qualitative case reviews look at practice to assure:**

- **Children are safely maintained in their homes whenever possible and appropriate.**
- **Children have permanency and stability in their living situations.**
- **The continuity of family relationships and connections is preserved for children (e.g. proximity of foster care placement, placement with siblings, visiting with parents and siblings in foster care, preserving connections, relative placement, and relationship of child in care with parents).**
- **Families have enhanced capacity to provide for their children's needs (e.g. needs and services of child, parents, foster parents are met; there is child and family involvement in case planning; the worker visits with child and with parent(s)).**

**2) Recent Findings**

In 2002 the Department did not achieve substantial conformity (substantial achievement based on cumulative item and outcome ratings) in either of the outcomes listed below.

The following were noted areas needing improvement which contributed to these ratings:

- facilitating visitation of children in foster care with their parents and siblings
- making diligent efforts to locate and assess relatives as potential placement resources for children
- assessing the needs of, nor providing services to, parents, foster parents, and children
- involving parents and children in case planning
- visiting with parents frequently enough to promote the safety and well-being of children

The following rating data are average percentages collected from CCOR of 4 area offices from March to June of 2008, and performance ratings from Rounds 1 and 2 of the Child and Family Service Reviews (CFSR) in 2002, and 2008, and LINK report outcome measure performance data (2008) whenever applicable. The data reflects performance ratings of reviewed cases (47 CCOR, 130 CFSR), and hundreds of case participant interviews including parents, children and service providers. \*The overall CCOR/CFSR specific percentages are a cumulative representation of the bulleted item percentages.

PERMANENCY OUTCOME 2: THE CONTINUITY OF FAMILY RELATIONSHIPS AND CONNECTIONS IS PRESERVED FOR CHILDREN.

**CFSR (Round 1 - 2002): 43% of cases Substantially Achieved**

**CCOR Pilots (2008): 50% of cases Substantially Achieved**

**CFSR (Round 2 - 2008): 50% of cases Substantially Achieved**

- **Placement with Siblings**
- **Visiting with parents and siblings in foster care**
- **Preserving connections**
- **Relative placement**
- **Relationship of child in care with parents**

**Placement with Siblings**

**Purpose of Assessment:** To determine if, during the period under review, concerted efforts were made to ensure that visitation between a child in foster care and his or her mother, father, and siblings is of sufficient frequency and quality to promote continuity in the child's relationship with these close family members.

- CCOR - 50%
- CFSR - 88%
- OM # 10: Sibling Placement - 84%

**Visiting with parents and siblings in foster care**

**Purpose of Assessment:** To determine if, during the period under review, concerted efforts were made to ensure that visitation between a child in foster care and his or her mother, father, and siblings is of sufficient frequency and quality to promote continuity in the child's relationship with these close family members.

- CCOR - 50%
- CFSR - 46%

**Preserving Connections**

**Purpose of Assessment:** To determine whether, during the period under review, concerted efforts were made to maintain the child's connections to his or her neighborhood, community, faith, extended family, tribe, school, and friends.

- CCOR - 75%
- CFSR - 75%

**Relative Placement**

**Purpose of Assessment:** To determine whether, during the period under review, concerted efforts were made to place the child with relatives when appropriate.

- CCOR - 65%

- CFSR - 72%
- OM # 4: Search for Relatives - 93%

**Relationship of child in care with parents**

**Purpose of Assessment:** To determine whether, during the period under review, concerted efforts were made to promote, support, and/or maintain positive relationships between the child in foster care and his or her mother and father or other primary caregiver(s) from whom the child had been removed through activities other than just arranging for visitation.

- CCOR - 53%
- CFSR - 45%

WELL-BEING OUTCOME 1: FAMILIES HAVE ENHANCED CAPACITY TO PROVIDE FOR THEIR CHILDREN'S NEEDS.

**CFSR (Round 1 - 2002): 50% of cases Substantially Achieved**

**CCOR Pilots (2008): 56% of cases Substantially Achieved**

**CFSR (Round 2 - 2008): 44.6% of cases Substantially Achieved**

- Needs and services of child, parents, and foster parents
- Child and family involvement in case planning
- Caseworker visits with parents

**Item 17: Needs and services of child, parents, and foster parents**

**Purpose of Assessment:** To determine whether, during the period under review, the agency made concerted efforts to assess the needs of children, parents, and foster parents (both at the child's entry into foster care or on an ongoing basis) to identify the services necessary to achieve case goals and adequately address the issues relevant to the agency's involvement with the family, and provided the appropriate services.

- CCOR - 36%
- CFSR - 48%
- OM # 15: Needs Met - 56% (52 cases reviewed per quarter OCM)

**Item 18: Child and family involvement in case planning**

**Purpose of Assessment:** To determine whether, during the period under review, concerted efforts were made (or are being made) to involve parents and children (if developmentally appropriate) in the case planning process on an ongoing basis.

- CCOR - 55%
- CFSR - 52%
- OM # 3: Appropriate Treatment Planning - 79.8% (52 cases reviewed per quarter OCM)

**Item 20: Caseworker visits with parents**

**Purpose of Assessment:** To determine whether, during the period under review, the frequency and quality of visits between caseworkers and the mothers and fathers of the children are sufficient to ensure the safety, permanency, and well-being of the children and promote achievement of case goals.

- CCOR - 47%
- CFSR - 49%
- OM # 16, 17 - 90%

The Department's quantitative measurement of OM # 16, and 17 illustrates a significantly higher percentage of effectiveness (over 90%) due to differences in measurement methodology. CCOR instrument measures the frequency, and quality, of social worker visits with both parents in both in-home and OOH cases.

### **3) PROGRAMS AND INITIATIVES TO IMPROVE FAMILY WORK**

#### **Better Together:**

In August 2008, the department partnered with Casey Family Programs to develop and implement a new training model called Better Together. The core of this program involves training birth parents and child welfare staff together so that we can learn more effective ways of engaging and partnering with families through the treatment planning process. Casey has implemented this model predominately to strengthen the foster care system, focusing the model on foster care alumni, foster parents and kinship caregivers. CT will pilot this model for birth parents. It operates under the premise that to bring about system change, we need bring the voice and experience of birth parents to the table to inform our case practice.

The core of this program involves training child welfare staff and parents together so that we can learn ways to improve our practice in the areas of:

- doing strength based assessments
- increasing levels of family engagement in developing treatment plans
- increasing the involvement of fathers and male partners
- increasing family and community supports in treatment planning
- providing services that the family is interested in receiving

A Planning Team was established consisting of birth parents, DCF staff and Casey Family program staff to select the Contractor and help organize and coordinate the roll out of this new training initiative statewide. Three Citizen Review Panel members (parents) serve on the Planning Committee.

In September 2008, Casey Family Programs released a Request for Qualifications (RFQ) to seek applications from qualified entities to develop and pilot the training curriculum consistent with the Better Together model. Based on the Review Committee Recommendations, Casey Family Programs established a contract with Madison Valley Consultants, LLC from Seattle, Washington.

In December 2008, the Contractor conducted a needs assessment with selected focus group participants (birth parents, DCF staff and community allies). The needs assessment was intended to assess current strengths and challenges to family engagement throughout the treatment planning process and to identify programmatic and curriculum implications for the *Better Together* model. Casey Family Programs offered a \$50 honorarium for all birth parent participants. The Department of Children and Families provided stipends to birth parents for transportation and childcare costs to further support their participation in this process.

A draft of the training curriculum has been completed and is currently under review by the Better Together Planning Committee. Once the curriculum has been finalized, the Contractor and Parent Facilitator will pilot the training to birth parents, DCF staff and key community constituents. The 7 hour workshop is scheduled for April 30, 2009. The Planning Committee will be developing a plan to identify training participants as well as the Parent Facilitator for the upcoming workshop. An evaluation component is included in the program. The Planning Committee intends to develop plans to ensure the program's

sustainability to ensure the principles, skills and activities learned is reinforced and integrated into DCF practice.

### **Reconnecting Families Program:**

Targeted Referrals:

- Designed for families with children (from birth through age 17) who were removed from their home due to CPS concerns and for whom supervised visits are required.
- Referrals can be initiated immediately following removal or at any time during the placement.
- Viable permanency plan for Reunification or Transfer of Guardianship.

Model Summary:

The following are key design elements of this model:

- Staged Model – includes preparation work prior to reunification, intensive work following reunification and post reunification work to monitor and provide support to the family.
- Active family engagement and participation in treatment planning. Family conferencing meetings to be held at critical junctures throughout the duration of the program. Meetings to be facilitated by contracted provider and can include parents, kin, extended family members, family supports and community service providers. Assist family in preparing for and developing strategies to address issues/problems that may surface following child's return home.
- Therapeutic Visitation focus on strengthening and improving communication and repairing relationships through modeling and coaching.
- Use of evidence-based tools to inform the development of the service plan and identify targeted interventions
- Some site and primarily home-based service delivery (including biological parent/kin, substitute caretaker's home)
- Post Reunification Crisis Intervention
- Length of service – four to six months
- Team approach – core members include the family, the Reconnecting Families Contractor, DCF, substitute caretaker for child and other providers involved with the family
- Small Caseloads to allow for flexibility in responding to the unique needs of families
- Mandatory after-hours and weekend in-home service delivery
- Transportation

An RFP was released in 8/07 and 11 contractors were awarded the contract to provide this service statewide. Implementation of this new service began 4/1/08. This program is funded by both federal and state funding.

DCF's Bureau of Child Welfare provided a pre-service orientation for all Reconnecting Families Providers in 4/08 focusing on the implementation of the new service delivery model as well as providing information relative to several DCF initiatives including: family conferencing, Structured Decision Making and the GAIN-Short Screener.

## **Preserving Connections - Sibling Connections:**

The Department of Children and Families recognizes the importance of sibling relationships and extends every effort to place siblings together when removal from their family of origin is necessary, unless there is a compelling reason in their best interest to the contrary. Despite these efforts, many children are placed apart from their siblings for significant periods of time when out-of-home care is required. All too frequently, contact among sibling groups is limited and sporadic in nature. For many children, this loss can be even more traumatic than the experience of being placed in the foster care system. When sibling relationships are severed, the fallout can often last a lifetime. Preserving sibling connections is critical to their sense of permanency and emotional well-being. The loss of this important family connection impacts their overall development and their ability to form healthy attachments.

Recognizing the realities of the foster care system and other out-of-home care options, many states have developed initiatives to preserve sibling connections through the establishment of a summer camp experience that provides opportunities for children/youth separated by placement to participate in activities together that strengthen sibling relationships and create meaningful childhood memories.

The Department of Children and Families is committed to improving practice in this area by enhancing sibling connections for children placed in the foster care system. To that end, the Department released a Request for Proposal in September 2007 to contract for a week long overnight camp experience for siblings placed apart in the child welfare system.

Channel 3 Kids Camp in Andover, CT was awarded the contract to engage, support and reconnect siblings who are placed in out of home care by providing a week long overnight camp experience and two follow up events focused on strengthening sibling relationships and create meaningful childhood memories.

A subcontract with Wheeler Clinic was developed to provide therapeutic intervention and support to all campers when necessary. Wheeler Clinic staff provided orientation and training to all camp counselors and actively participated in all camp activities.

In July 2008, over 50 children from across CT ranging in age from 5 to 18, attended the Sibling Connections Camp. Campers participated in typical recreational activities available through a traditional camp experience which included archery, arts and crafts, swimming, hiking, nature programs, performing arts, camping, computer programs, fishing, ropes and/or other experiential learning courses. Additionally, the camp provided structured sibling activities that were age and developmentally appropriate to enhance sibling connections. Two follow up events are scheduled with the same sibling groups to maintain these important connections.

The Department of Children and Families, Wheeler Clinic and the Channel 3 Kids Camp are in process of planning this year's event scheduled the week of August 10, 2009.

**Life Long Family Ties:**

The primary goal of Life Long Family Ties (LLFT) is to locate and help sustain lifelong connections and viable resources for children who are in the care and custody of DCF when other efforts to recruit a permanent family resource have not been successful. These resources can include: birth family, extended birth family members, teachers, neighbors, current and previous foster parents, family friends or people from the child's community who can have a positive impact on the life of the child or youth.

Children and youth should have a voice in the planning of their future. The input of the child/youth is critical and is achieved through ongoing contact between the LLFT Social Worker, the DCF Social Worker and the child. The LLFT program brings the child and their identified resources together for the chance to create positive changes in an effort to create a sense of permanency for the child/youth. Children and youth need to know that they have adults who they can turn to for support and unconditional acceptance. They should be afforded the stability that comes from permanent connections with caring and committed adults who can guide and nurture them into adulthood.

The Department contracts with The Village for Children and Families and Wheeler Clinic to provide direct service for this program.

The Life Long Family Ties Program was developed in an effort to identify connections and resources with those individuals who are or have been a significant part of a child's life. This concept was developed in an attempt to provide a safe, happy and healthy environment in which a child can continue to grow and flourish into adulthood. All of the individuals involved work together to create a child specific permanency plan that addresses:

- Safety
- Support
- Continuity of relationships
- Permanence

The benefits of lifelong connections include: the opportunity for a concerned adult to provide support to a child in need, birth families having a voice in the child's future, and allowing the professionals involved with the child to use a team approach that will achieve positive outcomes for the child/youth.

**Who is Eligible**

- Children/youth who are in the care and custody of DCF between the ages of 6-18 who can and want to actively participate in the process. Please consult with the child/youth to assure they are willing to participate with this service prior to making a referral. Referrals will be prioritized based on date of referral and number of years in DCF care.
- Children/youth that are in foster care or in state residential care (some out of state residential care facilities may be accepted if in close proximity to CT please confer with the Program Lead/Gatekeeper prior to making a referral)
- Children whose treatment plan goals are one of the following: adoption and another planned permanent living arrangement (aka APPLA)
- Children whose clinical team, caretakers, and DCF Social Workers agree to commit to and work with the Life Long Family Ties team in assuring the child's/youth's success in the program.

**Case Planning:**

Family engagement in treatment planning is a primary focus of the *Juan F.* Stipulated Agreement. To this end, the department is currently reviewing all policies and practices relative to treatment planning. Family engagement will be at the core of the department's new Practice Model currently in development by an independent consultant.

Additionally, the Department is in process of modifying both the Family and Child in Placement Treatment Plan documents to make them both user and family friendly. Drafts of the new Service Plans were forwarded to birth parents to elicit feedback to ensure the family perspective is incorporated in the department's efforts to improve practice relative to family engagement and case planning.

**Family Conferencing:**

Recognizing the need to engage and collaborate with families to enhance our treatment planning practices, the Department adopted a Family Conferencing Model in 2005. The Department hired an independent consultant to assist the department in program design, implementation and training, and provided ongoing consultation and support to DCF staff at all levels of the agency. The primary goal of the initiative was to increase the level of family involvement in case planning by providing opportunities to engage parents and their networks in problem-solving, focusing on the identified strengths and needs of the family. Family conferences were designed to assist the family in meeting their treatment plan objectives and ensuring child safety. Although there has been some improvement noted in our ability to engage and partner with families in certain areas throughout the state by some DCF workers, it continues to present significant practice challenges for staff statewide and remains a focus area for practice improvement.

**Collaborative Safety Planning -- Intensive Safety Planning (ISP):**

In an effort to expedite permanency and reduce length of stay for children in out-of-home care, the Department created and implemented a new service model that focuses on providing immediate services to families following the child's removal in an effort to reunify the child safely, prior to the Order of Temporary Custody hearing (typically held within 20 days of removal).

This model requires the family be engaged immediately to work with the Department and ISP provider to develop a plan to mitigate the safety factors that resulted in the child's removal. It emphasizes a team approach, the use of consultants to assist in safety planning and in the development of a service plan for the family. The model incorporates several best practice/evidence-based assessments, including the SDM Safety Assessment, which will identify safety factors for the families referred to the program and possible interventions that could be immediately implemented to allow the child to return home safely; and the GAIN Quick, (Global Appraisal of Individualized Needs) which is an informal, structured interview process that assesses families on nine specific life domains. This instrument will be completed by the ISP provider and is designed to identify needs and target services for the family quickly to help the family's transition to the community following completion of the program. Prior to the court hearing, a family conference will be held with the parents, kin and/or other family supports to review progress, reassess child safety, identify additional safety factors and determine whether interventions can be implemented immediately to allow the child to return home safely.

A Request for Proposal was released for a statewide procurement of this service. All contracts have been executed. All area offices have access to this service. There are 19 F.T.E staff providing this service statewide. The goal of the program indicates that 50% of the children referred will receive recommendations for a prompt reunification.

### **Domestic Violence Consultant Initiative:**

In 2006, the Department funded the Domestic Violence Consultation Initiative to increase its capacity to address domestic violence. The Initiative places 13 domestic violence consultants into the Area Offices statewide. A Statewide Services Administrator oversees the Initiative and provides policy consultation to the Department's Central Office. The goal of the Initiative is to support the agency's mission to promote the safety, permanency and well-being of children by improving case practice, elevating staff competencies and addressing practice, policy and resource challenges.

By design, the client for the domestic violence consultants is the Department's social work staff. The Safe and Together consultation model, developed specifically for domestic violence cases involving children, is used by the consultants to address the entire family. The consultants help the social work staff identify the impact of the domestic violence on the children and develop plans that a) intervene with the domestic violence perpetrator, b) create the most effective partnership possible with the protective parent, c) meet the needs of the children in the home and d) are sensitive to the role of mental health issues, substance abuse and culture.

Whenever possible, the consultants work to support the maintenance of the children safe and together with the domestic violence survivor. Integration of the domestic violence consultants into the Area Offices has been swift and far reaching. From March to December 2007, the consultants engaged in 4575 consultation activities including initial consults, home visits, follow ups, brief consults, and case conferences.

The domestic violence consultants regularly participate in case transfer, MAPs, MSS and other case specific meetings. Their involvement in a case frequently begins as soon as an investigation is opened. In addition to case specific work, the consultants have delivered staff development training for DCF staff and the Department's community partners. From March to December 2007, more than 78 training sessions were delivered to over 700 Department social work and 400 community provider staff. These trainings covered a variety of topics including the Safe and Together model, the new domestic violence investigations protocol, engaging batterers, and safety planning.

While measuring the full impact of an initiative of this scope is challenging, some data is available to begin assessing the Initiative's impact. In addition to feedback from the Area Offices and consultants themselves, data from the Structured Decision Making review process may point towards the results of the Department's efforts. During the period of February to December 2007, the removal rate by safety factor for domestic violence dropped from 5.9% to 4.4%, the lowest rate of all safety factors. This may be indicative of the Department's social workers' increased capacity to assess risk and safety, and developing plans that allow children to be safely maintained in home.

### **Formal Strength and Needs Assessment -- Structured Decision-Making (SDM):**

In January 2006, the Department contracted with the National Council on Crime and Delinquency (Children's Research Center) to develop and implement Structured Decision Making (SDM) in CT. SDM is a research, evidence-based practice model used by child welfare workers that provides a comprehensive set of assessment tools that promotes consistency and accuracy in decision making at critical junctures throughout the life of a case.

The two primary goals of SDM are to:

1. reduce harm to children;
2. expedite permanency for children in out-of-home care.

It accomplishes these goals through five key objectives:

- Identifies and structures critical decisions in the life of a case. SDM helps workers gather, document and evaluate the right information to make informed decisions.
- Increase consistency and reliability in decision making.
- Increases accuracy and reliability of critical decisions.
- Targets resources to families most at risk. SDM recommends families are treated differentially based on risk level and need.
- Uses case level data gathered by social workers about our families to guide decision making at all levels of the agency. It aggregates data to enable management to make appropriate decisions about resource development and allocation, staffing and workload management.

In order to complete the SDM tools, it requires workers to actively engage families to gather information to allow for more accurate assessments. Specifically, the Family Strengths and Needs Assessment (FSNA) is used to evaluate the presenting strengths and needs of each family. Strengths are used to help address family needs. This tool is used to systematically identify critical child/family issues and help plan effective service interventions. It assesses families (child/caregiver) on specific life domains. The FSNA assesses information about the entire family, not just the identified victim. The tool helps to focus case planning, monitors service provision, identifies resource needs in the state and assesses change in family functioning. The information obtained is used to inform the treatment plan.

Priority needs (maximum of 3) for the family are identified and incorporated into the treatment plan. All needs of children identified by the FSNA should be addressed in the treatment plan.

The Family Strength and Needs Reassessment also provides an opportunity to evaluate a family's progress toward reducing needs following a period of intervention by the Department. This tool guides the process for reviewing and updating the treatment plan.

The SDM tools are not intended to be completed jointly with the parent. It offers workers the structure to gather pertinent information in order to make informed decisions and increase consistency in decision making across the state.

Results of the tools can be shared with the family: identified safety factors, interventions to allow child to remain safely in the home, reduction of risk factors, the strengths and needs of all family members (parents and children) and identified service interventions to address family needs.

### **Family Preservation -- Intensive Family Preservation:**

IFP is a short-term, intensive, in-home service designed to intervene quickly in order to reduce immediate safety factors, the risk of future abuse and/or neglect and the need for out of home placement. This service is delivered to families with children at high risk of

out of home care or families with children just reunified following a period of time spent in out of home care.

IFP is an intensive 12 week, home based model that engages DCF active, intact families where significant safety and/or risk factors have been identified. The contractor's focus is on mitigating safety and/or risk factors so that removal of a child for safety reasons is not required and repeat maltreatment does not occur.

Families to be served under this model include biological, relative foster care, foster families and pre/post adoptive families referred by the Department of Children and Families. IFP Contractors provide services to families on their active caseload 24 hours per day, seven days a week, including weekends and holidays, if necessary in order to respond to the needs of families.

All 17 Contractors statewide are required to utilize the Global Appraisal of Individual Need – Quick (GAIN-Q) to assist in the identification of the treatment needs of the primary caretaker and to guide the focus of the IFP intervention. Feedback from the GAIN-Q will be the foundation for an individualized service plan, developed in consultation with the referring DCF social worker and family members. Contractors ensure families are linked to and engaged in community services in based on their individualized needs.

Concrete interventions, supports and guidance are provided to families to mitigate safety factors and to improve the overall functioning of family members. The goals of the program are to reduce the number of children experiencing repeat maltreatment and reducing the number of children requiring a removal from home in order to ensure their safety.

### **Foster and Birth Parent Communication Initiative:**

*Overview:* One of the main objectives for this initiative is to develop positive relationships between foster parents and biological parents in order to provide better care for the children in foster care. It is the hope that this initiative will ultimately encourage foster parents to provide supervised visits to the parent's whose children they have in their care

*A Practical guide for social workers:*

Step 1 (INFORM PARENT) - The social worker will give an overview of the intentions of this initiative to the biological parents and go over the Child's Profile form. Explain to parents that this will assist foster parents in caring for their child and gives them a voice in their child's care.

Step 2 (MEETING) - After consultation with SWS, when appropriate, the social worker will facilitate a meeting between foster parents and biological parents. Utilize Child's Profile to guide the discussion. Discuss logistics regarding ongoing phone contact and visitation.

*(The meeting should occur as soon as possible following the placement of the child)*

**Foster Parent Supervised Visitation Initiative:**

Step 3 (ASSESSMENT) - The goal of this step is to increase the number of cases where foster parents are supervising the visits between children and their parents. This will only be initiated on a case by case basis, after consultation with the SWS. There will be training provided in the future regarding structured supervised visitation.

If foster parent, biological parent, and DCF agree that visits will be supervised by the foster parent: the SW will meet with both parties and establish clear roles and expectations regarding the visits. The SW will ensure that both parties are clear about what types of information will be reported back to DCF (Visitation Worksheet). The SW will supervise the first few visits and at least one visit per month, and will continue to make ongoing assessments on how visitations are going (assessments should be made by, but are not limited to, ongoing discussions with all parties involved, reviewing information, and SW/SWS supervision).

Program benefits:

- Foster parent will know more about child
- Child sees biological parents interacting more positively with foster parents
- Reinforces permanency efforts
- Reduces Anxiety for parent
- Empowers parent
- Foster parents providing visitation allows DCF to manage resources (SW/SWCA) more effectively
- This will provide a more natural setting for all parties involved

**Fatherhood Activities:**

The Madonna Place Fatherhood Initiative Program began in 1998 as an extension of the Families First Program here at Madonna Place. Services at the time were primarily focused on case management and group work. In 2000, The CT Department of Social Services, DSS, selected Madonna Place as one of three pilot programs in the state. After a number of years of research by The University of Hartford, The Connecticut Department of Social Services, created a certification process in consultation with the National Practitioners Network for Fathers and Families, to ensure quality standards (see Certified Fatherhood Program Standards section) of operation for fatherhood programs. The first Fatherhood Certification Program took place in 2005. It included a comprehensive review of our program and Madonna Place successfully completed this process and became one of the original five Certified Fatherhood sites in Connecticut. There are currently 6 certified sites in Connecticut.

The purpose of the Program is to increase positive involvement and interaction between fathers and their children. We work with fathers to help them increase their ability to meet their parental responsibilities of providing social, emotional, medical, educational and financial assistance to their children.

Types of Services Offered:

- Voluntary Paternity Establishment Program
- Establishing Paternity through DNA Testing
- Child Support Arrearage Adjustment Program

- Employment Skill Assessments /Job Search Assistance
- Strength Based Case-Management focused on Goal Setting and empowerment
- Access to Monitored Parenting Time
- Family Court Support
- Peer and Educational Groups
- Relationship Building Group
- Referrals to community resources such as employment, legal assistance, mental health, and basic needs
- Transportation Assistance
- Basic Needs, such as food, clothing, and personal care items for the family

*Focus Group:* In recent years, The Department of Children and Families Bureau of Adolescent and Transitional Service developed a young men focus group, the Young Men's Advisory Council or YMAC. YMAC is charged with the task of identifying loop holes and possible policy changes needed to support young fathers in our care. YMAC continues to meet every other month to discuss our fatherhood initiatives.

*Housing:* Our agency has also developed a transitional living program for young fathers, the Sail program. Sail is located in Bristol Connecticut and has slots available for young fathers who may have total or partial custody of their child. Within the program the young men learn life skills and focus on their education and employment goals.

*Conference and Rite of Passage:* The Department of Children and Families Bureau of Adolescent and Transitional Service also support young fathers by participating in a number of multi agency fatherhood planning committees over two years, which include The Department of Social Services, The Department of Health and the Department of Corrections, as well as the Yale University Consultation Center. Those network efforts recently paid off by our agency hosting the first ever "Boys to Men" conference. Over a hundred young men were able to attend the one day event, along with twenty or so young men self selecting themselves to take part in a post conference "Rites of Passage" program hosted by Hartford Artist Collective Inc.

*Training:* We currently offer an in-service class on Engaging Fathers in Child Protective Services. To date we have offered the class 3 times and offerings will be on-going. We reached out to DSS and other community organizations to develop the content for the class. To date the class has been very well received. We have also updated our pre-services programs to include techniques on engaging fathers. Specifically, this two day course is designed to provide DCF staff with skills needed to assess fathers and engage fathers in the development of the case plan. In this training, participants will utilize different communication techniques required in working with fathers. Participants will be able to describe the different roles fathers have and the potential impact these roles have on service delivery. We will also look at the long-term benefits for children in DCF care when fathers are identified, located and involved early on in the life of a case.

### **Training Academy -- Pre-service and In-service:**

Trainings that involve family engagement are legion. In pre-service, Module One, Day Two discusses Values Clarification and Use of Authority. Family Engagement is discussed during this training. The Casework Planning Training, also part of Pre-service, has an engagement component as well.

The current Interviewing training is currently being restructured and will focus on utilizing different interviewing techniques, purposeful visits (which was adapted from the two day training from the National Resource Center for Family Centered Practice and Permanency Planning at Hunter College), and engagement.

The Training Academy has developed a Social Worker Case Aide Certification Program. This program will be offered in April 2009. Topics discussed in this five day training will be Child Development, Parenting Skills, Supervising Visits, Documentation and a Legal Component. The first three topics include engagement components.

The Training Academy Staff has been trained by the National Child Traumatic Stress Network on the Trauma Toolkit. An overview of this training was offered to training supervisors in March 2009. This training will be infused into the Pre-Service training for new employees. The focus of this training will be on 9 Essential Elements related to trauma that assist in ensuring the safety, permanency and well being of the children that the agency serves. The focus is to look at the trauma specifically that a child has experienced and refer to the child to trauma informed service providers, rather than looking at a set of symptoms or behaviors in an attempt to change them. Looking at child welfare through a trauma informed practice lens allows us to view the children and their behaviors differently, better assess their needs for services, and assist in the healing process for our youth and families

The Training Academy also offers an in service course on Engaging Fathers. This training talks about how fathers contribute to the cognitive development of children as well as the development of their language. A father's contribution to their children's emotional well being and how they play a vital role in influencing both sons and daughters are also discussed. Barriers to engaging fathers are also presented as well as strategies to overcome these barriers. A strength based approach to engaging fathers is emphasized in this training as well as encouraging fathers to take an active role in child rearing and case planning for their children.

#### **Key Behavioral Health Training Initiatives:**

DCF is working with Dr. Mary McKay of Mt. Sinai Medical Center of New York to implement an engaging families program in the states network of 23 Extended Day Treatment Centers. This is a one year learning collaborative based approach to increasing family engagement and involvement in treatment, a proven critical factor in effective care.

#### **Care Coordination:**

DCF is providing training, consultation, and ongoing coaching to providers and stake holders in the states system of community care coordination. This initiative will support the infrastructure and workforce development needs of those local Systems of Care. There will be three components to this initiative. Pre-service Training, In-service Training, and Consultation will be offered to the community collaboratives to establish/enhance basic competencies for care coordinators and other stakeholders. Training will include: the wrap-around model and individualized planning process including building teams and locating natural supports; crisis and safety planning; developing and implementing individualized plans of care; transition and discharge planning; and incorporation of CT-specific practices and standards such as the Ohio

Scales, System of Care, natural supports and resources, and parent perspectives. This initiative will also include funding for individual consultation to each collaborative that will assist them in the assessment and improvement of their care coordination practices and system development efforts, and the maintenance of fidelity to the wrap-around model of care.

**Wraparound Services:**

Wraparound is a team-based planning process intended to provide individualized, coordinated, family-driven care to meet the complex needs of children who are involved with several child- and family-serving systems (e.g. mental health, child welfare, juvenile justice, special education), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties. The wraparound process requires that families, providers, and key members of the family's social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal wraparound process is no longer needed.

The values associated with wraparound require that the planning process itself, as well as the services and supports provided, should be individualized, family driven, culturally competent and community based. Additionally, the wraparound process should increase the "natural support" available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. Finally, wraparound should be "strengths based," helping the child and family to recognize, utilize, and build talents, assets, and positive capacities. It should be noted that wraparound is more a specific method for treatment planning and care coordination than a single treatment like many that are often featured in lists of evidence-based practices. The theory of change for wraparound, however, provides rationale for why treatments included in the wraparound plan are likely to be more effective than they might be in the absence of wraparound (due to better treatment acceptability and family/child engagement, agreement about treatment goals, etc.), and why participation in the wraparound process itself may yield positive outcomes for youth/children and their families (due to increased optimism, self-efficacy, social support, coping skills, etc.).

The Wraparound services pilot consists of 66 Care Coordinators and 11 supervisors who actively partner with a program lead from the Department's Behavioral Health Division who provide support to mostly non-DCF involved families. Approximately 75-80 staff currently participate in the ongoing coaching/mentoring of the Wraparound process. In 2008, training was offered to CPS social workers and supervisors in 2 area offices.

Ongoing work is focused on training the Coaches to become a "master-coach" in an effort to build in-state coaching capacity.

**Mental Health Transformation Grant-Parent Leadership Training:**

This training is designed to strengthen the role of parents in the workforce by providing leadership training. A training curriculum on leadership skills has been selected, refined, and will be offered repeatedly throughout the state to the parents of children with emotional/behavioral difficulties. This initiative will (1) facilitate parents' increased

participation and influence in their child's treatment team; (2) prepare parents for paid and volunteer Family Advocate roles on behalf of other families and their children; and (3) assist parents in developing skills to shape state policy, thereby moving Connecticut closer to a family-driven system of care.

### **Engaging Families in Services: Implementing an Evidence-Based Approach**

Below is a program description of the Engaging Services in Families Learning Collaborative initiative for the statewide Extended Day Treatment providers

- Literature Review
  - Treat children/adolescents within the context of their families
- Stakeholders Perspectives: A Report on Extended Day Treatment 2006
  - Adopt a comprehensive family-focused philosophy & practice approach
  - Hear the voices of families
  - Engage parents/caregivers as full partners in all aspects of care
  - Increase the types and quality of family support services
  - Increase quality and quantity of communication throughout course of treatment
- EDT Practice Standards
  - Child-centered; Family-driven
  - To maximize effectiveness of treatment
  - To foster generalization of skill acquisition and treatment gains to the home environment
- Extended Day Treatment: Defining a Model of Care in Connecticut (2007)
  - A family-based treatment approach
  - Center-based, home-based, and supplemental parent training interventions
  - Family engagement specialist
- System of Care Values & Principles
  - Effective outreach, engagement and communication
  - Services coordinated with child's ecology
  - Ecological, child-in-environment perspective
  - Services congruent with families strengths, culture and environment
  - Include family/caregivers in all aspects of care

### **Joint Court Support Services Division/DCF Training:**

CSSD and DCF have embarked on a strategic plan to promote Risk Reduction among the juvenile offenders referred to it by the police, as well as FWSN children referred by schools and families. The entire thrust is to change the culture of juvenile probation and give our officers the tools needed to become effective agents of change rather than "enforcers" of court orders. It is believed that the mandate of community safety will be greatly enhanced by improvements in the life choices and behavioral changes that are possible with evidenced based practices and interventions.

These practices are being continuously reinforced through observation and feedback sessions, audio, and video taping. Specially designated "Risk Reduction Lead Officers"

have been selected and given advanced training. Through them, the office Supervisors are to be trained in specific techniques for delivering feedback and reinforcement to line staff on a regular and on-going basis to sustain this effort and change office culture, making “risk reduction” the central goal of Juvenile Probation services. This multi-year process has several key components,

- **Motivational Interviewing:** Known familiarly as MI, this interviewing technique is an effective evidence-based approach to overcoming the ambivalence that keeps many of our probationers from making changes in their lives, even as they repeatedly experience negative consequences for their actions. All Probation Officers and Probation Supervisors have now had more than 40 hours of training from Yale professor of psychiatry, Michael Pantalon.
- **Strength Based Initiative:** Juvenile Probation Officers and Supervisors have received more than 17 hours of training in the Strength Based (SB) approach to probation practice. In training this “paradigm shift” we join the national consciousness-raising momentum which has resulted from the recognition that focusing on the negative aspects of a clients behavior, personality and life situation is to miss his or her “strengths” which so often can be reinforced, emphasized and enhanced in ways that may result in reduced recidivism.
- **Automated Case Plan:** The Automated Case Plan provides an objective yet creative way for Probation Officers to distill the results of their extensive assessments, combined with the family’s and probationer’s input, into a prescriptive, printable plan which provides a “roadmap” to follow and update as necessary during the course of probation or supervision. The officer is reminded to target identified criminogenic needs with appropriate programs/interventions, and to periodically review the probationer’s progress towards mutually agreed upon goals, while ensuring that court orders are enforced.
- **Assessment of Individual Motivation:** Probation Officers and Supervisors have received more than 4 hours of training in an original, promising-practice, interviewing technique known commonly as the AIM. Developed by Central Connecticut State University professor of psychology, Chip Tafrate the AIM guides the officer in discovering the criminogenic need domains the probationer is most motivated to change. By targeting need areas in this way it is anticipated that changes in behavior which result in lower recidivism will be achieved.
- **Risk Reduction Leads Officers:** CSSD has made a crucial commitment to provide ongoing support of all the above Risk Reduction Initiatives by dedicating two officers to the newly created position of Risk Reduction Lead Officer. The promoted officers were not only recognized as high performing but showed advanced understanding of MI techniques and the Strength Based approach. Along with supervisors the RR Leads will travel to all thirteen probation offices to directly observe officers as they conduct interviews with juveniles and their families. By means of the ongoing support, critique and re-training by the Lead Officers CSSD has ensured that 70 hours of Risk Reduction training will become part of daily probation practice, thereby measurably reducing recidivism by juveniles in Connecticut.

**Prevention -- Parents With Cognitive Limitations:**

*Families and Service Delivery System* - The number of families headed by a parent with cognitive limitations is estimated to be 30-50% of parents served in the child welfare system (Azar).

People with cognitive limitations may have difficulty including but not limited to: planning; organizing; memory; regulating emotion; judgment; scheduling and keeping appointments and setting limits and following through. In every day life, they have trouble scheduling and keeping appointments, exhibit poor judgment, and have difficulty setting limits and following through. They often live in poverty and cope with chaotic daily circumstances. These limitations result in problems maintaining a home, a job, their children, and benefits. Isolation, lack of transportation, and few community supports tailored to meet their needs are persistent problems for these families.

Parents with cognitive limitations interact with many agencies: Social Services (entitlements); DCF (child protection) Social Security (SSI and SSDI); etc., as well as private agencies providing community and job supports. Fragmentation inherent in differing policy, eligibility, service providers, and funding sources complicate their lives. Most providers have not been trained to work with these families.

Service providers often inaccurately identify these parents as having mental illness or substance abuse issues. When services designed for these other populations are not effective for such parents, they are often labeled as resistant to the services and blamed for the ongoing difficulties within the family.

Most evidence-based curriculum has not been tailored to meet the needs of these families and therefore, is at best ineffective. At worst, it sets up unrealistic expectations for the parents. Parent education, when available, is short-term and uses methods developed for other populations.

In addition, most agencies do not provide family-centered services. Currently, Connecticut is only one of a handful of states where there is no single agency serving these families.

Member agencies include the Department of Children and Families; Department of Social Services; Bureau of Rehabilitation Services; State Department of Education; Department of Developmental Services; Department of Mental Health and Addiction Services; Court Support Services Division; Department of Correction; Children's Trust Fund; Connecticut Council of Family Service Agencies; The Connection, Inc.; The Diaper Bank; Real Dads Forever; Brain Injury Solutions, LLC; Brain Injury Association; Office of Protection and Advocacy for Persons with Disabilities; and Greater Hartford Legal Assistance.

To date, over 700 DCF workers and community providers have attended the training. Current State of Affairs and Proposed Solutions

*The Vision:* Connecticut will have a system that recognizes that many families are headed by a parent with cognitive limitations who will need varying degrees of supportive services throughout their lives. The system will be family focused, flexible and culturally competent.

This population needs to be recognized as distinctive and in need of services adapted to meet its needs. The Workgroup created an Interview Assessment Guide (re: schooling history, financial management, housekeeping, childcare skills, etc.) which has increased providers' ability to identify families. This Guide is not a screening tool but rather a guide to be used in the context of an on-going relationship.

The PWCL Workgroup developed a training, "Identifying and Working with Parents with Cognitive Limitations", the goals of which are to increase awareness and improve identification of and service delivery to this population by providing intervention strategies. The training has been offered in many communities throughout the State and additional trainings are being offered in 2008-2009.

The training is filled to capacity every time it is offered. Clearly, State workers and community providers have identified their need to increase their knowledge and skills in working with this population. Additional benefits of this training include: Structured networking opportunities which stimulate greater coordination. Geographic concentration of trainings has created community readiness in several communities. Collaboration with DCF's Training Academy has resulted in greater Departmental integration and the awarding of CECs for social workers.

*Recommendations:* Identify and secure funding for these trainings to continue so that providers can tailor their existing services to better meet the needs of these families. Review and revise/recommend assessment tools.

- In spite of the efforts of many, the drafting of budget options, and the 1 year planning grant in Bridgeport, there are currently few community supports that meet the on-going needs of these families who often require more intensive and longer term services than most of our systems currently fund. Research indicates that if these parents are to succeed they need: long-term support, intensive, individualized in-home support, case coordination and relationships that encourage healthy interdependence.
- Fund a continuum of direct services to families which would include parent education, educational advocacy, intensive in-home supports and housing options for DCF involved families as well as families at risk of involvement. As a result of current eligibility requirements, many of these services are not available to these families or not available in the intensity or duration needed by these families.

The Department could, in every contract, reserve a certain number of service slots that would be reserved for families that need services of greater intensity and duration. These services will need to address the developmental needs of the children in these families and these services need to be provided in the context of a relationship.

- Continue the partnership with agencies (e.g. Head Start and The Connection) to better serve these families.

For many of these families, multiple agencies are involved in their lives; communication between them and between the agencies and the families tends to

be poor, confusing and stressful. In addition, many of our systems fund services for an individual (e.g. child or substance abusing parent) but not for the family.

- Advocacy on the national and state level to encourage a family focus in funding streams. Establish a protocol for determining the lead agency as well as guidelines for working with these families in a team approach.
- Communication (written and oral) with families often includes jargon, complicated sentence structure and vocabulary that is unfamiliar to them.
- The PWCL Workgroup has drafted recommendations regarding the use of plain language in communicating with clients. Train all service providers in the use of plain language. Modify agency communication to be more easily understood.

Currently, Connecticut is only one of a handful of states where there is no single agency serving these families.

- Expand the charge of the Department of Developmental Services to serve these families.

#### **Community Outreach -- Citizen Review Panels:**

There are a number of parent advocacy groups in the state that are designed to review our practices specifically in the areas of behavioral health. FAVOR is a statewide Family Advocacy Organization for Children's Mental Health. Their mission is to enhance mental health services for children with serious emotional disorders by increasing the availability, accessibility, cultural competence and quality of mental health services for children through family advocacy. This organization agreed to broaden its focus and responsibilities and function as two of Connecticut's three Citizen Review Panels.

In order to support and encourage parental participation, the Department has agreed to allocate funding for members to receive stipends for transportation and childcare costs, as well as to assist FAVOR for associated meeting costs. Predominately, the membership of the panels facilitated by FAVOR consist of parents who have had some experience in working with the Department. Over the past several years, the panels have focused on family engagement, treatment planning and the Training Academy.

The Department has implemented many of their recommendations relative to these areas, recognizing the importance of consumer feedback in the improvement of our case practice. A panel member serves on the Training Academy Advisory Board and many of the panel members participate in the development of DRS and several members have been certified to provide training on DRS.