CHILDREN'S SERVICES WORKING GROUP PRIORITIES **December 23, 2010**

(page numbers refer to pages in Children's Services Policy Proposals document dated December 20, 2010; bolded items are priorities within their priority categories)

PRIORITY INITIATIVES: Things that should be addressed during the 2011 budget/legislative process

	Policy Initiative	**Immediate Fiscal Impact**
1.	**Create a Governor's Children's Cabinet (the coordination and streamlining proposals can be accomplished through this level of interagency collaboration) p.44**	Use existing gubernatorial and executive agency staff
2.	**Promote DCF Leadership:** The recommended actions re: children in out of home care, caring for young children and caring for adolescents can largely be accomplished through implementing the recommendations regarding DCF Leadership. pp. 34-36	No cost
3.	**Implement Differential Response System within DCF. p. 36**	Reallocating to front end with cost savings results expected
4.	**Expand existing successful early childhood mental and physical health prevention and early intervention initiatives (e.g. Child First, Nurturing Families, Family Resource Centers, School-based Mental Health Clinics, HeadStart and Birth to Three). p. 23**	Maximize federal dollars and Medicaid reimbursement
5.	Expand Vaccine Purchase Fund. p. 17	Vaccine purchase cost neutral
6.	Implement Statewide Primary Care Case Management. p.18	Cost savings from elimination of for-profit MCOs
7.	**Reduce Number of Uninsured Children. p. 20**	Medicaid cost per child (with federal match), but long term savings from health problem avoidance
8.	**Give the current Early Care and Ed Cabinet statewide advisory committee budgetary authority to begin to blend and braid funding streams across agency for program efficiencies and improved child outcomes p. 4**	Improved use of resources and strategic alignments for child outcomes
9.	Allow TANF parents who are not fully literate to utilize adult literacy training as portion of work requirement hours. p. 5	No cost-- will lead to more employment opportunity

10.	Plan for a more coherent and equitable financing system of early care and education; develop more integrated funding and policy approaches through common interagency agreements, contract language and outcome measures. p. 6	No cost -- efficiencies, improved streamlining, more attention to goal and outcome for resources
11.	Maximize federal funds such as Medicaid, including EPSDT for children's services. Expedite DCF certification of home-based mental health treatment so that all sites, such as Child First, obtain Medicaid reimbursement. pp. 9, 23, 51-56	Will leverage more federal dollars to support services for vulnerable families.
12.	Include Care for Kids in DSS point of entry plan/modernization project. p. 6	No cost-- helps expand child care access and resource info for families
13.	Create a continuum of home visitation services that can serve families. p. 7	Federal home visitation funds eligibility
14.	Strengthen state bullying prevention law to include cyber-bullying and ensure full implementation of law, which has not been properly implemented to create safe schools climate. p. 10	No cost—requires school policy development & implementation; Federal funding available, CT invited to apply in 2011
15.	Establish a state obesity prevention plan, including statewide training and evaluation. Track state and regional rates of overweight and obesity among children and racial and ethnic disparities. p.11	Access new obesity prevention grant funds through the federal Healthy, Hunger Free Kids Act of 2010
16.	Create a state preparedness response and recovery plan for children in natural and unnatural disaster with Save the Children and the Child Safety and Response Committee at DEMHS. p. 12	Federal dollars may be available through homeland security-- funds help not just in disaster planning but in overall data collection, public information and communications for children's services.
17.	Develop a low birth weight strategy to reverse the LBW trend, including ensuring WIC and food stamp enrollment for pregnant women, and increasing involvement of fathers. p. 13	$195 M/yr spent on unnecessary hospitalizations for low birth weight babies-- undo through federal funds available for WIC, teen pregnancy prevention, fatherhood initiatives
18.	Create a health care delivery/coordination system for children and families. p. 19	Regional care coordination can be developed with existing resources from primary care case management, Medicaid managed care, Medicaid behavioral health and

		dental carve out programs et al.
19.	Partake fully in all federal food programs; bringing in the 33% of families who are not using SNAP. p. 9	No cost--every extra dollar spent on SNAP (food stamps) generates $1.73 in GDP within a year.
20.	Maintain child care subsidies to families with incomes of less than 50% of the state median. p. 9	No cost-- keeps parents working
21.	Protect family support /strengthening programs and parent engagement. p. 9	Keeps families safe and civically engaged during declining resources to avert child and youth acting out, school failure et al
22.	Address reading crisis in state. Promote accountability to best practices (Blueprint for Reading Achievement and Common Care Standards) and incentivize teacher competencies in reading through a master teacher designation for teachers who improve reading in their classrooms. p. 5, 9	Reading crisis in state is harming educational success, competitiveness, a cadre of prepared workers
23.	Support streamlining of applications to ensure those most in need receive services—"No wrong door for entry". p. 9, 29	Will help people avert further crises with food, energy, child care, housing assistance
24.	Avert homelessness and protect children and youth who are homeless. p. 21	Utilize new federal foreclosure funds and current budget allocation to assist homeless youth.
25.	Articulate goals for children across agency and determine priority goals, strategies and accountability plans, create interagency contracts to meet goals for children such as hunger reduction, reading and/or low birth weight reduction. p. 45	Saves resources in administration and stays on point focused on outcome, diminishing "silos"
26.	Align human service agencies geographically. p. 48	Would improve access, allow for co-location of services, shared resources and regional strategic planning.
27.	Promote customer service framework with attention to response time, streamlined application processes, simplified case management opportunity, a family-centered approach, presumptive eligibility, and use of technology to improve speed and portals. p. 53	Helps families in this recession not fall under and down.

28.	Promote prevention as a practice for children and families, including implementing prevention legislation requiring Governor to report progress re shift from crisis spending to prevention spending for children. p. 23	Prevention has higher return on investment in such areas as mentoring, home visitation, reading, early care and education.
29.	**Implement the recommendation of Connecticut's Juvenile Justice Advisory Committee to require a court order before the detention of any child or youth to reduce Disproportionate Minority Contact.** p. 38	**No Cost**
30.	Create and begin to implement a plan to return the over 300 children who reside in out-of-state placements to Connecticut. p. 25	No cost
31.	Reduce reliance on costly residential placements by reinstating and expanding community-based mental health treatment to children at-risk of detention or placement such as the *Emily J*. services Diversion of Youth from the Juvenile Justice System. pp. 23-28, 40-41	Fiscal savings from reduced residential placement costs
32.	**Redesign of Planned Girls' Secure Facility to Better Serve the Needs of Girls** **Reconvene stakeholders from the Executive Implementation Team of the Court Support Services Division (CSSD)/DCF Strategic Plan, including outside providers and advocates, to:** **1. Examine if existing placements can be retooled to meet needs of these girls; and, if they cannot be,** **2. Reallocate funding from planned secure facility to a smaller facility and expansion of community-based alternatives to better meet girls' treatment needs.** p. 42	Possible cost savings
33.	Enhance inter-agency collaboration and coordination at all levels, starting at the top; re-establish the primacy of behavioral health among DCF's multiple missions. p. 27	Fiscal savings from reallocation to community-based services
34.	Improve transition services as young adults leave the DCF systems of care and enter the DMHAS systems of care. p. 27	No fiscal impact—policy change and implementation

35.	Identify an existing model for early childhood mental health prevention and intervention services (e.g. Child FIRST) and promote its expansion through leadership and institutional support. p. 23-28	No fiscal impact
36.	Promote the expansion of school-based mental health clinics as a way to provide greater access to care and to improve school climate. p. 29	No fiscal impact—fund through other organizations such as Federally Qualified Health Clinics (FQHCs) through federal grants and Medicaid dollars

SHORT-TERM INITIATIVES: Things that should be addressed by 2012/2013

	Policy Initiative	**Short Term Fiscal Impact**
1.	Medicaid Family Planning Expansion. p. 14	$807,250 CT costs (10% of total, federal match for rest)
2.	Upgrade Medicaid Eligibility System. p. 16	90% federal match available thru 12/31/15
3.	Ensure all school readiness plans have research-based literacy plans; provide training so plans are proven and likely to produce early language gains. p.5	Systemic response to early care and literacy to help usher in more prepared children for kindergarten
4.	Increase parent outreach and information so families are aware of choices in services such as quality childcare, services for English Language Learners et al. p. 4-6	Some services are not fully used and would bring in federal dollars if used to maximum
5.	Coordinate and expand early care and ed data collection and analysis across agencies.p. 4-6	No cost
6.	Plan for coordinated data across agency and focused on the child. p. 6, 44	Helps determine gaps and strengths and areas for investment
7.	Implement key child and family laws that have been noted as models but not fully implemented such as early reading success. p. 5	No cost
8.	Reduce disproportionate minority contact with the juvenile justice system by requiring collaboration between state agencies, local school districts and police departments to collect and analyze school-based arrest data and to reduce school-based arrests p. 38-41	Savings from reduced entry into juvenile justice system

9.	Reduce disproportionate minority contact with the juvenile justice system by increasing collaboration between state agencies and local school districts to improve educational outcomes for youth reentering the community from residential placement. p. 38-41	Savings from reduced recidivism
10.	Reduce the transfer of children and youth to adult court. p. 38-39	No cost
11.	Divert youth from the juvenile justice system by improving school-based interventions for children and youth who are at-risk for juvenile justice involvement, including truant children and youth. p. 29	Savings from reduced entry into juvenile justice system
12.	Divert youth from the juvenile justice system by exploring consolidation of State juvenile justice services, improving coordination of services for "cross-over" youth who are both child welfare- and juvenile justice-involved and requiring state agencies to actively seek federal reimbursement for diversionary and community-based treatment. p. 40-41	Fiscal savings from federal reimbursement
13.	Identify and implement proven programs like - but not limited to - the CT School-Based Diversion Initiative. (SBDI) p. 29	Minimal impact
14.	Build up local mental health infrastructure so we can keep CT mental health dollars in CT. p. 25	Net inflow of dollars and jobs to CT
15.	**Create a Department of Early Care and Education.** p. 4	Greater efficiency, more focus
16.	**Advisory Board to use Family Support Centers ("FSC") to process all FWSN petitions.** p. 40	No cost
17.	**Extend the Behavioral Health Partnership model and covered services to SustiNet and private insurance.** p. 25	Positive budget impact
18.	**Build capacity to collect and analyze outcomes data for statewide mental and physical health prevention and early intervention programs.** p. **23**	Long term positive budget impact

LONG-TERM INITIATIVES: Things that should be considered beyond 2013

1.	**Include in eligibility for Birth to Three programs mild developmental delays and environmental risks such as poverty.** p. 6	Will reduce cost of literacy problems in K-3
2.	Utilize facilities financing as designed in school readiness statute to expand supply of early care in regions with shortage of buildings. p. 6	Lets more parents work while children thrive in early education
3.	Explore set asides for a percentage of infants and toddlers programs. p. 6	Addresses early care needs where there are large gaps in service
4.	Licensors will visit early care facilities once a year for compliance and standards. p. 6	Quality improves child outcomes
5.	Coordinate and expand mentoring services through the Governor's Prevention Partnership, the Department of Children and Families (DCF) and Court Support Services Division (CSSD). p. 40	No impact
6.	Establish a coordinated statewide training network using National School Climate Standards as a guide for training new providers in evidence-based, community-proven approaches p. 10	Minimal fiscal impact
7.	Expand DCF services to age 21 Medicaid coverage to age 26 for former foster youth—to provide parity with non-DCF involved young adults p. 15	Federal Medicaid match
8.	Test newborns for Severe Combined Immunodeficiency to stall infection, allow for bone marrow transplants and promote healthy children. p.17	Low cost—may be offset by insurance payment

Children's Services Working Group
Policy Proposals

Submitted to Governor-Elect Malloy's Transition Team
December 20, 2010

Children's Services Working Group Policy Proposals
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DOING BUSINESS DIFFERENTLY:
LEADERSHIP & COORDINATION TO PUT CHILDREN FIRST

In difficult economic times, children are the only investment that keeps growing.

Adopt A Comprehensive Roadmap To Prioritize the Well-Being of Children and Families

The proposed actions in the enclosed document provide a comprehensive roadmap for the Governor to do business differently than recent administrations—to prioritize children and lead a truly coordinated response to their needs.

Coordinate and Integrate Systems and Policies

Historically, Connecticut's administration of children's programs has been hampered by siloed thinking and action -- beginning with the failure of executive branch agencies to work effectively together for children. We propose immediate and long-term actions—including creating a Governor's Children's Cabinet-- that promote system effectiveness and efficiencies and maximize available state and federal resources.

Institute Benchmarks and Accountability

Cross-agency coordination enables the Governor to set comprehensive and measurable outcomes for children and families collect relevant data, conduct analyses, track trends, and make strategic investments to improve the lives of children and all Connecticut citizens.[1]

Maximize Opportunities

Reallocating existing state dollars and leveraging federal funding streams increases access to needed services for more children and families. The proposed actions focus on maximizing opportunities for prevention and early intervention. "Front loading" resources to promote these structures for all children prevents avoidable problems from arising, and results in the healthier, more competent and productive adults that Connecticut needs to thrive in the 21st century.

Revitalize Connecticut's Workforce and Economy

Investing in children and families is a key to the state's fiscal health and an investment in Connecticut's future. Safer, healthier children and stable families are best prepared to enter and contribute to our workforce and economic goals.

Early Care and Education

EARLY CARE AND EDUCATION GOVERNANCE AND COORDINATION

I. Statement of Issue: High quality early care and education has been found to provide a significant counter to risk factors – including poverty, abuse or neglect, and limited parental education, among others – that affect many of the state's children.[2] Several studies have shown that for every dollar spent on high quality early childhood programs for at-risk children, it is estimated that there can at least a $17 return to society.[3] Given the potential benefits of such programs, it would be practical and beneficial to have a coordinated system for connecting families to these services and programs. Unfortunately, Connecticut currently lacks this type of effective, comprehensive system.

Instead, multiple state agencies control a vast array of funding streams and sources, with minimal coordination between programs or agencies.[4] Although there is a federally-funded State Advisory Committee, also known as the Early Childhood Education Cabinet, this group lacks the authority to control funding or to mandate specific actions to be taken by early care programs. This lack of centralized governance makes it difficult to maximize funding, promote quality measures across programs and agencies, encourage workforce development, streamline access to services, or ensure accountability for educational outcomes.

II. Proposed Action: (1) Support creation of a Department of Early Care and Education, which would direct all early care and education services and funding and coordinate services across agencies. It is understood that actual implementation of this department might have to be delayed for one or two years due to budget constraints. (2) Until an improved budget allows a Department of Early Care and Education to be funded, enhance the authority of the State Advisory Council (SAC) so that it might begin blending and braiding funding streams and implementing measures for quality improvement and coordination and alignment across programs and agencies.[5] The SAC is federally-funded, and should have access to additional funding through the federal Early Learning Challenge Grant, if it is passed, so there should be minimal expense to the state.
Tie-in with Malloy/Wyman Campaign Policy: Centralizing the governance of the early care and education system aligns with Malloy/Wyman Policy Goals of (1) focusing on Early Childhood Education; (2) transitioning toward a new, smarter system of funding for education; (3) promoting quality in the classroom; (4) maximizing federal funds; and (5) streamlining state government.

III. Long-term Needs/Vision: In the long-term, the ideal system of governance for Connecticut's early care and education system would resemble the structure of governance found in Massachusetts, with a Department of Early Care and Education that works in conjunction with the Department of K-12 Education, and the Department of Higher Education, as coordinated by an overarching Secretary of Education. The Department of Early Care and Education would also either control or coordinate services affecting early childhood health and mental health. It would control infant and toddler programs as well, promoting expansion of high quality programs for this age group. Ideally, a system of local or regional governance would be connected to the Department of Early Care and Education.

IV. Jobs Impact and Other Benefits: Centralizing the governance of Connecticut's early care and education programs would help maximize the use, funding, and quality of these services. This would not only benefit working parents, who would be better able to access affordable child care programs that would allow them to maintain employment, but would also support Connecticut's vibrant child care industry.[6] Most importantly, improved coordination of early care and education services would help better prepare Connecticut's future generations for success.

V. Dissenting Opinions and Other Relevant Items: If implementation of the Department of Early Care and Education is delayed once, it might be more likely to be further delayed or overturned in the future (i.e., see as a non-critical action).

IMPROVE EARLY LITERACY

I. Statement of Issue: As language development begins in the earliest years through sound, talking, and exposure to print, early literacy facilitates success for young children. Experts agree that language and literacy development play an important role in general child development and a specific role in learning to learn. However, many parents are unable to facilitate their child's literacy development, as they might work more than one job, lack English as their first language, or are not fully literate themselves.

Stressors on family life, compounded by growing economic constraints, lead some children to have limited exposure to rich language, dialogue or books. Some childcare providers address this deficit, but others, particularly informal care providers, are not trained in early language development or fully literate themselves.

More than one third of children from low-income communities enter formal kindergarten classes already behind their peers.[7] By fourth grade more than 50% of these children will not meet the standard for reading proficiency. Of every 100 children who leave first grade as poor readers, 88 will still be poor readers at the end of third grade, limiting their chances of academic and future workforce success.

II. Proposed Action: (1) Identify children who are lagging behind in literacy and promptly implement interventions through early care and Birth to Three programming that will decrease challenges. (2) Discuss the language and literacy needs of English Language Learners with their parents while encouraging them to read and speak to their children in their native tongue. (3) Allow TANF parents who are not fully literate to utilize adult literacy training as a portion of their required work hours. (4) Bring in natural partners (such as pediatricians, libraries, home visitation programs, etc.) to convey the importance of literacy to parents. Inform parents how children learn to read and what they can do to help their children. (5) Train early care and education providers in research based practices to improve early literacy exposure. (6) Ensure that every School Readiness council has a research-based literacy plan, which is being implemented per the requirements of the School Readiness law. (7) Facilitate reading programs in state prisons so that incarcerated parents can read to their children when they visit and can seek work upon release. (8) When pre-k children reach the k-12 system, coordinate transition and curriculum alignment so that literacy gains will not be lost.
Tie-in with Malloy/Wyman Campaign Policy: Addressing early literacy issues mirrors the Malloy/Wyman Policy Goals of (1) focusing on Early Childhood Education; (2) maximizing educational opportunities; (3) reducing the achievement gap and improving Connecticut students' academic competitiveness; (4) increasing cost-savings from reduced education expenditures later in life; and (5) maximizing federal funding (using CCDBG and Title I dollars to support efforts).

III. **Long-term Needs/Vision:** All children should be assessed for risk factors affecting early literacy and high quality early literacy services should be made available to those children who need them. Birth to Three should be utilized for early intervention and expanded to include children with mild developmental delays and environmental risks. Early education providers should be given adequate and proven training in early literacy development. Parents should be highly informed about the importance of early literacy, while parental literacy should be promoted through adult education, community college programs, family literacy opportunities in TANF, and courses offered at family hub sites for parents. Early language development should be assessed by pediatricians using proven and tested initiatives, such as Reach Out and Read, which could be funded through EPSDT.

IV. Jobs Impact and Other Benefits: Many studies of at-risk youth and adults, dropouts, teen parents, welfare recipients, and the men and women in prison in America document illiteracy or significant reading problems in these populations. By improving literacy, we can help these children and adults succeed. In the long-term, the state's economy will vastly benefit from a multilingual, highly literate workforce. Parents of current students may benefit from literacy services provided to families, improving the literacy skills of the current workforce.

V. Dissenting Opinions and Other Relevant Items

1) Language is naturally picked up by children. 2) If children cannot read, it is the family's fault. 3) Focusing on early literacy harms children's play.

IMPROVE EARLY CARE AND EDUCATION DATA, ACCESS, AND FINANCING

I. Statement of Issue: Connecticut's early care and education services and programs are managed by a wide variety of state agencies, with data collection, eligibility requirements, quality, and financing varying widely across programs.

Data remain fragmented and inconsistent across programs and agencies. Different programs release widely varying data measures of enrollment, which makes it nearly impossible to calculate the total number of children served by state subsidized programs; additionally, ethnic and racial data is largely unavailable.[8] Due to the absence of this enrollment and demographic data, it is extremely difficult to assess the extent and specifics of the unmet need for early care and education.

Many of the families which do require early care and education services are prevented from utilizing desired services for their children because they cannot navigate the multiple paths and rules for usage across programs. Additionally, they are often unable to determine which programs would best serve their children due to a lack of information about program quality and outcomes.

Financing of early care and education programs is uneven and historically based on agency funding streams, rather than the quality of services, age of children served, or actual cost of care. This variation in funding affects the quality of early care services and facilities.

II. Proposed Action: (1) Increase parent outreach and education efforts so that families are knowledgeable about the services available to them. (2) Include poverty as a factor for Birth to Three program eligibility. (3) Review financing to create a coherent and equitable financing system. (4) Develop more integrated funding approaches through common interagency agreements, contract language, and performance measures and outcomes. (5) Explore "set asides" in funding streams to ensure a particular percentage of resources serve the needs of infants and toddlers. (6) Bolster Early Learning Guidelines for infants, toddlers, and twos in all publicly funded settings to bolster quality. (7) Include Care4Kids in the Department of Social Services' current modernization project, which aims to streamline "point of entry" for programs such as HUSKY and SNAP. (8) Utilize the facilities financing component of the School Readiness law, which provides low-interest loans for facilities expansion and improvements, to maximize space and early care slots. (9) Implement Special Act 09-03, which requires the Department of Social Services, the Department of Public Health, and the State Department of Education to develop a single form for providers of child care and education services to report data necessary to receive state funding. (10) Coordinate and expand data collection and analysis across agencies.
Tie-in with Malloy/Wyman Campaign Policy: Addressing early care and education data, accessibility, quality and funding aligns with the Malloy/Wyman Policy Goals of (1) maximizing educational opportunities; (2) utilizing data to direct reform efforts; (3) promoting quality in the classroom; (4) engaging parents in a meaningful way; and (5) streamlining state government.

III. Long-term Needs/Vision: Reimbursement rates for state-funded centers providing care for infants, toddlers, and twos would be aligned with rates for School Readiness programs, and reimbursement rates for all programs would reflect true cost of care. A fully implemented Quality Rating and Improvement System would improve consumer knowledge of early care and education programs and encourage professional development through financial incentives. Kith and kin providers would be given financial and community supports to promote quality standards and improvement. The availability of quality settings would be expanded for all age groups, especially infants, toddlers, and twos. Licensors would visit facilities once every year to ensure compliance with minimum standards outlined in regulation, ultimately improving the health and safety of many children. A comprehensive, consistent data system would help better track student outcomes, as well as program and funding effectiveness.

IV. Jobs Impact and Other Benefits: By better assessing the unmet early care and education needs of Connecticut's children, and better distributing available funding, it can be ensured that those who are most in need are able to receive appropriate, quality services. Long-term, the provision of incentives to improve provider quality and increase available facilities will improve consumer choice and promote expansion of the early care industry.

V. Dissenting Opinions and Other Relevant Items

MAXIMIZE HOME VISITATION PROGRAMS

I. Statement of Issue: Scientific research has made it absolutely clear that the first three to five years of life is one of tremendous brain growth, and that the environment in which a child develops profoundly impacts his cognitive and emotional development. Each year more than 10,000 children are born into Connecticut families with at least one significant risk factor for abuse or neglect.[9] Although many parents want the very best for their children, they often face multiple challenges, which prevent them from nurturing and supporting their children's development. This can be changed.

Nationally, home visitation leads to improvements in women's prenatal health, reductions in children's injuries, greater involvement by fathers, increased employment, reductions in welfare and food stamps, and improvements in school readiness.[10] Skilled home visitors work with at-risk parents to create an action plan that draws on the family's strengths, community resources and the skills of the home visitor. Areas of focus generally include health behaviors during pregnancy, enhancing qualities of family care giving of infants and toddlers, and linking families with needed health and human services.

Connecticut has a few successful models of home visitation including Parents as Teachers, Nurturing Families, and Child First. The federal government has recently announced funds for home visitation.[11] Concurrently, the Robert Wood Johnson Foundation has funded our Child FIRST model as a national best practice creating a system of care for highly vulnerable families.[12] Every dollar invested in home visitation for Connecticut's high-risk families saves $6.12 in government spending.[13] Furthermore, these programs are some of the few in the state that target services for infants and toddlers.

II. Proposed Action: (1) Create a system/continuum of home visitation services that can serve families with all intensities of need. (2) Utilize federal funding opportunities to maximize program financing to include Medicaid, especially Early Periodic Screening Diagnosis and Treatment (EPSDT), Child Abuse Prevention and Treatment Act (CAPTA), and home visiting grants through the Patient Protection and Affordable Care Act (PPACA). (3) Maximize CT state dollars by prioritizing funding for state agency programs that are evidence-based and can leverage matching federal Medicaid reimbursement. (4) Expedite DCF certification of home-based mental health treatment so that all sites, such as Child FIRST sites, can obtain Medicaid reimbursement, which will leverage major federal dollars to support services.
Tie-in with Malloy/Wyman Campaign Policy: Promoting the use of home visitation programs aligns with the Malloy/Wyman Policy Goals of (1) maximizing federal funds; (2) emphasizing early intervention as wise investment; (3) engaging parents in a meaningful way; and (4) connecting families to their community.

III. Long-term Needs/Vision: Home visitation services should be increased across the state so that all at-risk families are able to receive these services from the onset of pregnancy.

IV. Jobs Impact and Other Benefits: Prevention and early intervention have been documented to generate the highest return on investment, with short-term cost savings from reductions in DCF involvement and special education, and significant long-term benefit from savings in juvenile justice, psychiatric treatment, welfare support, substance abuse treatment, and health care costs.[14] Furthermore, federal funding will be maximized. Federal dollars from the Home Visiting component of the Patient Protection and Affordable Care Act (PPACA) and from the Child Abuse Prevention and Treatment Act (CAPTA) can bring very significant dollars to CT in support of evidence-based practices, while leveraging of federal Medicaid dollars can bring a marked increase in services to Connecticut.[15] Lastly, it is anticipated that significant additional philanthropic dollars can be obtained with ongoing State of Connecticut support. For example, public-private partnerships have already leveraged $4.5 million dollars in support of Child FIRST replication.[16]

Children's Health, Safety, and Basic Needs

MEETING CHILDREN'S BASIC NEEDS

I. Statement of Issue – Meeting children's basic needs first and foremost requires actions to alleviate poverty. The persistence of poverty among children and their families diminishes child outcomes across all systems and gravely impacts the state's fiscal health. Connecticut has already experienced the largest increase in poverty of any state between 2007 and 2008. In 2009, 9.4% of our residents had incomes under the Federal Poverty Level, up from 7.3% in 2001. One out of five our children under the age of 12 are hungry or at risk of hunger, yet Connecticut is last among states for participation in the School Breakfast Program. Nearly one in four children feel the impact of father absence. During the last two decades in Connecticut there has been a significant lack of return on investment of public and private dollars expended for children's healthcare. Connecticut has the worst achievement gap in the country, partially caused by poverty- related issues such as low maternal literacy and limited exposure to language or books.

II. Proposed Action: A. Prioritization Schedule

- Provide childcare subsidies to families with incomes of less than 50% of the state median.
- Provide education and training programs to result in associate degrees for half the adults with high school diplomas.
- Partake fully in all federal options to ease **access to the Supplemental Nutrition Assistance Program (SNAP).** This includes increasing direct certification for SNAP households for free meals, including allowing WIC agencies to certify children up to one year, rather than current policy of six months.
- **Reallocate existing dollars and maximize federal dollars to expand programs that increase family engagement and resources to parent.** Examples include the Family Resource Centers, the Parent Trust, Nurturing Families and Help Me Grow programs)
- **Establish a "No Wrong Door" policy for all human services**. Some states and counties have successfully adopted one application for social services programs that is circulated to the appropriate agencies. One nationally cited example is Allegheny County, PA.
- **Incentivize reading instruction**. Create a master teacher designation for teachers who improve reading in their classrooms. Adopt accountability standards for reading achievement such as the Blueprint for Reading Achievement and Common Core Standards.

B. Fiscal impact: Childcare can be paid for through federal Child Care Development Block Grant Funds. SNAP (food stamps) come from federal funds and generate extensive dollars. Child support payments help the custodial parent and some funds go to the state. Significant federal dollars are available to address hunger. Private partnerships are available to match state funds for family strengthening and fatherhood initiatives.
C. Tie in with Malloy/Wyman Campaign Policy: The campaign policies reflect commitment to federal funds maximization, workforce development and school readiness and success as well as protecting the safety net.

III. Long Term Needs/Vision: A comprehensive, coordinated statewide plan is required to alleviate the root causes and minimize the risks of poverty**.**

IV. Jobs Impact and Other Benefits: Children who demonstrate the largest achievement gap in our state often have families which struggle daily with the impact of poverty. Addressing children's poverty will have significant ripple effects for statewide school success, workforce development and shape the next generation of working citizens.

BULLYING PREVENTION: PROMOTING A POSITIVE SCHOOL CLIMATE

I. Statement of Issue: Connecticut has experienced bullying-related tragedy in Meriden and a Columbine-style close call in Newington. One in four Connecticut high school students—and 35 percent of 9th graders—were bullied at school in the past year.[17] Other students are cyber-bullied.[18]

Bullying interferes with student health, safety and achievement at all grade levels. Connecticut high school students who report being bullied are more likely to get less sleep, miss school because they feel unsafe, have property stolen at school, carry a weapon to school, be depressed and attempt suicide.[19] Bullying may worsen the achievement gap because bullies often target others based on race, ethnicity or other differences.[20] It is associated with decreased academic achievement, health risks, and an increased risk of later criminal conviction among bullying perpetrators.[21]

Positive school climate is an essential part of reducing bullying, dropout and suspensions.[22] It does not happen by accident; it requires commitment of staff; intentional policies and practices; and ongoing maintenance.[23] Bullying, since it is a symptom of poor school climate, can only successfully be addressed with a comprehensive prevention approach. There is much work remaining, due to a gap between best and actual practices. Despite the existence of evidence-based strategies, many schools do not use them as intended, if at all.[24] Some schools have turned to ineffective and harmful measures such as out-of-school suspensions, employed four years ago at an alarming rate (up to 22%), two-thirds of which were for minor violations.[25] Some parents, frustrated by bullying and perceived unresponsiveness of their children's schools, have filed complaints with the state.[26]

II. Proposed Action: (1) Strengthen Connecticut's bullying prevention law to address cyberbullying, enumerate categories of protection, and improve accountability.[27] (2) Develop model policies for K-12 bullying prevention, as required by P.A. 08-160.[27] (3) Require that every school district publish its bullying policy on its website and that SDE publish web links to local policies and the date of latest action.[28] (4) Adopt the *National School Climate Standards*.[29] (5) Secure federal funds to establish a statewide school-climate/bullying survey instrument.[30] (6) Establish a statewide training network to promote positive school climate and prevent bullying.[31] (7) Reallocate resources to enable schools to implement Positive Behavioral Interventions & Supports (PBIS) and to reduce the use of suspensions by employing more effective alternative interventions.[32] (8) Prioritize providing local school districts with resources and guidance on methods to improve school climate.[33] (9) Establish a network of schools working on climate and bullying issues, so that they can share ideas and best practices while supporting each other through challenges; provide regular conferences and statewide events to promote networking among schools. (10) Promote school implementation of evidence-based and promising practices in bullying prevention and school climate.[34]

Tie-in with Malloy/Wyman Campaign Policy: Preventing bullying and improving school climate aligns with the policy goals of (1) strengthening public schools, (2) closing the achievement gap, (3) reducing dropout and crime, (4) developing healthier communities, and (5) promoting prevention.

III. Long-term Vision: All students are safe to learn and experience a positive school climate.

IV. Jobs Impact & Other Benefits: Based on a body of research linking safe, respectful learning environments to positive student outcomes, it is reasonable to expect that promoting positive school climate and preventing bullying in Connecticut schools will result in (1) reduction in dropout and suspensions, (2) improved student health and academic achievement, (3) narrowing of the achievement gap, (4) a decrease in crime, and (5) a better prepared workforce.

HEALTHY EATING & ACTIVE LIVING: PREVENTING THE COSTS OF OBESITY

I. Statement of Issue: Obesity is a public health epidemic that threatens the readiness of Connecticut's current and future workforce. It reduces the productivity of our state's economy, places an unsustainable burden on our health care system, and disables workers. Obesity-related health problems in Connecticut adults generate $856 million in annual medical expenses.[35]

The severe consequences of obesity extend to children. Obese children are more likely to have increased risk of heart disease[36] and to have self-esteem and health issues which negatively impact their studies and social life in school.[37] One third of all children born in 2000 are expected to develop diabetes during their lifetime.[38] Overweight and obese children are more likely to become obese adults.[39] The current generation may be on track to have a shorter lifespan than their parents.[40]

Nationally since 1970, the number of obese children ages 6-11 has quadrupled.[41] In Connecticut, 25 percent of high school students were overweight or obese in 2009.[42] Obesity is a health disparity issue: socioeconomic and race/ethnicity status significantly impact a child's risk..[43]

Unhealthy food choices and eating behaviors are major factors contributing to overweight and obesity.[44] Only 25 percent of Connecticut high school students are physically active every day; 21 percent eat the recommended 5 or more daily servings of fruits and vegetables.[45]

II. Proposed Action: (1) Access new obesity prevention grant funds through the federal Healthy, Hunger-Free Kids Act of 2010. (2) Encourage wider participation in the state's Healthy Food Certification program (only 60 percent of districts participate). (3) Develop a "Complete Streets" vision and plan for Connecticut, and implement P.A. 09-154 directing 1 percent of state and local highway/street transportation funds for bicycle and pedestrian usage. Coordinate this DOT strategy with state health goals being developed in DPH chronic disease initiative. (4) Establish a permanent council on childhood obesity, following up on the initial work of the temporary Connecticut Childhood Obesity Council, to track federal grants, bring together key state agencies, consumers, advocates, health care providers and legislators to advise the state on strategies, coordinate local governmental and community initiatives, and advise state leaders on policy and programmatic matters. (5) Establish a state obesity prevention plan, including statewide tracking and evaluation.
(6) Develop state strategy to fully maximize federal food security program funds. (7) Require limits on the use of video and computer screens in licensed child care facilities. (8) Track statewide and regional rates of overweight and obesity among children and racial and ethnic disparities.
Tie-in with Malloy/Wyman Campaign Policy: Developing healthy lifestyles at a young age aligns with the policy goals of (1) improving health care and lowering costs, (2) developing healthier communities, (3) strengthening student achievement, and (4) promoting prevention.

III. Long-term Vision: All children establish an active lifestyle and healthy eating early in life and maintain these behaviors throughout their lives.

IV. Jobs Impact & Other Benefits: Based on a body of research linking obesity prevention to positive health outcomes, it is reasonable to expect that promoting healthy eating and active living among Connecticut children and families will result in (1) healthier outcomes for children, (2) lower health costs, (3) fewer obesity-related deaths, (4) students better prepared to focus and learn, (5) improved academic achievement, and (6) a healthier workforce.

CHILD SAFETY AND SECURITY IN DISASTERS

I. Statement of Issue
Natural and unnatural disasters are on the rise. Over the last 12 months, Connecticut has been affected by a violent worksite shooting, a facility explosion, damaging winter weather, dangerous summer storms and tornadoes. Traditional approaches to disaster risk management often overlook children.

Save the Children graded all states on criteria of preparedness. They require: (1) all licensed child care facilities to have a written plan for evacuating and moving all kids to a safe location for multiple disasters; (2) all licensed child care facilities to have a written plan to reunify families after a disaster; (3) all licensed child care facilities to have a written plan that accounts for children with special needs during a disaster; and (4) all schools to have a disaster plan that accounts for multiple hazards. Connecticut meets only the fourth criteria.

II. Proposed Action – Immediate
A. Priorities: 1) Create a comprehensive statewide preparedness, response and recovery plan to ensure the safety and wellbeing of children before, during and after disasters. 2) Continue to partner across agencies through the Connecticut Child Safety and Response Subcommittee chaired by DEMHS, to explore disaster-related gaps. 3) Continue to participate on the FEMA Children's Working Group to ensure that a federal disaster response meets the unique needs of children. 4) Support the Save the Children partnership on an Emergency Child Care Initiative through June 30, 2011. Chaired by DSS, DPH and the Commission on Children, this initiative focuses on children in child care settings and addresses the four criteria noted above. 5) Enact regulatory or legislative changes to bring Connecticut in line with the criteria for emergency preparedness as identified by the National Commission on Children in Disasters, and Save the Children.

B. Fiscal Impact: In the US alone, natural and technological disasters cause an estimated $52 billion in damages each year. Many child care programs lack business continuity planning. **Dissenting opinion**-Homeland security is about war and violence and does not belong attached to children.

III. Long-Term Needs/Vision: In Connecticut, over 200,000 children are enrolled in child care centers, child day care homes and before- and after-school facilities. Most child care emergency plans are not coordinated with local emergency management officials, and many child care facilities do not have emergency communications or reunification plans ensuring that parents and children may be quickly reunited following an emergency.

CT should: Ensure statewide policy and emergency management procedural coordination focused on children; Establish Governor-elect Malloy and the State of Connecticut as a national leader in emergency preparedness to protect children; Ensure a comprehensive emergency plan for children birth to 18. This work can be paid for through federal CCDBG funding and potential homeland security dollars.

REDUCING LOW BIRTH WEIGHT

I. Statement of Issue: Connecticut's incidence of low birth weight (less than 2500 grams) babies is too high. In 2006, 8.2% of Connecticut newborns were low birth weight (LBW), a statewide increase of 24% from 1990. The rate is higher for racial/ethnic minorities: 12.7% for Blacks and 8.8% for Hispanics, compared with 7.0% for Whites. Eleven percent (11%) of LBW births in our state are to mothers who received late care, and 26% are to mothers who received no prenatal care. In addition to greater risk of infant death, low birthweight babies are at greater risk for conditions with long-term personal and societal costs, including cerebral palsy, vision impairments, cognitive deficiencies, developmental and learning disabilities, poor educational performance and behavioral problems. LBW infants accounted for $183,964,519 in preventable hospitalization charges in 2008 and had the highest average charge per stay ($70,837) of all preventable hospitalization health conditions. From 2004 to 2008, Medicaid preventable hospitalization charges grew by over 50%: LBW newborns accounted for over two-fifths of this growth with an increase of $30 million. Adequate prenatal care and social/emotional supports are key to healthy pregnancies and healthy newborns.

II. Proposed Action

A. Priorities
   1. Maximize WIC enrollment, especially for Medicaid-eligible women.
   2. Pursue federal grants to fund increased outreach and referrals for prenatal care.
   3. Implement Centering Pregnancy® prenatal care model.
   4. Increase programs that foster involvement of the father of the baby.

B. Fiscal Impact
   1. WIC has been shown to reduce LBW, especially among mothers with Medicaid.
   2. SDE and partners were awarded $6 million grant for supporting pregnant and parenting teens.
   3. Commission on Children has grant funding for implementing Center Pregnancy® in Hartford; thereafter, costs would be reimbursed by insurers that cover prenatal care.
   4. Federal funding is available for fatherhood initiatives.

C. Tie-in with Malloy/Wyman Campaign Policy: Addressing LBW is consistent with improving health care, emphasizing prevention, and (3) changing our fiscal focus from paying exorbitant costs of advanced preventable illness to prevention, early detection and treatment, thus saving lives as well as resources.

III. Long Term Need/Vision: Foster greater collaboration between State agencies, with a commitment to reduce health disparities in LBW and work collaboratively across programs. Explore best practices nationwide and implement those that make sense in Connecticut.

IV. Jobs Impact and Other Benefits: Reducing the rates of LBW would increase the number of healthy children in our state, giving them that basic first step in growing into successful students, contributing members to their community, and productive members of our state.

V. Other Relevant Items: Preconception and interconception care are also critically important for reducing low birthweight.

MEDICAID FAMILY PLANNING EXPANSION

I. Statement of the Issue: While there is wide-spread recognition in Connecticut that high school dropout rates are too high, often missing from the discussion are the issues of too-early pregnancy and parenthood. Teen pregnancy/parenthood and school dropout are closely associated. For example, fully 30 % of teen girls cite pregnancy or parenthood as a key reason for dropping out of high school; rates are even higher for African American and Latino girls. Only 40 % of teen moms finish high school.

II. Proposed Action:
Under the federal Affordable Care Act, the administration can expand access to family planning services to individuals who are not otherwise categorically eligible for Medicaid through a Medicaid State Plan Amendment rather than a "waiver" – a far simpler route.

A. **Prioritization Schedule:**

Much of the groundwork for the SPA has already been done by the current administration because of legislation – now five years old – which required the submission of a family planning waiver. (The waiver was never submitted to the federal government.)

The administration must submit a draft SPA to the regional CMS office. Once the regional office receives a SPA, the amendment *is considered approved* if CMS neither disapproves it nor makes a formal request for additional information within 90 calendar days.

B. **Fiscal Impact:**

Research has consistently shown over time that for every dollar state and federal governments spend on family planning, they reap at least $4 due to the cost savings from pregnancies averted.

- $8,072,501: estimated total cost of family planning/contraception to eligible users, **90%** reimbursed by the federal government. ($807,250: CT investment)
- $46,000,000: estimated possible savings from births averted (prenatal care, labor and delivery, inclusive of Medicaid costs to cover newborn and mother.)

C. **Connection to Malloy-Wyman campaign policy:**

A more comprehensive approach to reproductive health care/pregnancy prevention for sexually active adolescents *will contribute to school reform by contributing to the decrease in dropout rates.*
Twenty seven states with experience operating family planning waivers are now transitioning to the SPA expansions, having reaped the fiscal benefits of an investment in family planning that is heavily subsidized by federal dollars.

III. Long-term Needs

IV. Jobs Impact & Other Benefits: Important step to ensuring that as health reform rolls out, all Connecticut residents are insured.

V. Other Relevant Items

EXTEND MEDICAID COVERAGE TO YOUNG ADULTS FORMERLY IN THE CUSTODY OF DCF

I. Statement of Issue: Connecticut currently provides Medicaid coverage to young adults who were formerly in DCF custody till they turn 21. Since 2008, Connecticut has allowed parents to cover young adult children on employer-based insurance policies till age 26. Under the Affordable Care Act, this coverage option is now available under self-insured employment-based plans and has been expanded to young adults even if they are married or living out-of-state. The State of Connecticut should ensure that young adults who were formerly in state custody and are currently living in Connecticut have access to health insurance coverage during their transition to independence.

II. Proposed action:

A. Priorities

1. Extend Medicaid eligibility to young adults under 26 who were formerly in DCF custody.
2. Ensure that DCF and DSS have systems in place for informing these young adults about the availability of coverage, the importance of preventive care, and the need to renew to stay covered till age 26 if otherwise eligible.

B. Fiscal Impact

1. According to results of a recent survey, 1 of every 3 former DCF-involved young adults 21-23 were covered by Medicaid at the time of the survey.
2. Requires commitment of additional resources (DCF and DSS staff) for implementation and ongoing operation of the coverage initiative.

C. Tie-in to Malloy/Wyman policy: Consistent with ensuring that all children are insured and that all residents have access to affordable health insurance coverage.

III. Long-term Needs

VI. Jobs Impact & Other Benefits: Important step to ensuring that as health reform rolls out, all Connecticut residents are insured.

VII. Other Relevant Items

UPGRADE THE MEDICAID ELIGBILITY SYSTEM

I. Statement of Issue: Connecticut has the opportunity to simultaneously help children expeditiously access Medicaid health insurance and to improve overall Medicaid program processes. The Medicaid Eligibility computer system is 20 years old. Under the Affordable Care Act, additional federal funds (90% match) are available for upgrading the eligibility system to make it more cost-effective, accurate, reliable, beneficiary-friendly, and up-to-date technologically. This investment is more important now than ever before, given health reform, with its expanded coverage under Medicaid and the need for seamlessly coordinating coverage with the new health insurance exchange.

II. Proposed action:

A. Priorities
   3. Apply for enhanced federal matching funds for upgrading the system.
   4. Provide DSS with the additional resources (staffing, state funding) to design and implement the upgrade.
   5. Ensure that members of the public provide input into the development, operation, and evaluation of the new eligibility systems, with special attention to compliance with civil rights laws, provision of culturally and linguistically appropriate services, and effective communication with beneficiaries and providers.

B. Fiscal Impact
   3. 90% federal match available through 12/31/15 for upgrade of Medicaid eligibility systems.
   4. Requires commitment of additional resources (staff, 10% state funding) for design and implementation

C. Tie-in to Malloy/Wyman policy: Consistent with ensuring that all children are insured and that all residents have access to affordable health insurance coverage.

III. Long-term Needs

IV. Jobs Impact & Other Benefits: Important step to ensuring that as health reform rolls out, all Connecticut residents are insured.

V. Other Relevant Items

EXPANSION OF THE VACCINE PURCHASE FUND AND NEWBORN SCREENING PROGRAM

I. Statement of Issue: Vaccination is the ultimate preventative health strategy for children. Immunization saves lives, lowers medical costs and prevents serious illness and disabilities. The goal of the Department of Public Health (DPH) Immunizations Program is to achieve the highest possible age appropriate vaccination rates for each recommended vaccine for children. Since 2003, the Connecticut Department of Public Health Immunization Program provides vaccines at no cost to health care providers to administer to children so that cost of vaccine will not be a barrier to age-appropriate vaccination in this state (CGS 19a-7j). Insurers fund the vaccine purchase fund through an annual assessment by the Insurance Commissioner, making provision of childhood vaccines budget neutral. Despite being "budget neutral," coverage for new vaccines requires an increase in the budget line item and is thus subject to the budget cap.

The DPH Newborn Screening Program does not currently test for Severe Combined Immunodeficiency, a genetic disorder that is nearly always fatal in infancy without early diagnosis and effective treatment. Early diagnosis, before the infant has had a chance to develop any infections, is extremely valuable since bone marrow transplants in the first three months of life have a 96% success rate and are more effective than transplants at a later age.

II. Proposed Action

A. Priorities

1. Remove the vaccine purchase line-item from under the state budget cap.
2. Make the vaccine purchase expenditure non-lapsing.
3. Phase-in coverage for five vaccine formulations that are not currently available to all children in Connecticut, including three that are currently required for day care enrollment and will be required for pre-kindergarten enrollment in August 2011.
4. Hire two microbiologists to validate the method and perform routine testing for Severe Combined Immunodeficiency.
5. Purchase instrumentation and testing supplies

B. Fiscal Impact: Implementation of vaccine expansion is cost-neutral as this change is simultaneously an expansion option and a revenue-generating option per CGS Section 19a-7j.
Newborn screening: Increased revenue: $168,000, from increased charge to hospitals for newborn screening ($4 increase for 42,000 births/year, up from current charge of $56 per newborn); One-time cost for equipment: $130,000; Ongoing cost for additional staff: $158,258/year

C. Tie-in to Malloy/Wyman Policy: This proposal is consistent with investment in prevention as a critical component to averting vaccine preventable diseases and averting health care costs with early detection and treatment

III. Long-term Needs/Vision: To achieve highest possible age appropriate vaccination rates for each routinely recommended vaccine for children and adolescents, to leave no child under the age of two years vulnerable to out-of-pocket costs for receiving childhood vaccinations, and to reduce or **eliminate the burden of disease and death for vaccine preventable diseases.** Upon implementation, the newborn screening program would require only continued funding for staff and other expenses to perform the testing.

IV. Job Impact & Other Benefits: The Newborn Screening proposal creates an additional 2 positions in the state's Public Health Laboratory.

V. Other Relevant Items: CGS Section 19a-7f ties the Connecticut standard of care for immunization to the recommendations of the Advisory Committee on Immunology Practices (ACIP) and American Academy of Pediatrics (AAP). The Modell Foundation has committed to a $1/test match if the department is able to implement a newborn testing program.

IMPLEMENTATION OF STATEWIDE PRIMARY CARE CASE MANAGEMENT

I. Statement of Issue: Expanding Primary Care Case Management (PCCM) statewide in the HUSKY Program will save tax dollars by eliminating high administrative costs and profits associated with managed care. PCCM will improve the quality of health care for this vulnerable population. PCCM is a system of care in which primary care providers are responsible for and paid for coordinating care.

II. Proposed Action

A. Priorities

1. Replace capitated managed care plans with a statewide system of PCCM.
2. Establish a task force to plan rapid conversion of the existing program to PCCM, to formulate recommendations re contracting with an administrative services organization (ASO), and develop Medicaid state plan amendment re care coordination.

B. Fiscal Impact

1. Based on other states' experience with PCCM, substantial savings will be seen from the conversion within the first year, even with the necessary investment of administrative resources to develop infrastructure and provider support.
2. Additional ongoing savings from aggressive disease management programs also can be realized.
3. Ninety percent of the cost of care coordination services provided to individuals with two or more chronic conditions can be reimbursed by the federal government under a state plan amendment.

C. Tie-in to Malloy/Wyman Campaign Policy**:** Entirely consistent with campaign's proposal to "Expand Connecticut's Primary Care Case Management (PCCM) system, HUSKY Primary Care, to 400,000 low income children and parents in the HUSKY program."

III. Long-Term Needs/Vision: PCCM saves money in two ways: by ending the high administrative costs and profits inherent with risk-based contracting through for-profit companies; and by delivering care coordination to ensure that preventive care and early intervention reduces expensive complications and excessive costs for emergency care and hospitalization.

IV. Jobs Impact & Other Benefits: Many primary care providers will need to hire care coordinators. Some Connecticut-based employees of participating HUSKY health plans may lose their jobs.

V. Dissenting Opinions & Other Relevant Information: The Rell Administration was committed to the managed care model. When PCCM is firmly established with appropriate infrastructure, this model of care can be used to efficiently manage care for elderly and disabled Medicaid populations who are currently covered fee-for-service, without care management.

POLICY SUPPORT FOR CARE COORDINATION FOR IMPROVING CHILDREN'S HEALTH[46]

I. Statement of Issue: Fragmentation of health, mental health and other support services for children contributes to suboptimal health and human service delivery by creating**:**

- Difficulties for families in using services across sectors
- Inefficiencies in service delivery (duplication, excessive paper work, long waits for care)
- Challenges in maintaining quality and accountability due to inadequate integrated data systems
- Compromised outcomes
- Increased utilization of expensive services (emergency department, laboratory test)

II. Proposed Action: Designate and expand existing Title V regional care coordination centers to serve all children through their primary care medical home with **existing** resources in their regions. A public/private partnership is funding a pilot of the proposed concept in Hartford.

Priorities: Regional care coordination collaborations can be developed with **existing** resources from: Primary Care Case Management, Medicaid Managed Care Organizations, Medicaid Behavioral Health and Dental carve out programs, Department of Children and Families, and United Way Child Development Infoline.

Fiscal Impact: States have saved several million dollars in emergency department and hospital costs by implementing systems to better coordinate care.

Tie-In to Malloy/Wyman campaign policy: Emphasizes prevention, early detention and treatment, and reliance on medical home primary care model.

Long-term Needs/Vision: Ensure efficient use of health, mental health and social services with enhanced care coordination through medical homes. Care coordination through a medical home is a promising strategy for improving the delivery of services to vulnerable populations. Practice-based care coordination has been shown to be result in decreases in:

- parents missing days of work
- children's hospitalization rates
- families' need to come into the office for visits when their children were sick
- the utilization of emergency department visits, lab tests, and x-rays

Potential Benefits: Oklahoma and North Carolina have not only decreased the use of expensive, unnecessary services, but also have improved implementation of primary care services as measured by Healthcare Effectiveness Data Information Set (HEDIS) measures. Families can be expected to have improved access to services with minimum disruptions. We also can expect better health outcomes as the right services, reach the right people, at the right time. Periodic dissemination of performance and outcome data related to care coordination can support the implementation of the CT Child Health Improvement Program as mandated by the legislature (*Public Act No. 07 - 185).*

REDUCE NUMBER OF UNINSURED CHILDREN

I. Statement of Issue: Many Connecticut children are uninsured, despite the availability of publicly-funded free or low cost coverage in the HUSKY Program. The latest data from the US Census Bureau indicate that in 2009, an estimated 62,000 children under 18 (7.7%) were uninsured for the entire year in 2009.

II. Proposed action:

A. Priorities

1. Avoid cutbacks in eligibility and benefits for children, parents, and pregnant women
2. Avoid additional cost-shifting (increase premiums or co-payments) to families
3. Improve HUSKY Program contract oversight.
4. Maintain provider reimbursement at least at levels established in 2007
5. Convene a task force to study and recommend steps to ensure insurance coverage for children now and as health reform is implemented

B. Fiscal Impact

1. State costs for HUSKY coverage will increase with increased enrollment.
2. Enhanced Medicaid reimbursement under ARRA ends June 30, 2011
3. Additional staff in Central Office will increase state expenditures for state employees
4. In current managed care environment, cuts in provider reimbursement or failure to maintain levels set in 2007 may not result in significant savings to the state and will seriously threaten access to care
5. Task force can be convened at no cost, but will undoubtedly recommend steps with cost implications.

C. Tie-in to Malloy/Wyman policy: Consistent with comprehensive plan to extend health insurance coverage to every child in the state.

III. Long-term Needs: Access to care is a function of health insurance coverage. Children who are uninsured are less likely to receive preventive care or to have a consistent source for routine care and treatment for acute conditions. They are more likely to delay or do without needed care if it is unaffordable or unavailable to those without health insurance. All children need preventive care (immunizations, check-ups, dental sealants, vision and hearing screening) to keep them well and timely screening at regularly scheduled intervals for early detection of health problems when treatment is more effective and less costly than emergency visits or hospitalization. Health insurance is a long-term investment in Connecticut's future: Healthy children are better students and more likely to become healthy, productive adults.

IV. Jobs Impact & Other Benefits: Connecticut families are facing hard times during this economic downturn. Many employers have dropped health insurance coverage for their employees. This is not the time to cut eligibility or benefits in safety net programs.

ADDRESSING THE NEEDS OF HOMELESS YOUTH IN CONNECTICUT

I. Statement of Issue:

Connecticut must address its burgeoning homeless youth population. Over the past two years, Connecticut schools reported a 34 percent increase in the number of homeless students.[47] One program in New Haven is projected to serve 250 homeless youth this year, solely from the Greater New Haven area.[48] The National Network for Youth estimates that according to studies of a homeless youth sample, 33% had been in foster care, 51% had been physically abused, and 60% of girls and 23% of boys had been sexually abused.[49] These youth are moving from house to house, trying to stay in school, and sometimes resorting to prostitution in exchange for a bed.

II. Proposed Action:

A. Prioritization Schedule:

1. Connecticut must **maintain funding for homeless youth programming.** P.A. 10-179 sections 28-30 defines homeless youth and allows CT Department of Children and Families to set up outreach, respite care and transitional living supports for homeless youth. This funding must be maintained.
2. **Tighten up laws related to services for sexually exploited youth**. Currently Connecticut law specifically exempts from prosecution anyone under 16 who engages in sexual conduct with another person in return for money.[50] The law does not discuss services for these children, safe housing, and protocols for who will serve them. Consequently, these victims become homeless and return to a life of prostitution. These laws need to be tightened.[51]
3. **Require collaboration** between state agencies to address services for homeless youth. This would require cross-system collaboration between key agencies- CT Department of Children and Families, CT Department of Social Services, CT Department of Mental Health & Addiction Services, as well as the CT Judicial Branch and CT State Department of Education. Currently, there is no forum where all of these agencies coordinate to provide a comprehensive system of services for homeless youth.

B. Fiscal Impact:

The fiscal impact is minimal, since $1million in funding has already been appropriated by the legislature in 2010 through P.A. 10-179.

C. Connection to Malloy/Wyman campaign policy:

The Malloy/Wyman campaign policy discusses the importance of "'sustainable housing' programs that help those who are at risk of revolving –door homelessness to find stability…"[52] Addressing the homeless youth population is an important first step to preventing homelessness.

III. Long-term Needs/Vision:

A seamless provision of services to homeless youth that provides a comprehensive system to prevent adult and family homelessness.

IV. Jobs Impact & Other Benefits:

Reducing the number of homeless youth will in turn prevent future homeless individuals and families. This prevention initiative will save the state money by addressing the root causes of homelessness early-on.

Additionally, it will have significant economic benefit to the State of Connecticut through improved educational outcomes which will lead to a better prepared workforce and reduced long-term social services.

Children's Mental Health

EARLY CHILDHOOD MENTAL HEALTH PREVENTION AND INTERVENTION SERVICES: A CUTTING EDGE POLICY SUPPORTED BY NEUROSCIENCE[53]

I. Statement of the Issue

- Lack of health and mental health support services for very young children (0-5 years) and their families contributes to poor developmental outcomes and physical, emotional and academic difficulties across the lifespan. Addressing this can result in: (1) Early identification and treatment developmental and emotional problems; (2) Intervention during a period of rapid brain development that scientific research has demonstrated to have most long-lasting, significant positive outcomes on children's health, mental health, and academic success; (3) Improvement in caregiver-child relationships that are proven to buffer the developing brain from high stress or "toxic" environments.

II. Proposed Action

A. Priorities

1. Identify an existing model such as Child FIRST for high-risk young children and families that includes screening, assessment and intervention; the model must have robust data to demonstrate it has the power to decreased child emotional and behavioral problems, improve child language, decreased maternal depression, decrease DCF involvement, and increased access to existing community-based services.
2. Expand that model to all 15 DCF Areas in CT to ensure that all highly vulnerable children and families have access to comprehensive intervention.
3. Expedite DCF certification of home-based mental health treatment so that all new sites can obtain Medicaid reimbursement, thereby leveraging federal Medicaid dollars to support high quality, needed services
4. Maximize effectiveness of CT state dollars by reorganizing state agency programs so that they are both evidence-based and are able to leverage matching federal Medicaid reimbursement
5. Utilize federal funding opportunities to maximize program financing to include EPSDT (children's prevention legislation under Medicaid), CAPTA, and home visiting grants under the Affordable Care Act (PPACA)
6. Continue strong public/private partnership with philanthropy to support comprehensive community-based planning and implementation for early childhood and school readiness that fully integrates health and mental health with early care and education and family support services, using an RBA framework.

B. Fiscal impact

1. Prevention and early intervention generate the highest return on investment. Compare $6,000 for Child FIRST services for a family of four with $700,000 - $900,000 for psychiatric hospitalization for a single child for a year, or the costs of DCF involvement or special education.
2. Leveraging federal Medicaid dollars, home visiting funds from PPACA, and CAPTA grants can bring a marked increase in needed services to Connecticut
3. Public-private partnerships have already leveraged $4.5 million dollars in support of Child FIRST replication from the Robert Wood Johnson Foundation, Children's Fund of CT, Graustein Memorial Fund, and CT Health Foundation. Significant additional philanthropic dollars can be leveraged with documentation of ongoing State of CT support.
4. Investment in early childhood mental health will prevent the need for more costly services including DCF involvement, special education, more intensive clinical treatments, and involvement in juvenile justice services.

C. Tie-in to Malloy/Wyman campaign policy

- The above emphasizes maximization of federal funds as promoted by the Malloy/Wyman team; as with Autism, early intervention for children's mental health is critical, including universal screening, assessment, and access to multidisciplinary treatment; mental health policy is addressed in the Campaign Policy Book, noting 1 in 5 children suffer from a diagnosable mental illness.

III. Long-term Needs/Vision

- Ensure all young children (0-5) in Connecticut have access to comprehensive health and mental health services within a coordinated early childhood system of care that includes promotion, prevention, early identification, and effective treatment.

- Avoidance of utilization of expensive services as children grow and develop along negative developmental trajectories (intensive mental health treatments, hospitalizations, residential treatment, special education services, justice involvement and incarceration).

IV. Jobs Impact & Other Benefits

- Attract federal Medicaid funds, strengthen relationships between well-funded, national philanthropic organizations and local service providers.

SPEND SMARTER AND KEEP MENTAL HEALTH DOLLARS IN CONNECTICUT[54]

I. Statement of Issue:

- Connecticut is experiencing a child mental health crisis in that 200,000 children struggle with diagnosable mental illness, yet only about 25% have access to services they need and deserve.
- Millions of dollars are flowing out of Connecticut to pay for intensive inpatient mental health care. Children and youth with specialized treatment needs have extremely limited access to in-state treatment programs and are routinely referred out of state. There are more children admitted to out-of-state treatment facilities than to in-state facilities. This makes it more difficult for parents to visit their children and interferes with effective discharge and transition planning back into the child's home and community.
- Our state largely depends on a wait-to-fail approach, leading to increased utilization of expensive services such as inpatient hospitalization and residential treatment.
- Our children and their families struggle to access community-based services in part due to underinvestment in low-cost strategies. For example, there is only 1 DCF care coordinator serving 11,000 children in the Hamden/North Haven catchment area.
- Children with mental health needs are not effectively served through private insurance coverage. Thousands of children who are covered by insurance have no way of accessing mental health services. The state pays the cost of people on private insurance who must shift to state-funded services to get needed care.

II. Proposed Actions:

- **Keeping Connecticut dollars in Connecticut** to help bolster the state's child mental health services infrastructure, from prevention services to high acuity inpatient care.
- Reallocate existing behavioral health resources to implement and sustain evidence-based practices (EBP's) and promising practices whenever possible. EBP's with proven outcomes can leverage federal funds through Medicaid to achieve a minimum of 50 cents on the dollar.
- Systematically collect and analyze data within and across services to promote delivery of best practices and enhance performance of service providers.
- Extend the Behavioral Health Partnership (BHP) model and covered services to SustiNet and private insurance; managing and coordinating services (utilization management), covering a comprehensive service continuum, and reducing incentives for the denial of care. The BHP has emerged as a critical success, helping to efficiently distribute scarce mental health dollars, while boosting key quality indicators. At a minimum, private insurance companies should be required to cover medically necessary and appropriate mental health services and treatments for children (as the state currently requires for autism spectrum disorders, PA 09-115).

Tie-in to Malloy/Wyman Campaign Policy:

These recommendations address the following policy targets highlighted by The Policy Project: 1) "Assuring access to effective mental health care for all in need" 2) "Investing more in community-based treatment" 3) "Spending Connecticut dollars in Connecticut"

III. Long-term Needs/Vision: Children will be more likely to remain in their homes and communities. Use of EBP's can be an alternative to the most costly mental health services. EBPs typically have shorter duration of treatment with better outcomes than treatment as usual. EBPs have demonstrated long lasting effects. Early intervention and ***appropriate treatment can prevent the de***velopment of more serious, costly disorders across the lifespan. By **improving access**, the current disparities in access to mental health care will be diminished.

IV. Jobs Impact & Other Benefits: 1) States employing EBP's in place of standard treatment have **saved an average of $30,000 per child.** 2) Bolstering community-based services using evidence-based programs will help divert children from expensive inpatient hospitalization or residential placement, **saving hundreds of thousands of dollars per child per year.** 2) All funds used to treat high needs children using inpatient hospitalization or residential placement will be **spent in Connecticut and create jobs in the state.** 3) Extending BHP covered services and a non-risk model to SustiNet and private insurance will greatly reduce the reliance on the state for coverage and services for children and families with mental health services needs. It also has the potential to generate a funding stream for other needed reforms across the system, as outlined in the "Mental Health Care 'Blueprint' for Children in Connecticut." This plan utilizes the dollars that the health insurance companies use for mental health and pools it in a state fund -- as we currently do for immunizations.

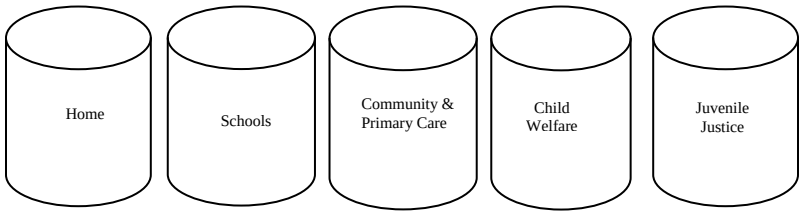
V. Potential Dissenting Opinions & Other Relevant Items: 1) Insurance Industry - insurers will need to be incentivized to buy-in to the "Blueprint." The idea is to pay more for efficiency and outcomes, and the model has the potential to save them money (see the "Mental Health Care 'Blueprint' for Children in Connecticut" by the *Joint Task Force of the CT Chapters of the American Academy of Pediatrics and Child and Adolescent Psychiatry*).

BEHAVIORAL HEALTH LEADERSHIP AND INTERAGENCY COLLABORATION

I. Statement of Issue:

- DCF's behavioral health charge has a secondary status in the daily culture and structure of the DCF system.
- The lack of behavioral health leadership at the highest levels is a strong contributor to the fragmentation across the agency's "silos" of behavioral health, child protection, and juvenile justice.
- From 1998 to 2007, the referrals from DCF to the DMHAS rose from 41 to 1,829, an increase of almost 4500%. This does not include the new young adult cases accepted directly by the adult system. DMHAS estimates that young adults account for an estimated 35% of their incoming clients.[55]
- There is a lack of appropriate services and transition planning for youth and young adults transitioning into the adult mental health system. Specialized Young Adult Services are only available in certain parts of the state.[56]
- Poor inter-agency coordination and communication in the transitioning of young adults from DCF to DMHAS results in a high financial and social cost to Connecticut taxpayers. DCF and DMHAS are required by departmental policies and a memorandum of understanding (MOU) to create and execute transition plans for each young adult that is moving from DCF to DMHAS care. However, plans are often not written or, when they do exist, are not followed; poor transitions lead to higher school dropout and suicide rates, increased homelessness, elevated unemployment rates, and rising criminal justice involvement.[57]

We must break down silos that separate the settings in which mental health services are delivered in Connecticut.



*Schools are de facto the largest provider of mental health services to children in the U.S.

II. Proposed Actions:

- Multiple state agencies have responsibility for the creation, delivery, financing and implementation of mental health services**.** The Office of the Attorney General also has a responsibility to make sure that the mental health parity law is adhered to. All responsible agencies need to coordinate the planning and delivery of mental health services, communicate effectively, jointly assess needs, monitor and make accountability certain, and avoid investing in competing or redundant services.
- The broader mandate of DCF as the children's behavioral services system has been buried in child welfare and should hold a central and upper-level focus within the agency. High-level leadership in behavioral health is necessary to achieve this goal and a reorganization of DCF to give primacy to behavioral health issues.
- A DCF led and coordinated planning process with CT's Child Guidance Clinics, children's residential providers, families and advocacy organizations, and other relevant stakeholders to bring out of state placements back into CT and strategically plan for the mainstreaming of these children back into their communities.
- Hold DCF and DMHAS accountable for timely transition planning and collaborative programming. Codify the MOU between the two agencies.
- Develop statewide availability of specialized Young Adult Services

- At a minimum, DCF and DMHAS should be required to report annually to the Administration and legislative committees of cognizance on their process for transitioning children to DMHAS as they age out of DCF care to provide a clear picture of the population and needs. The report should include a detailed description of the population, their diagnostic profiles, the transition process, and barriers to attaining specific service metrics.

Tie-in to Malloy/Wyman Campaign Policy: These recommendations address the following policy targets highlighted by The Policy Project: 1) "Assuring access to effective mental health care for all in need" 2) "Investing more in community-based treatment" 3) "Spending Connecticut dollars in Connecticut" 4) "Institute Benchmarks and Greater Accountability"

III. Long-term Needs/Vision: 1) Increased attention and access to behavioral health services across relevant state agencies and systems. 2) DCF will be able to embrace its mandate and come out from under the consent decree. 3) Better outcomes for Connecticut's children and families and less cost to the state. 4) A "no wrong door" approach to supporting mental health in children; all children have access to the same range and quality of services regardless of the point at which they access the "system".

IV. Jobs Impact & Other Benefits: 1) Savings to the state by avoiding the complex needs of the growing population of young adults who are failed by the DCF system 2) Diversion of children from expensive inpatient hospitalization or residential placement, saving hundreds of thousands of dollars per child per year. 3) Youth transferred to DMHAS with successful transition plans are more likely to make positive adjustments, require fewer services, and be stable and productive. 4) All funds used to treat high needs children using inpatient hospitalization or residential placement will be **spent on Connecticut services and jobs.**

V. Potential Dissenting Opinions & Other Relevant Items: 1) State agency leadership and staff may have concerns regarding greater accountability and documentation, as well as issues related to competing resources and separate programming budgets.

BOLSTERING SCHOOL-BASED MENTAL HEALTH: A POLICY TO ADDRESS OUR CHILD MENTAL HEALTH CRISIS AND NARROW THE ACADEMIC ACHIEVEMENT GAP

I. Statement of the Issue

- Research shows that Connecticut's achievement gap, the worst in the nation, will not improve unless schools attend to students' social and emotional needs while promoting academic success.
- Research further demonstrates that schools act as our state's de facto mental health system; about 75% of children receiving mental health services do so in a school setting.[58]
- Comprehensive school climate strategies are key to addressing the achievement gap and bullying, while school-based mental health clinics boost access to much-needed mental health services for children.
- Schools are motivated to address school climate, yet lack resources, data, a support network, and coordinated training options to help them implement practices specified by state law.
- The rate at which Connecticut schools use emergency seclusion and restraints as a behavior management strategy is about ten times greater than in California – last year there were more than 18,000 incidents in our state.[59]
- There are too many children in our schools who are at risk for juvenile justice involvement and lack the appropriate community based services to alter their trajectories.

II. Proposed Actions

A. Prioritization Schedule

1. Establish a coordinated statewide training network using *National School Climate Standards* as a guide and train new providers in evidence-based, community-proven approaches, including – but not limited to – Olweus Bullying Prevention Program and Positive Behavioral Interventions and Supports (PBIS).
2. Strengthen and expand school-based mental health clinics by financially healthy community-based organizations, including – but not limited to - Federally Qualified Health Clinics (FQHC) to access Medicaid funds and appropriate federal grants.
3. Bolster the monitoring of in-school emergency seclusion and restraints of children and aim to lower the number of yearly incidents significantly.
4. Implement programs, including – but not limited to – the Connecticut School-Based Diversion Initiative (SBDI) to prevent at-risk students from entering the juvenile justice system; such systems aim to build partnerships with Emergency Mobile Psychiatric Services (EMPS) providers to provide immediate crisis stabilization and linkages to appropriate community-based supports.[60]
5. Maintain state funding levels to all 62 school-based Family Resource Centers (FRCs) as they provide families with a single point of entry to essential support services as well as direct service programs upon which state social service and education agencies depend.[61]

B. Fiscal Impacts

1. Statewide network for training and information-sharing: **Minimal impact on state budget**. Recommendation is to leverage private/corporate support to train new providers and to organize conferences. Schools can pay for some services using existing funds, while the State Department of Education (SDE) may re-allocate funding/staff to expand trainings.
2. School-based mental health clinics managed by financially robust community providers: **No impact on state budget, inflow of federal funds for services and infrastructure**. Financially healthy providers – like FQHCs - are well-funded through Medicaid dollars and federal grants that can be directed to service delivery, capital expansion, and hiring.

C. Tie-in to Malloy/Wyman campaign policy

- The overall impact of addressing school climate and expanding the network of school-based mental health clinics is to *emphasize prevention and early intervention, provide access to effective mental health care for all in need, and to eliminate barriers to learning so that teachers can teach, thus narrowing the achievement gap.*

III. Long-term Needs/Vision

- Improving school climate is a prevention strategy with proven efficacy that will yield positive outcomes for in both academic achievement and behavioral health.
- The presence of school-based mental health clinics also enhances school climate in that school professionals can focus on learning, while leaving behavioral emergencies to mental health clinicians.
- School-based services will reduce the need for involving school resource officers and the legal system.

IV. Jobs Impact & Other Benefits

- The inflow of federal funds for school-based mental health clinics will lead to new jobs for clinicians and for construction workers during capital expansion projects.
- A federal Safe Schools/Healthy Students grant could create new SDE jobs.
- Improved school climates will bolster morale of teachers, reduce bullying incidents, decrease school dropout rates, and dissipate the stigma associated with seeking mental health treatment.
- Programs like SBDI enhance relationships between schools and local EMPS providers and community-based supports.
- School-based FRCs are local drivers and hubs of interagency collaboration, a central theme to improving the delivery of mental health services for children.

V. Potential Dissenting Opinions & Possible Responses

- Opinion: Schools feel intense pressure to raise achievement scores and sometimes believe that attention paid to social and emotional issues takes away from instructional time.
- Response: Many school superintendents have welcomed these programs into their districts. They have reaped the benefits of improved educational and behavioral outcomes.

Child Welfare

CARING FOR YOUNG CHILDREN

Statement of Issue: Young children involved with DCF, prenatal through age 5 years, and their families require targeted and specialized assessments and interventions to enhance their healthy development and promote their prospects for permanency—whether that means reunification with their families or adoption. National and statewide data finds that very young children, those under age five, continue to be the fastest growing segment of the child welfare population. Infants comprise the largest cohort of the young child foster care population and they remain in care twice as long as older children. Disproportionate numbers of young children in foster care are at-risk for a wide range of medical and developmental delays related to inadequate prenatal care, exposure to maternal substance abuse and abuse/neglect. Despite their vulnerability, a significant percentage of these young children do not receive basic health care such as immunizations, and specialized needs resulting from developmental delays and emotional and behavioral conditions are even less likely to be addressed.[62] In addition, extensive research shows that young children need to grow up in families to develop properly. Even high-quality institutional or congregate (group) care involves shift workers, severely undermining children's abilities to form attachments and long-term relationships. Yet historically, Connecticut has had one of the highest rates of congregate care use for young children in the nation.[63]

Proposed Action: A. Prioritization Schedule

- **Leverage Federal Laws, Programs and Dollars to Develop Specialized Attention to Young Children in Foster Care.** (i.e. ASFA, CAPTA, EPSDT, IDEA Part C, Head Start).
- **Eliminate Congregate Care for Children Under Age 6.** [64]
- **Require DCF to Collect and Report Infant-Toddler Specific Outcome Data.** Data should include and inform DCF's capacity to serve young children in family settings.
- **Design and Monitor Outcomes of Training to DCF Staff and Caregivers on the Developmental, Medical and Mental Health Needs and Risks of Young Children.**
- **Develop Specific DCF Protocols for the Removal and Placement of Infants and Toddlers.**[65]
- **Develop Targeted Recruitment and Retention Efforts To Increase Relative and Foster Families with the Home Capacity, Skills and Knowledge Required for the Successful Care of Infants and Toddlers.**

B.**Fiscal Impacts – Cost savings and revenue.** Maximizing federal funds and programs can bring more dollars into the state for young children. Successful early intervention efforts can divert children from more costly services. Eliminating congregate care produces **cost savings available for reinvestment** in family care. Reallocating existing training and staff resources to focus on young children is **cost neutral** and can achieve **future cost savings**.

Long-Term Needs/Vision: Connecticut will have outcome measures and policies that are a model for a cost-effective, specialized approach to ensuring healthy development and permanency for young children in foster care.

Jobs Impacts and Other Benefits: Minimizing risks and supporting the needs of young children in foster care and their caregivers is an investment in Connecticut's future workforce. It also allows more families of young children to enter or return to the workforce. Leveraging federal dollars can create new jobs for early childhood professionals.

Dissenting Opinions and Other Relevant Items: The oversight authority of the courts should be harnessed in partnership with DCF and other stakeholders to enhance positive outcomes for young children in care.[66]

CARING FOR ADOLESCENTS

Statement of Issue: Connecticut must improve services and planning for adolescents and older youth in state care. DCF reports that a majority of the youth who "aged out" in 2008 and 2009 lacked adequate education and experienced mental health and substance abuse problems, unemployment, early pregnancy and parenting, institutionalization, homelessness and incarceration.[67] Many lacked access to appropriate medical and mental health care and left care without any formal family connections.[68] DCF acknowledges that services for adolescents are insufficient in quality and quantity and that adolescents with mental health disabilities experience discharge delays from expensive residential levels of care due to program deficiencies at DCF and DMHAS. [69] Adolescents in DCF care are at great risk for involvement in the juvenile and adult justice systems.[70] In addition, DCF's policies are not aligned with child welfare best practice and federal Title IV reimbursement guidelines that permit DCF to care for its foster youth through age 21. Connecticut's Young Adult Services program at DMHAS also remains ill equipped to meet the needs of number of youth who transition from DCF to the adult mental health system.[71]

Proposed Action: A. **Prioritization Schedule –**

- **Reduce Reliance on Congregate Care for All Children and Reallocate Funds (and Reinvest Savings) to Develop Adolescent-Specific Family Placement and Resource Options.[72]**
- **Develop Staff Performance Expectations and Outcome Measures to Ensure that DCF Engages Adolescents as Partners in Permanency, Treatment and Transition Planning.**
- **Expand Child Welfare Services to Age 21**: Align DCF policies with federal recommendations that permit youth age 18-21 with mental health or other special needs to remain in the care of DCF. Current DCF policy permits youth past age 18 to remain only if they are enrolled full time in a state accredited post-secondary educational or vocational program.[73] Federal law reimburses states for extending child welfare services to twenty-one year olds even if such youth were "medically unable" to participate in a full time post-secondary educational program.[74]
- **Create an Interagency Strategy to Reduce Teen Pregnancy Among Youth In and Aging Out of Foster Care and Address the Needs of Pregnant and Parenting Youth in State Care.[75]** DCF should be the lead agency in this effort and the Departments of Public Health, Social Services, Developmental Disabilities and Mental Health and Addiction Services are obvious partners.
- **Pursue SSI Eligibility For Youth with Disabilities In DCF Care:** An appropriate and carefully timed application for SSI can help youth access income as they transition to independent living.[76]
- **Reinvigorate Youth Leadership Development Initiatives at DCF and statewide.**

B. **Fiscal Impacts – Maximizes federal revenue streams**. Connecticut can seek federal Title IV-E reimbursement for youth the agency supports through age 21. DCF would receive the federal SSI rate ($674/month in 2010) for each eligible child placed in DCF's care, regardless of commitment status.[77] **Cost savings** from realigning resources from costly congregate care to family care and reducing teen pregnancy. **Expenditures necessary to expand services to young adult would be mitigated by Title IVE reimbursement.**

Long-Term Needs/Vision: DCF and all state agencies that serve children will provide services shaped by the unique developmental and emotional needs of adolescents and young adults.

Jobs Impacts and Other Benefits: Youth development is a workforce investment. The proposed actions help children to age out of state care better prepared for a healthy and productive adulthood.

Dissenting Opinions and Other Relevant Items: DCF has raised concerns about the costs associated with ensuring timely referrals to DMHAS and DMHAS has raised significant concerns about its current capacity to meet the needs of youth referred to the Young Adult Services program.

DCF LEADERSHIP

Statement of Issue: DCF remains an agency in crisis and requires a new leadership team with proven competence in family and community engagement, child welfare, and mental and behavioral health reform to improve and sustain outcomes for children and families.[78] DCF also requires immediate action to assess, recruit and retain individuals who are a "good fit" as frontline practitioners and supervisors. In addition, the current organizational structure of multiple, siloed bureaus, an excessively staffed central office, and a ten-layer "chain of command" between a family and the Commissioner impede effective and efficient practices and accountability.[79] The structure delays timely decisions and access to services, resulting in the failure to meet the needs of children and provide appropriate treatment planning.[80] The Bureaus of Child Welfare, Behavioral Health and Medicine, Continuous Quality Improvement, Juvenile Services, and Prevention and External Affairs continue to operate independently. DCF's recent cross-agency strategic plan articulates expectations for collaboration and coordination, but has failed to produce observable, system-wide practice change toward integration.

Proposed Action:

A. **Prioritization Schedule**-

- **Rigorously Assess Current Leadership and Management Staff Throughout DCF:** The assessment should move beyond structural change and ask whether DCF has the right people with the proven skills and knowledge in the right positions to effect and sustain fundamental change. Leaders will need significant experience and a proven track record in child welfare, child development and well-being, children's mental health and juvenile justice, plus experience in "turning around" struggling child welfare agencies.
- **Strengthen and Monitor DCF Supervisor Performance:** DCF's goals and outcome measures should shape the supervisory job description and performance evaluation.[81]
- **Strengthen and Monitor Frontline Practice Competencies:** The job description, supervision and performance evaluation of frontline staff should measure, at minimum, knowledge and practice competency in family and child engagement, child development, child and adolescent mental health, trauma, transition planning and case record documentation.[82]
- **Relocate Central Office Staff with Expertise in System and Practice Work to the Area Offices To Build Capacity to Engage and Collaborate with Community Providers and Stakeholders**: DCF has numerous highly credentialed mental and medical health care, child welfare, and education experts housed in Central Office and siloed in specific bureaus. Their work and expertise must be infused in frontline practice and decision-making.
- **Assess and Align the Effectiveness and Efficiency of Costly DCF Facilities with Child and Family Outcomes (Riverview Hospital, CCP and CJTS)**

B. **Fiscal Impacts**: **Cost savings** with elimination of duplicative and inefficient management positions, increased access to most appropriate and least restrictive services and placements for children and families and redundant or ineffective positions/layers of management. High-quality child welfare practice can lessen the need for more costly child welfare and mental health services. Cost Neutral with reallocation of existing resources to promote leadership, supervision and training.

Long-Term Needs/Vision: Successful exit from the Juan F. consent decree with leadership and organizational to sustain and grow progress.

Jobs Impacts and Other Benefits: Improving outcomes for children and families increase the health and productiveness of Connecticut's present and future workforce.

Dissenting Opinions and Other Relevant Items: With a current budget of $850 billion, DCF does not lack resources. Rather, DCF lacks competent leadership to manage its ample resources in ways that are transparent, accountable, measurable and sustainable for children and their families.

CHILDREN IN OUT-OF-HOME CARE

Statement of Issue: All children deserve to grow up in families. Yet, DCF continues to allow children to spend significant years of their childhood outside a family home.[83] Historically, Connecticut has one of the highest rates of use of congregate care for young children in the nation.[84] While DCF has agreed to add 850 foster family homes by April 2010 to reduce the state's dependence on congregate care, the agency has achieved less than one-third of that goal.[85] DCF places many children in temporary congregate care settings based solely on availability, rather than the need for a particular level of care.[86] In addition, more children reside in out-of-state residential treatment programs than in-state programs,[87] limiting contact with their families, social workers and attorneys, eroding DCF's oversight, and hindering effective transition planning. Connecticut also falls short of ensuring that older children who "age out" of foster care have adequate supports. The Juan F. Court Monitor found that each year approximately 90 youth leave DCF care without any formal family relationships.[88] DCF regulations and practice are barriers to kinship care; resulting in the number of DCF children living in relative foster care to fall well below the national average. DCF must first keep children with their parents whenever possible. When children must be removed from home, DCF must maximize the likelihood that they will be raised in families.[89] The reliance on expensive congregate care must be "right-sized" as a critical component of DCF system reform and Connecticut's fiscal strategy.[90]

Proposed Action: A. **Prioritization Schedule –**

- **Reallocate and Maximize Funds To Keep (And Quickly Return) Children With Parents:**
  - Implement a statewide Differential Response System.
  - Improve access and delivery of "voluntary" services.
  - Maximize Medicaid/EPSDT Reimbursement to expand successful models of early clinical intervention and home visitation (i.e. Child FIRST and Nurturing Families).
  - Audit and Ensure Compliance with the federal IDEA Referral Provisions for Children age 0-3.
- **Improve Recruitment and Retention of Resource Families Including Relatives:**
  - Require Family Group Conferencing Prior to DCF Removal.
  - Require In-Person Engagement by DCF workers with Relatives.[91]
  - Eliminate DCF Regulations that Hinder Kinship Care (i.e. income and bedroom capacity).
  - Require Scheduled Audits of Denials for Relative Foster Parent Applications.
  - Develop a Family-To-Family Program to support biological and foster parent collaborations.
- **Augment Foster Parent Retention Efforts and Supports:**
  - Establish "money follows the child" policy across placements for timely, continuous services.
  - Ensure 24/7 therapeutic support from staff with clinical and child development expertise to all DCF licensed foster parents and eliminate the "foster parent support worker" position.
  - Expand staff training on foster family engagement and monitor performance expectations.
- **Develop Capacity To Meet the Needs of Children Who Are Placed Out-of-State:** Treatment gaps impact children with developmental disabilities, sexual dyscontrol, and self-injurious behavior.
- **Maximize Title IV-E Reimbursement**: The most recent (2008) Auditors of Pubic Accounts Report found that DCF failed to claim $1 million per year in Title IV-E reimbursements.[92]

B. **Fiscal Impacts – Cost savings**. If DCF meets the stipulated goal to add 850 foster homes, 508 children in congregate care can be placed in these homes for an estimated savings of $32.5 million. The savings can be reinvested to prevent removals and retain and recruit kinship and foster families. Building local capacity will keep health care dollars in Connecticut.

Long-Term Needs/Vision: Savings from reduced use of congregate care can be re-allocated to increase Connecticut's capacity for services in short supply and prevention services.

Jobs Impacts and Other Benefits: Job retention and creation as parents receive supports to remain employed while caring for their children, youth aging out of state care are better prepared to enter the workforce, and the state closes treatment gaps with in-state programs.

Dissenting Opinions and Other Relevant Items: The proposed actions require communication and partnership with DCF staff, community stakeholders, and policymakers to succeed.

CHILD WELFARE PREVENTION

Statement of Issue: Connecticut's child welfare system requires a renewed focus on prevention and early intervention. According to a recent report by DCF, approximately 80 percent of families that were screened for a child protective services investigation had a previous investigation. This statistic indicates that many families are not receiving the help they need when they first come to the attention of DCF and that they would benefit from ongoing, wraparound services and supports in their homes and communities.[93]

Proposed Action: A. **Prioritization Schedule –**

- **Include Children in DCF Care In Prevention and Early Childhood Initiatives Developed For All Children**: Children and their families involved with DCF require equal access to and priority slots for existing programs. Examples include Early Head Start, Head Start, Nurturing Families as well as the blueprint set forth by the Connecticut Early Childhood Education Cabinet. Access should also include kinship and foster parents.
- **Maximize Federal Dollars for Prevention To Expand Successful Models of Prevention**: Leveraging federal Medicaid reimbursement and dollars from the federal Home Visiting component of the Patient Protection and Affordable Care Act and the Child Abuse Prevention and Treatment Act can generate significant revenue to support and expand evidence-based prevention and early intervention models. Examples are Connecticut's successful Child FIRST and Nurturing Families.[94]
- **Implement a Differential Response System (DRS) Statewide** - DRS provides an alternative, family-centered approach that allows child welfare agencies to differentiate its response to accepted reports of abuse and neglect. Differential response systems evaluated in other states are found to reduce repeat reports of child maltreatment, foster care placements, and costs over time.[95] After more than four years of planning and an unsuccessful Hartford DRS pilot, DCF remains at the precipice of the planning process to implement DRS, with no definitive model or blueprint for statewide implementation.[96]
- **Track and Reinvest funds from the reduction in out-of-home care into prevention and community-based services with measurable good outcomes**.
- **Adopt a Poverty Exemption Policy**: A state poverty exemption would enhance DCF's ability to effectively distinguish poverty from neglect in its prevention and service provision strategies. More than ten states have a "poverty exemption" to clarify the state definition of neglect and distinguish neglect from poverty.[97]

B. **Fiscal Impacts** - The current federal financing structure for child welfare services is tilted to promote foster care rather than services and supports that can keep families together. Maximizing federal Medicaid dollars, reallocating state dollars and partnering with the private and philanthropic sectors to expand front-end supports can produce cost savings over time. The savings can be reinvested to further grow the state's preventative services and supports.

Long-Term Needs/Vision: A poverty exemption in state statute combined with differential response and comprehensive preventive and early intervention services supports the vision for a proactive child welfare system focused on child and family well-being.

Jobs Impacts and Other Benefits: Increased prevention services should mean additional jobs in the private sector in faith-based and community-based social service agencies.

Dissenting Opinions and Other Relevant Items: Because past DRS initiatives were never scaled up for statewide implementation and because of the current state budget deficit, some are skeptical that differential response can be effectively implemented statewide. Others advocate for a privatized DRS system.[98] There are no known studies that assess the implementation of a specific state poverty exemption policy. Should Connecticut implement a poverty exemption, an evaluation of the policy's impact should be a required component.

Juvenile Justice

REDUCING DISPROPORTIONATE MINORITY CONTACT IN THE JUVENILE JUSTICE SYSTEM

I. Statement of Issue:

Connecticut's rate of Disproportionate Minority Contact ("DMC") in the juvenile justice system remains one of the worst in the United States despite over 15 years of efforts to reduce DMC.[99] Based solely on their race or ethnicity, Connecticut's Black and Latino youth are more likely than their white peers to be: referred to court than to a community agency; brought to detention; held in detention until adjudication; transferred to adult court; and placed in a secure facility post-adjudication.[100] This disparity further exacerbates Connecticut's achievement gap, which is also one of the worst in the nation.

II. Proposed Action:

A. Prioritization Schedule:

1. Implement the recommendation of Connecticut's Juvenile Justice Advisory Committee to **require a court order before the detention** of any child or youth;[101]
2. Create a plan to **return the over 300 children who reside in out-of-state placements** to Connecticut;[102]
3. Require collaboration between state agencies, local school districts and police departments to **collect and analyze school-based arrest data and to reduce school-based arrests**;[103]
4. Increase collaboration between state agencies and local school districts to **improve educational outcomes for youth reentering the community** from residential placement;[104] and
5. **Reduce the transfer** to and handling of children and youth by the adult court.[105]

B. Fiscal Impact:

Requiring a court order prior to detention has **no anticipated fiscal cost and potentially a fiscal savings**.[106] Reducing school-based arrests will result in **savings** from reduced entry into the juvenile justice system.[107] Similarly, improving educational outcomes for youth reentering the community and reducing the transfer of children and youth to adult court will result in **savings from reduced recidivism** and decreased social service needs. Returning children from out-of-state placement will result in a **fiscal savings** by reducing the costs of residential treatment and the costs of transportation to the out-of-state facilities for children, state agency workers and parents.[108]

C. Connection to Malloy/Wyman campaign policy:

Bringing children back from out-of-state placements is directly aligned with the health care goal of adequately funding in-state mental health facilities and investing in community-based treatment.[109] Reducing the number of school-based arrests through a rigorous analysis of school-by-school data promotes the public safety goal of better intervening in the "school-to-prison" pipeline. Improving educational outcomes for reentering youth serves the public safety goals of reducing recidivism by better reintegrating individuals into their communities and providing youth with opportunities for positive development to help them make better decisions.

III. Long-term Needs/Vision

Significantly reducing DMC will involve system-wide reform of the treatment of youth of color, including within Connecticut's school systems, where the achievement gap and school discipline policies combine to create a school-to-prison pipeline that pushes youth of color out of the education system. To improve educational achievement, workforce readiness and life outcomes for youth of color, Connecticut state and local agencies must plan to further the reduction of DMC and report annually to the Governor on the implementation and effectiveness of their plans.

IV. Jobs Impact & Other Benefits

Reducing DMC has the potential for significant economic benefits to the State of Connecticut, through improved educational outcomes for youth of color which lead to a better prepared workforce and reduced long-term social services and criminal justice costs.[110] Additionally, returning children and youth from out-of-state placements to in-state treatment has the potential to create mental health jobs within Connecticut.[111]

V. Dissenting Opinions & Other Relevant Items

During the 2010 legislative session, the State Division of Criminal Justice and the Connecticut Police Chiefs Association submitted testimony opposing a bill that would have required a court order before any child could be placed in a detention center.[112]

DIVERSION OF CHILDREN AND YOUTH FROM THE JUVENILE JUSTICE SYSTEM

I. Statement of Issue:
Over the last decade, Connecticut has reformed its juvenile justice system to shift from reliance on costly, restrictive placements to cost-effective community-based treatment. These reforms show that addressing the root causes of behavior through evidence-based services and promising practices improves outcomes for individual children and promotes public safety.[113] However, Connecticut needs to continue these reforms, by diverting more children from juvenile justice involvement, ensuring children are treated fairly regardless of race, ethnicity or location, and stemming the growing role that school discipline plays in juvenile justice involvement.

II. Proposed Action:

A. Prioritization Schedule:

1. **Reduce reliance on costly residential placements** by **reinstating and expanding community-based** mental health treatment to children at-risk of detention or placement such as the *Emily J.* services;[114]
2. **Implement recommendation** of Connecticut's Family with Service Needs ("FWSN") Advisory Board to use Family Support Centers ("FSC") to process all FWSN petitions;[115]
3. **Improve school-based interventions** for children and youth who are at-risk for juvenile justice involvement, including truant children and youth.[116]
4. **Explore consolidation** of State juvenile justice services,[117] **improve coordination of services** for "cross-over" youth who are both child welfare- and juvenile justice-involved and require state agencies to actively **seek federal reimbursement** for diversionary and community-based treatment;[118]
5. **Coordinate and expand mentoring services** through the Governor's Prevention Partnership, the Department of Children and Families ("DCF") and Court Support Services Division ("CSSD").[119]

B. Fiscal Impact:

Reinstating *Emily J.* services will result in **long-term cost savings** through the replacement of expensive institutionalization with cost-effective community-based treatment.[120] The following chart summarizes estimates from State agencies of the expected costs for different services and placements:

Placement/Service	Estimated Cost Per Day of Placement/Service	Average Length of Placement/Service	Estimated Total Cost Per Child of Placement/Service
HomeCare[121]	$32	9 weeks*	$2000*
Multi Systemic Therapy ("MST")	$49	6 months*	$9,000* (including quality assurance costs)
Intensive In-Home Child and Adolescent Psychiatric Services ("IICAPS")	$55	6 months*	$10,000*
Multidimensional Therapeutic Foster Care ("MTFC")	$201	9 months*	$55,000*
CARE Program[122]	$120*	2 weeks*	$1,680
Juvenile Detention	$377**	15 days*	$5,655
Non-secure Residential	$375**	6 months***	$68,438
Secure Residential	$562**	11 months***	$188,036
Connecticut Juvenile Training School ("CJTS")	$744***	6 months***	$135, 780

*Estimate provided by CSSD
** Estimate provided by OFA
*** Estimate provided by DCF

Consolidation and/or more rigorous coordination of State juvenile justice services will have **little or no fiscal impact**.[123] Federal reimbursement for diversionary and community-based treatment will provide **additional**

revenue streams for these services. Improving school-based interventions will result in **long-term cost savings** by preventing involvement in the juvenile justice system. Supporting the work of the Governor's Prevention Partnership will have **no impact on the state budget** as the Partnership leverages corporate, private and federal funding to improve mentoring systems.[124]

C. Connection to Malloy/Wyman campaign policy:

The Malloy/Wyman public safety campaign policies emphasize the effectiveness of diversion: how crime and costly juvenile justice involvement can be prevented through positive youth development and how diversionary services can intervene in the "school-to-prison pipeline" to keep children and youth on track educationally. Additionally, the mental health care policies emphasize the importance of early intervention and prevention, as well as community-based treatment, to sustain long-term recovery. Furthermore, the education policies are well served by diversionary and community-based services that engage families positively for the benefit of their children and that better prepare children and youth to be productive, workforce-ready adults.

III. Long-term Needs/Vision

Connecticut must ensure that the juvenile justice system addresses the unmet needs of children and youth who enter it to remedy the root causes of their delinquent behaviors. However, Connecticut must also ensure that children and youth do not enter the juvenile justice system solely to gain access to services; rather, children and youth must be able to access diversionary services without the damaging impact of court involvement.

IV. Jobs Impact & Other Benefits

Positive youth development, through diversionary and community-based services, will create a better prepared workforce through improved academic achievement, better mental health and substance abuse recovery, and greater exposure to career opportunities.

V. Dissenting Opinions & Other Relevant Items

REDESIGN OF PLANNED GIRLS' SECURE FACILITY TO BETTER SERVE GIRLS' NEEDS

I. Purpose

The Department of Children and Families ("DCF") has worked to create a continuum of juvenile justice services for girls, however, still missing are appropriate services for the highest risk girls. Consequently, these girls languish at York Correctional Institution, Riverview Hospital or the detention centers; are sent out-of-state; and bounce from residential placement to residential placement. Although the Legislature appropriated design and demolition funds for such a facility, all proposals have stalled.[125] The State must act to insure that these girls' needs can be met appropriately, but the State also has the opportunity to reconsider whether the currently planned, large residential facility is the most cost-effective way to do so. [126] Since the date of the facility's design, the girls' juvenile justice population has decreased, rather than increasing as was anticipated.[127] This population decrease suggests that the currently planned residential facility would be underused and would divert resources from more appropriate service-delivery models.

II. Proposed Action

A. Prioritization Schedule:

Reconvene stakeholders from the Executive Implementation Team of the Court Support Services Division ("CSSD")/DCF Strategic Plan, including outside providers and advocates, to:

1. **Examine if existing placements can be retooled** to meet needs of these girls;[128] and, if they cannot be,
2. **Reallocate funding** from planned secure facility to a **smaller facility and expansion of community-based alternatives** to better meet girls' treatment needs.[129]

B. Fiscal Impact:

Retooling current residential placements will result in **large fiscal savings**. Even if it is determined that a new facility is still needed, reallocating funding to a smaller facility and expansion of community-based alternatives would also result in **fiscal savings**.

C. Connection to Malloy/Wyman Campaign Policy:

Reducing reliance on a self-contained, residential facility directly supports the Malloy/Wyman health care policy of increasing community-based mental health treatment to better sustain long-term recovery.[130]

II. Long-term Needs/Vision

By rethinking this facility and its design, funds will be available to expand community-based, wraparound services for girls and to bring girls who are in out-of-state residential facilities back to Connecticut, yielding more positive long-term outcomes for girls by providing them with services in or near the communities to which they will return.

IV. Jobs Impact & Other Benefits

An expansion of community-based services for these girls will result in increased mental health care jobs in the state. Such an expansion also has the potential to improve the workforce readiness of these girls through positive youth development services.

V. Dissenting Opinions & Other Relevant Items

Children's Services Coordination

STATEWIDE COORDINATION AND INTEGRATION

Statement of Issue: Connecticut requires a comprehensive, coordinated multi-agency strategy to maximize positive outcomes for children, families and communities. The current siloed operation of state agencies that serve children and families fosters inadequate access to needed services, duplication and fragmentation of services, and ineffective use of state and federal dollars.

Proposed Action:

A. Prioritization Schedule - **Create a Governor's Children's Cabinet**: A Children's Cabinet promotes collaboration and accountability for dollars and other resources (staff, technology) and dismantles service silos among all state agencies with the responsibility to serve children and families. The National Governor's Association supports the creation of Governor's Children's Cabinets as a mechanism to promote coordination and improve child and family outcomes.[131] At least 16 states have a Children's Cabinet established by the governor to improve statewide child and family outcomes. Benefits of Children's Cabinets are well documented including: improved coordination and efficiency across state agencies; maximized federal, state and private funding streams; reduced duplication of services resulting in cost-savings to reinvest in prevention and early intervention, enhanced accountability for ALL dollars expended on children's services by setting benchmarks and tracking measurable outcomes, easier access to multiple services for families, and aligned initiatives to achieve economic and workforce goals through investments in the education and skills of children. The Cabinet requires strong gubernatorial leadership and its members (including agencies providing services to children and those connected to outcomes for children and families such as the Departments of Transportation, Correction, Economic and Community Development, and the OPM) must have decision- making responsibility and authority, and must be guided by measurable outcomes and quarterly reports to the Governor.

B. Fiscal Impacts - **Cabinets promote cost savings**. Cabinets can be authorizing agents for maximizing federal dollars, pooling federal, state or private dollars, or reconfiguring services across agency lines to promote cost-savings and efficiency. Some Children's Cabinets produce a cross-agency "Children's Budget" for the governor that all existing funding streams and resources for children's services and assists the governor in prioritizing funding decisions in alignment with his/her goals for child and family outcomes.[132] **The creation of the Cabinet is cost neutral or low cost.** Some States have hired dedicated program and administrative staff for their Children's Cabinets. Most expect Cabinet members to donate their agency's staff time to support Cabinet operations and initiatives and many access funds from federal programs such as Child Abuse Prevention and Treatment Act. Several Cabinets harness resources from the business and philanthropic sectors.[133]

C. **Long-Term Needs/Vision**: The Governor's Children's Cabinet can be a model for accountability and efficiency across all human services agencies and state government. Policy or legislative changes may be needed to execute and sustain the Cabinet's work. New information technology may be necessary to achieve integration and coordination across agencies.[134]

D. **Jobs Impacts and Other Benefits**: The Cabinet can align investments in the well-being and education of children and families with economic and workforce development goals and focus children's initiatives as an investment in the state's future workforce.

Dissenting Opinions and Other Relevant Items: There is an Early Care and Education Cabinet has a narrower focus on children age birth through grade three. The Children's Cabinet under Governor Malloy would be distinguishable by its comprehensive interagency coordination and collaboration for all programs and funding related to all children and families throughout childhood, adolescent and young adulthood.

PROMOTE PREVENTION POLICY & PRACTICE

I. Statement of Issue: An ounce of prevention is worth a pound of cure, so the saying goes. Prevention means dealing with potential problems before they become problems. In policy terms, it constitutes intervention with a particular population before a problem is manifested. Prevention achieves positive results by reducing risk factors known or suspected to cause a problem while encouraging protective factors that promote health and well-being.

Prevention looks at the life span of the child and seeks to ensure that parents, schools and community work together to nurture, teach and sustain a child's successful growth to adulthood. Prevention is a stopgap to crisis and crisis-related spending; it is also a Results-Based Accountability strategy. When utilized comprehensively, policymakers can help to decrease school failure, aggression, hospital stays, long-term residential treatment, suicide and many other negative outcomes. In terms of reducing taxpayer expenditures, prevention is the real cost-effective deal. For every dollar invested in the following quality programs, the potential savings are:[135]

Immunization: Connecticut saves $6.21	Home Visitation: Connecticut saves $6.12
Preschool: Connecticut saves $18.89	Mentoring: Connecticut saves $3.28

Investment in proven prevention initiatives can improve quality of life, increase safety, promote resilient communities, and reduce costly expenses. Prevention is a key antidote for state dollars spent to alleviate social problems. A state government that invests wisely in prevention is more accountable and efficient, and saves taxpayers money.

P.A. 06-179, *An Act Concerning State Investment in Prevention* sought to prevent children and youth from falling behind in the first place—and save taxpayer dollars in the process. It set this goal for all state agencies that serve children and families: allocation of at least 10 percent of their budgets to prevention services by the year 2020.

II. Proposed Action: (1) Commit the Executive Branch to work toward the state goal in statute that, by the year 2020, at least 10 percent of total recommended appropriations for each state agency that provides prevention services to children, youth and families will be allocated for prevention services (CGS Section 4-67v). (2) Refer to the biennial Governor's prevention budget in the Governor's budget address. Sound the call for prevention: require all state agencies to actively seek ways to reduce the cost of crisis by investing in evidence-based and promising preventive practices.
(3) Incentivize prevention practice by giving departments a percentage of the money they save to reinvest in the practice. For example, if quality preschool deters special education placements by a certain percentage, allow the State Department of Education to reinvest a portion of those savings back into the prevention practice and/or to continue to improve the quality of that practice.
Tie-in with Malloy/Wyman Campaign Policy: Investing in prevention aligns with the Policy Goals of (1) promoting prevention and (2) making state government efficient.

III. Long-term Vision: (1) Every child is born in good health; (2) Every child is ready for school; (3) Every child and youth succeeds in school; (4) Every child and youth is safe; (5) Every youth chooses healthy behaviors; (6) Every youth is ready for the workforce.

IV. Jobs Impact & Other Benefits: Prevention investment leads to significant fiscal savings.

STREAMLINING APPLICATION PROCESSES FOR BENEFIT PROGRAMS

I. Statement of Issue: Many families experience difficulties obtaining and retaining benefits. The independent nature of various programs has led to uncoordinated and difficult application processes, a highly fragmented service delivery system, and limited outreach to families. This is a particular issue in Connecticut, where program benefit information is often not well publicized and benefit levels or procedures change (e.g. Care4Kids, HUSKY) due to policy decisions with insufficient public notice. Online applications for public benefits offer a proven way to improve families' access to state and federal benefits while lowering state costs.

II. Proposed Action: To reduce barriers and improve access to benefits for low-income families, Connecticut can take steps to streamline and integrate program access: (1) Develop a single online application for multiple programs, along with coordinated screening tools and benefit calculators; (2) Integrate access through 2-1-1 Navigator, call centers and local organizations; (3) Develop a comprehensive response by increasing outreach, bundling services and simplifying benefits; and (4) Upgrade the Medicaid Eligibility System, which is twenty years old.

After creating one-stop online application hubs, these states have seen the following benefits:[136]

- After implementing its online ACCESS Florida system, Florida has saved $83 million annually in administrative costs. Over 85 percent of the state's benefit applications are received online.
- Since the implementation of Florida's new program, error rates have decreased and the state has achieved a 35 percent reduction in staff with an 18 percent increase in workload.
- Through online applications, access to benefits improves for working parents who might not have flexible employment schedules and families with transportation barriers.[137]
- Online services can present information to families on additional services they might be eligible to receive and information can be presented in multiple languages.
- While the cost of setting up online services can be high, savings are significant and the long-term maintenance costs can be modest. Oregon Helps costs just $4000 a year to operate.[138]

Using technology to maximize federal benefits also yields a benefit to the state economy. The Bridge to Benefits program in Minnesota calculated that efforts to maximize benefits had the potential to inject $1 billion into the state's economy in just one year by enabling more state residents to draw federal funds through EITC, food assistance, child care, school meal programs and energy assistance. Each dollar provided through SNAP generates $1.73 in economic activity.[139]

Tie-in with Malloy/Wyman Campaign Policy: Streamlined program access aligns with Malloy/Wyman Policy Goals of (1) preserving the "safety net", (2) improving access to health and human services, (3) maximizing federal funds, and (4) promoting efficiency in state government.

III. Long-term Vision: All eligible families access benefit programs in the most rapid and efficient manner possible in order to maximize the benefits that program participation provides.

IV. Jobs Impact & Other Benefits: Based on other states' experience, it is reasonable to expect that streamlining the application process for health and human service programs will result in an improved participation rate for eligible families in food and human service programs, maximization of federal funds, and increased economic activity in communities due to an influx of federal funds.

Putting Children First – Transformation Strategies

PUTTING CHILDREN FIRST – TRANSFORMATION STRATEGIES

Here are some recommendations that can transform Connecticut state government by putting children first:

A. **Mandate accountable, coordinated and data and family-driven systems, policies and funding streams.** The systems which affect children's lives in Connecticut—health care, early and K-12 education, child welfare, mental health, juvenile justice—lack coordination, transparency and strategy. Too often, the response given a child or family is dependent on the "door" through which the child or family enters, and not on the individualized response appropriate to the presenting need. All systems interacting with children must be family-driven, because, as one working group member put it, "children don't raise themselves." As a corollary, the children that the state is "raising", i.e. children in the child protection and juvenile justice worlds, must be fully a part of the conversation around the supports and opportunities we will provide for our youngest residents. In order to assess the effects and effectiveness of our children's infrastructure, we need uniform expectations and processes for gauging progress, outcomes and quality. For this we need data that is uniformly collected, reported and evaluated.

B. **Articulate goals for children across agency,** determine priority goals and have agencies work together towards the goal, detailing what each entity will do.[140] Create master contracts, across agency, on action steps and deliverables as well as methods to assess the success or need for slight revision in plan. This lessens bureaucracy, provides focus, and promotes coherent strategies more accessible to the public. Given recent trends, examples for this might include every child reading by third grade and/or a shared hunger reduction strategy. Pool, blend or braid funds across agency, as needed, to ensure vulnerable children, youth and families get what they need for success.

C. **Geographically align state human service agencies.** Connecticut's five primary human service agencies (DSS, DMHAS, DCF, DDS and DPH) are not geographically aligned. DSS and DDS are aligned in a three-region system, and DMHAS and DCF both have five regions. DPH has an entirely different structure with 80 local health administrative boards. Realignment of at least DCF, DMHAS and DDS would allow for improved interagency partnerships, streamlined access for our most vulnerable families, possible co-location of services, shared resources, and regional integrated strategic planning across all the agencies with specific performance goals.

D. **Address racial and ethnic disparities in health, education, juvenile justice and child welfare.** Too many children of color end up in services and programs that impede their potential and dreams. Reduce Disproportionate Minority Contact in the juvenile justice an child welfare systems, address racial and ethnic health disparities and the educational achievement gap, and promote cultural competence in service delivery.

E. **Implement key laws for children that have passed and study their effects**. Too many laws for children that were deemed models in the nation, were not implemented at all, implemented partially, or not implemented with policy fidelity. Examples include laws on (1) child poverty reduction, (2) prevention, (3) early reading success, (4) anti-bullying and (5) children in the recession. The last example, *An Act Concerning Children in the Recession* (P.A. 10-133), requires immediate action by multiple executive branch agencies on several critical issues, including the streamlining of program access and the development of a cross-agency emergency response to address family needs in times of high unemployment.

F. **Aggressively seek federal funds to support families.** Now, when the state's own resources are focused on repairing the budget holes from previous years and restoring fiscal health for the future, maximizing federal funding support is essential. As part of the federal government's pursuit of a national agenda promoting a healthy, safe, well-nurtured and educated population, significant opportunities exist for many

of the systems implementing the policies in the proposals presented below. DCF may offer a prime opportunity for federal funding: many of its services can be—but are not—funded with Medicaid dollars.

G. **Reduce state agency response time**. Service response time of agencies, such as the Department of Social Services (DSS), needs to be minimized in order to address the crises that families are experiencing in a timely fashion.

H. **Streamline application processes for benefit programs.** Many families experience difficulties obtaining and retaining SNAP, Care 4 Kids, HUSKY, TFA and other program benefits. Connecticut can take several steps to streamline and integrate programs access. ***(see full-page proposal in this section)***

I. **Restore presumptive eligibility.** Community agencies previously had the ability to determine client eligibility. If this were re-implemented, it would expedite the process, allowing families to receive benefits more quickly and prevent situations from worsening.

J. **Simplify case management**. After families enter the service delivery point of entry, their case management should be centralized in one site to address their needs.

K. **Empower parents to lead on behalf of their community.** Research shows that when parents are involved with learning in positive ways, positive results occur. Child development is enhanced, attendance and achievement improve, community safety improves and parents and students develop better attitudes toward school.

L. **Children's services: It's about jobs.** In making jobs-related decisions for Connecticut, recognize that children's services in health, education and other fields play two critical roles in employment, providing many jobs for the current workforce, as well as preparing children to be healthy, skilled members of the state's future workforce.

M. **Use 21st century technology to build a more efficient children's services infrastructure**. This would include the use of electronic health and education records to improve information flow across "silos" of care, as well as tele-health where appropriate to improve access to care through technology.

Funding Opportunities

FUNDING OPPORTUNITIES

A. **Hunger**

There are significant federal dollars to address hunger. Approximately 1/3 of those eligible in our state do not access these resources. With federal funding, the 1/3 not accessing food should be targeted through intentional outreach. Dollars brought in for food help children, pregnant mothers and also stimulate dollars in the local community.

Unless otherwise noted, in this section state data is from EndHunger CT! and national data is from NCSL (National Conference of State Legislatures)

Supplemental Nutrition Assistance Program

Federal funds: $34.6 billion CT share of SNAP federal funds: $417.1 million

CT participation rate: 69%

National school lunch program provides low-cost and free nutritious lunch to children in school

Federal funds: $9.3 billion

CT share of School Lunch federal funds: $69.6 million[141]

WIC-Special Supplemental Program for Women, Infants and Children-Provides foods, education and referral to health and social services to low income women and infants and children up to age 5 who are at nutritional risk. Provides vouchers for WIC recipients to redeem at Farmers' Markets

Federal funds: $6.2 billion CT share of WIC funds: $50.4 million

Child and adult care food program (CACFP) -Provides meals to children and elderly individual in day-care settings (including At- Risk suppers - a new program)

Federal funds: $2.4 billion CT share of CACFP federal funds: $11.8 million

National School Breakfast program-Provides low-cost or free breakfast to children in school

Federal Funds: $2.37 billion CT share of SBP federal funds: $17.1 million

CT participation rate: 39%

Additional Annual Funding of 60 of 100 students eating lunch also ate breakfast: $7.13 million[142]

Summer Food Service Program -Provides free meals and snacks to children through age 18 when school is not in session

Federal funds: $326 million CT share of SFSP federal funds: $1.6 million

CT participation rate: 26% Reimbursement if State Reached in July a Ratio of 40 Children per 100 in School Year National School Lunch Program: $1.35 million[143]

Senior Farmers' Markets Nutrition Programs (SFMNP) –Provides low-income seniors with coupons for eligible foods a t farmers markets and community supported agriculture programs

Federal Funds: $21.8 million

Fresh Fruit and Vegetable Program-provides fresh fruits and vegetables in elementary schools

Federal funds: $101 million[144] CT share of FFVP federal funds: $1.7 million[145]

Special milk program-provides milk to children in schools and child care, not participating in other child nutrition programs

Federal funds: $14.9 million CT share of SMP federal funds: $265,023[146]

(Note: the funding in this program generally decreases as funding in other school nutrition programs increases, as it is only available for children not participating in other federally funded child nutrition programs)

B. **Home Visitation**

The Patient Protection and Affordable Care Act of 2010 is expected to include funding for Maternal, Infant, and Early Childhood Home Visiting Programs to improve outcomes for families who reside in at-risk communities. HHS has allocated $88 Million for Home Visiting Program. In the Affordable Care Act Initial Funding for Maternal, Infant, and Early Childhood Grants, Connecticut will receive $829,224.

The Child First program, a home visitation model designed in Ct to reach those most vulnerable families with young children, has received four million dollars from the Robert Wood Johnson Foundation as a model home visiting program for the states. This program, led by Dr. Darcy Lowell of Bridgeport Hospital, is currently up for expansion. The sites include New Haven, Waterbury, Hartford, and Bridgeport.

The federal government has just awarded our state six million over three years, for targeted outreach and home visitation to teen mothers.

C. **Safe Schools Grant**

The U.S. Departments of Education, Health and Human Services, and Justice are collaborating to fund school and youth violence prevention grants under the Safe Schools/Healthy Students Initiative (SS/HS). Through grants made to local education agencies, the SS/HS Initiative provides schools and communities across the United States with the benefit of enhanced school and community-based services in an effort to strengthen healthy child development, thus reducing violent behavior and substance use.

The school-based community partnerships include rural, urban, suburban, and tribal projects. School districts submit comprehensive plans created in partnership with law enforcement officials, local mental health authorities, and often with juvenile justice officials and community-based organizations as well.

Plans are required to address five elements: a safe school environment and violence prevention activities, alcohol and other drug prevention activities, student behavioral, social, and emotional supports, mental health services and early childhood social and emotional learning programs.

More than $32.8 million in grants have been awarded to 18 states and the District of Columbia through this program. Connecticut received $2.8 million in a SS/HS to Hartford Public Schools in FY03.

Kevin Jennings, Director of the Office of Safe and Drug-Free Schools at the U.S. Department of Education, encouraged the Commission on Children to collaborate with local education agencies and other partners for bullying prevention efforts under this federal funding opportunity, which he expects will reopen later in FY11.

D. **SNAP Standard Utility Allowance Waiver for certain states**

On 12/2, the Food and Nutrition Service (FNS) of the US Department of Agriculture issued a memo for SNAP Standard Utility Allowance Waiver (SUA) for states that previously extended the SUA for the first three months of the FY 2011. The waivers were devised by FNS to address fluctuation energy prices, which impacts the amount a household receives in SNAP benefits.

In October 2010, FNS issued a blanket SUA waiver memo to allow states to extend FY 2010 SUA amounts by three months. Ten states adopted the extension including Connecticut. CT now has the option to extend the FY 2010 SUA for an additional three months, which would put the end-date at March 31, 2011.

For the final six months in the FY 2011, beginning April 1, the adopting state can adjust their SUAs to FY 2011 using their FNS-approved methodologies. However FNS will not require the adopting state to lower the SUA amount more than $66, which will ensure that a household will not see more than a $20 reduction in benefits for the remainder of FY 2011. (NCSL 202-624-5400)

E. **Pew and McArthur Foundation partnership in corrections reform**

Incarceration in America has more than quadrupled, with two million people behind bars and two million children with an incarcerated parent. Incarcerated young men are disproportionately African American. In 2005, nearly one in ten African American young men (20-35) was behind bars, a rate that has doubled since 1990.

The Pew Foundation, in partnership with the MacArthur Foundation, is interested in partnership with 10 states to build the tools so that states can internally see what is working and what is not. They hope to help states replicate the Washington State Institute for Public Policy which currently helps its state assess savings and proven prevention practice in corrections as well as a host of other policy domains. Their first policy area in this work is in corrections reform.

Pew and MacArthur hope to help states simultaneously reform corrections for youth and young adults while building an internal system of assessment and proven interventions within government. This would help both decrease budgets and bolster success. Senator Daily and Representatives Toni Walker, Mike Lawlor, and Diana Urban are working on this with the CT Commission on Children.

F. **Fatherhood resources in the federal government**

New fatherhood funds have just been announced by Congress. Details forthcoming.

G. **Early Care and Education Coordination and Integration**

The brain develops to 80% of its capacity in the first five years of life. What an infant or toddler does in the course of a day influences lifelong learning patterns. Quality early care provides children with nurturance, comfort, and appropriate interaction with adults and peers, along with fun and an active play environment. Children who have traditionally been at risk of failing in school are more affected by the quality of child care experiences than other children. The quality of early care practices is related to children's cognitive development. .

Yet children's programs are spread out across many different agencies. They utilize varied funding streams, standards, eligibility criteria and policies that are not aligned. This fragmentation creates a complicated system for parents with limited time juggling work and family obligations. Improved coordination of services would improve efficiencies, consumer utilization, enhance customer service and engage families more substantively in service and policy opportunities. Many families stop utilizing desired services for their children because they cannot navigate the multiple paths and rules for usage. A coherent system of care and learning helps create coherence for the child and the family.

The Early Care and Education Cabinet has raised just under one million dollars to work on an integrated system. Areas include data collection, professional development, standards and parent engagement. The goals are to create a sustainable community system for infants, toddlers and two to four year olds that is seamlessly coordinated with the school readiness councils and other designated sites. Each participating agency will take responsibility for their part and discrete functions in making the state system work for the young family.

H. **SNAP E & T 50/50 match program**

Maximize Federal Food Stamp Funds to Reduce Child and Family Poverty

Connecticut is the first state to expressly direct federal Food Stamp matching funds to reduce child poverty. The Snap E & T 50/50 match funds are part of the Nutrition Title of the Farm Bill.

Over 100 towns have come together to maximize federal reimbursement of these funds. Upon reimbursement, the dollars will go into the community for proven poverty reduction strategies that the community together determines. Reimbursement comes from federal and state approved expenditures related to job training and increased wages.

These funds, averaging a total of up to $6 million per year will help to support many local organizations already serving low-income individuals and families by giving them new federal resources to expand and focus their efforts.

I. **Emergency Loan Fund**

As noted above, **this year the Connecticut legislature passed landmark legislation, Public Act 10-133, on Children in the Recession. The bill addresses ways to mitigate the long-term impact of recessions on the young and focuses on hunger, housing, child care, family stressors and low birth weight babies.**

The legislation seeks to find systemic responses to the crises facing the young and looks to streamline service access, on-line screening and consumer-improved services. One specific component of the law looks at the viability of enacting a state children and recession fund that would provide funds and/or low-interest loans to families facing short-term crisis.

Philanthropy is potentially interested in providing matching dollars to this effort; idea is to conduct statewide campaign, possibly utilizing "text to donate" process, to raise a combined total of $500,000 to $1 million for the short-term statewide bridge fund.

Families could then apply through local agencies to access these monies for one-time emergency help with utilities, heating, one-time car repair, one-time rent or security deposit payment, etc. This fund would be in place during times when the state unemployment rate exceeds 8%.

J. **Child Welfare Programs Waiver Authority**

Pending now in Congress is H.R. 6156 which would allow states increased funding flexibility ion the development of service alternatives and on the overall delivery of child welfare services. This waiver, if passed, extends Title IV-E from 2011 to 2016 and will give states an enhanced ability to provide early intervention and crisis intervention services what will safely reduce out of home placements and improve child outcomes. It will allow states to reinvest savings into their programs and will also provide both state and federal legislators more information on what innovation s are effective to transform the lives of children who are at risk of abuse and neglect.

K. **Planning funds**

The U.S. Department of Health and Human Services (HHS) awarded nearly $49 million to help 48 states and the District of Columbia plan for the establishment of health insurance exchanges. A key part of the Affordable Care Act, starting in 2014, health insurance exchanges – new, competitive, consumer-centered private health insurance marketplaces – will put greater control and greater choice in the hands of individuals and small businesses.

The state-based exchanges will make purchasing health insurance easier by providing eligible consumers and businesses with "one-stop-shopping" where they can compare and purchase health insurance coverage. Americans

will have the same health care choices as members of Congress – who will also purchase coverage through the exchanges. Individuals and families purchasing health insurance through exchanges may also qualify for tax credits and reduced cost-sharing depending on their income.

These grants of up to $1 million each will give states the resources they need to conduct the research and planning needed to build a better health insurance marketplace and determine how their exchanges will be operated and governed, including:

- Assessing current information technology (IT) systems and infrastructure and determining new requirements.
- Developing partnerships with community organizations to gain public input into the exchange planning process.
- Planning for consumer call centers to answer questions from their residents.
- Determining the statutory rules needed to build the exchanges.
- Hiring key staff and determining ongoing staffing needs.
- Planning the coordination of eligibility and enrollment systems across Medicaid, the Children's Health Insurance Program (CHIP), and the exchanges.
- Developing performance metrics, milestones and ongoing evaluation.

Although state exchanges are not required to be operational until 2014, these planning grants begin the path toward 2014 when health insurance exchanges will take what is now a very complicated and confusing process and turn it into a simple, easy to navigate experience that benefits consumers, not insurance companies.

Doing Business Differently

[1] NGA Center for Best Practices. (2009, Sept.) *Shaping a healthier generation.* Washington, DC: National Governors' Association. http://www.nga.org/Files/pdf/0909HEALTHIERGENERATION.PDF.

Early Care and Education

[2] RAND Labor and Population Research Brief, "Proven Benefits of Early Childhood Interventions" (2005) (available at http://www.rand.org/pubs/research_briefs/2005/RAND_RB9145.pdf).

[3] RAND Labor and Population Research Brief, "Proven Benefits of Early Childhood Interventions" (2005) (available at http://www.rand.org/pubs/research_briefs/2005/RAND_RB9145.pdf on p. 3). Other reports have estimated the per dollar return from investment in early care and education to be even higher. *See* "A Children's Stock Portfolio: One Smart Investment, *Connecticut Commission on Children* (April 2007) (available at http://www.cga.ct.gov/coc/PDFs/prevention/040207_stockportfolio_v1.pdf on p. 10), suggesting that "for every dollar invested in high-quality preschool in Connecticut, the return on investment is approximately $18.89 in life-long gains."

[4] *For descriptions of early care and education funding streams and programs, see* Cyd Oppenheimer, "Connecticut Early Care and Education Progress Report, 2009," *Connecticut Voices for Children* (May 2009) (available at http://ctkidslink.org/publications/ece09progress.pdf). An updated report, "Connecticut Early Care and Education Progress Report, 2010," by Annemarie Hillman and Cyd Oppenheimer will be available from *Connecticut Voices for Children* in January 2011.

[5] A widely underutilized source of funding for early care and education programs is the Sheff remedy. Affordable, high quality early care and education is an incredible tool for reducing educational disparities and should be an important component of one the state's most well-known and critical efforts to improve educational quality for minority students.

[6] In a study published in 2004, it was noted that Connecticut's early care and education industry "is a significant driver of the state's economy," providing more employment than Connecticut's pharmaceutical industry. The study further estimated that the "total employment impact" of Connecticut's child care industry is more than 29,000 jobs. *See* Stan McMillen and Kathryn Parr, "The Economic Impact and Profile of Connecticut's ECE Industry," *CCEA University of Connecticut* (September 2004), ii (available at: http://ctkidslink.org/publications/ece04econimpactfull10.pdf).

[7] *First Words, First Steps: The Importance of the Early Years, Connecticut Infant Toddler Working Group,* 22 (available at http://www.cga.ct.gov/coc/PDFs/earlychildhood/First_Words_draft_02-04-08.pdf).

[8] *For descriptions of early care and education data issues, see* Cyd Oppenheimer, "Connecticut Early Care and Education Progress Report, 2009," *Connecticut Voices for Children* (May 2009) (available at http://ctkidslink.org/publications/ece09progress.pdf). An

updated report, "Connecticut Early Care and Education Progress Report, 2010," by Annemarie Hillman and Cyd Oppenheimer will be available from *Connecticut Voices for Children* in January 2011.

[9] "Home Visitation: One Smart Family Investment," in *A Children's Stock Portfolio: One Smart Investment, Connecticut Commission on Children* (April 2007) (available at http://www.cga.ct.gov/coc/PDFs/prevention/040207_stockportfolio_v1.pdf).

[10] *See* "Home Visitation: One Smart Family Investment," in *A Children's Stock Portfolio: One Smart Investment, Connecticut Commission on Children* (April 2007) (available at http://www.cga.ct.gov/coc/PDFs/prevention/040207_stockportfolio_v1.pdf); Sweet, M.A., & Applebaum, M.I., "Is Home Visiting an Effective Strategy? A meta-analytic Review of Home Visiting Programs for Families with Young Children," *Child Development, 75* (2004), 1435-1456.; Love, J.M., Kisker, E.E., Ross, C., Raikes, H., Constantine, J., Boller, K., et al., "The effectiveness of Early Head Start for 3-year-old children and their Parens: Lessons for Policy and Programs," *Developmental Psychology, 41* (2005), 885-901; Olds, D.L., "The Nurse-Family Partnership: An Evidence-based Preventive Intervention," *Infant Mental Health Journal, 27* (2006), 5-25; Olds, D.L., Sadler, L., & Kitzman, H, "Programs for Parents of Infants and Toddlers: Recent Evidence from Randomized Trials," *Journal of Child Psychology and Psychiatry,48* (2007), 355-391; Gomby, D.S., Culross, P.L, & Behrman, R.E., "Home Visiting: Recent Program Evaluations: Analysis and Recommendations," *The Future of Children, 9* (2009), 4-26.

[11] Section 2951 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148).

[12] Award: Child FIRST Replication Project, Robert Wood Johnson Foundation , Grant #66121, September 2009 – February 2012., $3.195 million.

[13] "Home Visitation: One Smart Family Investment," in *A Children's Stock Portfolio: One Smart Investment, Connecticut Commission on Children* (April 2007) (available at http://www.cga.ct.gov/coc/PDFs/prevention/040207_stockportfolio_v1.pdf).*See also* Lowell, DI, Carter, AS, Godoy, L, Paulicin, B, Briggs-Gowan, MJ, "A Randomized Controlled Trial of Child FIRST: A Comprehensive, Home-Based Intervention Translating Research into Early Childhood Practice," in "Raising Healthy Children: Translating Child Development Research into Practice," ***Child Development,*** in press (January/February 2011):82.

[14] *See* Knudsen, E.I., Heckman, J.J., Cameron, J.L., & Shonkoff, J.P., "Economic, Neurobiological, and Behavioral Perspectives on Building America's Future Workforce," *Proceedings of the National Academy of Science, USA, 103* (2006), 10155-10162; National Scientific Council on the Developing Child, *Perspectives: The Cradle of Prosperity* (2006) (available at http://www.developingchild.net); National Scientific Council on the Developing Child, *Perspectives: Child Development Is Economic Development* (2006) (available at http://www.developingchild.net).

[15] *See* Keeping Children and Families Safe Act of 2003 – Public Law 108-36; U.S. Department of Health and Human Services, Administration for Children, Youth and Families, "Information Memorandum: Modifications to the CAPTA State Grant Program by the Keeping Children and Families Safe Act of 2003" (Public law 108-36). Log No. : ACYF-CB-IM-03-04, Aug. 11, 2003; PPACA discussion of support for evidence based home visiting practices practices: https://grants.hrsa.gov/webExternal/DisplayAttachment.asp?ID=E1B2AB5C-07D0-4B90-9621-C4B3B35024D5.

[16] Supported by Robert Wood Johnson Foundation, Children's Fund of CT, W.C. Graustein Memorial Fund, CT Health Foundation, Hartford Foundation for Public Giving, CT Community Fund, Community Foundation of Greater New Haven, Fairfield County Community Foundation, United Way of Coastal Fairfield County.

Children's Health, Safety, and Basic Needs

[17] Connecticut Department of Public Health. (2010.) Connecticut School Health Survey, 2009. http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388104&dphNav_GID=1832&dphPNavCtr=|#46988

[18] More than 900,000 U.S. high school students reported being cyber-bullied in one year. See Duncan, A. (2010, Aug. 11). *The myths about bullying*. U.S. Department of Education. http://www.ed.gov/news/speeches/myths-about-bullying-secretary-arne-duncans-remarks-bullying-prevention-summit

[19] Connecticut Department of Public Health. (2010.) Connecticut School Health Survey, 2009. http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388104&dphNav_GID=1832&dphPNavCtr=|#46988

[20] Oregon Students of Color Coalition. (2008). *No end in sight.* Portland, OR: Author. http://www.basicrights.org/images/NoEndInSightReport.pdf

[21] Limber, S.P. (2002). *Addressing youth bullying behaviors.* Proceedings from the American Medical Association Educational Forum on Adolescent Health: Youth Bullying. Chicago, IL: American Medical Association. Retrieved August 12, 2005, from www.ama-assn.org/ama1/pub/upload/mm/39/youthbullying.pdf; Fox, J., Elliott, D., et al. (2003). *Bullying prevention is crime prevention.* Washington, DC: Fight Crime: Invest in Kids. http://www.fightcrime.org/sites/default/files/reports/BullyingReport.pdf;.

[22] It helps students feel safe, promotes youth development and increases academic achievement. In schools with positive climates, bullying occurs rarely and is addressed immediately by students and staff. See National School Climate Council. (2009). *National school climate standards: Benchmarks to promote effective teaching, learning and comprehensive school improvement.* Available at http://schoolclimate.org; Zins, J.E., Weissberg, R.P., Wang, M.C. & Walberg, H.J. (Eds.). (2004). *Building academic success on social and emotional learning: What does the research say?* New York: Teachers College Press.

[23] The Connecticut Early Childhood Education Cabinet recognizes that positive school climate is a key factor in terms of closing the state's large achievement gap between white students and students of color. See Connecticut Early Childhood Education Cabinet.

(2006). *Ready by 5 and Fine by 9: Connecticut's Early Childhood Investment Framework.* Available at http://www.cga.ct.gov/coc/PDFs/earlychildhood/ready5_fine9.pdf.

[24] Greenberg, M.T. et al. (2003). Enhancing school-based prevention and youth development through coordinated social, emotional and academic learning. *American Psychologist, 58*, 466-474; The Governor's Prevention Partnership. (2008). Prevention feasibility and student behaviors of concern in Connecticut schools. Unpublished report; LaRocco, D.J., Nestler-Rusack, D. & Freiberg, J. (2007). Public School Principals' Experiences with Interpreting and Implementing Connecticut's Anti-Bullying Law: A Statewide Survey. Available at http://www.sde.ct.gov/sde/lib/sde/pdf/School_Improvement/Bullying/PrincipalBullyingSurvey2007Report.pdf.

[25] Ali, T., & Dufresne, A. (2008.) *Missing out: Suspending students from Connecticut schools.* Connecticut Voices for Children.

[26] The State Department of Education, Connecticut Commission on Children, the Office of the Child Advocate, and the Governor's Prevention Partnership frequently receive calls from families concerning bullying incidents.

[27] Improving accountability would help to ensure that all school districts, including the 59 school districts that have not updated their policies since enactment of P.A. 08-160, comply with the state law. See Connecticut Department of Education. (2010). *Report on the status of analysis of bullying policies in Connecticut*. http://www.cga.ct.gov/coc/PDFs/bullying/SDE_bullying_report_02-01-10.pdf

[28] This action would encourage school districts to revise policies regularly and increase awareness of school procedures.

[29] The *National School Climate Standards* provide a consistent means of communicating the value of comprehensive, research-based prevention and intervention strategies to schools statewide See National School Climate Council. (2009). *National school climate standards: Benchmarks to promote effective teaching, learning and comprehensive school improvement.* Available at http://schoolclimate.org.

[30] Federal education funds for this purpose are expected to be available again through the Safe Schools, Healthy Students grant program. Such funds may be used to establish a single school-climate/bullying survey instrument (for use with students, staff and parents) to be administered statewide, so that schools have a common reference point, can select sound strategies based on needs revealed by the survey, can measure the impact of strategies they implement, and can compare their progress with that of other schools and the state as a whole.

[31] This network could approve current providers and identify/train new providers to bring evidence-based initiatives (such as the Olweus Bullying Prevention Program) to scale statewide.

[32] Dufresne, A., Hillman, A., Carson, C., & Kramer, T. (2010). *Teaching discipline.* Connecticut Voices for Children.

[33] In order to achieve this, SDE could double the FTE number of SDE staff assigned to bullying prevention (from 1 to 2) by reassigning one staff person, enabling SDE to meet unmet TA needs identified by schools in SDE's 2010 report.

[34] The U.S. Government maintains a list of evidence-based programs related to bullying at http://www.findyouthinfo.gov/topic_bullying_programs.shtml.

[35] Finkelstein, EA, et al. (2004). State-level estimates of annual medical expenditures attributable to obesity. *Obesity Research* 12:18-24. Downloaded from http://www.muni.org/iceimages/healthchp/Annual%20medical%20expenditures.pdf (Jan. 28, 2009).

[36] Daniels, S.R., Arnett, D.K., Eckel, R.H., et al.(2005).Overweight in children and adolescents: pathophysiology, consequences, prevention, and treatment. *Circulation, 111*(15), 1999-2012.

[37] Tremblay, M., Inman, J., Williams, J.(2000).The relationship between physical activity, self-esteem, and academic achievement in 12-year-old children. *Pediatric Exercise Science, 12,* 312-323; Calfas, K., Taylor, W.(1994).Effects of physical activity on psychosocial variables in adolescents. *Pediatric Exercise Science*, 6(4), 406-423.

[38] Centers for Disease Control and Prevention, National Center for Health Statistics.(2007).National Diabetes Surveillance System. Incidence of Diabetes: Crude and Age-Adjusted Incidence of Diagnosed Diabetes per 1000 Population Aged 18-79 Years, United States, 1997–2004. Retrieved April 17, 2007 from: http://www.cdc.gov/diabetes/statistics/incidence/fig2.htm.

[39] White House Task Force on Childhood Obesity. (2010). *Solving the problem of childhood obesity within a generation.* Washington, DC: Executive Office of the President of the United States.

[40] Olshansky, J., Passaro, D., Hershow, R., Layden, J.et al.(2005, May 17).A Potential Decline in Life Expectancy in the United States in the 21st Century. *The New England Journal of Medicine, 352*(11), 1138- 1144.

[41] The number of obese adolescents ages 12-19 has tripled over that time period. Trust for America's Health. (2010). F as in fat: 2010. Washington, DC: Author. http://healthyamericans.org/reports/obesity2010/Obesity2010Report.pdf

[42] Connecticut Department of Public Health. (2010.) Connecticut School Health Survey, 2009. http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388104&dphNav_GID=1832&dphPNavCtr=|#46988. Adult obesity in Connecticut has increased dramatically as well: one in five adults (21.4 percent) is obese and more than half (59.3 percent) are overweight or obese (2007-2009 3-year average. Trust for America's Health. (2010). F as in fat: 2010. Washington, DC: Author. http://healthyamericans.org/reports/obesity2010/Obesity2010Report.pdf).

[43] In Connecticut, 15.5% of low-income children ages 2-5 are already obese. Trust for America's Health. (2010). F as in fat: 2010. Washington, DC: Author. http://healthyamericans.org/reports/obesity2010/Obesity2010Report.pdf. and rates of childhood obesity vary substantially by race: from 9.6% among white children to 17.5% among Latino children and 21.1% among African American school children. In other words, in our state, Latino children are almost twice as likely and African American children are more than twice as likely to be obese compared to white children (Centers for Disease Control and Prevention (CDC). YRBSS: Youth Risk Behavior Surveillance System. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1999-2007. http://www.cdc.gov/HealthyYouth/yrbs/index.htm.)

[44] Connecticut Department of Public Health. (2007). Childhood obesity in Connecticut. Downloaded from http://www.ct.gov/dph/lib/dph/ChOb_Fact_Sheet_Fall07.pdf (Jan. 28, 2009).
[45] Physical activity based on 60 minute daily minimum. Connecticut Department of Public Health. (2010). *The obesity epidemic and Connecticut students* (interpreting results of the 2009 Connecticut Youth Risk Behavior Survey) http://www.ct.gov/dph/lib/dph/hisr/pdf/CSHS2009_obesity_combo.pdf.
[46] *See*, Honigfeld L., "Care Coordination in the Pediatric Setting: Linking Children and Families to Services," *Child Health and Development Institute of Connecticut* (2007); Dworkin P, Honigfeld L, & Myers J, "A Framework for Child Health Services. Supporting the healthy development and school readiness of Connecticut's children," (2009); Honigfeld L., "A Proposal for a Regional Care Coordination System," *Child Health and Development Institute of Connecticut* (2010).
[47] CT State Department of Education, Consolidated State Performance Report, 12/16/10, available through CT State Department of Education, Division of Family and Student Support Services.
[48] Youth Continuum, HOSTS program, contact information available at http://www.youthcontinuum.org .
[49] "Unaccompanied Youth: Fast Facts" National Network for Youth, citing YouthCare, Inc., 1998, available at http://www.nn4youth.org/media/factsheets/FactSheet_Unacompanied_Youth.pdf .
[50] P.A. 10-115, An Act Providing Safe Harbor for Exploited Children.
[51] For an example of a comprehensive bill, see Illinois House Bill 6462: Illinois' Safe Children Act which not only ensure that victims of commercial sexual exploitation are immune from prosecution but also places them in the child protection system with time limits for investigation as well as services.
[52] Malloy Policy Project, Housing Affordability & Opportunity, p 2 of 4.

Children's Mental Health

[53]*For more information, see:*
· Lowell DI, Carter AS, Godoy L, Paulicin B, Briggs-Gowan MJ: A randomized controlled trial of Child FIRST: A comprehensive home-based intervention Translating research into early childhood practice. Child Development 2011: 82
· National Scientific Council on the Developing Child (2004). *Young Children Develop in an Environment of Relationships: Working Paper No. 1*. Retrieved from www.developingchild.harvard.edu
· National Scientific Council on the Developing Child (2004). *Children's Emotional Development is Built into the Architecture of their Brains: Working Paper No. 2*. Retrieved from www.developingchild.harvard.edu
· National Scientific Council on the Developing Child (2008). *Mental Health Problems in Early Childhood Can Impair Learning and Behavior for Life: Working Paper No. 6*. Retrieved from www.developingchild.harvard.edu
· Perry, D. F., Kaufmann, R. K., & Knitzer, J. (Eds.). (2007). Building bridges: Linking services, strategies, and systems for young children and their families. Baltimore, MD: Paul H Brookes Publishing.
[54] *For more information, see:*
· Chorpita, B.F. & Regan, J. (2009). Dissemination of effective mental health treatment procedures: Maximizing the return on a significant investment. *Behaviour Research and Therapy, 47*, 990-993.
· Cohen, J., Mannarino, A.P., & Deblinger, E. (2006). *Treating Trauma and Traumatic Grief in Children and Adolescents*. New York: The Guilford Press.
· Davis, C., Human Service Collaborative (January 2007). *Developing a Therapeutic Support Service*. Farmington, CT: Child Health and Development Institute of Connecticut, Connecticut Center for Effective Practices.
· Fixsen, D.L., Blase, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*, 531-540.
· Fixsen, D., Naoom, S., Blase, K., Friedman, R., & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature.* Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, National Implementation Research Network (FMHI Publication #231).
· Franks, R.P. (2010). Role of the Intermediary Organization in Promoting and Disseminating Mental Health Best Practices for Children and Youth: The Connecticut Center for Effective Practice. *Emotional & Behavioral Disorders in Youth*, 10 (4), 87-93.
· Franks, R.P., Schroeder, J.A., Connell, C.M., & Tebes, J.K. (2008). *Unlocking Doors: Multisystemic Therapy for Connecticut's High-Risk Children & Youth*. Farmington, CTHenggeler, S.W. & Lee, T. (2003).
· Multisystemic Treatment of serious clinical problems. In A. Weisz (Ed.), *Evidence-based Psychotherapies for Children and Adolescents* (pp. 301-322). New York, NY: Guilford Press.
· Meyers, J.C. (2000). *Delivering and Financing Children's Behavioral Health Services in Connecticut.* Farmington, CT: Child Health and Development Institute of Connecticut.
· Vanderploeg, J.J., Bracey, J.R., & Franks, R.P. (May 2010). *Strengthening the Foundation: Analysis of Connecticut's Outpatient Mental Health System for Children*. Farmington, CT: Child Health and Development Institute, Connecticut Center for Effective Practice.
· Vanderploeg, J.J. & Meyers, J.C. (July 2009). *The Intensive In-Home Services Decision Tree: A Framework for Decision-Making in Connecticut*. Farmington, CT: Child Health and Development Institute, Connecticut Center for Effective Practice.
· "The State of Children's Mental Health in Connecticut: A Brief Overview" (Connecticut Voices for Children. 2000)
· "The Cost of Failure" (State of Connecticut Office of the Child Advocate. 2000)

[55] Department of Mental Health and Addiction Services (DMHAS), Legislative Report, *Young Adult Services: Current Status and Future Directions*, 2007.
[56] Department of Mental Health and Addiction Services (DMHAS), Legislative Report, *Young Adult Services: Current Status and Future Directions*, 2007.
[57] State of Connecticut Office of the Child Advocate, *Young Adults in DCF Care: What Happens to Young Adults Who Must Transition from the Department of Children and Families to the Department of Mental Health and Addiction Services or the Department of Mental Retardation?*, 2007.
North Central Regional Mental Health Board, *Young Adults Services: System or Regional Recommendations*, 2008.
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"The State of Children's Mental Health in Connecticut: A Brief Overview" (Connecticut Voices for Children. 2000)
"The Cost of Failure" (State of Connecticut Office of the Child Advocate. 2000)
Regional Mental Health Boards of Connecticut, *2007-09 Review and Evaluation Summary Report: Statewide Review of Young Adult Services*.
Burns BJ, Costello EJ, Angold A, Tweed D et al. Children's Mental Health Service Use Across Service Sectors, Health Affairs, Vol. 14, No. 3, 1995: 149-159.

[58] *See* Rones M and Hoagwood K. School-Based Mental Health Services: A Research Review. *Clinical Child & Family Psychology Review*, Vol. 3, No. 4, 2000: 223-241; Burns BJ, Costello EJ, Angold A, Tweed D et al. Children's Mental Health Service Use Across Service Sectors, *Health Affairs*, Vol. 14, No. 3, 1995: 149-159.
[59] Shaddox, C. Use of Student Restraints, Seclusion Top 18,000. *New Haven Independent*, December 6, 2010.
[60] Bracey JR, Vanderploeg JJ, Franks RP. Conecticut School-Based Diversion Inititative: A Brief Progress Report. Connecticut Center for Effective Practice. 23 Nov 2010.
[61] A report on FRC outcomes: http://www.sde.ct.gov/sde/cwp/view.asp?A=2678&Q=320774

Child Welfare

[62] The special risks and need of infants and toddlers at-risk for maltreatment and involved with child welfare systems is well-documented. For example, S. Dicker et. al., *Improving the Odds for the Healthy Development of Young Children in Foster Care*, National Center for Children in Poverty (January 2002).
[63] Alexandra Dufresne, "Protecting Children and Youth in Connecticut's Child Welfare System: Candidate Briefing October 2010, Connecticut Voices for Children, at www.ctkidslink.org/publications/CB10childwelfare.pdf.
[64] Several States have "outlawed" or strictly limited the use of congregate care for infants and toddlers. Examples include Maryland, Florida, Nevada, and Michigan.
[65] For example, DCF should develop a protocol for the removal of infants from their homes that includes attempts to obtain specific information that should include, at minimum, basic information about the child's schedule, care, (including such things as sleep position, current and past formula issues, etc), health, preferences and relationships with current and former caretakers. This and additional recommendations related to DCF's care of infants and toddlers may be found in the recent report on the Death of Michael B. State of Connecticut Office of the Child Advocate, Excerpted Special Public Report, Findings and Recommendations, Fatality Review of Baby Michael (May 2010).
[66] Some states have created Court Teams for Young Children. www.zerotothree.org/maltreatment/court-teams/index.html
[67] Department of Children and Families, *Annual Report Concerning At-Risk Children and Youth*, February 2010, pp. 20, 22.
[68] Juan F. Court Monitor's Office, *Juan F v. Rell Exit Plan Quarterly Report: April 1, 2010-June 30, 2010* (September 2010), p. 22. DCF ranks among the then worst performing states in the number of children who "age out" without a permanent family. McCoy-Roth, Marci, & Ross, Tim (2010). Number of Youth Aging out of Foster Care Continues to Rise, Fostering Connections Resource Center, found on the web at: http://www.fosteringconnections.org/tools/assets/files/Connections_Agingout.pdf
[69] State of Connecticut Community Health Services Block Grant for FY 2010, pp. 17-18; DCF Budget Options for FFY 2009-11, dated Nov. 10, 2008, Priority 8.
[70] See Brief of *Amicas Curiae*, Child Advocate for the State of Connecticut in Support of Plaintiff's Opposition to Defendant's Motion to Vacate, Civil No. H89-859 (CFD) (August 2010).
[71] See E. Griffith et al., *Report of the Ad Hoc Committee to Review Connecticut's Services to Young Adults in the Context of Jane Doe's Death* (2008).
[72] Annie E. Casey Foundation. (2010). Rightsizing Congregate Care: A Powerful First Step in Transforming Child Welfare Systems. Baltimore, MD (available online: www.aecf.org)

[73] DCF Policy does not permit youth to remain with DCF if they have specialized needs and require additional transition or remedial services prior to post-secondary enrollment or if they have disabilities that prevent them from participating in a full-time educational program.

[74] FOSTERING CONNECTIONS 42 USC § 675(8)(B)(iv). Massachusetts provides an example of the proposed action. See also Courtney, M. E., Dworsky, A., & Peters, C. M. (2009). *California's Fostering Connections to Success Act and the Costs and Benefits of Extending Foster Care to 21*. Seattle, WA: Partners for Our Children.

[75] Youth in and aging out of foster care have disproportionately high teen pregnancy rates. Researchers also document that children born to teen parents are significantly more likely than children born to adult parents to enter the foster care system. Teen childbearing cost taxpayers $9.1 billion in 2004. Fully $2.3 billion of these costs can be attributed to increased child welfare costs from foster care and Child Protective Services. With support from the Annie E. Casey Foundation, the National Campaign to Prevent Teen and Unplanned Pregnancy and the Healthy Teen Network, convened eight states (Arizona, Colorado, Illinois, Maryland, Massachusetts, Michigan, Oklahoma, and Virginia) in April 2009 to share and develop innovative strategies to reduce teen pregnancy among youth in and aging out of foster care. www.thenationalcampaign.org/fostercare/default.aspx

[76] It may not make sense to apply for every child in DCF's care, i.e. SSI recipients who also receive Title IV-E funds in excess of the SSI benefit will have their SSI benefit terminated, many children could benefit from SSI eligibility.

[77] There are some exceptions including where the parent is also getting Title IV-E benefits and where a child is placed in a state institution.

[78] For more than a decade, the same individuals have been at the helm at DCF. The vast majority of the Executive Team, including the Commissioner and the Chief of Staff, as well as Bureau Chiefs, Regional Directors, Area Directors and Program Directors has been promoted from within the agency. These individuals held key leadership positions during the time that the Office of the Child Advocate, the Office of the Attorney General, the Juan F. Court Monitor, and the Legislative Program Review and Investigations Committee documented numerous, persistent and substantially similar system problems and children received inadequate care and treatment. These individuals held positions with responsibility to expedite fundamental change needed to bring DCF back from the brink of federal receivership and propel DCF beyond draft plans for girls, adolescents, children with mental health and developmental disabilities and a promising new differential response system for child protection work. During their tenure, the current team has achieved only limited progress in these critical areas since 2006, and that progress has been slow, fragile and is not yet embedded in DCF's culture and infrastructure.

[79] The layers in the "chain of command" between the caseworkers assigned responsibility for each and every child and family in the system and the Commissioner's office has grown to nine and potentially 10 with the recent addition of an Assistant Bureau Chief of Child Welfare. The number of individuals assigned to the DCF central/administrative office far exceeds the numbers in other executive branch service agencies.

[80]On September 22, 2010, the federal court denied the state's motion to vacate the Juan F. v. Rell Consent Decree and its revised exit plan (adopted in 2006 and revised in 2008), finding that "because the department has not yet met all the targets laid in the exit plan, children in the state's care face unneeded delay and disruption and continue to go without important services." For this reason, the court ruled, "this case will not end until the state has fully met its responsibilities in addressing the needs of these children. The noncompliant Outcome Measures include Measure 3 (requiring adequate treatment plans) and Measure 15 (requiring that the child's identified needs be met).

[81] Building a Model and Framework for Child Welfare Supervision, National Resource Center for Family-Centered Practice and Permanency Planning & National Child Welfare Resource Center for Organizational Improvement (2009)

[82] Current performance appraisal instruments are generic and used across all agencies. DCF performance appraisals must be specific to performance duties and expectations.

[83] As of August 2010, 978 of the children in DCF care – including 223 children under the age of 12 – were placed in congregate care. Juan F. Court Monitor's Office, *Juan F v. Rell Exit Plan Quarterly Report: April 1, 2010-June 30, 2010* (September 2010), p. 33. (Hereinafter "Court Monitor's Report").

[84] In Connecticut, an evaluation of DCF's SAFE Homes by Yale University researchers in 2005 concluded that SAFE Homes were prohibitively expensive and failed to result in better outcomes than placement in foster homes. Currently, the SAFE Home cost per bed is nearly $84,000 a year, as compared to $9,000 for foster care for an infant, $16,500 for foster care for a child with complex needs, and $19,100 for foster care for a minor parent with a child. Alexandra Dufresne, "Protecting Children and Youth in Connecticut's Child Welfare System: Candidate Briefing October 2010, Connecticut Voices for Children, at www.ctkidslink.org/publications/CB10childwelfare.pdf; DeSena, A. D., et al. (2005). Safe homes: Is it worth the cost. Child Abuse and Neglect, 29, 627-643. (http://www.justbeginning.org/resources#117)

[85] DCF agreed to a statewide net gain of 850 foster family homes by June 30, 2010, over a June 2008 baseline of 3,388 homes. By June 2010, however, DCF had achieved a net gain of just 342 homes.

[86] Indeed, the *Juan F.* Court Monitor found that in 27.1 percent of cases in Connecticut, placement in the temporary congregate care

facility was decided *based on availability alone.* In other cases, many of the documented rationales for selection of a congregate setting over a family setting were secondary, "as the main rationale was the need for immediate placement and the lack of available and appropriate foster and therapeutic foster homes." Court Monitor Report on Children in Overstay Status within Temporary Congregate Care Placement Settings, March 17, 2008, pp. 20-21.

[87] Currently, 340 children currently reside in residential treatment programs outside Connecticut.

[88] Court Monitor's Report, p. 22.

[89] Research unequivocally shows that children do best when raised by caring adults in a family, not in staffed institutions such as residential treatment programs, group homes, SAFE homes, shelters and DCF-run facilities and hospitals. Richard Barth, "Institutions vs. Foster Homes: The Empirical Basis for a Century of Action" (Jordan Institute for Families, University of North Carolina at Chapel Hill School of Social Work) (June 2002); Alexandra Dufresne, "Protecting Children and Youth in Connecticut's Child Welfare System: Candidate Briefing October 2010, Connecticut Voices for Children, at www.ctkidslink.org/publications/CB10childwelfare.pdf.

[90] Annie E. Casey Foundation. (2010). Rightsizing Congregate Care: A Powerful First Step in Transforming Child Welfare Systems. Baltimore, MD (available online: www.aecf.org).

[91] Currently, relatives receive only a letter within 30 days of removal.

[92] Auditors of Public Accounts, www.cga.ct.gov/apa/pdf2010/DCF_81000_08.pdf.

[93] Connecticut Department of Children and Families. DCF Fiscal Year 2010. Town Pages. Retrieved December 13, 2010, from http://www.ct.gov/dcf/lib/dcf/agency/pdf/tp_2010.pdf

[94] Child FIRST is an early childhood system of care and public-private partnership that seeks to decrease the incidence of serious emotional disturbance, developmental and learning problems and abuse/neglect among high-risk young children through screening, assessment and intervention. In 2010, Child FIRST the Robert Wood Johnson Foundation (RWJF) awarded $3.2 million to replicate Child FIRST's successful early childhood system of care in five new Connecticut communities. The RWJF has called Child FIRST, "a model of potential national significance" and works directly with the Child Health and Development Institute, the fiduciary for the Child FIRST replication, to fund lead agencies around Connecticut to institute Child FIRST's intervention model in their communities. The replication is supported by the Connecticut Center for Effective Practice of the Child Health and Development Institute of Connecticut to ensure rigorous adherence to the model.

[95] Child Welfare Information Gateway. (2008). Differential Response to Reports of Child Abuse and Neglect. Washington, DC: U.S. Department of Health and Human Services Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/issue_briefs/differential_response; Loman, L. A., & Siegel, G. L. (2004). Alternative response. Research on Missouri, Minnesota, and Virginia: Findings in Six Areas. St. Louis, MO: Institute of Applied Research.

[96] *For an overview of DCF's more recent outreach and planning process for DRS see Casey Family Services, The Connecticut Department of Children and Families Differential Response System: Executive Report (June 11, 2010).*

[97] The Center for the Study of Social Policy identified states with a poverty exemption statute: Arkansas, Florida, Kansas, Louisiana, Pennsylvania, New Hampshire, North Dakota, Texas, Washington, West Virginia and Wisconsin. Among these states, Wisconsin and West Virginia may provide the best source of current information on policy implementation, accountability, and related training. A state poverty exemption has the potential to provide a layer of legal protection to caring but impoverished parents who might otherwise face inappropriate child neglect allegations, unnecessary court involvement, and the trauma of their child being removed from their family and placed in foster care. By carving out clear, objective criteria, state poverty exemptions seek to make more effective use of neglect statutes, child protection staff, and resources.

[98] There are limited outcome measures for privatized DRS systems. More research is needed to ascertain which, if any, child welfare programs may benefit from privatization. In 2003, Children's Rights, Inc. received funding from Annie E. Casey Foundation to conduct a study of six privatization initiatives across the country. The findings and recommendations can be found in M. Freundlich and S. Gerstenzang, An Assessment of the Privatization of Child Welfare Services: Challenges and Successes (2003).

Juvenile Justice

[99] In Connecticut, responsibility for addressing DMC was assigned to the state's Office of Policy and Management (OPM), through its Juvenile Justice Advisory Committee ("JJAC"). OPM's Juvenile Justice Advisory Committee has a DMC Subcommittee and maintains a website that provides information about DMC (http://www.ct.gov/opm/cwp/view.asp?a=2974&q=383632). The JJAC has commissioned three studies of DMC in Connecticut. Spectrum Associates Market Research conducted these studies, including an initial study published in 1995 and follow-up studies published in 2001 and 2009. (see "DMC Studies," available at http://www.ct.gov/opm/cwp/view.asp?a=2974&q=460242).

[100] Dorinda M. Richetelli, Eliot C. Hartstone, Ph.D. and Kerri L. Murphy, *A Second Reassessment of Disproportionate Minority Contact in Connecticut's Juvenile Justice System* (2009) (available at http://www.ct.gov/opm/lib/opm/cjppd/cjjjyd/jjydpublications/final_report_dmc_study_may_2009.pdf).

[101] All three DMC studies reflect that DMC occurs at the decision point to send a child to detention. Richetelli, *supra* note 2, at 30. However, the 2009 study also shows that DMC was eliminated for children charged with non-serious juvenile offenses when the arresting officer was required to obtain a court order before transporting the child to the detention center. *Id*. at 51. Consequently,

requiring a court order before admitting a child to detention was a specific recommendation of Connecticut's JJAC, included in the most recent study. *Id*.

[102] Youth who are sent out-of-state are predominantly youth of color, and those who are in detention remain in detention waiting for an out-of-state placement twice as long as youth waiting for an in-state placement. Additionally, reports from the Department of Children and Families ("DCF") indicate that these children stay in out-of-state placements for an average of well over a year. Youth who are sent out-of-state have more difficulty maintaining existing supportive relationships, accessing family-related treatment, and reunifying with their family and community quickly. Furthermore, out-of-state programs do not receive the same level of scrutiny regarding damaging practices such as restraints and seclusions. Many of these youth can be and should be placed in community-based placements in Connecticut where they can be treated in a less restrictive environment and allowed to foster nurturing relationships with family, friends and mentors.

[103] A 2008 report by the ACLU examined three Connecticut school districts and concluded that school-based arrests were disproportionately used for youth of color. HARD LESSONS LEARNED: SCHOOL RESOURCE OFFICER PROGRAMS AND SCHOOL-BASED ARRESTS IN THREE CONNECTICUT TOWNS. (available at http://www.aclu.org/files/pdfs/racialjustice/hardlessons_november2008.pdf) As the most recent DMC report describes, reducing school-based arrests is an important step to eliminating DMC. Richetelli, *supra* note 2, at 50. Additionally, a review conducted by the Court Support Services Division ("CSSD") of children and youth who were rearrested within three months of the conclusion of probation showed that 40% were arrested at school and that youth of color were more likely to be rearrested than their white peers.

[104] For children and youth committed to DCF for serious juvenile offenses, Black and Hispanic children and youth are significantly more likely to be placed at the Connecticut Juvenile Training School ("CJTS"). Richetelli, *supra* note 2, at 42. Requiring state agencies and local school districts to collaborate in planning for more effective reentry services will help reduce the long-term impact of this disparity, as well as the recidivism rate. (Currently, 66% of those leaving CJTS return because of rearrests or technical violations.)

[105] Under current Connecticut law, a child as young as 14 can be tried in adult court and 17-year-olds are still automatically tried in adult court, awaiting the full implementation of the Raise the Age legislation, which will occur on July 1, 2012. Pub. Act 09-7 §82ff. Because the adult court system lacks the rehabilitative services of the juvenile system, research shows that children who are transferred to the adult court system are more likely to recidivate than those in the juvenile court system. *See, e.g.*, Centers for Disease Control, *Effects on violence of laws and policies facilitating the transfer of youth from the juvenile to the adult justice system*, Morbidity and Mortality Weekly Report 56: 1-11 (2007).

[106] During the 2010 legislative session, the fiscal note for File No. 499 ("An Act Concerning Child Welfare and the Juvenile Justice System And Erasure of Juvenile Records") anticipated no fiscal impact for law enforcement agencies due to a requirement for a court order prior to admission to detention and a fiscal savings for CSSD due to reduced admissions to detention facilities.

[107] The State Department of Education's ("SDE") ED-166 form, which is used for reporting significant disciplinary incidents, includes a collection field for school-based arrests. However, this data is self-reported by the school districts and SDE has questioned its accuracy, particularly because the person completing the ED-166 form may not know whether the student has been arrested or not. Furthermore, SDE does not make this data public so that communities can have access to it. Consequently, the need for collaboration to ensure accurate data persists, a need that is exemplified by the data analysis recently begun by CSSD of school-based arrests within court files.

[108] The 2007 *WR v. DCF* Settlement Agreement provides a model for revenue to move youth from residential treatment to community-based treatment that could also be used to pay for returning children from out-of-state placements.

[109] This proposal is also akin to the Malloy/Wyman campaign policy of creating a Connecticut Center for Autism and Developmental Disabilities, to address the significant costs of out-of-state placement for children on the autism spectrum.

[110] DMC affects the ability of youth of color to prepare for post-secondary education and employment. According to a 2003 study, up to three-fourths of youth incarcerated as ninth-graders either never re-enroll in school or drop out within a year, resulting in a four-year graduation rate of 15%. Robert Balfanz *et al*., "Neighborhood Schools and the Juvenile Justice System: How Neither Helps the Other and How that Could Change." Presented at the School to Jail Pipeline Conference, Harvard University (2003). Even in cases where punishments are mild, students are less likely to graduate and more likely to end up back in the court system than their peers. These benefits echo the Malloy/Wyman public safety policy of providing offenders with expanded services and job training to reduce long-term costs to the State.

[111] The potential for creation of mental health jobs in Connecticut is similar to the impact envisioned by the Center for Autism and Developmental Disabilities mentioned in note 12.

[112] Both claimed that this provision would create a burdensome process for police officers. In the fiscal note for File No. 499, the State Office of Fiscal Analysis determined that such a provision would necessitate that police officers seek, on average, court orders for one or two juveniles each day *statewide* and did not predict any increased cost to law enforcement agencies (available at http://www.cga.ct.gov/2010/FN/2010HB-05521-R000499-FN.htm). Many other states require similar provisions and have systems for obtaining court orders that are not burdensome or expensive which Connecticut can explore for replication.

[113] Despite the decrease in the use of residential placements and juvenile detention, juvenile delinquent acts have been reduced by 25 percent in the last decade. The Connecticut Juvenile Justice Alliance, *Safe and Sound: A New Approach to Juvenile Justice and Its Effect on Public Safety in Connecticut* 3 (December 2010).

[114] The settlement agreement in the *Emily J.* lawsuit provided for a system of screenings and assessments as well as a wide range of community-based mental health services for children in at-risk of remaining in juvenile detention, including care coordination, Multi-dimensional Treatment Foster Care ("MTFC"), outpatient substance abuse treatment, a therapeutic group home, Multi-systemic Therapy ("MST"), wraparound home-based therapeutic services, therapeutic mentors, and flex funds for other wraparound services. Settlement Agreement, Emily J v. Rell, 3:93CV1944 (June 3, 2005) (available at http://www.kidscounsel.org/EmilyJJune32005Agreement.pdf). Many of the linchpins of the *Emily J.* array of services have been substantially reduced in the last year.

[115] Using FSC workers to process FWSN petitions will reduce the workloads of juvenile probation officers, allowing them more time to work with 16- and 17-year-olds who are entering the juvenile justice system due to the Raise the Age legislation. Transferring processing of FWSN petitions to the FSCs was a recommendation of Connecticut's FWSN Advisory Board. Family With Service Needs Advisory Board, *Report to the General Assembly* 19 (2008) (available at: http://www.ctjja.org/resources/pdf/FWSN-advisorybd-report.pdf). Currently, FSCs only handle the high-risk youth who come through the FWSN system.

[116]School systems feed a large number of children and youth into the juvenile justice system, as noted in the Malloy/Wyman public safety campaign policies. A recent review of children rearrested within three months of the conclusion of probation by CSSD found that about 40% of these arrests occurred at school. Improving school-based interventions would help prevent juvenile justice involvement: encouraging partnerships between schools and outside mental health agencies to provide in-school services; implementing system-wide behavioral intervention systems; reducing the use of school-based arrest and disciplinary exclusions; creating pathways for direct referral from schools to Juvenile Review Boards ("JRB") or other diversionary projects, including truancy prevention projects; involving school districts with community partners at Local Implementation Service Team ("LIST") meetings; and requiring that school districts file FWSN petitions within 15 days of a family's failure to cooperate to solve truancy problems.

[117] Currently, diversionary and pretrial juvenile justice services are fragmented between DCF and CSSD which can cause confusion about how children access services. Consolidating these services in one agency should be explored to determine if it would improve services and reduce redundancies.

[118] Streams of federal reimbursement may be available for diversionary and community-based services provided through FSCs, FWSN centers, respite centers and community-based treatment programs. Seeking these reimbursements was an explicit recommendation of Connecticut's FWSN Advisory Board. FWSN Advisory Board report, *supra* note 3 at 20. Currently, CSSD seeks reimbursements for some services provided through the federal Temporary Aid for Needy Families ("TANF") program but does not maximize other federal reimbursement streams.

[119] Research shows that mentoring of at-risk youth can improve academic achievement, school attendance, peer-family relationships and reduce risky behaviors. J. Tierney et al., *Making a Difference: An impact study of Big Brothers/Big Sisters. Public/Private Ventures* (1995) (available at http://www.ppv.org/ppv/publications/assets/111_publication.pdf).

[120]Data from DCF and CSSD suggest that community-based treatment can cost almost 15 times less than residential placement. For example, the total cost of six months of Multi-Systemic Therapy ("MST"), an in-home, intensive therapeutic service is estimated at between $7,000 to $9,000 while the total cost of six months of placement at the Connecticut Juvenile Training School ("CJTS") is estimated at over $133,000. Multidimensional therapeutic foster care ("MTFC") costs, on average, $150 per day, while placement in a detention center or a non-secure residential costs, on average, around $375 per day. The Connecticut Juvenile Justice Alliance, *supra* note 1 at 6-8; Connecticut Juvenile Training School Advisory Board, *Report to the Commissioner of the Department of Children and Families* (December 2010). Additionally, because the community-based treatment models are evidence-based, research supports their effectiveness, while research does not currently support the effectiveness of residential placements.

[121] HomeCare provides psychiatric medication management to children in community-based settings.

[122] The CARE Program is a two-week respite program, contracted by CSSD, that connects children and youth to resources in their communities upon release.

[123] Consolidation of the State juvenile justice services may result in a fiscal savings if any duplication of services is eliminated.

[124] Additionally, research shows that every dollar spent on mentoring programs saves $3.28 dollars otherwise spent on criminal justice, school failure, child abuse, substance abuse and other negative outcomes. Washington State Institute for Public Policy, Benefits and costs of prevention and early intervention programs for youth (2004) (available at http://www.wsipp.wa.gov/rptfiles/04-07-3901.pdf).

[125] In 2006, the Legislature appropriated funding for staffing and operating expenses of a self-contained, secure treatment facility for girls. Pub. Act No. 06-186. In 2007, a partial bonding authorization for a self-contained, secure treatment facility for girls was enacted and supplemented by the 2009 authorization. Pub. Act No. 07-7; Pub. Act No. 09-2.

[126] Consensus has never existed around building a large girls' secure facility. Indeed, a report by Dr. Marty Beyer, a girls' juvenile justice expert, indicated that girls' needs could more appropriately be met—without the tremendous cost of a new residential facility—through retooling current residential placements into hubs of service. Marty Beyer, *A System of Services for Girls in Connecticut* (2005) (available at http://www.ct.gov/dcf/lib/dcf/juvenile_services/pdf/beyer_report_final_2005%5B1%5D.pdf).

[127] As approved by the bond commission, the original facility design included 16 secure beds and 8 step-down beds, but that design was based on two assumptions which have proven to be incorrect. First, the assumed increase of girls in the juvenile justice system due to "Raise the Age" has not been as large as predicted by the design of the facility. Second, the number of girls being referred to the juvenile justice system has not stayed the same: in the past year, the number decreased by at least 75%. Consequently, the facility envisioned by the original design is likely now too large for this population.

[128] In her report, Dr. Beyer advocates for hubs of diversified services to meet the needs of girls in the least restrictive settings. These hubs would including arrays of residential and community-based services that would allow a girl to maintain connections to staff members as she transitioned among the levels of care. As envisioned by Dr. Beyer, each service array would include: trauma-based individual and group treatment; intensive home-based work with families; the ability to place a girl in a non-relative home, supported by residential and community-based staff; and educational programming to appropriately meet residential and community needs. These hubs would allow for shorter residential stays and provide a fully array of intensive, community-based services to better meet girls' needs. Beyer, *supra* note 2.

[129] As mentioned in note 3, the current facility design is likely too large, so a smaller facility and an expansion of community-based treatment, including Multidimensional Treatment Foster Care, Multi-Systemic Therapy, MultiDimensional Family Therapy, educational programs, vocational exploration and training, independent living and community-based living for girls with young children, should be better suited to meet the needs of this population.

[130] Reforms in the Connecticut juvenile justice system over the last decade have shown that community-based treatment is less expensive and better reduces recidivism than residential treatment. The Connecticut Juvenile Justice Alliance, *Safe and Sound: A New Approach to Juvenile Justice and Its Effect on Public Safety in Connecticut* (December 2010).

Coordination

[131] National Governor's Association Center for Best Practices, *A Governor's Guide to Children's Cabinets* (2004) Cabinet membership include Commissioners and executive level staff from a broad array of agencies including child welfare, children's mental health, education, public health, developmental services, juvenile justice, corrections, social services, economic development and transportation. Many Cabinets include representatives from the judicial and legislative branch and from the parent, business, advocacy and philanthropic communities. Gubernatorial leadership is critical to the Cabinet's success. In many states, the Governor established the Cabinet through executive order and then worked with the legislature to pass legislation that codified the Cabinet. Often, Governors chair Cabinet meetings and in all states the Cabinet reports its recommendations, outcomes and progress to the governor on a regular basis.

[132] For example, Louisiana's Children's Cabinet is charged with developing a Children's Budget based on the recommendations of its members, the advisory board and other stakeholders. The Budget includes recommended line items and amounts, as well as priority rankings for each item in terms of the Cabinet's overall agenda. See also M. Flynn-Khan et. Al., *Adding it up: A guide to developing a children, youth, and families budget*, Washington, DC: Forum for Youth Investment and The Finance Project (2006).

[133] Several states have instituted "out-of-the-box" strategies to provide administrative support to their Children's Cabinets. For example, Maine harnessed in-kind resources from VISTA volunteers.

[134] Significant dollars have been spent building information systems to collect and report data rather than to facilitate the elimination of silos and streamlined points of entry for human services consumers. Stewards of Change (SOC) is a business that is dedicated to collecting and sharing learning related to integration and technology within child welfare and human services systems. SOC hosts an annual conference highlighting innovations in improving integration of human services and child welfare integrated systems that is held in cooperation with the Yale School of Management and supported by the Annie E. Casey Foundation. See www.stewardsofchange.com

[135] Connecticut Commission on Children. (2007). *A children's stock portfolio.* Hartford: Author. http://www.cga.ct.gov/coc/PDFs/prevention/040207_stockportfolio_v1.pdf.

[136] NGA Center for Best Practices. (2006, Aug. 31). *Improving access to benefits for low-income families.* Washington, DC: National Governors Association. http://www.nga.org/Files/pdf/06LOWFAM.pdf.

[137] One study found that approximately 85 percent of Pennsylvania applications for social services through the COMPASS website are placed from private homes – a finding that suggests low-income families may have greater access to online services than previously thought. The study also found that a little under half of all applications submitted through COMPASS occur during non-business hours. Citied in NGA Center for Best Practices. (2006, Aug. 31). *Improving access to benefits for low-income families.* Washington, DC: National Governors Association. http://www.nga.org/Files/pdf/06LOWFAM.pdf.

[138] Schott, L., & Parrott, S. (2005, Jun. 20). *Using the internet to facilitate enrollment in benefit programs.* Washington, DC: Center on Budget and Policy Priorities. http://www.cbpp.org/12-14-04tanf.pdf

[139] Annie E. Casey Foundation. (2010, Apr.). *Improving access to public benefits.* Baltimore, MD: Author. http://www.aecf.org/~/media/Pubs/Topics/Economic%20Security/Family%20Economic%20Supports/ImprovingAccesstoPublicBenefitsHelpingEligibl/BenefitsAccess41410.pdf

Putting Children First – Transformation Strategies

[140] Cornelius Hogan, former Vermont director of human services, accomplished this when he brought his state's executive branch leaders together, along with legislators, and addressed crisis issues for families by calling on each agency to identify what it would do to address the immediate situation. This process created a team approach, supplemented by Hogan's use of a common set of indicators to measure and track progress in addressing needs of families.

Funding Opportunities

[141] http://frac.org/newsite/wp-content/uploads/2010/07/ct.pdf
[142] http://www.frac.org/pdf/breakfast09.pdf
[143] http://www.frac.org/pdf/summer_report_2010.pdf
[144] http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Nutrition/FFVP_AppLetter.pdf
[145] http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Nutrition/FFVP_AppLetter.pdf
[146] Phone conversation 12/15/10 with C. Resha, CT State Department of Education Bureau of Health, Nutrition, Family Services and Adult Education

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