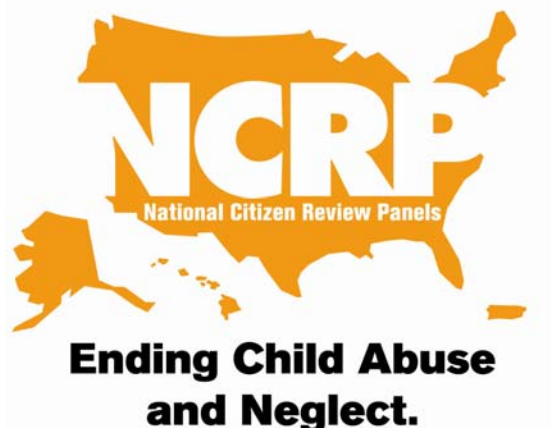


**The Power of Community**



**Citizen Review Panel**

**Annual Report to  
The CT Department of Children and  
Families**

**Submitted by  
The State Advisory Council**

**June 15, 2009**

**Appointed Members  
State Advisory Council  
Department of Children and Families**

**Chairs**

Virginia Del Monaco, *Parent*

Dr. Irvin Jennings, *Provider*

**Members**

Molly Cole, *Child Care Professional*

Ivy Farinella, *Parent*

Pamela Ferguson, *Parent*

Catherine Holahan, *Attorney*

Laurie Landry, *Provider*

Pat Lorenson, *Person Interested in Children's Services*

Judge Joseph Marino, *Person Interested in Children's Services*

Maureen Price-Boreland, *Provider*

Valentin Rosario, *Community Provider*

Barbara Sheldon, *Parent*

**Invited Guest**

Pamela Trotman, *Office of Policy and Management*

## **Background:**

Section 17a-4 of the Ct General Statutes established the State Advisory Council (SAC) and set out required membership and the powers and duties of the SAC. Under this law, the SAC makes recommendations to the Department of Children and Families about programs, legislation, and other matters to improve services. Specifically, the SAC is charged with the following duties:

- Make recommendations to the commissioner regarding programs legislation or other matters which will improve services for children and youth;
- Review and advise the commissioner regarding the proposed budget on an annual basis;
- Educate the community at large on the policies, duties and programs of the department; and
- Issue any reports it deems necessary to the Governor and the Commissioner of the Department of Children and Families.

Addendum #1 is an OLR Bill Analysis regarding "An Act Concerning the Transformation of Youth from the Department of Children and Families to the Department of Mental Health and Addiction Services" that is of interest to the SAC.

Addendum #2 is a summary of a bill passed in this legislative session based upon the Program Review and Investigations Committee of 2007 study of DCF Monitoring and Evaluation that defines the new relationship between the SAC and DCF.

## **Membership**

As of June, 2009 the Council has thirteen appointed members and 4 vacancies which must be filled by parents who use or have used services administered by the Department of Children and Families.

The membership by statute includes 17 members appointed by the Governor and must include at least 5 persons who are child care professionals, 1 child psychiatrist, and 1 attorney. The other members shall be representatives of young persons, parents and others interested in the delivery of services to children and youth. At least one-half of the SAC must be parents or family members of children who have received, or are receiving, behavioral health services, child welfare services or juvenile services.

## Activities in 2008-09

- Reviewed and made specific comments and recommendations regarding the strategic plan currently being developed by DCF
- Reviewed and discussed the SAC role in monitoring the Mental health Block Grant
- Participated in the CFSR process
- Received legislative updates
- Gave input into the RFI process
- Discussed changes in the Differential Response System, and the Ombudsman's Office
- Reviewed and gave input on new medical policies being implemented within the Department
- Developed plans and operational guidelines for the State Advisory Council, including the development of a list serve, the plan to access reports from other advisory groups and committees to the Department, organizational structure including agendas and minutes.
- Met with various legislators involved with children's issues.

## The State Advisory Council Citizen Review Panel

In addition to the state statutory requirements, the State Advisory Council is also one of three designated CT Citizen Review Panels established under federal CAPTA (Child Abuse Prevention and Treatment Act) legislation. As a Citizen Review Panel the SAC is charged with evaluating the extent to which the State is fulfilling its child protection responsibilities in accordance with its CAPTA state plan. Designation of an existing advisory body as a Citizen Review Panel is allowed under CAPTA, and Connecticut is among a handful of states whose CRP's fulfill a dual role. Since part of the CRP function is to review the status of child protective services, the Panel has included the most recent data on hotline reports and substantiated cases of child abuse.

**Data on CT Child Protective Services: Reports to the Hotline in 2007 (most recent data)** [http://www.ct.gov/dcf/lib/dcf/agency/pdf/tp\\_2008.pdf](http://www.ct.gov/dcf/lib/dcf/agency/pdf/tp_2008.pdf)

In 2007 there were 24,611 accepted reports into the Hotline. Of those 5,888 were substantiated, reflecting a substantiation rate of 24%. Allegations (not all are accepted reports) into the hotline represented the following categories/numbers:

39,124	Allegations of physical neglect
13,182	Allegations of emotional neglect
7,426	Allegations of physical abuse
1,980	Allegations of sexual abuse
1,551	Allegations of educational neglect
1,548	Allegations of medical neglect.

Categories of substantiated reports are as follows

49%	Educational neglect
30%	Medical neglect
28%	Physical Neglect
27%	Sexual Abuse
26%	Emotional Neglect
8%	Physical Abuse

## **Citizen Review Panel Report Methodology**

At the commencement of our work on the CRP report, the SAC members reflected on our collective responsibility to serve as a Citizen Review Panel to the Department of Children and Families and planned for how to fulfill that responsibility as effectively as possible. The value of the SAC is in the very nature of our diversity in experiences with respect to DCF. We are made up of parents, families, professionals and providers. We are each part of different networks of parents, families, professionals and providers in our own communities across the state. We each have our own experiences with and knowledge of DCF, as well as the experiences of others within our own networks, on which to draw when we come together collectively as the SAC.

In order to maximize our recommendations as a CRP, in the fall of 2008, the SAC identified three key areas on which to focus for the CRP report. The selection of the three areas was based on information provided from the department as well as information regarding critical issues in child protective services identified by council members, including family members. The three areas of focus selected were:

### **1. Dispute /Complaint Resolution Process**

The issue of Dispute/Complaint Resolution was chosen for two reasons. First, the Council believes that the data from the Ombudsman's Office could be an effective tool to drive quality improvement and system/policy development. Second, the Council was concerned with the implications of handling individual complaints in the region. Issues included in this topic area relate to retaliation against families who complain and retaliation against staff when the Ombudsman gets involved. Questions to be addressed include the protocol used in addressing complaints. Is this fact finding? Is it hearsay?

**Data Sources Reviewed:** Data sources included data from the Ombudsman's Office; Anecdotal data through council members; patterns of complaints in the region and how they are handled, feedback loops that relate to Quality Improvement.

**Policies to Review:** All policies in DCF that relate to the Ombudsman and/or complaints, disputes and appeals.

### **2. Transition to Adulthood for Youth with Mental Health Needs**

Both providers and families identified this area of focus, due to the significant challenges as youth transition from DCF into adult services. Discussion under this topic relates to protocols and resources available to assist DCF in transitioning youth with mental health needs into adult services and supports.

**Data Sources:** Data from DCF on transition of youth into adult services. .

**Policies to Review:** All policies relating to transition out of DCF services, including the Memorandum of Understanding (MOU) between DCF and DMHAS.

### 3. Educational Issues for Youth in CPS

This topic area includes:

- *Educational stability for youth in foster care.* The issue of educational stability for youth in foster care has been an issue both nationally and in the state of Connecticut. Legislation has been introduced at least twice at the state level to allow youth in foster care to remain in their home school even if they are placed out of that district.
- *Surrogate parents/special education preparation for foster parents.* This topic focuses on the involvement of surrogate parents and foster parents at PPT/IEP meetings.

**Data Sources:** Data from Ct Voices for Children. Any data DCF has on surrogate parents, PPT/IEP activity

**Policies to Review:** Surrogate parent policies; any DCF policies relating to educational placements; Training Academy training agendas relating to special education training for staff.

## Findings and Recommendations

### 1. Dispute/Complaint Resolution

#### Policy Review

"The role of the ombudsman is to receive and investigate inquiries and complaints relating to Department services in an effort to bring about a resolution for the best interests of children. Inquiries or complaints may be made either by telephone, in-person or in writing. (Ombudsman's Office Policy 2-4-1).

DCF Policy allows the Office of the Ombudsman to respond to complaints and inquiries from children and families who are involved or not involved with DCF, foster and adoptive parents, providers and others who have a dispute with the department. Additionally, the Office can respond to complaints or inquiries from DCF operated facilities, private residential facilities, group homes, hospitals and child care agencies. Response time ranges from immediate to three days for phone calls, three days for contacts from the court monitor, child advocate or governor's office, and up to ten days from letters and e-mails. The Commissioner can request an immediate response for some inquiries.

The investigation process includes contact with the following to request a summary/update on the case and/or a draft response regarding the inquiry or complaint:

- Appropriate Area Director
- Ombudsman's Office Liaison
- Facility Superintendent
- Bureau chief
- Division Director

Upon receipt of a response, the Ombudsman's office will review and conduct further investigation. If there is no merit to the complaint, the office will contact the referring source within two days to explain the finding. If there is merit to the complaint then the appropriate DCF staff will be contacted to resolve the situation. Case conferences may be scheduled as appropriate. The Ombudsman has the option of consulting with the Commissioner or Deputy Commissioners for resolution. Once a decision has been reached, the referring source will be informed of the results.

## **Data**

Data reviewed from the Ombudsman's office shows a comparison of total calls into the offices indicates that calls have increased from 3,788 in 2006 to 6,735 in 2007 – a gain of 2,947 calls. A co-location of DCF at York Correctional Center may explain some of the increase, and represents an increase of 1,910 calls regarding DOC issues in 2007. There were 2,206 inquiries from York in 2007. CJTs grievances increased from 142 in 2006 to 256 in 2007. The bulk of the other contacts were by phone (2,518) and e-mail (569). More calls were received from clients in 2007 – up from 1,795 in 2006 to 3,519 in 2007. There was also an increase in calls from grandparents up from 153 in 2006 to 288 in 2007.

## **Discussion**

The policy does nothing to protect anyone – parents, staff or others - from retaliation. Regarding confidentiality, the DCF policy states: "The Ombudsman shall make every attempt to maintain neutrality and promote harmony in sensitive situations. The Ombudsman is subject to state statutes, regulations and Department policies and procedures regarding confidentiality." There is no statement in the policy that protects complainants.

While this data reveals numbers and issues, it tells us little about investigative process, outcomes and links to quality improvement. For example, we know nothing from the data on how many contacts were found to have merit, the types of contact that had merit, and whether there are any specific offices that had more complaints with merit. Of those that had merit, what was the investigative process and resolution? We cannot discern if there were repeated complaints about the same case, staff person, issue or

DCF office. We do not know how much time is spent on actual investigations beyond soliciting a written response from the appropriate staff or DCF office. In essence, we know little of the quality of the investigations, and how much is actually done to evaluate and examine staff, process and policies that come under scrutiny through the Ombudsman's Office.

## **Recommendations**

1. Add a statement into the policy that protects any individual from retaliation, and gives them further recourse if they feel that there was retaliation based on their contact with the Ombudsman's Office.
2. Improve the data collection process to show outcomes of the investigations, reports with and without merit, time spent, policies or programs impacted from complaints with merit. Develop a feedback loop to the State Advisory Council on complaints with merit.

## **Transition to Adult Services of Youth with Mental Health Needs**

### **Policy Review**

Adolescents in the care of DCF all have different needs in terms of transition to adulthood. Some receive support and training to prepare them for independent living and are not in need of or eligible for additional supports once they pass from DCF care. Other young adults have significant mental health needs and need to transition to the Department of Mental Health and Addiction Services (DMHAS) for support services.

Policy 42-2 addresses Adolescent Services in DCF (children 14 years of age and older). The stated goal of the Bureau of Adolescent and Transitional Services is to provide "the necessary supports and resources to assist each and every youth age 14 – 21, in the acquisition of skills that will help them succeed as adults. To that end, the Department maintains an Independent Living Program with a number of services:

- Aftercare
- Community Housing Assistance Program (CHAP)
- Community Housing and Employment Resources (CHEER)
- Community Life Skills Programs
- Supportive Work and Educational Transition (SWET)

DCF has responsibility for maintaining regular contact with youth age 18 years of age or older who continue to receive DCF services. A treatment planning process begins with the Adolescent Planning Conference that provides a roadmap for independent living service delivery and ends with the Adolescent Discharge plan as the transition from care plan.

Young adults with mental health disorders who are in DCF care often require transition from DCF to the Department of Mental Health and Addiction Services (DMHAS). DMHAS has an array of Young Adult Services to provide appropriate supports for young people who are transitioning out of the DCF system of care and are diagnosed with a major mental illness. These specialized services are provided at different program sites. Services generally include clinical, residential educational and/or vocational supports. Priority is granted to youth who have had some form of involvement with the Department of Children and Families. The absence of DCF involvement will not preclude an otherwise eligible young person from receiving services.

Individuals may be referred to young adult services in DMHAS as early as age 16. In general the services do not begin until age 18, and in some case age 21. According to DMHAS policy, the DCF Regional Worker from the Area Office sends a complete referral packet to the DCF to the Central Office Transition Coordinator. However, DCF states that all referrals are made at the area office level, which is why there is no easily accessed data on transition. Those young adults who are also eligible for DDS services await a DDS determination prior to a referral to DMHAS.

There is an interagency agreement or Memorandum of Understanding (MOU) between DCF and DMHAS which provides for how transition from DCF to DMHAS should occur.<sup>1</sup> According to that agreement, DCF shall refer individuals in its care to DMHAS at age 17, or if possible, at least six months prior to the anticipated date of transition. After that referral, a determination of eligibility is supposed to be made within 30 days. If the client is eligible for DMHAS services, then a transition planning meeting is supposed to occur within 30 days of the eligibility determination. If eligibility is denied, then there is a hearing process with its own timeline to challenge that denial.

When the SAC members requested data on this population to determine the extent of the problem, it was discovered that there is little data tracking and no uniform system to determine and anticipate what the need for DMHAS services will be with enough time to adequately plan to accommodate those young adults. The data that was provided to the SAC is below.

## **Data**

The Department of Children and families has no centralized data on transition to DMHAS, since all referrals to DMHAS are handled at the Area Offices. In FY 08 and 09 (data was provided through 4/30/09, so this is not two full years of data) a total of 735 young adults were transitioned from DCF to DMHAS.

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<sup>1</sup> Interagency Agreement: Client Transition from the Department of Children and Families to the Department of Mental Health and Addiction Services.

Area Office	Male Referrals FY - 08	Female Referrals FY - 08	Total Referrals FY - 08	Male Referrals FY - 09*	Female Referrals FY - 09*	Total Referrals FY - 09*	Total Referrals FY - 08/09*
Bridgeport	8	14	22	13	9	22	44
Danbury	5	8	13	8	6	14	27
Hartford	26	16	42	40	18	58	100
Manchester	28	18	46	14	25	39	85
Meriden	8	6	14	5	1	6	20
Middletown	7	10	17	8	4	12	29
Milford	19	19	38	11	11	22	60
New Britain	23	21	44	21	22	43	87
New Haven	12	16	28	7	8	15	43
Norwalk	2	2	4	1	1	2	6
Norwich	17	15	32	11	17	28	60
Parole	7	1	8	9	7	16	24
Stamford	1	1	2	2	2	4	6
Torrington	10	9	19	4	14	18	37
Waterbury	15	14	29	13	14	27	56
Willimantic	13	13	26	15	10	25	51
<b>Totals</b>	<b>201</b>	<b>183</b>	<b>384</b>	<b>182</b>	<b>169</b>	<b>351</b>	<b>735</b>

Age of youth at the time of referral to DMHAS ranged from 16 years to over 18.

FY 2008		
Age Range	Total	%
16 - 16.9	208	54.17%
17 - 17.9	135	35.16%
18+	41	10.68%
<b>Total</b>	<b>384</b>	

FY 2009*		
Age Range	Total	%
16 - 16.9	218	62.11%
17 - 17.9	93	26.50%
18+	40	11.40%
<b>Total</b>	<b>351</b>	

DCF does have access to data on placement of youth at the time the referral was sent to DMHAS.

Placement	FY-2008	FY-2009*	Total FY 08-09*
AWOL	1	3	4
CHAPS	3	2	5
Children's Psychiatric Hospital	14	10	24
DDS placement (CLA/SLA)	3	0	3
Detention Center	2	3	5
Foster Care	69	80	149
Group Home 1.5	15	14	29
Group Home 2.0	33	27	60
In Community	52	54	106
Out of State	62	52	114
Prison	8	6	14
Residential Treatment Center	106	87	193
SWETP	0	1	1
Temporary Facility	15	14	29
TLAP	1	0	1
<b>Total Referrals</b>	<b>384</b>	<b>351</b>	<b>735</b>

## Discussion

There is much the available data cannot tell us. It does not indicate the length of involvement in the transition planning for young adults, the quality of the transition plan and the actual outcomes for the young adults. It also does not help anticipate the number and types of services that will be needed from DMHAS with enough time to get those services put in place. This data is limited because it is not centralized within DCF and because we did not have access to outcome data at DMHAS. However, it would seem appropriate for DCF to maintain some form of outcome data as these cases close and the young adult transitions.

Despite the policies and the MOU between DCF and DMHAS, there is widespread concern among SAC members, parents and providers in the communities, and child-serving agencies in the state, that there is a lack of accountability and interagency collaboration between DCF and DMHAS to prevent young adults from falling through the cracks. This concern was well documented in testimony before the Select Committee on Children in February of 2008 in support of legislation (HB-5495) to bring about that accountability and collaboration. The proposed legislation would have required DCF and DMHAS to issue joint annual reports on transition activities for children in DCF care who were likely to need mental health or substance abuse services from DMHAS when they age out of DCF care. This legislation was supported by Commissioner Susan Hamilton of DCF, as well as the Chief Child Protection Attorney, the Child Advocate, Connecticut Legal Services, the Center for Children's Advocacy, the Connecticut Legal Rights Project, the National Alliance on Mental Illness (NAMI-CT), as well as parents and youth, some of whom are also members or former members of the SAC. The legislation passed unanimously out of both the Select Committee on Children and the Human Services Committee, but was not passed into law.

That legislation would have required both DCF and DMHAS to compile data in order to issue a joint report. DCF would have been required to compile the following:

### ***Children Likely to Need DMHAS Services at Age 18***

In addition to containing a detailed description of the transition process, reports must include the following information about children age 14 and older in DCF care:

1. how many may need DMHAS services and the types of services they are likely to need until they reach age 22,
2. diagnostic and behavioral issues related to DCF's reasons for a potential DMHAS referral,
3. identified permanency plans, and

4. anticipated impact on DCF and DMHAS budgets for the two years following the date the report is issued.

The bill requires reports to include the same information on children in DCF care who are age 16 or older.

### ***Characteristics of DCF Children Age 16 and Older Likely to Need DMHAS Services***

The bill requires reports to contain other information about youth in DCF care who are age 16 and over and identified as potential DMHAS clients. This is:

1. the average length of time between the (a) youth's 16<sup>th</sup> birthday and DCF's referral to DMHAS, (b) DCF's referral and DMHAS' acceptance of the referral, and (c) referral and completion of a written transition plan that describes the strengths and service needs for transitioning the youth to DMHAS;
2. how many are in discharge delay status in residential treatment or psychiatric hospitals (i. e. are on waiting lists for services in less restrictive settings);
3. placement settings and identified permanency plans; and
4. how many have been adjudicated delinquent, arrested as adults, and incarcerated in a Department of Correction facility, including the average length of incarceration.<sup>2</sup>

The proposed legislation also would have required DMHAS to report on its actions in response to the referrals, reasons for denials, and details about services for young adults who were accepted for service.

This type of accountability and collaboration is desperately needed in order to prevent youth with mental health needs from falling through the cracks when they pass from DCF care. Unfortunately, rather than increasing support for this population, the Commissioner has informed the SAC of the possibility that the Bureau of Adolescent and Transitional Services will be eliminated. Eliminating the division of DCF that has expertise with this population and that would be responsible for tracking the necessary data would severely impeded efforts to improve the quality of transition for youth with mental health needs.

### **Recommendations**

DCF should not eliminate its Bureau of Adolescent and Transitional Services at the Central Office level.

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<sup>2</sup> OLR Bill Analysis: HB 5495, available on <http://www.cga.ct.gov/2008/BA/2008HB-05495-R000395-BA.htm>

DCF should develop more detailed collaborative policies with DMHAS that address the quality of the transition planning and actual transition.

DCF should maintain centralized data on outcomes and planned treatment at the time of transition.

DCF should track and report on the number of children and youth in DCF's care who are likely to need DMHAS services when passing from DCF's care, consistent with the 2008 proposed legislation HB 5495. The tracking should start when children and youth are at age 14 and continue until they transition to DMHAS. This information should help to ensure that DMHAS has the capacity to meet the needs of the young adults when they do transition.

Explore funding through the Fostering Connections to Success and Increasing Adoptions Act of 2008. This bill includes many IV-E requirements, including additional IV-E funding for youth ages 18-21, but DCF would have to opt into this new option. The bill has a strong focus on outcomes for older youth, and there is a federally mandated transition plan, and the youth must be involved in the transition planning. The bill also requires increased collaboration with LEA's, and increased oversight and coordination of health care.

## **Educational Services**

### **Policy Review**

Policy 45-10. Surrogate Parents: A child is eligible to have a surrogate parent appointed if the child requires, or may require special education or early intervention and at least one of the following is applicable:

- The commissioner of DCF has been appointed as the child's guardian or statutory parent
- The child's parent or guardian cannot be identified, cannot be located, is unavailable to represent the child regarding special education or early intervention services and agrees, or fails to object, to the appointment of a surrogate parent.

The policy outlines the procedure for appointing a surrogate parent.

The DCF Staff member assigned to the case is responsible for communicating with the surrogate parent as appropriate and ensures that the surrogate receives notice of a placement or changes in the status of placement, an invitation to attend the PPT and a copy of the Determination made at the Placement Review Team. Educational consultants through USDII are available to DCF personnel regarding surrogate parent matters. The Educational consultants can review the status of the child, ensure that a surrogate is appointed, and resolve any issues between the DCF staff member assigned to the case and the surrogate parent. The surrogate parent has the same right of access to any DCF records as would the child's natural parent or guardian regardless of

whether such parent or guardian retains such rights. Foster parents may request appointment as a surrogate parent if DCF supports the appointments. The foster parent must be in good standing and actively support the Department's treatment goals and plans. SDE is responsible to train the foster parent if that parent is appointed as a surrogate.

In cases involving children enrolled in the Birth to Three System, the surrogate parent is the foster parent, and that designation is made by Birth to Three program managers.

The Unified School District I ensures that beginning no later than the first IEP in effect when a child is 16 or younger, if deemed appropriate by the PPT, the IEP must include goals and objectives in the areas of Postsecondary Education or Training, Employment, and Independent Living Skills/Community Participation. Additionally, upon graduation, a Summary of Performance Plan is developed which provides the student with a summary of his/her academic achievement and functional performance, and includes recommendations as to how to assist the student in meeting his/her postsecondary goals. Additionally the USD II communicates with the local education agency which will have jurisdiction for the student upon discharge. Records are transferred to the new school district.

### **Training of DCF staff**

Staff receive a six hour class that is mandatory for new social workers. It is taught by an educational consultant. Goals of the training:

- Social workers will be able to demonstrate an awareness of their role and responsibilities of the education Consultants in their offices
- Social workers will be able to demonstrate an understanding of their role in relationship to the educational issues of the children on their caseloads
- Social workers will be able to demonstrate an understanding of the process for notifying a Local Education Agency of a child placement
- Social workers will demonstrate an understanding of the methods and resources available to them to help ensure that a child receives an appropriate educational program

Content areas:

- Education Laws
- Review of the educational neglect policy
- McKinney/Vento Homeless Assistance Act
- Surrogate Parents
- Legal foundation, eligibility and referral process for special education services
- Review of PPT and Special Education Evaluations
- Parent's Rights

- Trends in Special education
- Section 504 of the Rehabilitation Act of 1973
- Overview of USDII
- Review of Test Scores
- Review of the Foster Parent Handbook

## **Data**

This is a much more difficult issue to track through data. DCF does not keep track of the number of school changes for children in its care, or specifics on surrogate parent/foster parent issues in special education. Further, information on IEP, issues at PPT's and challenges in the special education system or Birth to Three system are not captured by DCF. Thus, anecdotal data is all that is available. We do know, from the forums with foster parents in 2008, that they are often frustrated with the surrogate parents, and do not know that they can be appointed as the surrogate parents. They are less aware, receive less training and are less supported through the special education process than many active biological parents who have a child in special education. They are less likely to access services through a special education advocate, relying more on the DCF staff and USD II for assistance, which they feel is not adequate when there are serious issues in special education.

## **Discussion**

Policies and supports in place through DCF policies promote a general awareness of special education laws and services. However, many of the children in DCF care have significant challenges, are more likely to have frequent program/school disruptions, and therefore are more likely to have significant issues discussed at PPT meetings. Thus, general training, while helpful, may not significantly prepare the foster parent, the surrogate parent or the DCF worker to advocate for an appropriate school program.

Further, school stability that allows for foster children to remain in their home schools must be ensured by DCF. DCF is in the best position to arrange for transportation to the child's previous school district if continuity is in the child's best interest.

### **Recommendations**

Ensure that foster parents know that they can be appointed as the surrogate if they choose to request it.

Ensure that DCF staff and foster parents know how to access additional special education training and know how to access the services of a special education advocate.

The Fostering Connections to Success and Increasing Adoptions Act requires child welfare agencies to include a plan for ensuring the educational stability of the child while in foster care. Specifically, the agency must include assurances that

- The child's foster care placement takes into account the appropriateness of the current educational setting and the proximity to the school in which the child is enrolled at the time of placement; and
- The state child welfare agency has coordinated with the appropriate local educational agencies to ensure that the child remains in the school in which the child is enrolled at the time of placement.

The new law provides federal funding through Title IV-E reimbursement for the reasonable transportation costs to a child's home school.

# **Addendums**

## OLR Bill Analysis

### sHB 5495

#### ***AN ACT CONCERNING THE TRANSITION OF YOUTH FROM THE CARE OF THE DEPARTMENT OF CHILDREN AND FAMILIES TO THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES.***

#### **SUMMARY:**

Beginning July 1, 2009, this bill requires the departments of Children and Families (DCF) and Mental Health and Addiction Services (DMHAS) commissioners, within available appropriations, to issue joint annual reports on transition activities for children under DCF care who are likely to need mental health or substance abuse services from DMHAS when they age out of DCF care. In most cases, this occurs when they reach age 18.

The reports go to the Appropriations, Children's, and Human Services committees and the Community Mental Health Strategy Board.

EFFECTIVE DATE: July 1, 2008

#### **REPORT CONTENTS**

##### ***Children Likely to Need DMHAS Services at Age 18***

In addition to containing a detailed description of the transition process, reports must include the following information about children age 14 and older in DCF care:

1. how many may need DMHAS services and the types of services they are likely to need until they reach age 22,
2. diagnostic and behavioral issues related to DCF's reasons for a potential DMHAS referral,
3. identified permanency plans, and
4. anticipated impact on DCF and DMHAS budgets for the two years following the date the report is issued.

The bill requires reports to include the same information on children in DCF care who are age 16 or older.

##### ***Characteristics of DCF Children Age 16 and Older Likely to Need DMHAS Services***

The bill requires reports to contain other information about youth in DCF care who are age 16 and over and identified as potential DMHAS clients. This is:

1. the average length of time between the (a) youth's 16<sup>th</sup> birthday and DCF's referral to DMHAS, (b) DCF's referral and DMHAS' acceptance of the referral, and (c) referral and completion of a written transition plan that describes the strengths and service needs for transitioning the youth to DMHAS;
2. how many are in discharge delay status in residential treatment or psychiatric hospitals (i. e. , are on waiting lists for services in less restrictive settings);
3. placement settings and identified permanency plans; and
4. how many have been adjudicated delinquent, arrested as adults, and incarcerated in a Department of Correction facility, including the average length of incarceration.

### ***DMHAS Actions***

Reports must also include the number of youth DCF referred to DMHAS who were denied services and the reasons for the denials. For youths whose referrals DMHAS accepted, they must include:

1. the average length of time between the youth's 18<sup>th</sup> birthday and placement in a clinically appropriate level of care;
2. how many are receiving services through DMHAS' Young Adult Services Division, how many are being served in other DMHAS divisions, and the services provided;
3. how many youth refuse, withdraw, or are discharged from services, along with the average length of time between DMHAS' acceptance and the youth's refusal, withdrawal, or discharge; and
4. how many have been arrested or incarcerated before their 21<sup>st</sup> birthdays.

### ***Other Information***

The bill directs the DCF and DMHAS commissioners to jointly review and include in the report barriers to:

1. making DMHAS referrals within 30 days of a potential client's 16<sup>th</sup> birthday,
2. completing eligibility determinations within 30 days of the referral,
3. developing appropriate transition plans within 30 days after DMHAS' acceptance of the client;
4. providing clinically appropriate services to youth in DCF care who may later be referred to DMHAS, and
5. providing clinically appropriate services to young adults when they transition to DMHAS.

**COMMITTEE ACTION**

Select Committee on Children

Joint Favorable Substitute Change of Reference

Yea 8 Nay 0 (03/05/2008)

Human Services Committee

Joint Favorable

Yea 18 Nay 0 (03/18/2008)

**Select Committee on Children**  
**JOINT FAVORABLE REPORT**

**Bill No.:** HB-5495

**Title:** AN ACT CONCERNING THE TRANSITION OF YOUTH FROM THE CARE OF THE DEPARTMENT OF CHILDREN AND FAMILIES TO THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES.

**Vote Date:** 3/5/2008

**Vote Action:** Joint Favorable Substitute Change of Reference to Human Services

**PH Date:** 2/28/2008

**File No.:**

**SPONSORS OF BILL:**

Select Committee on Children Office of the Child Advocate

**REASONS FOR BILL:**

This bill was designed to prevent those transitioning out of Department of Children and Families' care with mental health needs to the Department of Mental Health and Addiction Services from falling through the cracks. It forces accountability and interagency collaboration between DCF and DMHAS.

The substitutions for the bill added phrase "within available appropriations" in regards to how the agencies jointly report. It also changed "children" to "youth" in certain sections to include DMHAS since they do not handle children (those under 18).

**RESPONSE FROM ADMINISTRATION/AGENCY:**

**Susan Hamilton, Commissioner, Department of Children and Families:** DCF is in support of the bill. It is committed to working with the Office of the Child Advocate and the Department of Mental Health and Addiction Services. It believes that by working in tandem "considerable progress has been made in addressing the transition of youth from DCF to DMHAS in the past few years and support any and all interagency efforts to continue that progress and to address current challenges to ensuring effective and successful transition of youth."

**Pat Rehmer, MSN, Deputy Commissioner, Department of Mental Health and Addiction Services (DMHAS):** While DMHAS appreciates the efforts of the Office of the Child Advocate, there are still some major concerns on the table in regards to what is required of them and some technical wording. Where the bill refers to "children" it needs to be changed to "youth" as DMHAS does not provide services to those under 18. It is also concerned by the report that is mandated by the bill. "We believe the bill language regarding the report should be worded in such a way as to stipulate what information DMHAS and DCF can provide together, and what DMHAS and DCF will provide separately." This will clarify each agency's responsibilities respectively. Also, some of the required information is not available to DMHAS, but they are

willing to engage in a discussion with the Committee and the Office of the Child Advocate as to what data can and cannot be provided. DMHAS also will need an additional full-time staffer to track and produce data. If this bill passes, DMHAS requests that appropriations are added.

**Carolyn Signorelli, Chief Child Protection Attorney, Commission on Child Protection:** She supports this bill because it “provides necessary oversight of the transition process for youth with mental health needs from DCF care to DMHAS services.” By understanding the current process, the necessary reforms can be made. The bill “imparts excellent guidance regarding outcomes to be studied which will provide an the baseline to not only develop strategies, but to eventually measure the effectiveness of their implementation.”

**Jeanne Milstein, Child Advocate, State of CT:** The interagency agreement between DCF and DMHAS is not sufficient as “youth with serious mental health needs continue to fall through the cracks.” Once a referral is issued, “it can take as much as 8 months before DMHAS determines whether the youth may receive services and several months before a transition meeting occurs.” Sometimes these plans are not executed or implemented poorly. Many of these youth become “homeless and/or incarcerated. Tragically, last year, one such youth was murdered by several other youth in a DMHAS program for young adults.” Many of these youths have experienced mental health needs from such a young age that it has prevented them from living the typical childhood or to learn basic living skills. In order for a successful transition process “each youth needs a carefully designed transition plan that outlines how and when they will receive skills training, services, and supports tailored to their individual needs.” This bill would force accountability by requiring the agencies to provide annual reports to the Select Committee on Children, Human Services, Appropriations and the Community Mental Health Strategy Board. “Connecticut cannot continue to allow youth who have been removed from their biological homes to languish in DCF care only to turn 18 with no prospect for a future, no permanent connections, and no hope.”

#### **NATURE AND SOURCES OF SUPPORT:**

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**Anne Louise Blanchard, Managing Attorney, Children at Risk Unit, Connecticut Legal Services (CLS):** DCF and DMHAS have an interagency agreement to provide for suitable transition between DMHAS and DCF when eligible children enter into adulthood. However, the agreement has failed in instances. An example of such failure was CLS client Shonna K who entered DCF at a young age and suffered from significant “mental health disorders and emotional problems stemming from childhood abuse.” When she turned 18, DCF did not have a

transition plan with DMHAS. CLS filed for an injunctive relief to get a suitable transition plan for her, but DCF “failed to honor the agreement.” Shonna was eventually placed in a facility, but when she turned 21, “DCF and DMHAS still had failed to convene an interagency meeting to develop an appropriate transition program.” Again CLS had to intercede on her behalf to legally force the agencies to plan for her transition to DMHAS. “DCF and DMHAS had still failed to comply with their obligations under the DCF-DMHAS Interagency Agreement.” While similar bills have been proposed through the years, “this year we have a much more basic request—to require DCF and DMHAS to simply report on the status of the youth in their care and the transition process between the two agencies. It is our hope that by enacting reporting requirements, DCF and DMHAS will be more aware of the youth in their care who need a planful transition. It is also our hope that reporting requirements will assist both agencies to engage in a more accurate identification of youth needing to transition to DMHAS and a more appropriate and timely transition process for them.” She says that the money the state spends annually on mentally ill youth that are in DCF care is wasted if they are not properly transitioned at 18 or 21.

**Lorna Grivois:** She has a son who is in the Young Adult Services (YAS) Program. While she appreciates the clinical and psychiatric services that it offers, she believes there are some serious issues. She believes that YAS needs to “provide more developmentally age appropriate and safe housing, train YAS staff to know how to work with young adults with mental health challenges and include pre and post assessments, provide proven developmentally age appropriate vocational training and supports for further education.”

**Karyl Lee Hall, Esq., Connecticut Legal Rights Project:** The current efforts of both DCF and DMHAS to “provide effective treatment to young adults in Connecticut is a failure.” These young adults are “vulnerable because of their age, because of their diagnosis and because of their histories, which almost without exception, are heartbreaking and bleak.” The bill will help the agencies see where the problems lie, and assist in determining what changes need to be made. “DCF and DMHAS will not only have to report the data but will have to own it as well...Raised Bill No. 5495 will help to provide the information we need to change the system to achieve better results and it will focus on the agencies responsible for the services we are providing to young adults.”

**Barbara Sheldon:** She has been advocating for a bipolar young adult from Greenwich who lacked proper transition from DCF to DMHAS. “DCF did not make a referral to DMHAS.” He spent some time at an out of state facility and planned to return to enter a DMHAS funded supervised apartment, have a case manager, receive therapy, vocational planning, etc.. When he was discharged, it was discovered the apartment was not ready, so he had to be discharged to his home with no services. He spent more than a month at home with no services. He began decompensating. While he has moved into his apartment, to date he has received no vocational training or a mentor. She feels that this example exemplifies why there needs to be a coordinated, smooth transition plan between DCF and DMHAS.

**Stephen Grivois:** He has been diagnosed with Fetal Alcohol Syndrome, Cerebral Palsy, Dysthymia and an anxiety disorder in addition to learning disabilities and memory issues. He is quite independent living in his own apartment and works as a cook at Mohegan Sun. He belongs to Young Adults United and is a client of Young Adult Services (YAS). He has complaints about his case worker being unreliable and not being understanding. The staff does not respond well to the young adults. He suggests “they need to be staff who understand both mental health challenges and young adult culture.” He also says that the youth needs better

housing opportunities and proper training in order to become more fully independent. He also suggests that YAS provide transportation to and from jobs and that they need to “understand and accept our limitations but also help us grow and succeed with them.” He assures that he may have “mental health challenges” but he is “capable of success” with the right assistance.

**Cheri Bragg, Coordinator, Keep the Promise Coalition:** This group advocates for “Blue Ribbon Solutions” which are necessary to “maintain and expand critical mental health services for adults and children and housing options to meet their needs.” The good news is that the number of young adults transitioning from DCF to DMHAS over the past years has increased. Unfortunately, adequate support systems have not kept up with the steady rise in young adults who have “been needlessly detained at Cedarcrest Hospital.” There needs to be a continual assessment to determine where to target the needs of the young adults in order to improve the prospects for these young adults.

**Alicia Woodsby, Public Policy Director, National Alliance on Mental Illness, CT (NAMI-CT):** “We believe that this bill is urgently necessary, and long overdue, to ensure that young adults with serious mental illnesses 'aging out' of the Department of Children and Families (DCF) care will be connected with services and treatment from the Department of Mental Health and Addiction Services (DMHAS), and that the state track outcomes in the current service system to establish a clear understanding of the population and their needs.” With the standing system, young adults fall through the gap between the two systems. This often results in homelessness, incarceration, dependence on emergency care, etc.. She says that the bill “probes the issue to determine the barriers to ensuring successful transitions and has the potential to generate Results-Based Accountability standards for the Department.” Studies have shown that youths who transition out of foster care are at a high risk for becoming homeless. 25% of former foster youth have reported that they have been homeless at least one night 2.5 to 4 years after foster care. “Anywhere from 40 to 85% of kids in foster care have mental health disorders, depending on which report you read.” It is important that to maintain the quality and continuity of treatment through the transition stage is important for preventing the development of new or deterioration of existing mental health conditions.

**Josh Michtom, Esq., Staff Attorney, Center for Children's Advocacy:** This bill will help “gather important information about young people's transition from DCF to DMHAS care, at a moment when some of Connecticut's most vulnerable citizens can fall through the cracks.” Children in the care of DCF need to have a timely transition to DMHAS in order to maximize their “chances for success in life, and reducing the likelihood of negative effects on society at large.” An example of such is a DCF client, Melissa, who had been committed for almost her whole life and remained “voluntarily” with DCF when she turned 18. Even though she had a documented history of mental health needs, the only provision that was made for her was that she had to sign a contract stating she would make efforts to procure an independent living arrangement that aligned with DCF practices. She was also told that she could only get services if she asked for them. She has since been arrested twice for assault charges and is in jail. “Children can end up without support or languishing in inappropriate placements and without proper mental healthcare while transitions are put into place.” At 18, DCF, as a child's guardian, often times leaves them without support. “...For youth with mental illness who have grown up in DCF care, that first foray into adulthood can be precipitous and difficult to undo, leading frequently to poverty, homelessness, poor health, and incarceration.” This bill makes the first strides to make sure young people with significant mental health issues are not “cast aside or left to their own devices without the resources to make good decisions.” There is an undeniable need to coordinate and force accountability between DCF and DMHAS.

**Sarah Lombardo, Student, University of Connecticut School of Social Work:** She believes that this bill will help DCF youth transition into adults. She facilitates a group of young adults that have mental health needs and says that through the group the youths have grown and have come out of their shells. “The services that *do* work really *are* making a difference in the lives of our youth.” She hopes for support for this bill so “DCF can understand why youth are not getting the help they really need and eventually ensure all youth can receive better treatment and services as they become adults.”

**NATURE AND SOURCES OF OPPOSITION:**

None expressed.

**Reported by:** Kelly A. Juleson-Scopino

**Date:** 03.11.08

# LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

## Department of Children and Families (DCF) Monitoring and Evaluation (2007)

Study Results Focusing on RBA Program Performance Questions  
(Full report at [www.cgalites/2007/pridata/Studies/PDF/DCF\\_Final\\_Report.PDF](http://www.cgalites/2007/pridata/Studies/PDF/DCF_Final_Report.PDF))

### Scope of PRI Study

- Assess existing internal and external efforts to monitor and evaluate DCF, the state consolidated children’s agency responsible for child protective services, children’s behavioral health, juvenile justice services, and prevention services related to children and families
- Identify ways to make the current accountability system more effective to help DCF improve its performance and meet state goals for children and families

### How Much Did We (DCF) Do?

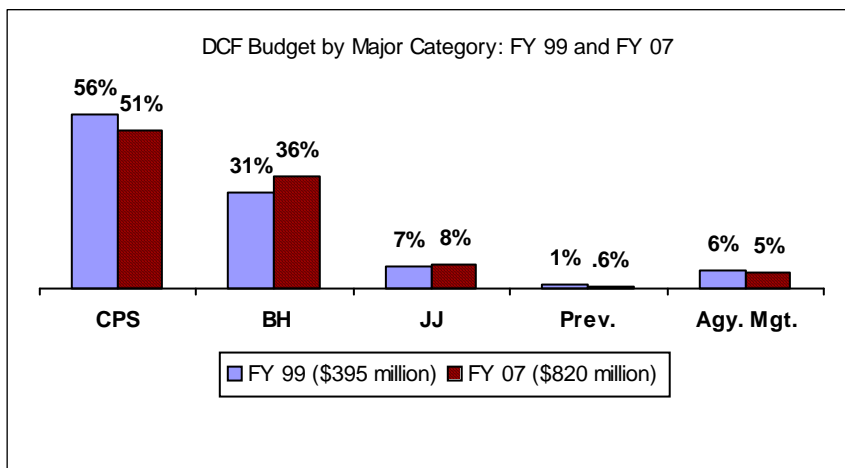
#### Performance Measure 1 – Number of children and families served by DCF

Snapshot of Children and Families Served by DCF (FY 06)		
Total Caseload	17,770	child protective services cases
Abuse/neglect reports	43,500	received
	7,568	substantiated
Foster Care	3,216	average number in care
Adoption	498	adoptions finalized
Juvenile Justice	1,200	delinquents committed
	500	parole cases
	100	juv. training school avg. daily census
Behavioral Health	2,000	community-based program capacity
	874	in residential treatment
	80	psych. hospital avg. daily census

- DCF does not centralize or summarize client information; trend data on key agency client measures are not regularly compiled and reported

#### Performance Measure 2 – Resources allocated by DCF mandate area

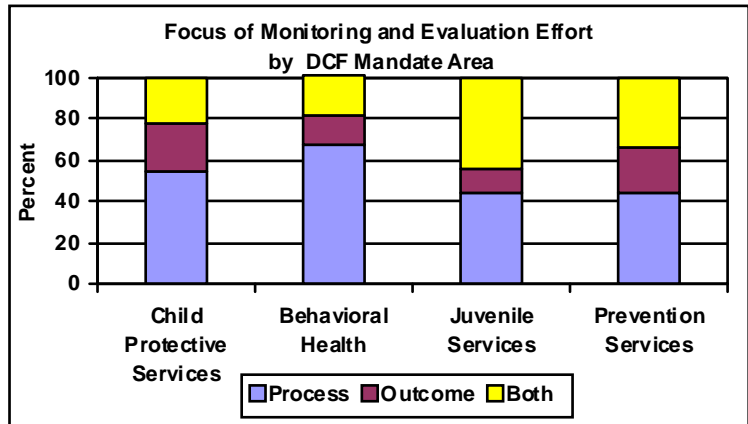
- Child protective services (CPS), which includes 14 area office operations and the bulk of DCF staff, accounted for half of the agency’s \$820 million FY 07 budget.
- Between FY 99 and FY 07, allocations for behavioral health (BH) and juvenile justice (JJ) increased while the portion of the budget spent the CPS and on agency management decreased. Prevention funding remained very small (1 percent or less of total spending.)



# LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

## **Performance Measure 3 – Amount of internal and external monitoring and evaluation of DCF**

- PRI study analyzed over 100 different monitoring and evaluation documents produced during the previous three to five years; sources included internal quality assurance and contracted research studies and various external oversight efforts (e.g., by federal agencies, courts, legislative committees, Office of Child Advocate (OCA), mandated advisory groups)
- Nearly half of all efforts analyzed focused on DCF child protective services mandate
- Little attention on agencywide mission, broad goals of safety, permanency, and improved well-being (only 7 percent of all efforts)
- More than half of all monitoring and evaluation efforts focused solely on service delivery (process); much less emphasis on end results for clients (outcomes)

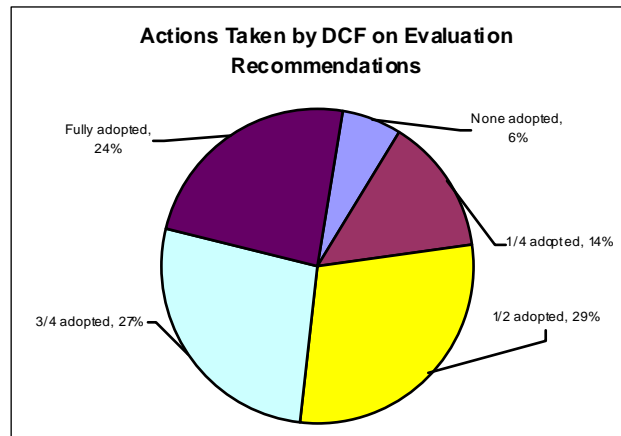


**PRI Recommendations:** Focus more attention on outcomes throughout the DCF accountability system; DCF dedicate staff resources to integrating, analyzing, and reporting on outcomes related to all goals and mandate areas

## **How Well Do We (DCF) Do It?**

### **Performance Measure 3 – Use of results from internal and external monitoring and evaluation**

- Overall, DCF adopted between 50 to 75 percent of recommendations from all types of monitoring and evaluation efforts
- Corrective actions recommended by external sources including courts and federal agencies had highest rates of adoption
- Areas of strength in using results data to improve agency performance:
  - Juan F. exit plan process
  - On-site independent monitors at DCF facilities
  - Revised internal special review process (for child fatalities/critical incidents)
  - Agency licensing process



# LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

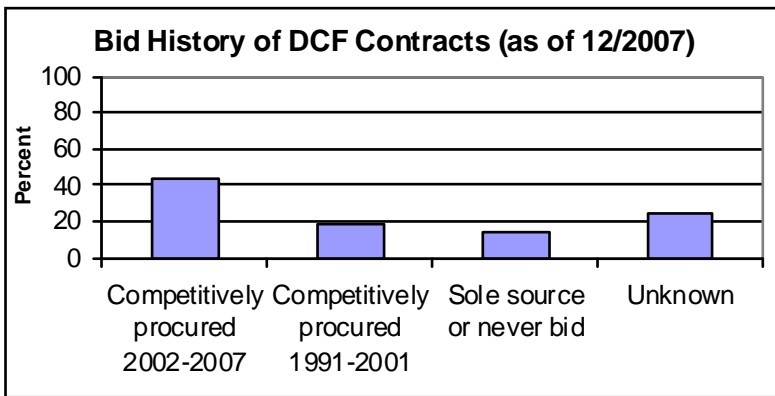
- Major weaknesses in DCF accountability system:
  - Quality improvement efforts fragmented; regular integration and analysis of results data lacking
  - Information systems within DCF and OCA inadequate; some obsolete, many incompatible
  - DCF contracting procedures provide little accountability for poor performance (see below)
  - Ineffective use of important feedback from OCA investigations, various internal quality assurance reports and contracted evaluations
  - Noncompliance with statute concerning abuse and neglect reports about delinquent children
  - Possible deficiencies with DCF's internal process for handling abuse/neglect reports filed against staff

**PRI Recommendations:** DCF make better use of results information to improve performance; specifically: centrally collect all information; expand internal capacity for analysis; establish strong research relationships with academic partners, require formal responses to results-based findings such as those produced by Office of Child Advocate; consider ways to integrate and upgrade automated information systems

OCA investigate adequacy and integrity of DCF process for responding to allegations of child abuse and neglect involving DCF employees; also examine compliance with C.G.S. Sec. 17a-103c (re: abuse/neglect reports about committed delinquents)

### **Performance Measure 4 –Implementation of Best Practices for Contractor Monitoring**

- DCF performance-based contracting ineffective; best practices not in place:
  - Data reporting requirements vague or not specified in contract documents
  - Monitoring of contractor performance haphazard; site visits rare
  - Consequences for poor performance seldom imposed
  - Inadequate follow up and support for contracted providers to address deficiencies



- Almost one in five active contracts (18%), with total annual value of \$193 million, last went out to bid in 2001 or earlier
- Bid status “Unknown” (meaning DCF could not provide date when contract last went out to bid) for 24 percent, which had total annual value of \$13.5 million

**PRI Recommendations:** DCF adopt and implement contract management best practices such as: specifying required outcome data; team approach for working with contractors; aggregating and analyzing data received from providers; and holding providers accountable for expected contract outcomes (e.g., withhold payments for unsatisfactory work); also consider reallocating some contracting staff from accounting functions to performance monitoring

## LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

### **Performance Measure 5 – Utilization of statutorily required reports and advisory groups for feedback on progress toward goals**

- Twelve different DCF advisory groups established in statute, some with overlapping or unnecessary functions
- Effectiveness of State Advisory Council for Children and Families (SAC), primary group for stakeholder input and oversight, limited by unclear role, lack of support
- Seventeen different monitoring reports required in statute but many never produced and others obsolete or duplicative

Status of Mandated Reports	
Not done	4
Done once	4
Fulfilled	3
Underway	6

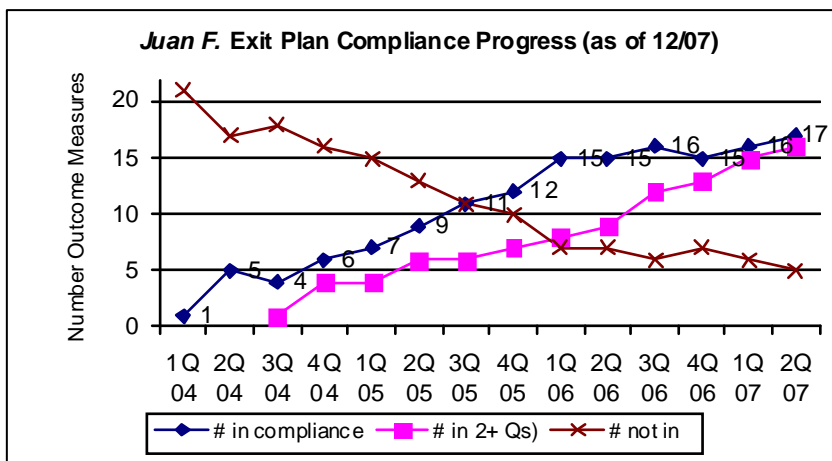
**PRI Recommendations:** Streamline advisory groups and strengthen roles of those providing critical stakeholder input and external accountability (i.e., SAC, area and facility advisory group); eliminate redundant/ineffective reporting requirements

### **Is Anyone Better Off?**

#### **Performance Measure 6 -- Evidence that DCF Monitoring and Evaluation Efforts Improve Outcomes for Connecticut Children and Families**

- Beyond the exit plan process for federal *Juan F.* child welfare consent decree, no systematic tracking of progress in achieving the state's desired results for Connecticut children and families
- Regarding *Juan F.* compliance:

- DCF reached targets for 17 of the 22 exit plan outcome measures as of Dec. 2007
- For 15 outcome measures, DCF sustained compliance for 2 or more consecutive quarters
- Most exit plan measures indicate compliance with process goals (e.g., timeliness) and do not reflect quality of services provided



- DCF performance well below benchmarks for two areas most critical to well-being of children and families: appropriate treatment planning and meeting needs

**PRI Recommendation:** DCF and Judicial Department undertake a pilot program that integrates the agency and the court treatment planning processes to promote fuller participation by all parties and more consistent, comprehensive, and higher quality plans

## LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

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- Available outcome data compiled during PRI study from monitoring and evaluation documents indicated some positive trends as well as areas of continuing challenge for DCF; for example, reported agency outcome information showed:
  - Improvements at CT Juvenile Training School (CJTS) over its initial five years of operation, specifically:
    - Decreased use of restraints and seclusions
    - More treatment provided for substance abuse, clinical, and vocational needs
  - More work needed to lower the 35 percent recidivism rate at CJTS (22 percent return, 13 percent go on adult criminal justice system)
  - Juveniles in detention system increasingly diverted away from residential placements to community settings in response to *Emily J.* settlement agreement
  - System gridlock in behavioral health treatment system for children a continuing problem *but*:
    - Availability of community-based services, including evidence-based models, expanded after DCF managed care program (KidCare) established
    - Most children in crisis served by KidCare Emergency Mobile Psychiatric Services avoided residential/inpatient care
  - Numbers of foster homes decreasing despite stepped-up recruitment and retention efforts
  - Substantial improvement in timeliness of investigations by DCF “Hotline” (abuse and neglect reporting system)
  - Connecticut showed substantial compliance in last two federal foster care eligibility reviews *but*:
    - DCF continues to struggle to meet other federal foster care and adoption standards
  - Preliminary evaluation results for some prevention services appear promising (e.g., The Wilderness School program); others seem less successful (e.g., Positive Youth Development initiatives targeted at preventing or reducing substance abuse)
- After 30 years as a consolidated children’s agency, DCF mandates remain “siloe”; outcome information and automated systems still not integrated across bureaus, results data not always shared throughout the department
- DCF lacks well-defined agencywide goals and established benchmarks which would allow comparisons of performance across programs, over time, and to national standards

***PRI Recommendations:*** Establish in statute an ongoing, comprehensive, strategic planning process with vision and mission statements and goals developed in consultation with community/stakeholders that reflect the full scope of all department mandates; track and regularly report progress to legislature and public

*DCF reinforce and expand role of its Service Evaluation and Enhancement Committee, to better integrate all monitoring and evaluation efforts, initiate proactive interventions, and to ensure results information is used to reach strategic plan goals*