

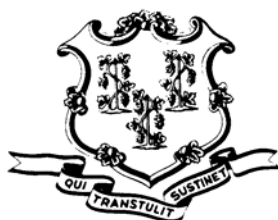
*STATE OF CONNECTICUT*

# **Child Poverty and Prevention Council**

## **January 2007 Progress Report**

**For submission to the  
Honorable M. Jodi Rell, Governor**

**and members of the  
Appropriations Committee, Education Committee,  
Human Services Committee, Public Health Committee  
and Select Committee on Children of  
the Connecticut General Assembly**



Robert L. Genuario, Secretary

Office of Policy and Management

Chair of the Child Poverty and Prevention Council

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## I. EXECUTIVE SUMMARY

In June 2006, Governor Rell signed into law Public Act 06-179, An Act Concerning State Investment in Prevention and Child Poverty Reduction and the Merger of the State Prevention and Child Poverty Councils. This public act combined two councils -- the active Child Poverty Council and the inactive Prevention Council -- into one coordinated body.

The purpose of the newly constituted Child Poverty and Prevention Council is to:

1. Develop and promote the implementation of a ten-year plan to reduce the number of children living in poverty in the state by fifty percent; and
2. Establish prevention goals and recommendations and measure prevention service outcomes to promote the health and well-being of children and families.

This new council will build upon the work of its predecessor councils. In January 2005, the Child Poverty Council released its ten-year plan to reduce child poverty containing 67 recommendations for executive and legislative branch consideration. The recommendations are organized under six major objectives, which are not in priority order. The objectives are to:

- Enhance families' income and income-earning potential;
- Help low-income families build assets;
- Enhance affordability of health care, housing, child care, and early childhood education;
- Support safety net programs for families with multiple barriers;
- Enhance family structure and stability; and
- Further study.

This first report of the new Child Poverty and Prevention Council contains a progress update on the actions taken to-date by the State of Connecticut to implement the ten-year plan to reduce child poverty (see Section VI). In summary, 33 actions were taken to implement recommendations in 2005 and 39 actions were taken to implement recommendations in 2006.

In accordance with Connecticut General Statutes Section 4-67x, this report also contains:

1. A summary of measurable gains made toward the child poverty and prevention goals (see Section III);
2. A copy of each agency's report on prevention services (see Appendix D);
3. Examples of successful interagency collaborations to meet the child poverty and prevention goals (see Section IV); and
4. Recommendations for prevention investment and budget priorities (see Section V).

In summary, the report contains the following information with regard to these four main items:

### **1. Measurable gains made toward the child poverty and prevention goals.**

The Council's child poverty goal is to reduce poverty among children in Connecticut by 50% over ten years. When the Council's ten-year plan was released in 2005, the most up-to-date figures on child poverty were based on 2003 figures. Currently, the most recent figures are based on 2005 data. Both of these rates reflect child poverty in Connecticut prior to any action by the Council. The Council is focusing on reducing child poverty both among families below 100% of the federal poverty level (\$16,600 for a family of three in 2006) and families below 200% of the federal poverty level. The trend over the most recent three-year period has been:

- In 2003, 10.8% of Connecticut children lived in families with income under 100% of the federal poverty level and 22.6% of Connecticut children lived in families with income under 200% of the federal poverty level.
- In 2004, 10.5% of Connecticut children lived in families with income under 100% of the federal poverty level and 23.3% of Connecticut children lived in families with income under 200% federal poverty level.
- In 2005, 11.5% of Connecticut children lived in families with income under 100% of the federal poverty level and 25.2% of Connecticut children lived in families with income under 200% of the federal poverty level.

The Council's child poverty and prevention goals were endorsed at the December 2006 meeting. The Council agreed that the following list represents a preliminary reflection of the Council's goals and that the Council will continue to refine and adjust goals, as some may be further specified and others may be determined to be strategies rather than goals. Where available, baseline data for the indicators are included in Section III of the report and recommendations for action are included in Section V. The Council's goals are to:

- Reduce the number of children living in poverty in the state by fifty percent;
- Increase access to health care;
- Increase access to stable and adequate housing;
- Increase the percentage of pregnant women and newborns who are healthy;
- Decrease the rate of child neglect and abuse;
- Increase the percentage of children who are ready for school at an appropriate age;
- Increase the percentage of children who: learn to read by third grade, succeed in school, graduate from high school, enter post-secondary education, and successfully obtain and maintain employment as adults;
- Decrease the percentage of children who are unsupervised after school;
- Reduce unhealthy behaviors among youth (e.g. teen pregnancy, smoking, auto accidents);
- Decrease the incidence of child and youth suicide;
- Decrease the incidence of juvenile crime; and
- Increase the positive involvement of fathers with their children; and
- Encourage ongoing future leadership on child poverty and prevention issues.

## 2. Agencies' reports on prevention services.

Each state agency represented on the Council provided a report on at least two prevention services provided by their agency. Prevention services are defined as "policies and programs that promote healthy, safe and productive lives and reduce the likelihood of crime, violence, substance abuse, illness, academic failure and other socially destructive behaviors". The agency prevention programs described in Appendix D are:

<b>Children's Trust Fund</b> Sex Abuse Project Family Empowerment Initiative The Help Me Grow Program Kinship and Grandparent Respite Fund Nurturing Families Network The Parent Trust Fund Shaken Baby Syndrome Prevention	<b>Department of Mental Retardation</b> Family Supports Birth to Three
<b>Department of Children and Families</b> Positive Youth Development Initiative Youth Suicide Prevention	<b>Department of Public Health</b> Captain 5 Day Nutrition Education Immunization Program

Shaken Baby Syndrome Prevention	
<b>Department of Education</b> Even Start Family Resource Centers Early Childhood/School Readiness Head Start Services and Enhancement	<b>Department of Social Services</b> Fatherhood Initiative Family Supportive Housing
<b>Department of Mental Health and Addiction Services</b> Best Practices Initiative Local Prevention Council Programs	<b>Office of Policy and Management</b> Norwich Reintegration Education Neighborhood Youth Center

### 3. Examples of successful interagency collaborations

The Council has identified the following examples of successful interagency collaborations to meet the child poverty and prevention goals. These initiatives are described in detail in Section IV and include:

- **Supportive Housing.** The Connecticut Supportive Housing Initiative is a collaboration between the Departments of Mental Health and Addiction Services (DMHAS), Social Services (DSS), Economic and Community Development (DECD), the Connecticut Housing Finance Authority (CHFA), and the Office of Policy and Management (OPM). Supportive housing is permanent affordable housing matched with a range of support services designed to break the cycle of homelessness. The purpose is to enable formerly homeless persons to achieve stability and maintain self-sufficiency in the community. After successfully completing a 300 unit demonstration program, the State embarked on the pilots initiative to create 650 supportive housing units, and then Governor Rell’s Next Steps initiative to create an additional 500 units.
- **Mental Health Transformation.** In response to the President’s New Freedom Commission on Mental Health and recently released federal action agenda, Governor M. Jodi Rell has charged 14 key state agencies and the Judicial Branch to transform all mental health services and associated systems to offer the state’s citizens an array of accessible services and supports that are culturally responsive, person and family-centered, and have as their primary aim the promotion of resilience, recovery, and inclusion in community life. Connecticut intends the outcome of a successful transformation to be a recovery-oriented system of mental health care that will offer the State’s citizens meaningful choices from among an array of effective services that will build on personal, family, and community assets, and will be offered in an integrated and

coordinated fashion within the context of locally-based and managed systems of care, thereby ensuring continuity of care both over time and across agency boundaries.

- **Governor’s Early Childhood Research and Policy Council.** The Governor’s Early Childhood Research and Policy Council was established by Executive Order #13 of Governor M. Jodi Rell in February 2006 to engage leadership from the governmental, higher education, business, and philanthropic communities with regard to early childhood strategic planning and investment partnerships. The Council has 31 members appointed by the Governor and is co-chaired by three persons from the philanthropic community, the business community, and the education community.
- **Connecticut Birth to Three System.** Birth to Three, under Part C of the Individuals with Disabilities Education Act, was designed to be an interagency system since there is no one agency in any state that can meet all the needs of infants and toddlers with disabilities and their families. The exact design of each state’s system is up to the state lead agency, as advised by the Interagency Coordinating Council which meets bi-monthly. In Connecticut, that Council includes representatives from: the Departments of Education, Social Services, Public Health, Children and Families; the Board of Education and Services for the Blind; the Office of Protection and Advocacy; the Commission on the Deaf and Hearing Impaired; parents, providers, legislators, and physicians.

#### **4. Recommendations for prevention investment and budget priorities**

Sixty seven recommendations to reduce child poverty are contained in Section VI of this report. The recommendations are organized in six major objectives, which are not in priority order. The objectives are to:

- Enhance families’ income and income-earning potential;
- Help low-income families build assets;
- Enhance affordability of health care, housing, child care, and early childhood education;
- Support safety net programs for families with multiple barriers;
- Enhance family structure and stability; and
- Further study.

At the December 2006 meeting, the Council endorsed an additional 27 recommendations to promote healthy, safe and productive lives and reduce the likelihood of crime, violence, substance abuse, illness, academic failure and other socially destructive behaviors.

## II. BACKGROUND

### A. State Prevention Council

The State Prevention Council was created under Public Act 01-121, An Act Concerning Crime Prevention and a State Prevention Council, to evaluate and promote prevention work in the State of Connecticut. In essence, the mandate was to establish a prevention framework for the state, develop a comprehensive state-wide prevention plan, offer recommendations to better coordinate existing and future prevention expenditures across state agencies and increase fiscal accountability.

The Council met regularly to ensure that the requirements of the public act were implemented in a comprehensive manner. The membership of the Council included representatives from the Office of Policy and Management, the Chief Court Administrator, and the Commissioners of the departments of Children and Families, Education, Mental Health and Addiction Services, Mental Retardation, Public Health and Social Services.

One of the main tasks of the Prevention Council was the development of a statewide prevention plan. The Council conducted research, analysis and deliberated extensively during the planning and development phase of the plan. The plan included four major recommendations that served to advance formation of comprehensive approaches for prevention within the state. The recommendations were to:

- increase public awareness of the value of prevention
- strengthen state and local networks involved in prevention
- improve data collection on prevention programs
- share and implement best practices

The Council felt that these recommendations, when implemented, would provide the Council with the information and tools necessary to effectively evaluate and analyze prevention initiatives in the state and set priorities for future prevention programming. The State Prevention Plan was submitted to the General Assembly in 2003.

As stipulated in the public act, the Governor's Budget for the 2003-2005 Biennium included a prevention report with recommendations for

appropriations for primary prevention services administered by state agencies that served on the State Prevention Council. The report was released in February 2003.

In 2003, the legislature enacted Public Act 03-145, An Act Concerning the State Prevention Council and Investment Priorities, which required the Council to continue its work to foster the development and implementation of a comprehensive and coordinated statewide system of prevention in Connecticut. In January 2004, the Prevention Council's progress report was submitted to the General Assembly. This report highlighted statewide prevention initiatives within the policy domains of Early Childhood Development and Youth Development and its relationship to the four recommendations.

In accordance with the stipulations set forth in the public act, the Council submitted its final prevention report in March 2004. The report highlighted the accomplishments and outcomes for statewide prevention initiatives.

## **B. Child Poverty Council**

In the Spring of 2004, the Connecticut legislature enacted Public Act 04-238, An Act Concerning Child Poverty establishing a Child Poverty Council. The Council was charged with recommending strategies to reduce child poverty in the State of Connecticut by fifty percent (50%) within ten years.

The legislation required that the Council consist of the following members or their designees: the Secretary of the Office of Policy and Management; the President Pro Tempore of the Senate; the Speaker of the House of Representatives; the Minority Leader of the Senate and the Minority Leader of the House of Representatives; Commissioners of the Department of Children and Families, Education, Higher Education, Labor, Mental Health and Addiction Services, Mental Retardation, Public Health, Social Services, Corrections, Transportation, Economic and Community Development, Health Care Access; the Child Advocate, the chair of the State Prevention Council, the Executive Director of the Children's Trust Fund, and the Executive Director of the Commission on Children.

The Council engaged in numerous strategies to gather the appropriate data to assist in the formation of its recommendations and presented its first report to the Legislature in January 2004. The report contained 67 recommendations to reduce child poverty in Connecticut by fifty percent over a ten year period. The recommendations were organized under six major objectives:

- enhance families' income and income-earning potential;
- help low income families build assets;
- enhance affordable health care, housing, child care and early childhood education;
- support safety net programs for families with multiple barriers;
- enhance family structure stability; and
- further study child poverty issues and solutions.

In July 2005, the legislature enacted Public Act 05-244, An Act Concerning the Implementation of the Recommendations of the Child Poverty Council. This public act made the executive director of the Commission on Human Rights and Opportunities a member of the Child Poverty Council and required the Council to meet at least twice a year to review and coordinate state agency efforts to meet the goal of reducing child poverty by 50% by June 30, 2014. The Council's annual implementation reports to the legislative committees included progress made toward meeting this goal. The Council continued its work to develop strategies to implement, monitor and report on the implementation of the recommendations.

A number of the Council's recommendations were proposed by Governor Rell and enacted by the legislature in FY 2006-07 and, in January 2006, the Child Poverty Council submitted a report on progress made towards the implementation of the plan to meet the child poverty reduction goal and the extent to which state actions were in conformity with the plan.

### **C. Child Poverty and Prevention Council**

In June 2006, the Connecticut legislature enacted Public Act 06-179, An Act Concerning State Investments in Prevention and Child Poverty Reduction and the Merger of the State Prevention and Child Poverty Councils.

This public act requires the newly formed Child Poverty and Prevention Council to adhere to provisions of the previous councils and imposes additional responsibilities relating to prevention services. The Child Poverty and Prevention Council is comprised of members of both the Child Poverty Council and the State Prevention Councils. In 2006, the Chief Court Administrator was added to the Council.

The public act directs the Child Poverty and Prevention Council to:

- Establish prevention goals and recommendations and measure prevention service outcomes to promote the health and well-being of children and their families.
- Report to the Governor and various legislative committees on the state's progress in prioritizing expenditures for prevention services in budgeted state agencies with membership on the council including:
  - Summarizing measurable gains made toward the child poverty and prevention goals established by the Council.
  - Providing examples of successful interagency collaborations to meet the child poverty and prevention goals established by the Council.
  - Recommending prevention investment and budget priorities.

The public act also requires each state agency with membership on the council that provides prevention services to children and families to submit an agency prevention report to the Council which must be included in the Council's report to the Governor and legislature. Each agency report must include at least two prevention programs.

#### **D. Inventory**

In order to identify existing programs in Connecticut that address child poverty, the Council developed a statewide inventory in 2004. The Council developed and disseminated an inventory questionnaire to fifteen (15) state agencies to gather data on existing statewide programs that serve children and their families in the area of poverty prevention, self-sufficiency programs focused on lifting people out of poverty and/or programs that provide support services for people in poverty.

The Child Poverty Inventory is a comprehensive list of statewide programs that provide assistance to people in poverty or at risk of falling into poverty. Not all of these programs have a specific mandate to address poverty, but they may have a positive impact on lifting families and children out of poverty.

In FY 2004, the State of Connecticut funded eighty-one (81) statewide programs that provided assistance to people in poverty or at risk of falling into poverty. In FY 2004, the State allocated nearly \$2.4 billion that includes a combination of federal (\$1,089,770,825), state (\$1,278,927,574) and private (\$26,108,394) funding.

The Child Poverty Inventory is organized by agency and the programs are categorized under each agency by program types. The program types are listed under the following categories:

- Prevention (19 Programs)
- Self-Sufficiency (19 Programs)
- Support for people in poverty (43 Programs)

Of the \$2.3 billion in state funding, 31% funded prevention and self-sufficiency programs in FY 04 and 69% funded programs to provide support for people in poverty. Seventy one percent of programs are funded through the Department of Social Services, Public Health and Education. The remaining 29% is divided among the following departments: Higher Education, Mental Health and Addiction Services, Children Trust's Fund, Children and Families, Mental Retardation, Labor, Correction, and Economic and Community Development.

The prevention programs listed in the 2004 inventory were as follows:

**Job Center Program:** This Department of Corrections program provides pre-employment training, transitional counseling and employment referral for the successful re-integration of offenders back into the workforce. FY04 \$16,930

**Educational Training Program:** This Department of Corrections program provides academic skills in the areas of reading, language arts, science and social studies to incarcerated inmates. FY04 \$16,930 (Federal), \$1,669,970(State)

**Oral Health Promotion and Disease Prevention:** This Department of Public Health Program is designed to implement effective culturally appropriate oral health promotion, and disease prevention programs that adopt, adapt and enhance best practices. FY04 \$216,021-(State)

**Abstinence - Only Education:** This Department of Public Health Program provides community based sex education, to promote abstinence from sexual activity among racially and ethnically diverse youth between the ages of nine and fourteen. FY04 \$352,231 (Federal)

**Prevention Programs:** This Department of Mental Health and Addiction Services program provides an array of capacity building and public awareness on prevention through local and statewide agencies. FY04 \$2,031,593 (Federal), \$40,000 (State)

**STD Control Program:** This Department of Public Health program provides a variety of services to adolescents to reduce the transmission and incidence of selected STD. FY04 \$1,085,643 (Federal), \$1,074,130 (State).

**5 Day Nutrition Education Program:** This Department of Public Health program targets parents, preschool children, and teachers in Head Start and School Readiness programs through workshops using imaginative and fun activities to teach nutrition. FY04 \$657,000 (Federal)

**Head Start Program:** This program provides comprehensive services in education, health and job training to children and families. FY04 \$50,597,771 (Federal), \$4,521,150 (State)

**Family Planning Program:** This Department of Public Health program provides family planning services to all persons desiring them, targeting particularly undeserved populations. FY04 \$1,076,964 (State)

**Head Start Collaborative Program:** This Department of Social Service program is designed to improve outcomes and opportunities for young children from birth to age five through comprehensive child development services for low-income families. FY04 \$ N/A

**Even Start Program:** This Department of Education program provides intensive family literacy services to parents and children to help parents become full partners in the education system and help break the cycle of poverty and low family literacy. FY04\$ 1,815,059 (Federal)

**Immunization Program:** This Department of Public Health program provides access to vaccines for medically underserved children through community awareness, outreach and referral services, and community partnerships. FY04 \$15,009,000 (Federal), \$471,591,007 (State)

**Teen Pregnancy Prevention Program:** This Department of Social Service program provides comprehensive community based programming through community partnerships to spread awareness about pregnancy prevention. FY04 \$2,063,299 (State)

**Early Reading Success Program:** This Department of Education program supports the implementation of a district reading plan to improve reading skills and achieve reading competency among children K-3. FY04 \$17,386,872 (State)

**Volunteer & Recreation Services:** This Department of Corrections program provides inmates with numerous opportunities to develop intellectually, physically and morally through addiction awareness, educational services and chaplaincy services. FY04 \$ N/A

**Childhood Lead Poisoning Program:** This Department of Public Health program uses a three-pronged approach to address childhood lead poisoning issues in an

effort to reduce and eliminate the incidence of lead poisoning in the children. FY04 \$919,748 (Federal), \$536,780 (State)

**Tobacco Use Prevention and Control Program:** This Department of Public Health program provides guidance and direction on: preventing youth from starting to smoke by using cessation services. FY04 \$1,010,252 (Federal), \$101,025 (State)

**Lead Environment Management and Environmental Practitioner Licensure:** This Department of Public Health program provides a wide range of program activities that relate to lead poisoning prevention and in particular, childhood lead poisoning prevention. FY04 \$472,000 (Federal), \$ 427,000 (State)

**Community Health Centers:** This Department of Public Health program provides a wide range of high quality preventative and primary care services to individuals, children and families. FY04 \$ 410,200 (Federal), \$4,359,492 (State)

### **E. Website**

The Child Poverty and Prevention Council webpage, which contains the January 2005 Initial Child Poverty Plan and the 2006 Child Poverty Progress Report, is on the State of Connecticut, Office of Policy and Management Home page. The website address is:

<http://www.opm.state.ct.us/pdpd1/cpc/childpovertycouncil.htm>

### III. CHILD POVERTY AND PREVENTION GOALS

The Council's child poverty goal, as set in statute, is to reduce the number of children living in poverty in the state by fifty percent. The Council's prevention goals were adopted at the December 2006 Council meeting. The Council agreed that the following list represents a preliminary reflection of the Council's goals and that the Council will continue to refine and adjust goals, as some may be further specified and others may be determined to be strategies rather than goals. As of January 2006, the Council's child poverty and prevention goals are to:

- Reduce the number of children living in poverty in the state by fifty percent;
- Increase access to health care;
- Increase access to stable and adequate housing;
- Increase the percentage of pregnant women and newborns who are healthy;
- Decrease the rate of child neglect and abuse;
- Increase the percentage of children who are ready for school at an appropriate age;
- Increase the percentage of children who: learn to read by third grade, succeed in school, graduate from high school, enter post-secondary education, and successfully obtain and maintain employment as adults;
- Decrease the percentage of children who are unsupervised after school;
- Reduce unhealthy behaviors among youth (e.g. teen pregnancy, smoking, auto accidents);
- Decrease the incidence of child and youth suicide;
- Decrease the incidence of juvenile crime;
- Increase the positive involvement of fathers with their children; and
- Encourage ongoing future leadership on child poverty and prevention issues.

Pursuant to C.G.S. Section 4-67x, the Council's January 2007 report must provide a summary of measurable gains made toward the child poverty and prevention goals. The progress made toward the goal to reduce the number of children living in poverty in the state by fifty percent is discussed in Section VI of this report. The baseline data provided below for the newly-adopted prevention goals represents the best data available to-date. This data may be supplemented in coming years as other ongoing prevention-based data collection initiatives get underway, including:

- The state's Mental Health Transformation Initiative, led by DMHAS;
- The Youth Futures Committee, established pursuant to Public Act 06-182; and
- The Early Childhood Research and Policy Council, established by Executive Order of Governor Rell.

Each prevention goal is followed by available baseline indicators to provide a sense of where the state stands currently with regard to the goal.

**Goal: Increase access to health care.**

**Baseline Indicators:**

- **Health care insurance coverage.** The percentage of people without health insurance coverage was 6.4% in 2006.<sup>1</sup>
- **Health care insurance coverage for children.** The percentage of children under age 19 who do not have health insurance was 2.7% in 2006.<sup>1</sup>
- **Well-baby visits.** In the fourth quarter of 2001, 55.8% of 4- to 24-month-olds and 29.6% of 3 to 5-year-olds enrolled in HUSKY A had the recommended number of well-baby visits.<sup>2</sup>
- **Well-child care.** In 2004, 56% of children enrolled in HUSKY A received well-child care.<sup>3</sup>

**Goal: Increase access to stable and adequate housing.**

**Baseline Indicators:**

- **Affordability of home purchase.** An average price single-family home cost 5.2 times the state per capita personal income in 2003.<sup>4</sup>
- **Affordability of home rental.** The hourly wage that a full-time worker would have to earn in order to afford an average two-bedroom apartment at fair market rent was 2.5 times the state minimum wage in 2003.<sup>5</sup>
- **Number of homeless persons.** The number of children and individuals who experienced homelessness over a twelve month period was 33,000, of whom 13,000 were children, in 1999.<sup>6</sup>

- **Long term or repeated homelessness.** The number of households that have been homeless at least a year or more, or experience repeated episodes of homelessness was approximately 3,000 in 1999.<sup>7</sup>

**Goal: Increase the percentage of pregnant women and newborns who are healthy.**

**Baseline Indicators:**

- **Late or no prenatal care.** In SFY 2004, 12.9% of mothers obtained prenatal care after the first trimester of their pregnancy or did not obtain prenatal care.<sup>8</sup>
- **Low birthweight.** In SFY 2004, 8% of births were considered low birthweight (less than 2,500 grams)<sup>9</sup>
- **Infant mortality.** In SFYs 2002-2004, the infant mortality rate was 5.8 infant deaths in the first year of life per 1,000 live births.<sup>10</sup>
- **Immunization.** In 2005, 81.5% of children 19-35 months of age were fully immunized (81.5% for 4:3:1:3:3:1 vaccination series in 2005)<sup>11</sup>
- **Lead screening.** In 2004, 45.3% of children from one to two years of age received a blood lead screening during that year.<sup>12</sup>

**Goal: Decrease the rate of child neglect and abuse.**

**Baseline Indicators:**

- **Substantiated abuse or neglect.** In SFY 2004, there were 14 substantiated cases of child abuse or neglect per 1,000 children.<sup>13</sup>
- **Children removed from home.** In 2004, 10.9% of victims of child maltreatment were removed from their homes and placed in the custody of the Department of Children and Families.<sup>14</sup>

**Goal: Increase the percentage of children who are ready for school at an appropriate age.**

### **Baseline Indicators:**

- **Preschool experience.** In SFY 2005, 77% of kindergartners statewide had preschool experience and in SFY 2004, 56% of kindergartners in ERG I had preschool experience.<sup>15</sup>
- **Kindergarten Assessment.** The SDE is charged with developing a kindergarten assessment which is scheduled to be in place in Fall 2009. The SDE has done a proxy assessment of kindergarten readiness in the Fall of 2006 consisting of a survey to all kindergarten teachers in the state. The information will be available soon and will be used to establish a baseline and future assessments will be used to measure progress toward this goal.

**Goal: Increase the percentage of children who: learn to read by third grade, succeed in school, graduate from high school, enter post-secondary education, and successfully obtain and maintain employment as adults.**

### **Baseline Indicators:**

- **CMT score in 3<sup>rd</sup> grade reading.** In 2006, 54.4% of 3<sup>rd</sup> graders reached the goal in reading on the Spring 2006 Connecticut Mastery Test (CMT).
- **CMT score in 4<sup>th</sup> grade reading.** In 2006, 57.8 % of 4<sup>th</sup> graders overall and 27.5% of 4<sup>th</sup> graders receiving free or reduced-price lunch met the 4<sup>th</sup> grade Connecticut Mastery Test (CMT) goal in reading.<sup>16</sup>
- **School districts in need of improvement under NCLB.** In SFY 2006, 22 public school districts were “in need of improvement” under NCLB (i.e. failing to meet Adequate Yearly Progress for two consecutive years).<sup>17</sup>
- **Out-of-school suspension or expulsion.** In SFY 2004, 28,035 incidents resulted in out-of-school suspension and 1,002 incidents resulted in expulsion.<sup>18</sup>
- **Graduate from high school.** In 2004, the four-year cumulative high school dropout rate (i.e. the percentage of students in the graduating class who have dropped out between grades 9 and 12), was 8.8% statewide and 20.9% in ERG I for the Class of 2004.<sup>19</sup>

**Goal: Decrease the percentage of children who are unsupervised after school.**

**Baseline Indicators:**

- **After school and other activities: self-reports.** In 2005, the percentage of students who reported that they took part in organized after school, evening, or weekend activities (such as school clubs, sports, community center groups, music/art/dance lessons, drama, church, or other supervised activities) on one or more of the past seven days was 58.5% for one or more days and 22.7% for five or more days.<sup>20</sup>

**Goal: Reduce unhealthy behaviors among youth (e.g. teen pregnancy, smoking, auto accidents).**

- **Teenage births.** The teenage birth rate was 13.8 births per 1,000 females ages 15-17 in SFY 2004.<sup>21</sup>
- **Self-reports of cigarette usage.** The percentage of high school students who reported that they smoked cigarettes during the past 30 days was 18.1% in 2005 survey year.<sup>22</sup>
- **Self-reports of marijuana usage.** The percentage of high school students who reported that they used marijuana during the past 30 days was 23.1% in 2005 survey year.<sup>23</sup>
- **Self-reports of alcohol usage.** The percentage of high school students who reported that they smoked cigarettes during the past 30 days was 45.3% in 2005 survey year.<sup>24</sup>
- **Self-reports of riding with driver who had been drinking alcohol.** The percentage of high school students who report that they did not ride with a driver who had been drinking alcohol during the past 30 days (70.3% in 2005 survey year)<sup>25</sup>

**Goal: Decrease the incidence of child and youth suicide.**

**Baseline Indicators:**

- **Suicide rate.** The suicide rate among young people, ages 15-24, was 5.3 deaths per 100,000 in 2003.<sup>26</sup>

- **Self-reports of suicide attempts.** The percentage of high school students who reported that they attempted suicide during the past 12 months was 12.1% in 2005 survey year.<sup>27</sup>

**Goal: Decrease the incidence of juvenile crime.**

**Baseline Indicators:**

- **Juvenile violent crime arrests.** The juvenile arrest rate for offenses included in the Violent Crime Index (VCI) was 290 VCI crime arrests of persons under age 18 for every 100,000 persons ages 10–17 in 2003.<sup>28</sup>
- **Juvenile arrests for drug violations.** The juvenile arrest rate for drug violations was 479 drug arrests of persons under age 18 for every 100,000 persons ages 10-17 in 2003.<sup>29</sup>

**Goal: Increase the positive involvement of fathers with their children.**

**Baseline Indicators:**

- **Marriage rates among low income families.** In 2005, 3.5% of married couple families with children had income below the federal poverty level while 28.3% of female-headed families with children and no husband present had income below the federal poverty level.<sup>30</sup>

**Goal: Encourage ongoing future leadership on child poverty and prevention issues.**

**Baseline Indicators:**

- **To be determined.**

## IV. EXAMPLES OF SUCCESSFUL INTERAGENCY COLLABORATIONS

The Council identified the following examples of successful interagency collaborations:

- Supportive Housing
- Mental Health Transformation Grant
- Governor's Early Childhood Research and Policy Council
- Connecticut Birth to Three System

A brief description of each initiative is included below.

### **Connecticut Supportive Housing Initiative**

Back in the early 1990's, Connecticut, like most other states, was struggling with a growing homelessness problem. The solutions the state had been using up until that point – emergency shelters and housing affordability strategies – were not working. Many of the people experiencing homelessness had mental health, physical health, or substance abuse problems which inhibited their ability to maintain housing, even when a rental subsidy was provided. As a result, they were cycling in and out of expensive acute care facilities, which was costly in terms of tax dollars as well as human lives.

State leaders knew they needed a different approach. Under the leadership of the State Office of Policy and Management (OPM), the State of Connecticut teamed up with a national non-profit organization - the Corporation for Supportive Housing (CSH) - to pilot a unique solution called supportive housing. Supportive housing is permanent affordable housing matched with a range of support services designed to break the cycle of homelessness. The purpose is to enable formerly homeless persons to achieve stability and maintain self-sufficiency in the community. After successfully completing a small demonstration program, the State embarked on the Supportive Housing Pilots Initiative to create 650 supportive housing units in 2001 and then Governor Rell's Next Steps Supportive Housing initiative to create 500 additional supportive housing units was authorized and funded in 2005.

The collaboration was accomplished by bringing together five state agencies – OPM, the Department of Mental Health and Addiction Services, the Department

of Social Services, the Department of Economic and Community Development, and the Connecticut Housing Finance Authority – to coordinate funding for the housing and the supportive services. Each agency put resources on the table and worked together to develop a plan and policies for the program and a common request for proposals. This model is embodied in several working documents that can serve as templates for other communities. These include a memorandum of understanding that outlines the commitments and roles of the agencies; and the joint request for proposals that outlines quality standards and the funding process.

The Supportive Housing Pilots Initiative is significant both for its local impact as well as its national replicability. The Supportive Housing Pilots Initiative has:

- Proven to be an effective approach to ending homelessness. Hundreds of men, women and children who had been chronically homeless are now stably housed and connected to needed social, mental health, health, education services. Tenants are going back to school, reconnecting with family, getting jobs, and paying taxes.
- Saved the state significant dollars that would have been otherwise spent on crisis approaches to care, institutionalization and repetitive short term treatment. Our experience has been that the average Medicaid reimbursement for inpatient services per tenant dropped 71% from \$15,000 to \$4,500. Supportive housing is a cost-effective approach.
- Laid a foundation for future initiatives by putting into place an interagency mechanism for funding, developing a base of over 40 nonprofit providers statewide with experience in supportive housing creation, and expanding the reach of supportive housing to 30 communities. Last year the State authorized funding for an additional 500 supportive units through a new program built on these components.
- Positively impacted local communities by rehabbing rundown housing. And in other communities, formerly homeless individuals and families are integrated into apartment buildings seamlessly and successfully.

### **Mental Health Transformation Grant**

In response to the President's New Freedom Commission on Mental Health and recently released federal action agenda, Governor M. Jodi Rell has charged 14 key state agencies and the Judicial Branch to transform all mental health services and associated systems to offer the state's citizens an array of accessible services and supports that are culturally responsive, person and family-centered, and

have as their primary aim the promotion of resilience, recovery, and inclusion in community life.

Connecticut intends the outcome of a successful transformation to be a recovery-oriented system of mental health care that will offer the State's citizens meaningful choices from among an array of effective services that will build on personal, family, and community assets, and will be offered in an integrated and coordinated fashion within the context of locally-based and managed systems of care, thereby ensuring continuity of care both over time and across agency boundaries.

There are six major components to the proposed transformation efforts, consistent with the six goals recommended by the New Freedom Commission. These are: 1) Connecticut's citizens will understand that mental health is essential to overall health and will treat it with the same urgency as physical health, 2) mental health care will be person and family-driven and oriented to promoting resilience and recovery, 3) disparities in mental health care that are based on culture, ethnicity, race, or gender will be eliminated so that all citizens will be able to participate equally in the promise of recovery, 4) early mental health screening, assessment, and referral to services will become common practice, 5) excellent mental health care, supported by research, will be provided, and 6) technology will be used to increase access to care and information. In addition to these, Connecticut has added an additional goal of workforce transformation.

### **Governor's Early Childhood Research and Policy Council**

The Governor's Early Childhood Research and Policy Council was established by Executive Order #13 of Governor M. Jodi Rell to engage leadership from the governmental, higher education, business, and philanthropic communities with regard to early childhood strategic planning and investment partnerships. The Council has 31 members appointed by the Governor and is co-chaired by three persons from the philanthropic community, the business community, and the education community.

The Governor established the Council in February 2006 in recognition that early education success, beginning with readiness for Kindergarten, predicts later academic success and that investment in high-quality early childhood education results in a robust return.

The Council is charged with:

- a. Advising the Early Childhood Education Cabinet, established pursuant to Public Act 05-245, on research findings, policy solutions and strategic financing opportunities related to investments in early childhood initiatives;
- b. Recommending ways to build and support a network of early childhood researchers across Connecticut’s education systems, including academic scholars at business and other professional schools;
- c. Engaging Connecticut’s academic researchers in design of a longitudinal study of children’s development and reviewing existing research that evaluates early childhood programs;
- d. Examining, from a business perspective, possible strategies to increase the efficiency and effectiveness of Connecticut’s early care and education “industry”; and
- e. Proposing addition “return on investment” studies necessary to evaluate and support early childhood care and education, quality improvement and expansion.

### **Connecticut Birth to Three System**

Birth to Three, under Part C of the Individuals with Disabilities Education Act, was designed to be an interagency system since there is no one agency in any state that can meet all the needs of infants and toddlers with disabilities and their families. The exact design of each state’s system is up to the state lead agency, as advised by the Interagency Coordinating Council which meets bi-monthly. In Connecticut, that Council includes representatives from:

- Department of Education (both preschool education and the coordinator of programs for homeless children)
- Department of Social Services
- Department of Public Health
- Department of Children and Families
- Department of Mental Retardation
- Board of Education and Services for the Blind
- Office of Protection and Advocacy
- Commission on the Deaf and Hearing Impaired

Others on the Council include parents, providers, legislators, and physicians

As the lead agency for the system, DMR has interagency agreements with the following agencies and topics

<b>Agency</b>	<b>Scope of Agreement</b>
Education	Clarifies child find and transition responsibilities of

	Birth to Three vs. local Boards of Education. There is also a separate agreement related to the training of early childhood special education personnel through the Comprehensive System of Personnel Development. A joint training calendar is managed by the State Education Resource Center (SERC).
Public Health	Addresses issues of children identified through newborn hearing screening and how and when children are referred
Children and Families	Addresses issues of children who are involved in substantiated cases of abuse and how they should be referred as well as the appointment of surrogate parents for children in foster care
Social Services	Agreement with the Disability Determination Unit to identify children applying for SSI who might be eligible for Birth to Three
BESB	Agreement of how they will provide direct services to children who are visually impaired in conjunction with the child's comprehensive Birth to Three program
UConn Extension Service	Joint agreement with Dept. of Ed to produce a newsletter for parents and professionals addressing issues of children with disabilities, birth through age five
Children's Trust Fund	Agreement on the co-funding of Child Development Infoline and how referral to CDI are triaged between Help Me Grow and Birth to Three as well as how and when data can be shared
Charter Oak College	Agreement to manage the portfolio review process for individuals applying for a Birth to Three credential
Early Head Start	Agreement on planning, case management, and services for children that are dually enrolled in Early Head start and Birth to Three

Other interagency activities without an agreement:

Education-we are enrolling children in Birth to Three in SDE's public school information system. Children receive an ID number that will be theirs until they graduate from high school. This will allow both Birth to Three and SDE to retrieve longitudinal aggregate data.

Public Health – Until such time as children with mild and unilateral hearing loss are eligible for Birth to Three, Public Health has developed a “Listen and Learn” program in which Child Development Infoline can refer those children to the three Birth to Three programs that specialize in hearing impairment and DPH will pay those programs to monitor the children’s hearing.

Social Services – DSS promulgated Medicaid regulations specific to Birth to Three enabling the state to capture \$4m in federal Medicaid funding.

Administrative Services - The Fiscal Service Center handles not only the Medicaid billing for Birth to Three, but they also handle the commercial health insurance billing for the state-operated Birth to Three program.

Children and Families – Birth to Three serves on the steering committee for the SAMHSA grant to establish an effective system of care for children under the age of six in southeast Connecticut. The program is called Building Blocks.

How do we know that Birth to Three is successful?

1. Connecticut Birth to Three serves 3.16% of children under the age of three in the state (based on a one-day count). While this is not as many children as we would like to serve, it is the 11th highest percentages in the country. Therefore it appears that Connecticut is doing a better job of identifying children early than 78% of the states.
2. Early intervention evaluation and plans, early intervention services, and transition conferences for children turning three are delivered in a timely manner for 94% of children and families.
3. 84% of families participating in the program report that early intervention services have helped them to help their children develop and learn
4. At least 97% of children exiting from Birth to Three have improved developmental functioning to a level nearer to their same-aged peers. At least 48% are at age level comparable to their same-aged peers at exit

Although 70% of children who exit Birth to Three at age three are eligible for preschool special education, only 49% of children who received Birth to Three services are receiving special education by Kindergarten.

## V. RECOMMENDATIONS FOR PREVENTION INVESTMENT PRIORITIES

One of the statutory requirements of the Council is to make recommendations for prevention investment and budget priorities. In developing these recommendations, the Council relied on information provided by national and state child poverty experts, and the Brookings Institution and the Center for Law and Social Policy, and the Connecticut Early Childhood Education Cabinet.

### **Reduce the number of children living in poverty in the state by fifty percent;**

See Section VI for 67 recommendations.

### **Increase access to health care;**

Without the critical supports of health care and housing, prevention efforts across the board are in jeopardy of failure.

1. Ensure public or private health care coverage for parents. (Child Poverty Council Recommendation III H)
  - a. Provide tax incentives to small businesses that offer health insurance to employees and their dependents.
  - b. Consider use of State Children's Health Insurance Program (SCHIP) or other funds to subsidize small employers to make it more affordable for families to provide health insurance coverage.
  - c. Continue to explore ways to expand health coverage for parents.
  - d. Enhance mechanism to provide information about employer sponsored health insurance coverage for TFA participants transitioning off cash assistance.
2. Ensure access to sufficient number of health care providers in the community and timely appointments. (Child Poverty Council Recommendation III.I.)

3. Strengthen health care coordination and outreach to improve effectiveness. (Child Poverty Council Recommendation III J)
4. Enhance prevention and early intervention programs. (Child Poverty Council Recommendation III K)
  - a. Increase education about preventing disease and accessing disease prevention services, e.g. diabetes, obesity.
  - b. Provide immunizations for all children.
  - c. Increase early identification and accessible, culturally appropriate health promotion and care services for all families, especially families with a parent or child with mental illness or substance abuse problems.
5. Enhance medical and behavioral health care availability for families with special needs. (Child Poverty Council Recommendation III L)
  - a. Strengthen care for children with special health care needs through transitional programs and medical home models through the Department of Public Health.
  - b. Expand availability of behavioral health inpatient and outpatient treatment services for all children and parents in need.
  - c. Increase transitional living options for people discharged from inpatient behavioral health treatment facilities.
6. Ensure that HUSKY children receive regular well child visits and an annual developmental assessment. (Governor's Early Childhood Research and Policy Council)

### **Increase access to stable and adequate housing;**

1. Reduce housing costs. (Child Poverty Council Recommendation III D)
  - a. Expand availability of state rental assistance subsidies.
  - b. Expand the Transitional Rental Assistance Program (T-RAP) to allow families to remain eligible for a longer period of time. In addition, the

state should allow use of T-RAP for individuals re-entering education and needing assistance with rent.

2. Expand availability of affordable, family-sized housing units. (Child Poverty Council Recommendation III E)
  - a. Provide incentives to housing developers to develop family-sized units
  - b. Maintain a Housing Trust Fund.
  - c. Expand supportive housing for families
  - d. Expand use of Low Income Housing Tax Credits to help finance housing and rehabilitation efforts.
3. Support maintenance of owner-occupied housing by providing subsidy or tax incentive to low-income property owners for rehabilitation projects. (Child Poverty Council Recommendation III F)
4. Enforce laws ensuring non-discrimination based on rent source. (Child Poverty Council Recommendation III G)

### **Increase the percentage of pregnant women and newborns who are healthy;**

1. Provide all families and caregivers (including non-custodial parents) with information about child development, prenatal through age 8. (Estimated biennial cost of \$2,101,767 by the Governor's Early Childhood Research and Policy Council).
2. Expand eligibility categories in the Birth-to-Three Program to include mild developmental delays and environmental risks. (Estimated biennial cost of \$9,523,307 by the Governor's Early Childhood Research and Policy Council).

### **Decrease the rate of child neglect and abuse;**

1. Maintain and expand an infrastructure to support young at-risk families through early intervention. Provide culturally competent newborn-through-five home visiting medical and social services to enhance

parent/child interaction and parenting skills, parent education, work and life skills and to access community resources and build social support. (Recommendation V.D. of the Child Poverty Council)

**Increase the percentage of children who are ready for school at an appropriate age;**

1. Provide a system of “education through birth” by continuing to support school readiness and early childhood educational programs. (Recommendation III C of the Child Poverty Council)
  - a. Create one coordinated system for early childhood education.
  - b. Enhance pre-school teacher training, including on-site consultation for pre-school teachers to encourage continuing education toward advanced degrees.
  - c. Amend the pre-school system to allow for full-day, full-year or school-day, school-year pre-school programming.
  - d. Advocate for year-round school programming for grades K-3 in low-income districts.
  - e. Provide comprehensive early childhood education programs with mandated parent involvement.
2. Support the design and implementation of the kindergarten assessment with statewide implementation due in Fall 2009. (Estimated biennial cost of \$2 million by the Governor’s Early Childhood Research and Policy Council).
3. Provide health, mental health and education consultation to preschool programs to enhance the skills of directors and teachers for meeting the comprehensive needs of children. (Estimated biennial cost of \$610,000 by the Governor’s Early Childhood Research and Policy Council).
4. Increase high-quality preschool. (Brookings Institution). Assure fiscal support for high-quality preschool for all 3- and 4-year-olds in families at or below 185% of the federal poverty level, and increase this income eligibility standard as state resources permit. (Estimated biennial cost of \$50,644,992 by Governor’s Early Childhood Research and Policy Council).

5. Address state reimbursement inequities for center-based preschool programs. (Estimated biennial cost of \$6,620,295 by the Governor's Early Childhood Research and Policy Council).

**Increase the percentage of children who: learn to read by third grade, succeed in school, graduate from high school, enroll in higher education, and successfully obtain and maintain employment as adults;**

1. Enhance drop out prevention efforts. (Child Poverty Council Recommendation III P)
2. Continue to link training to industries and encourage training programs to develop curricula to meet workforce shortage and high growth employment areas. (Child Poverty Council Recommendation).
3. Support first generation learners in access to and success in higher education.
4. Support strengthened teacher education in successful reading instruction approaches.
5. Increase low-income parents' access to literacy, post-secondary, and vocational education. (Child Poverty Council Recommendation I.B.)
6. Enhance literacy programs for adults including Adult Basic Education (ABE) and GED services. (Child Poverty Council Recommendation I.B.1)
7. Increase vocational training opportunities for populations that do not have a high school diploma or have limited English proficiency. (Child Poverty Council Recommendation I.B.2)
8. Provide assistance with vocational and post-secondary education expanses such as tuition, books, supplies, child care, transportation, tools or license fees. (Child Poverty Council Recommendation I.B.3)
9. Expand subsidies for low-income individuals to attend community college, e.g. through means-tested tuition relief (Child Poverty Council Recommendation I.B.4)

10. Increase English as a Second Language programming by partnering with business or offering incentives to businesses that provide English as a Second Language programming. (Child Poverty Council Recommendation I.B.5).
11. The Council should explore options to provide low-income individuals with an expectation of success regarding possibilities and techniques for achievement. (Child Poverty Council Recommendation I.B.6)

### **Decrease the percentage of children who are unsupervised after school;**

1. Expand, enhance and subsidize after-school programming. (Child Poverty Council Recommendation III M)

### **Reduce unhealthy behaviors among youth (e.g. teen pregnancy, smoking, auto accidents);**

1. Provide family planning and decrease teen pregnancy. (Child Poverty Council Recommendation V.B.)
2. Target populations that demonstrate rates of unhealthy behaviors that are substantially higher than the state average.
3. Continue tobacco monitoring programs at DMHAS.

### **Decrease the incidence of child and youth suicide;**

1. Promote awareness that suicide is preventable and that mental health is important to overall health (DCF prevention strategy).
  - a. Promote a public awareness campaign that promotes the adult role in facilitating the mental health of children and youth.
  - b. Use non-traditional service providers and community partners to develop appropriate messages and strategies to reach diverse populations.

2. Promote, develop and implement effective prevention strategies (DCF prevention strategy).
  - a. Encourage DCF providers to discuss firearm safety with caregivers and include in client assessment.
3. Promote improved access to behavioral health care for children and youth (DCF prevention strategy).
  - a. Ensure that DCF caregivers and gatekeepers are education about HUSKY and Medicaid coverage for children and youth.
  - b. Reduce utilization of out of home care.
4. Promote the provision of quality behavioral health care (DCF prevention strategy).
  - a. Promote the appropriate use of clinical behavioral health interventions prior to the use of psychotropic medications.
  - b. Develop and implement effective transition plans with participation of parents/caregivers and community service providers.

### **Decrease the incidence of juvenile crime;**

1. Reduce the number of children entering the juvenile justice system. (Connecticut Juvenile Justice Strategic Plan, 2006)
  - a. Support interagency prevention services in order to promote positive youth development and limit court involvement of children, youth, and families.
2. DCF and CSSD should partner with education professionals to develop strategies for the appropriate exchange of information and the handling of problematic behaviors so that children have access to a full range of services to support their success in school. (Connecticut Juvenile Justice Strategic Plan, 2006)

- a. Develop policies and procedures to facilitate the appropriate exchange of information between schools and juvenile justice agencies.
  - b. Partner with local education agencies to develop alternatives to suspension and expulsion, such as educational advocates and alternative education programs that serve the child, the school, and the community.
- 3. Assess the system response to Family with Service Needs (FWSN)-referred children and their families, and ensure effective protocols and programming to increase interagency coordination and access to services. (Connecticut Juvenile Justice Strategic Plan, 2006)
  - a. Review and modify as needed the implementation of the FWSN protocol.
  - b. Implement and expand a FWSN Diversion Demonstration Program that diverts FWSN referrals from the court to the community for intervention services.
- 4. Support local development of Youth Service Bureaus.
- 5. Address school attendance and truancy.

**Increase the positive involvement of fathers with their children;**

- 1. Encourage youth to delay child-bearing until marriage and when education and career planning are completed. (Brookings Institution)
- 2. Reduce marriage disincentives in existing benefit programs wherever possible, not just by extending benefits up the income scale but also by making marriage a condition for receiving more types of assistance. (Brookings Institution)
- 3. Increase involvement of positive adult mentors in the life of children and youth without fathers.

**Encourage ongoing future leadership on child poverty and prevention issues.**

1. Increase public awareness of the value of prevention, including preventing child poverty. (State Prevention Council, 2003)
2. Strengthen state and local networks involved in child poverty and prevention efforts. (State Prevention Council, 2003)
3. Improve data collection on child poverty and prevention programs, including how to define prevention. (State Prevention Council, 2003)
4. Share and implement best practices. (State Prevention Council, 2003)

## VI. CHILD POVERTY PROGRESS REPORT

This section of the report describes progress made to-date in implementing the Council's ten-year plan to reduce child poverty and the extent to which state actions are in conformance with the plan.

The Council's child poverty goal is to reduce poverty among children in Connecticut by 50% over ten years. When the Council's ten-year plan was released in 2006, the most up-to-date figures on child poverty were based on 2003 figures. Currently, the most recent figures are based on 2005 data. Both of these rates reflect child poverty in Connecticut prior to any action by the Council.

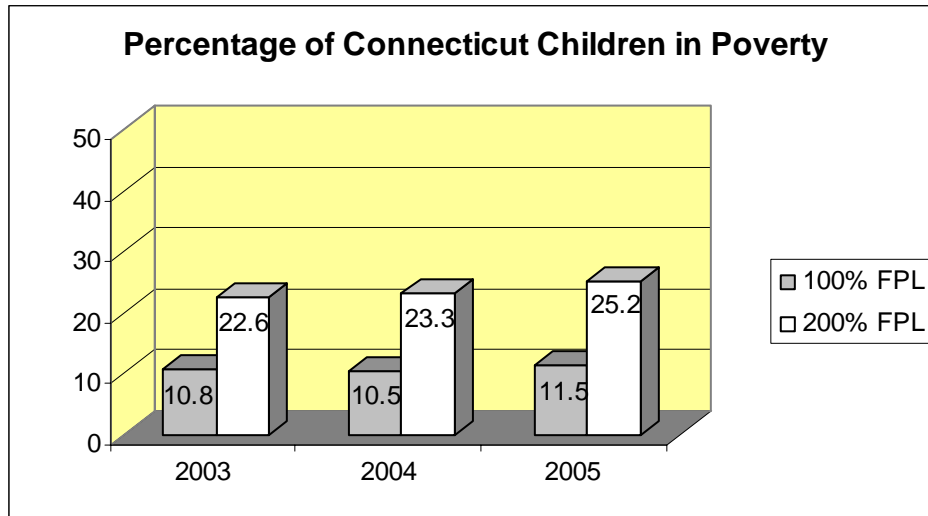
The Council is focusing on reducing child poverty both among families below 100% of the federal poverty level (\$16,600 for a family of three in 2006) and families below 200% of the federal poverty level (\$33,200 for a family of three in 2006)

To measure the child poverty rate in Connecticut, the Council uses two separate Census Bureau sources. To measure children in families with incomes under 100% of the federal poverty level, the Council relies upon data from the American Community Survey (ACS). The ACS is a large continuous demographic survey conducted by the Census Bureau. The survey produces annual and multi-year estimates of population and housing characteristics and produces data for small areas, including tracts and population subgroups. Although the ACS uses a larger sample than the Current Population Survey (CPS), it does not produce data on 200% of the federal poverty level, so CPS data is used by the Council to measure the number of children living in families with income below 200% of the federal poverty level. The CPS is a monthly survey of households conducted by the U.S. Census Bureau for the Bureau of Labor Statistics. Using a sample of 60,000 households nationwide, the CPS collects basic labor force data by telephone and personal interviews.

Using these sources, the child poverty rate in Connecticut has been:

- In 2003, 10.8% of Connecticut children in families with income under 100% FPL and 22.6% of Connecticut children in families with income under 200% FPL;

- In 2004, 10.5% of Connecticut children in families with income under 100% FPL and 23.3% of Connecticut children in families with income under 200% FPL; and
- In 2005, 11.5% of Connecticut children in families with income under 100% FPL and 25.2% of Connecticut children in families with income under 200% FPL.



While this slight increase in the child poverty rate is of concern, this report will show that many of the recommendations of the Child Poverty Council have been implemented very recently and will likely have a positive impact on the state's child poverty rate in the years ahead. Annual progress reports by the Child Poverty Council will continue to use census data to track trends and progress toward meeting the child poverty reduction goal.

To put the state child poverty rate in context, it should be compared with other similar measures. For example, the national poverty rate for children living in families with income under 100% of the federal poverty level in 2005 was 18.2% and the national poverty rate for children living in families with income under 200% of the federal poverty level was 38.4% in 2005.

In 2005, the Office of Workforce Competitiveness released a report on a self-sufficiency standard for Connecticut, which measures how much income is needed for a family of a certain composition in a given place to adequately meet their basic needs - without public or private assistance. The report found that a family of three in Connecticut would need to earn two and one half times the

2006 minimum wage of \$7.40 in order to meet the self-sufficiency income. The report did not identify the percentage of Connecticut families that had incomes below the self-sufficiency standard.

One of the major strengths of the Child Poverty Council has been the development of strong partnerships with several state agencies, the legislative branch and non-governmental agencies working towards the development of an effective, comprehensive plan of action to reduce child poverty in the state by 50% over the next ten years.

The overwhelmingly positive response by the Governor and the legislature to the recommendations of the Child Poverty Council -- demonstrated by the major investments and significant contributions made by the state in 2005 and in 2006 to further address child poverty -- is a very encouraging beginning for the first two years of the Child Poverty Council.

The Council believes that its recommendations should continue to be a high priority for decision-making during upcoming legislative sessions. By providing some new resources and, as importantly, targeting existing resources and providing a coordinated framework, Connecticut has a real opportunity to reduce child poverty in the short and long term.

Below is a comprehensive list of the Council's 67 recommendations contained in its ten year plan (in bold type) with a brief description of the actions taken to-date by the state to implement the plan (underlined).

## **I. Enhance Families' Income and Income Earning Potential**

Action Taken in 2005: Minimum Wage Increased. Public Act 05-32 increases the state's minimum hourly wage from \$7.10 to \$7.40 on January 1, 2006 and to \$7.65 on January 1, 2007.

Action Taken in 2006: Informational Public Hearing Held. On February 2, 2006, the Human Services Committee held an informational public hearing which provided an opportunity to receive local and national information on Welfare Reform activities geared towards lifting people out of poverty. Invitees were the Child Poverty Council, the TANF workgroup, the Human Services Committee, and the Appropriations Committee.

**A. Support and enhance job training and education for recipients of Temporary Family Assistance (TFA).**

Action Taken in 2006: Implemented TANF Reorganization Plan. To bring the state into compliance with the federal requirements set forth in the federal Deficit Reduction Act of 2005 concerning the operation of the temporary assistance for needy families (TANF) program, an additional \$6.5 million was appropriated to be allocated as follows:

- \$2 million for Vocational Education and Basic Education;
- \$1.2 million for Community Education and Training Opportunities (CETO);
- \$2.6 million for Work Experience;
- \$700,000 to expand employment services for the most employable and for people who are currently working less than 30 hours per week.

- 1. Allow post-secondary education and vocational training to count toward the federal work participation requirement under the Temporary Family Assistance (TFA) program.**
- 2. Provide a more comprehensive up-front assessment of barriers to employment to more quickly identify those fragile families/high barrier populations.**
- 3. Implement a system to address the needs of Jobs First Employment Services (JFES) participants having inadequate reading or math skills, including assessing each participant to determine the problem and how to address it to the extent possible.**
- 4. Spend higher proportion of Temporary Family Assistance (TFA) funds on job training and education.**

**B. Increase low-income parent's access to literacy, post-secondary, and vocational education.**

Action Taken in 2005: Implemented Post-Secondary Strategies for Economic Competitiveness. Beginning in September 2005, the Governor is convening a quarterly meeting of board chairpersons from the higher education systems, public and private, and the chairpersons from the State Boards of Education and Higher Education to develop planning and policy guidance for the Jobs Cabinet with respect to long-term education strategies that support the state's economic competitiveness. There is no cost to implementing this recommendation.

**1. Enhance literacy programs for adults including Adult Basic Education (ABE) and GED services.**

Action taken in 2005: Expanded Workplace Literacy. Using existing funding, the Governor has proposed expanding the availability of workplace literacy program for employers who employ persons with limited English proficiency or who have limited literacy. To do so, the Connecticut Employment and Training Commission will encourage state and local partnerships to improve literacy proficiency.

**2. Increase vocational training opportunities for populations that do not have a high school diploma or have limited English proficiency.**

Action Taken in 2005: Established an Adult Education Competitive Grant. PA 05-245, § 41 – requires the State Department of Education (SDE) to establish an adult education competitive grant program for young adults in FY 07. The total amount awarded under the program cannot exceed \$500,000. The grants must be awarded to provide new and unique methods of educating young adults entering adult education.

**3. Provide assistance with vocational and post-secondary education expenses such as tuition, books, supplies, child care, transportation, tools or license fees.**

Action Taken in 2005: Expanded In-State Tuition. PA 05-110 makes any member of armed services stationed in Connecticut or his or her spouse eligible for in-state tuition at public colleges and universities.

Action Taken in 2005: Increased Scholarships. Section 42 of Public Act 05-3 of the June Special Session increases from \$2,000 to \$3,000 the maximum per-student award for those attending Connecticut institutions under the Capitol Scholarship Grant Program. The Capitol Scholarship Grant Program provides awards to students based upon academic merit and financial need.

Action Taken in 2006: Provided Funds for the Federal Maintenance of Effort Requirement for the Capitol Scholarship Program. In order to qualify for a federal match, the funding level of the Capitol Scholarship Program must increase yearly. The additional funding of \$86,953 for FY 07 qualifies Connecticut for matching federal funds.

- 4. Expand subsidies for low-income individuals to attend community college, e.g. through means-tested tuition relief.**

Action taken in 2005: Established Pilot Programs to Pay Community College Students' Expenses. Public Act 05-244, AAC the Implementation of the Recommendations of the Child Poverty Council, allows the Board of Trustees for Community-Technical Colleges to establish up to three pilot programs, within available appropriations, to provide for household and family expenses of students with dependents while such students are attending a Community-Technical College. Participation in the pilot program is limited to students who are eligible for a federal Pell grant.

- 5. Increase English as a Second Language programming by partnering with businesses or offering incentives to businesses that provide English as a Second Language programming.**
- 6. The Council should explore options to provide low-income individuals with an expectation of success regarding possibilities and techniques for achievement.**

Action Taken in 2006: Funded the Connecticut Career Resource Network. CCRN is the primary source of Connecticut-specific career information used by the education community: teachers, guidance counselors, students and their parents as well as by the workforce investment system. It has provided the information needed to help learners, from youth to adults, make informed decisions about their career choice and preparation. This information is provided through publications, workshops and conferences, internet-based information systems, training, and marketing of career-related materials. When federal funding was eliminated in the FY 07 budget, Governor Rell recommended \$150,000 in state funding for this program and the legislature concurred.

- C. Continue to link training to industries and encourage training programs to develop curricula to meet workforce shortage and high growth employment areas.**

Action Taken in 2005: Increased Workforce Development Funding. The Governor proposed, and the legislature funded, an additional \$2.5 million for job creation and job training programs including the Jobs Funnel, Connecticut Career Ladder Pilot Program, Connecticut Career Choices (CCC) and the Small Business Innovation and Research Program.

- The Jobs Funnel, a joint public/private effort, initially started in Hartford as a partnership between unions, non-profit agencies and the state, has expanded to other areas including New Haven, Bridgeport, Norwalk and Waterbury. Focused on preparing graduates for jobs in the construction trades, the Jobs Funnel has expanded to include hospitality, retail and health care occupations. Over 3,400 people have been served with approximately 750 graduated, having gone from welfare, homeless shelters and chronic unemployment to good paying jobs with an average salary of \$16 per hour and rewarding careers.
- The Connecticut Career Ladder Pilot has established a continuum of education and training programs that lead to career advancement in occupations with projected workforce shortages such as healthcare, childcare, and technology. The pilots are building linkages between education and training institutions, working with community based providers to support workforce development, increase education and skills of entry level workers and support career advancement.
- Connecticut Career Choices (CCC) is at the core of the State's Technology Workforce Strategy. This initiative focuses on fostering interest in technology careers, adapting existing curriculum to industry-recognized skills standards in specific technology areas and creating greater ties between technology business and education. New directions for CCC in the coming year include: (1) a closer working relationship with SDE to develop curriculum in science, technology, engineering and math, using the Connecticut Educational Network as a delivery mechanism; (2) continued work with students and teachers from former pilot site schools, including offering experiential learning opportunities linked to information technology and health/medical curriculum; (3) providing access to online educational environments for course curriculum and instructional resources; (4) grant programs focused on development of a core science teachers/leaders group and science curriculum and implementing a three-course science and technology sequence articulated to the community college system; and (5) a statewide information technology research and development competition called the Connecticut Innovation Challenge.

Action Taken in 2006: Created the Twenty-First Century Jobs Program. Governor Rell recommended \$1.5 million to create the Twenty-First Century Jobs Program and the FY 07 state budget enacted by the legislature appropriates \$1 million in funding for this program. This matching program will require employers to pay for at least 50 percent of

the training. The program will provide financial incentives and technical assistance to small businesses that cannot afford employee training programs. The program will help employers sustain high growth and economically vital industries in Connecticut by supporting training for incumbent workers. Employees will benefit by obtaining skills to start or move up in their careers.

Action Taken in 2006: Expanded Apprenticeship Opportunities.

Governor Rell recommended the expansion of the 21<sup>st</sup> Century Apprenticeship System to create new and additional apprenticeship initiatives in occupations such as childcare development specialists and youth development practitioners, and in the fields of healthcare, information technology, and advanced manufacturing. The Governor also recommended the provision of direct services to apprenticeship sponsors (employers, labor-management organizations) and to apprentices. The FY 07 state budget funded this expansion with \$250,000 and four new positions.

Action Taken in 2006: Funded Opportunity Industrial Centers. The FY 07 state budget provided \$500,000 for the five Opportunity Industrial Centers (OIC) which provide comprehensive job training, life skills, and related services to economically disadvantaged, unemployed, and underemployed individuals, including persons of limited English speaking ability.

Action Taken in 2006: Funded Incumbent Worker Training. The FY 07 state budget provided \$500,000 for Incumbent Worker Training which provides workers with workplace-based skill training with an emphasis on small and mid-sized manufacturing firms. Workers trained include workers needed by expanding businesses, unskilled entry level workers in need of training due to dislocation or obsolescence of their skills, workers in need of training due to technological advances and workers who need skill development to qualify for advancement.

- D. Explore expansion of the Hiring Incentive Tax Credit program authorized under §12-217y of the Connecticut General Statutes which is available to companies that hire recipients of the Temporary Family Assistance (TFA) program and other programs to aid individuals in obtaining employment.**
- E. Provide additional incentives for businesses to locate in areas accessible to low-income individuals.**

- F. Provide resources to the Connecticut Department of Labor, the Workforce Investment Boards and other CTWorks partners and strengthen the employer service component of the CTWorks centers as a “one-stop” for services that employers need.**

Action Taken in 2005: Streamlined One-Stop Business Services. The Governor has proposed to create and regularly convene a Commissioner Steering Committee comprised of the agencies that are participants in the on-line permitting, licensing, and registration system to create a network of business development in each agency. There is no cost to implementing this proposal.

Action Taken in 2005: Made CT-CLIC Transactional. Over 27 agencies administer about 900 licensing/permitting activities for businesses in the state. Businesses may download applications, but must submit applications and fees through the U.S. mail or by hand delivery. The Governor proposed, and the legislature funded, \$500,000 to begin the process of bringing e-businesses to the state agencies. The process will include electronic applications and payment of fees that will reduce the application and processing time.

- G. The Council should seriously study tax relief methods including the following:**
- 1. Create dependent exemptions against the state income tax.**
  - 2. Create a child care and/or child education credit that phases out as household income increases and is at least partially refundable for parents whose income tax liability is too low to take full advantage of the credit (offset some of a family’s costs in providing quality educational experiences for their children).**
  - 3. Expand property tax rebates (now available for low-income elderly and disabled homeowners and renters) to low-income families who are raising children (offset high housing costs).**

- H. Provide outreach to increase awareness of and participation in the federal Earned Income Tax Credit (EITC) for families that are eligible.**

Action Taken in 2005: Promoted use of federal Earned Income Tax Credit. Public Act 05-244, AAC the Implementation of the Recommendations of the Child Poverty Council, requires the Department of Social Services (DSS), within available appropriations, and in consultation with the Child Poverty Council, to promote greater utilization of the federal EITC to

municipalities, public and private employers, Community Based Organizations (CBO) and other entities that have frequent contact with low-income families and to enhance financial literacy and self-sufficiency programs. In November 2005, DSS convened a workgroup to develop strategies to promote the federal EITC program. Follow-up meetings will be held to finalize strategies for implementation. DSS has received \$50,000 for this purpose.

- I. **Establish a refundable state Earned Income Tax Credit (EITC) program to supplement low-wage parents (This recommendation was adopted by a vote of 13 to 4.)**

## **II. Help Low-Income Families to Build Assets**

- A. **Strengthen the Connecticut Department of Labor's Individual Development Account (IDA) program that assists low income earners to accumulate assets such as an automobile, education and/or other assets necessary to become more economically self-sufficient. Develop and/or enhance matched savings accounts such as IDAs and Universal Savings Accounts. Make IDAs available to all working families.**

Action Taken in 2006: Funded Individual Development Accounts. The FY 07 state budget provided funding in the amount of \$250,000 for DOL's IDA initiative.

- B. **Encourage entrepreneurship.**
- C. **Encourage homeownership programs that facilitate homeownership, especially in central cities and among minorities. Expand the second mortgage pool which allows purchase of a home without down payment.**
- D. **Curb predatory lending by addressing loopholes that may be in the law.**

## **III. Enhance Affordability of Health Care, Housing, Child Care and Early Childhood Education**

- A. **Increase access to affordable child care.**

Action Taken in 2006: Increased Access to Child Care. \$1.5 million was appropriated in FY 07 to increase access to child care in order to meet new

federal work requirements under the TANF program. Of these funds, \$725,000 will be dedicated to the Employment Success program.

- 1. Increase the Care4Kids child care subsidy to more closely match the current market costs.**
- 2. Increase the number of Care4Kids child care certificates.**

Action Taken in 2005: Expanded child care subsidies for low-income working families. "Care 4 Kids", the child care assistance program administered by DSS provides child care assistance payments to various categories of families. These families are categorized into priority groups. One of these priority groups, (PG-4), includes families who are employed and who do not receive cash assistance through TFA. These non-TFA working families must, at the time of application, have incomes less than 50% of the state median income. In FY 05, intake to the PG-4 portion of the child care subsidy program was re-opened due to additional funds that were provided, including \$4 million in TANF performance bonus funds. The additional TANF bonus funds were not needed in FY 05 because general fund budgeted resources were sufficient to meet program needs. As a result, the Governor proposed carrying forward the \$4 million in TANF performance bonus funds for use in the biennium so that intake to the PG-4 portion of the child care subsidy program could remain open and the legislature agreed.

Action Taken in 2006: Maintained Open Enrollment in Child Care Certificate Program. Governor Rell recommended an additional \$217,263 for child care subsidies to maintain open enrollment in the child care certificate portion of the program. This funding was included in the FY 07 state budget.

- 3. Expand facilities for child care.**
  - 4. Expand Care4Kids eligibility to cover those in education or job training programs.**
- B. Ensure quality child care.**
- 1. Enhance training of child care workers, especially for "kith and kin" providers. Continue to support the differential rate to encourage use of licensed child care centers.**

**2. Ensure adequate wages and health insurance benefits for child care workers.**

**C. Provide a system of “education through birth” by continuing to support school readiness and early childhood educational programs.**

Action Taken in 2005: Increased funding for School Readiness slots. Approximately 7,000 children are projected to be in the existing School Readiness program during the FY 06-07 biennium. Providers in these programs have struggled financially, often with unmet capital needs. Staffing has been problematic, with high turnover. To address these problems, the Governor proposed an additional \$2 million in FY 06 and \$4 million in FY 07 to increase slot funding from \$7,500 to \$7,750 and finally to \$8,025. The legislature provided this funding and an additional \$850,000 in each year of the biennium. The Governor also proposed \$2 million in capital funding to address unmet needs for enhancement and expansion of school readiness programs and day care centers in both FY 06 and FY 07. The legislature provided this capital funding.

Action Taken in 2005: Created a Kindergarten Assessment Program. The Governor provided \$400,000 in FY06 to finance the creation of a developmentally appropriate kindergarten assessment program. This assessment would provide empirical data with which to measure whether preschool populations are coming to kindergarten ready to achieve and succeed. The legislative budget delayed implementation of this assessment until FY 07.

Action Taken in 2005: Enhanced Child Care. The state budget provided \$4.35 million to DSS in each year of the FY 06-07 biennium to increase childcare center subsidies, provide scholarships for childcare workers, for quality enhancement efforts, and for the accreditation and facilitation project.

Action Taken in 2006: Increased Early Childhood Funding. Governor Rell proposed funding for five new districts under the Early Childhood Competitive Grant Program and to provide for new slots for ERG I towns under the Priority School District Grant. The FY 07 state budget included \$6.5 million for the five new districts and 1000 new slots. Public Act 06-135 implements this change.

**D. Create one coordinated system for early childhood education.**

Action Taken in 2005: Established an Early Childhood Cabinet. The Governor proposed \$1 million in FY 06 funding be appropriated to the Department of Education for a new Early Childhood Advisory Cabinet to be used for a variety of functions. The legislative budget reduced this funding by \$600,000 and by \$800,000 in FY 07.

**E. Enhance pre-school teacher training, including on-site consultation for pre-school teachers to encourage continuing education toward advanced degrees.**

Action Taken in 2005: Enhanced Preschool Teacher Training. Public Act 05-245 § 1 raises the minimum school readiness staff qualifications. § 4 allows DSS Quality Enhancement grants to be used for staff scholarships for training for any type of early childhood education or child development credential. It also expands the use of grants for supportive networks to include all child care providers, not just family day care homes. § 50 establishes a 21-member committee to review and assess pathways to baccalaureate degrees in early childhood education and child development to promote the professionalization of the early childhood education workforce.

Action Taken in 2006: Developed Alternative Route to Certification in Early Childhood Education. \$133,000 was appropriated to develop and implement an alternative route to certification in early childhood education and school administrators.

**F. Amend the pre-school system to allow for full-day, full-year or school-day, school-year pre-school programming.**

**G. Advocate for year-round school programming for grades K-3 in low-income districts.**

**H. Provide comprehensive early childhood education programs with mandated parent involvement.**

**I. Reduce housing costs.**

Action Taken in 2006: Supported housing programs. The FY 07 state budget contained \$250,000 to enhance the Security Deposit Guarantee program in the Department of Social Services.

**J. Expand availability of state rental assistance subsidies.**

Action taken in 2005: Provided additional Rental Assistance Program (RAP) Certificates. The legislative budget provided \$1.8 million in both FY 06 and FY 07 for additional RAP certificates to offset federal reductions in the Section 8 voucher program.

**K. Expand the Transitional Rental Assistance Program (T-RAP) to allow families to remain eligible for a longer period of time. In addition, the state should allow use of T-RAP for individuals re-entering education and needing assistance with rent.**

**L. Expand availability of affordable, family-sized housing units.**

**1. Provide incentives to housing developers to develop family-sized units.**

**2.. Create a Housing Trust Fund.**

Action Taken in 2005: Created a Housing Trust Fund. Public Act 05-5, June Special Session, creates a Housing Trust Fund and authorizes the State Bond Commission to capitalize it by issuing up to \$100 million in bonds, with \$20 million effective each July 1, from 2005 to 2009. It establishes a Housing Trust Fund Program to expand affordable housing opportunities for low- and moderate-income people and requires the bond proceeds to be used for this purpose. The State Bond Commission allocated the first \$10 million to the Department of Economic and Community Development on December 9, 2005.

Action Taken in 2006: Funding Disbursed from the Housing Trust Fund. In October 2006, seven housing projects were awarded \$6.6 million from the Housing Trust Fund completing the first year's allotment of \$20 million from the five-year, \$100 million fund. This initial \$20 million investment in housing will create and preserve 695 units of housing and leverage \$76 million in other investments.

**3. Expand supportive housing for families**

Action Taken in 2005: Created 175 new supportive housing units for families. As part of Governor Rell's initiative to create 500 new units of supportive housing, the Governor proposed, and the legislature funded, 175 units for families with multiple barriers to housing and employment stability. Annual costs for the 175 family units include

\$2,187,675 to fund capital costs, \$1.1 million for service provision, and \$841,500 for rental certificates. State agencies, including OPM, DCF, DSS, DECD, CHFA, DMHAS and the Corporation for Supportive Housing are currently preparing an interagency Memorandum of Understanding and a Request for Proposals to be released in January.

Action Taken in 2006: Expanded the Supportive Housing for Recovering Families program. The SHRF program offers support services and safe housing to families involved with DCF. The program serves families statewide. Case management services are supported from the budget of DCF and housing supports are provided through a combination of DCF funding, DSS RAP certificates and federal section 8 vouchers. As demand for services exceeded the program's capacity of 365 families, funding in the amount of \$990,400 was provided in the DCF budget and \$1.26 million in the DSS budget to reflect an expansion of the program to serve an additional 100 families in FY 07.

**4. Expand use of Low Income Housing Tax Credits to help finance housing and rehabilitation efforts.**

- M. Support maintenance of owner-occupied housing by providing subsidy or tax incentive to low-income property owners for rehabilitation projects.**
- N. Enforce laws ensuring non-discrimination based on rent source.**
- O. Ensure public or private health care coverage for parents.**
  - 1. Provide tax incentives to small businesses that offer health insurance to employees and their dependents**
  - 2. Consider use of State Children's Health Insurance Program (SCHIP) or other funds to subsidize small employers to make it more affordable for families to provide health insurance coverage.**
  - 3. Continue to explore ways to expand health coverage for parents.**

Action Taken in 2005: Provided HUSKY coverage to adults in families with incomes up to 150% of the federal poverty level. Effective July 1, 2005, the enacted budget provided new funding in excess of \$39 million (\$55 million in FY 07) that allows DSS to expand Medicaid eligibility for families with income up to 150% of the federal poverty

level. Increasing the threshold from 100% to 150% is expected to serve an additional 25,000 individuals annually.

Action Taken in 2005: Expanded family planning services. Public Act 05-120 requires DSS to apply for a federal waiver to provide Medicaid coverage for family planning services for families with income up to 185% of the federal poverty level.

Action Taken in 2005: Created a study. Public Act 05-280 requires the Insurance and Real Estate Committee to study possible implementation of a "Nutmeg Health Partnership" to (1) increase the number of residents with health insurance, (2) provide broader health care access, and (3) make health care more affordable.

Action Taken in 2006: Restored Self-Declaration. \$2 million was provided in the FY 07 state budget to restore the self declaration policy under the HUSKY program. Section 16 of Public Act 06-188 implements this change.

- 4. Enhance mechanism to provide information about employer sponsored health insurance coverage for TFA participants transitioning off cash assistance.**
- P. Ensure access to sufficient number of health care providers in the community and timely appointments.**

Action Taken in 2006: Approved Bonding for Community Health Centers. In September 2006, Governor Rell announced a major investment in quality health care for thousands of residents served by Connecticut's non-profit community health centers, authorizing \$25.8 million to expand medical and dental facilities in Hartford, New Haven, Bridgeport, Waterbury, Torrington, Meriden, Stamford, Norwalk, New Britain, Norwich, East Hartford, Willimantic, and Putnam. The funding was approved by the state Bond Commission in October 2006 and will enable community health centers to serve an estimated 85,000 new patients with primary and specialized health care.

- Q. Strengthen health care coordination and outreach to improve effectiveness.**

Action Taken in 2006: Enhanced HUSKY Outreach. In September 2006, Governor Rell announced \$1 million in new funding for community outreach and public information aimed at boosting the number of children

and teenagers enrolled in Connecticut's HUSKY health care program. The funding will support grassroots efforts by schools and community organizations to encourage parents to sign their children up for health coverage.

**R. Enhance prevention and early intervention programs.**

Action Taken in 2006: Enhanced Dental Services Under the HUSKY Program. Governor Rell recommended two initiatives to enhance dental services for children enrolled in the HUSKY program. First, the Access for Baby Care (ABC) program will be implemented on a pilot basis. Under this program, a child's pediatrician will examine an infant at regular intervals before the age of three and apply topical fluoride to prevent tooth decay. The mother and child will also be taught better oral hygiene practices. The FY 07 state budget included \$1.85 million to implement the ABC program. Second, to increase preventive care, DSS will expand the dental program to include sealant coverage for premolars. These sealants will help prevent tooth decay, which can progress to more extensive disease. The state budget provided \$1.1 million to implement this program in FY 07.

Action Taken in 2006: Provided Funding for Increased Rates to Birth-to-Three Programs. To improve access and availability to the Birth-to-Three program, funding of \$989,000 was provided in FY 07 to support an increase in the reimbursement to contracted programs.

Action Taken in 2006: Implemented Prevention Programming. \$1.4 million is provided in the FY 07 DCF budget to support the replication of effective or innovative community-based prevention models within Connecticut including those that prevent the incidence of child abuse and neglect, children's behavioral health problems and juvenile justice involvement.

**1. Increase education about preventing disease and accessing disease prevention services, e.g. diabetes, obesity.**

Action Taken in 2006: Implemented a Comprehensive Cancer Control Plan. Pursuant to Section 27 of Public Act 06-186 and Section 52 of Public Act 06-195, \$5.5 million was transferred from the Tobacco and Health Trust Fund to DPH to support the costs of implementing a Comprehensive Cancer Control Plan. The plan will provide for: a) creation of a statewide smoking cessation program targeting Medicaid recipients; b) development and implementation of a program to

encourage colorectal screenings; c) development and implementation of a statewide clinical trials network; d) identification of services for and provision of assistance to, cancer survivors and e) identification of, and the provision of services to, organizations that offer education programs on hospice or palliative care.

Action Taken in 2006: Continued Support of a Pilot Asthma Awareness Program. Section 27 of Public Act 06-186 transfers \$150,000 from the tobacco and Health Trust Fund to DPH in FY 07 to continue support of a pilot asthma awareness and prevention education program in Bridgeport.

Action Taken in 2006: Expanded the Easy Breathing Asthma Initiative. The Easy Breathing Asthma Initiative is aimed at improving asthma recognition and treatment by primary care providers and improving access to asthma related medical care for children. Section 27 of Public Act 06-186 transfers \$650,000 from the Tobacco and Health Trust Fund to DPH to continue support for the pediatric component of the Easy Breathing Program (\$500,000) and extend the existing Easy Breathing Program contract to serve adults (\$150,000).

## **2. Provide immunizations for all children.**

Action Taken in 2006: Provided Meningococcal Conjugate Vaccine for Adolescents. Governor Rell proposed funding, in the amount of \$1,598,000 to allow for purchase of sufficient Meningococcal Conjugate Vaccine to ensure that all children aged 11 years and older are vaccinated. The meningococcus bacterium can cause a life-threatening infection of the bloodstream or brain. Death occurs in 10-14% of persons with meningococcal disease and is highest in infants and adolescents. This funding was appropriated in the FY 07 state budget, which includes providing vaccine for all college entrants living in dormitories which is currently paid for with expiring private funding.

Action Taken in 2006: Provided Pertussis Vaccine for Adolescents. Governor Rell proposed funding, in the amount of \$346,950 to support the costs of expanding Connecticut's childhood immunization program to include pertussis for adolescents aged 11-18 years in accord with a recent recommendation of the U.S. Advisory Committee on Immunization Practices. Pertussis (whooping cough) is a highly contagious respiratory tract infection. Immunity from the current childhood pertussis vaccine wanes over time, leaving adolescents susceptible. This funding was included in the FY 07 state budget to provide an estimated 27,000 doses to adolescents ineligible for Medicaid.

- 3. Increase early identification and accessible, culturally appropriate health promotion and care services for all families, especially families with a parent or child with mental illness or substance abuse problems.**

Action Taken in 2006: Increased Earmarking of Newborn Screening Fees for Laboratory Costs. The Connecticut Statewide Newborn Screening Program has experienced a growth in caseload since 2005 due to an expansion of testing from 8 to 42 disorders, including rare, genetic and metabolic disorders. A 260% increase in caseload has occurred. Governor Rell proposed that the transfer of funding from Newborn Genetic Screening fee receipts be increased by \$155,000 to accommodate increased costs of testing. Section 20 of Public Act 06-188 implements this change.

Action Taken in 2006: Enhanced Newborn Genetic Screening. All newborns identified with presumptive positive results in the Connecticut Statewide Newborn Screening Program are referred to one of two state-designated Genetic Regional Treatment Centers at UConn or Yale. These treatment centers provide comprehensive testing counseling, education, treatment and follow-up services. To meet an increase in demand for services from these two Genetic Regional Treatment Centers, Governor Rell recommended additional funding, in the amount of \$124,000. This funding was included in the FY 07 state budget.

Action Taken in 2006: Supported School Based Health Centers. Additional funding, in the amount of \$930,000 is provided in the FY 07 state budget to support school based health center services.

- S. Enhance medical and behavioral health care availability for families with special needs.**

Action Taken in 2006: Increased Support for the Connecticut Children's Medical Center. The FY 07 state budget provided a \$4 million increase in the grant to the Connecticut Children's Medical Center, with an additional \$2 million in FY 06 surplus funds to develop a financial stabilization plan.

- 1. Strengthen care for children with special health care needs through transitional programs and medical home models through the Department of Public Health.**
- 2. Expand availability of behavioral health inpatient and outpatient treatment services for all children and parents in need.**

Action Taken in 2005: Established a Behavioral Health Partnership. The Governor's budget included \$9.8 million in FY 06 and \$12.9 million in FY 07 to move forward with the KidCare initiative to coordinate the clinical management and administration of behavioral health services for adults and children covered under the HUSKY A and HUSKY B programs and the DCF Voluntary Services Program. The legislative budget reduced the funds available for this effort to \$4.8 million in FY 06 and \$8 million in FY 07.

Action Taken in 2005: Expanded Adult Mental Health Initiatives. The Governor added \$3.1 million to the DMHAS budget to continue ongoing "Second Initiatives" programs begun at the recommendation of the Community Mental Health Strategy Board. These programs include funding for Assertive Community Treatment (ACT) teams, mobile crisis and respite programs, programs that provide step-down from inpatient stays and programs that provide intensive community services tied to housing. The Governor also added \$217,500 to develop an interactive, comprehensive web based inventory of services that will assist individuals with locating services, \$1.2 million to fund community support services for difficult-to-discharge acute clients, and \$500,000 for additional acute care services. The legislature funded these initiatives and added \$750,000 to upgrade ACT teams to implement a Medicaid rehabilitation option.

Action Taken in 2005: Enhanced Children's Mental Health. The FY 06-07 state budget provides \$1 million to DCF for flexible funding.

Action Taken in 2005: Funded Additional Slots under the Katie Beckett Waiver. The state budget provided \$1.5 million in both FY 06 and FY 07 for additional slots under the Katie Beckett Waiver.

Action Taken in 2005: Addressed Mental Health Services for Young Adults. Public Act 05-280 § 86 allows DMHAS, within available appropriations, to expand services for young adults with psychiatric disabilities to cover additional state catchment areas, requires DMHS to identify service gaps for this population, and report by 1/1/07 on the need to expand existing services or add new ones.

Action Taken in 2006: Established Pilot Child and Adolescent Rapid Emergency Stabilization Services. The FY 07 state budget included \$395,000 to establish pilot child and adolescent rapid emergency stabilization services in the Hartford region. This grant is to develop a

comprehensive model for the delivery of acute care to children and adolescents in psychiatric crisis.

**3. Increase transitional living options for people discharged from inpatient behavioral health treatment facilities.**

**T. Expand, enhance and subsidize after-school programming.**

Action Taken in 2005: Enhanced after-school programming. Public Act 05-245 allows SDE, in conjunction with the After-School Committee and within available appropriations, to provide grants to school districts, municipalities, and nonprofit organizations for programs that take place when school is not in session.

Action Taken in 2006: Provided Funding for After School Programs. An additional \$3 million was included in the State Department of Education FY 07 budget for after school programs.

Action Taken in 2006: Enhanced Community Based After School Initiatives. An additional \$1.3 million was included in the Department of Social Services FY 07 budget for community based after school initiatives.

**U. Enhance availability of transportation.**

Action Taken in 2006: Increased Funding for the Transportation for Employment Independence Program Governor Rell proposed providing an additional \$500,000 to the Transportation for Employment Independence Program (TEIP) which provides transportation services to TANF/TFA eligible individuals and low income families. The additional funding, which was provided in the FY 07 state budget, will be used to partially offset the loss of federal funds which are no longer available.

**V. Develop incentives to recruit and retain qualified teachers to work in low income school districts**

**1. Enhance drop out prevention efforts.**

**IV. Support Safety Net Programs for Families (with parents who have multiple or extraordinarily high barriers to employment)**

- A. Provide intensive case management to identify the ways to reduce barriers to employment for families identified with extreme barriers to employment.**
- B. Rethink the 21 month time limit in the Temporary Family Assistance (TFA) Program. (This recommendation was adopted on a vote of 10 to 5.)**
- C. Improve food stamp participation rates.**

## **V. Enhance Family Structure and Support**

Action taken in 2005: Increased Rates for Relative Guardians. The Department of Children and Families submitted a legislative proposal, which was enacted in Public Act 05-254, making relative guardians eligible for DCF's higher subsidized guardianship rate after they have cared for the child for six, instead of 12, months.

Action Taken in 2006: Enhanced Community Services. The FY 07 budget for the Department of Social Services included \$91,000 to establish a Grandparents Information Network on the 211 system as a clearinghouse to provide information to grandparents caring for their grandchildren.

- A. Create stable, two-parent homes with two earners.**
  - 1. Increase economic opportunity for men in order to increase marriage rates.**
  - 2. Enhance fatherhood initiatives and child support enforcement**

Action Taken in 2006: Strengthened Child Support Enforcement. Governor Rell proposed a bill - ultimately enacted as Public Act 06-149 - which permits DSS to implement electronic funds transfer for child support payments, enhances the department's investigative authority and enforcement options, makes uniform the three-year cap on past due child support, increases certain parents' support obligations, and conforms law to recent child support guideline changes.

Action Taken in 2006: Continued the Fatherhood Initiative. An additional \$250,000 was included in the FY 07 state budget to continue the Fatherhood Initiative.

- B. Provide family planning and decrease teen pregnancy**
- C. Ensure culturally competent case management services.**
- D. Establish and maintain an infrastructure to support young at-risk families through early intervention. Provide culturally competent newborn-through-five home visiting medical and social services to enhance parent/child interaction and parenting skills, parent education, work and life skills and to access community resources and build social support.**

Action Taken in 2005: Expanded Nurturing Families Network. Rather than establish the Governor's proposed Great Beginnings Program, the legislature appropriated \$785,000 in FY 06 and \$1,385,000 in FY 07 to expand the Nurturing Families Network by starting three new programs each year of the biennium to expand from 23 to 29 sites. These programs provide support services to parents of newborns at risk of abuse or neglect, including health related services, parent education, assisting with multiple family problems, breaking social isolation and developing life skills. In 2004, the program screened and provided services to approximately 3,400 new parents through its three components: Nurturing Connections, Nurturing Parenting Groups, and Home Visitation.

Action Taken in 2005: Transferred Administration of Nurturing Families Network. Public Act 05-246 transfers responsibility of the Nurturing Families Network program from DCF to the Children's Trust Fund.

Action Taken in 2005: Coordinated the Early Intervention System. The Children's Trust Fund, the Department of Social Services, the Commission on Children and the Department of Public Health, in partnership with representatives of Healthy Start and Nurturing Families programs and legislators have formed a workgroup to explore strategies to expand early intervention services for at-risk families. The workgroup contracted consultant services to specifically investigate how Connecticut could draw down federal Medicaid funding for Nurturing Family Services similar to the current Medicaid reimbursement system for Healthy Start. The workgroup is also developing options to better coordinate programs to avoid duplication, expand services in order to provide efficient and effective services in order to maximize limited resources.

Action Taken in 2006: Expanded the Nurturing Families Network. An additional \$614,110 is included in the FY 07 DCF budget and two

positions in the CTF budget to support an expansion of Nurturing Families Network programming in New Haven. The expansion of the Nurturing Families Network to eight neighborhood sites with New Haven will allow the program to provide intensive home visiting services to 250 first-time parents. This will increase the number of at-risk families served in New Haven to 350 per year. An estimated 500 first-born children in at-risk families are born in New Haven annually. All 800 first-time mothers in New Haven will be screened and 300 low-risk new mothers will be offered parent information, support and community referrals via the Nurturing Connections program. Nurturing Parenting Groups will be able to serve 120 families. This program assists parents in developing skills, attitudes and behaviors to be better parents, and alleviates social isolation. The annualized cost of the initiative in FY 08 will be \$2,086,960.

- E. Convince the general public and the business community of their self interest in ending poverty**

## **VI. Further Study**

- A. Undertake a study to identify the eligibility cliffs in Connecticut's various assistance programs and develop recommendations regarding the most effective and economically-efficient ways to provide supplemental assistance to support families' journeys to economic self-sufficiency.**
- B. Evaluate the effectiveness of the implementation of Child Poverty Council recommendations**

Action Taken in 2005: Addressed Performance-Based Standards and Outcomes. Public Act 05-244, AAC the Implementation of the Recommendations of the Child Poverty Council, requires the Office of Policy and Management (OPM), within available appropriations, to: 1) develop a protocol requiring state contracts for programs aimed at reducing poverty for children and families to include performance-based standards and outcome measures related to child poverty reduction; and 2) require such state contracts to include performance-based standards and outcomes. No funding was appropriated to OPM for this purpose.

# Appendix A

## **Public Act No. 06-179**

### **AN ACT CONCERNING STATE INVESTMENT IN PREVENTION AND CHILD POVERTY REDUCTION AND THE MERGER OF THE STATE PREVENTION AND CHILD POVERTY COUNCILS.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 4-67v of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

For the biennial budget for the fiscal years commencing July 1, [2003, and ending June 30, 2005] 2007, and July 1, 2008, the Governor's budget document shall, within available appropriations, include a prevention report [presenting] that corresponds with the prevention goals established in section 4-67x, as amended by this act. The prevention report shall:

(1) Present in detail for each fiscal year of [such] the biennium the Governor's recommendation for appropriations for prevention services classified by those budgeted agencies [involved in the State Prevention Council and showing,] that provide prevention services to children, youth and families;

(2) Indicate the state's progress toward meeting the goal that, by the year 2020, at least ten per cent of total recommended appropriations for each such budgeted agency be allocated for prevention services; and

(3) Include, for each applicable budgeted agency and [its subdivisions,] any division, bureau or other unit of the agency, (A) a list of agency programs that provide prevention services, (B) the actual prevention services expenditures for the fiscal year [ending June 30, 2003] preceding the biennium, by program, (C) the estimated prevention services expenditures for the first fiscal year [commencing July 1, 2003, and] of the biennium, (D) an identification of research-based prevention services programs, [The Governor's budget shall also include] and (E) a summary of all prevention services by each applicable budgeted agency [,] identifying the total for prevention services included in the budget.

Sec. 2. Section 4-67s of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

As used in sections 4-67s to [4-67v] 4-67x, inclusive, as amended by this act:

(1) "Prevention" means policies and programs that promote healthy, safe and productive lives and reduce the likelihood of crime, violence, substance abuse, illness, academic failure and other socially destructive behaviors.

(2) "Research-based prevention" means those prevention programs as defined in this section that have been rigorously evaluated and are found to be effective or represent best practices.

Sec. 3. Section 4-67x of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

(a) (1) There shall be a Child Poverty and Prevention Council consisting of the following members or their designees: The Secretary of the Office of Policy and Management, the president pro tempore of the Senate, the speaker of the House of Representatives, the minority leader of the Senate and the minority leader of the House of Representatives, the Commissioners of Children and Families, Social Services, Correction, Mental Retardation, Mental Health and Addiction Services, Transportation, Public Health, Education, Economic and Community Development and Health Care Access, the Labor Commissioner, the Chief Court Administrator, the Chairman of the Board of Governors for Higher Education, the Child Advocate, [the chairperson of the State Prevention Council,] the chairperson of the Children's Trust Fund and the executive directors of the Commission on Children and the Commission on Human Rights and Opportunities. The Secretary of the Office of Policy and Management, or the secretary's designee, shall be the chairperson of the council. The council shall (1) develop and promote the implementation of a ten-year plan, to begin June 8, 2004, to reduce the number of children living in poverty in the state by fifty per cent, and (2) within available appropriations, establish prevention goals and recommendations and measure prevention service outcomes in accordance with this section in order to promote the health and well-being of children and families.

(b) The ten-year plan shall contain: (1) An identification and analysis of the occurrence of child poverty in the state, (2) an analysis of the long-term effects of child poverty on children, their families and their communities, (3) an analysis of costs of child poverty to municipalities and the state, (4) an inventory of state-wide public and private programs that address child poverty, (5) the percentage of the target population served by such programs and the current state funding levels, if any, for such programs, (6) an identification and analysis of any deficiencies or inefficiencies of such programs, and (7) procedures and priorities for implementing strategies to achieve a fifty per cent reduction in child poverty

in the state by June 30, 2014. Such procedures and priorities shall include, but not be limited to, (A) vocational training and placement to promote career progression for parents of children living in poverty, (B) educational opportunities, including higher education opportunities, and advancement for such parents and children, including, but not limited to, preliteracy, literacy and family literacy programs, (C) housing for such parents and children, (D) day care and after-school programs and mentoring programs for such children and for single parents, (E) health care access for such parents and children, including access to mental health services and family planning, (F) treatment programs and services, including substance abuse programs and services, for such parents and children, and (G) accessible childhood nutrition programs.

(c) In developing the ten-year plan, the council shall consult with experts and providers of services to children living in poverty and parents of such children. The council shall hold at least one public hearing on the plan. After the public hearing, the council may make any modifications that the members deem necessary based on testimony given at the public hearing.

(d) Funds from private and public sources may be accepted and utilized by the council to develop and implement the plan and the provisions of this section.

(e) Not later than January 1, 2005, the council shall submit the plan, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and human services and to the select committee of the General Assembly having cognizance of matters relating to children, along with any recommendations for legislation and funding necessary to implement the plan.

(f) (1) On or before January 1, 2006, and annually thereafter, until January 1, 2015, the council shall report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and human services and to the select committee of the General Assembly having cognizance of matters relating to children on the implementation of the plan, progress made toward meeting the child poverty reduction goal specified in subsection (a) of this section and the extent to which state actions are in conformity with the plan. The council shall meet at least two times annually [to review and coordinate state agency efforts to meet the child poverty reduction goal specified in subsection (a) of this section] for the purposes set forth in this section.

(2) On or before January 1, 2007, the council shall, within available appropriations, report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters

relating to appropriations, education, human services and public health and to the select committee of the General Assembly having cognizance of matters relating to children, on the state's progress in prioritizing expenditures in budgeted state agencies with membership on the council in order to fund prevention services. The report shall include (A) a summary of measurable gains made toward the child poverty and prevention goals established in this section; (B) a copy of each such agency's report on prevention services submitted to the council pursuant to this subsection (g) of this section; (C) examples of successful interagency collaborations to meet the child poverty and prevention goals established in this section; and (D) recommendations for prevention investment and budget priorities. In developing such recommendations, the council shall consult with experts and providers of services to children and families.

(g) (1) On or before November 1, 2006, and on or before November 1, 2007, each budgeted state agency with membership on the council that provides prevention services to children shall, within available appropriations, report to the council in accordance with this subsection.

(2) Each agency report shall include at least two prevention services for the report due on or before November 1, 2006, and the report due on or before November 1, 2007, not to exceed the actual number of prevention services provided by the agency. For each prevention service reported by the agency, the agency report shall include (A) a statement of the number of children and families served, (B) a description of the preventive purposes of the service, (C) for the report due on or before November 1, 2007, a description of performance-based standards and outcomes included in relevant contracts pursuant to subsection (h) of this section, and (D) any performance-based vendor accountability protocols.

(3) Each agency report shall also include (A) long-term agency goals, strategies and outcomes to promote the health and well-being of children and families, (B) overall findings on the effectiveness of prevention within such agency, (C) a statement of whether there are methods used by such agency to reduce disparities in child performance and outcomes by race, income level and gender, and a description of such methods, if any, and (D) other information the agency head deems relevant to demonstrate the preventive value of services provided by the agency. Long-term agency goals, strategies and outcomes reported under this subdivision may include, but need not be limited to, the following:

(i) With respect to health goals, increasing (I) the number of healthy pregnant women and newborns, (II) the number of youths who adopt healthy behaviors, and (III) access to health care for children and families;

(ii) With respect to education goals, increasing the number of children who (I) are ready for school at an appropriate age, (II) learn to read by third grade, (III) succeed in school, (IV) graduate from high school, and (V) successfully obtain and maintain employment as adults;

(iii) With respect to safety goals, decreasing (I) the rate of child neglect and abuse, (II) the number of children who are unsupervised after school, (III) the incidence of child and youth suicide, and (IV) the incidence of juvenile crime; and

(iv) With respect to housing goals, increasing access to stable and adequate housing.

[(g)] (h) Not later than July 1, 2006, the Office of Policy and Management shall, within available appropriations, develop a protocol requiring state contracts for programs aimed at reducing poverty for children and families to include performance-based standards and outcome measures related to the child poverty reduction goal specified in subsection (a) of this section. Not later than July 1, 2007, the Office of Policy and Management shall, within available appropriations, require such state contracts to include such performance-based standards and outcomes. The Secretary of the Office of Policy and Management may consult with the Commission on Children to identify academic, private and other available funding sources and may accept and utilize funds from private and public sources to implement the provisions of this section.

[(h)] (i) For purposes of this section, the Secretary of the Office of Policy and Management, or the secretary's designee, shall be responsible for coordinating all necessary activities, including, but not limited to, scheduling and presiding over meetings and public hearings.

[(i)] (j) The council shall terminate on June 30, 2015.

Sec. 4. Section 17b-16 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

The Labor Department, in cooperation with the Department of Social Services, shall provide information and assistance in obtaining, within available appropriations, the federal earned income credit established pursuant to 26 USC 32, to each applicant for or recipient of assistance from the department. The Labor Department, in cooperation with the Department of Revenue Services, shall promote the earned income credit program to recipients of benefits pursuant to section 17b-112. The Department of Social Services, in consultation with the Child Poverty and Prevention Council established in section 4-67x, as

amended by this act, shall, within available appropriations, promote greater utilization of the federal earned income credit to municipalities, public and private employers, community-based organizations and other entities that have frequent contact with low-income families and shall enhance financial literacy and self-sufficiency programs. School and business partnership funds, private funds and other available funds may be used for purposes of this section.

Sec. 5. Sections 4-67t, 4-67u and 4-67w of the general statutes are repealed.  
(*Effective October 1, 2006*)

Approved June 9, 2006

## APPENDIX B

### COUNCIL MEMBERS

Robert L. Genuario, Chair  
Secretary  
Office of Policy and Management

Valerie Lewis  
Commissioner  
Department of Higher Education

George Coleman  
Interim Commissioner  
Department of Education

Mary Marcial  
Director of Programs  
Department of Correction

Patricia Downs  
Executive Director  
Department of Economic and  
Community Development

John McCarthy  
Legislative Liaison  
Department of Labor

Darlene Dunbar  
Commissioner  
Department of Children and Families

Mary Mushinsky  
State Representative  
Connecticut General Assembly

Karen Foley-Schain  
Executive Director  
Children's Trust Fund

Andrew Norton  
Chief of Staff  
House Republican Office

Norma Gyle  
Deputy Commissioner  
Department of Public Health

Peter O'Meara  
Commissioner  
Department of Mental Retardation

MaryAnn Handley  
State Senator  
Connecticut General Assembly

Raymond Pech  
Assistant Director  
Commission on Human Right and  
Opportunities

Dennis King  
Manager of Community Advocacy  
Department of Transportation

Barbara Quinn  
Judge  
Superior Court

Thomas Kirk  
Commissioner  
Department of Mental Health and  
Addiction Services

Catherine Sarault  
State Republican Office  
Connecticut General Assembly

Cristine Vogel  
Commissioner  
Office of Health Care Access

Faith VosWinkel  
Assistant Child Advocate  
Office of Child Advocacy

Patricia Wilson-Coker  
Commissioner  
Department of Social Services

Elaine Zimmerman  
Executive Director  
Commission on Children

**Child Poverty and Prevention Council Staff:**

Anne Foley  
Senior Policy Advisor  
Office of Policy and Management

Pamela Trotman  
Planning Specialist  
Office of Policy and Management

## Appendix C

### State Agency Work Group

Marybeth Bonadies  
Director of Research and Planning  
Office of Health Care Access  
860-418-7014  
[marybeth.bonadies@po.state.ct.us](mailto:marybeth.bonadies@po.state.ct.us)

Lisa Davis  
Section Chief  
Department of Public Health  
860-509-8074  
[lisa.davis@po.state.ct.us](mailto:lisa.davis@po.state.ct.us)

Patricia Downs,  
Executive Director  
Department of Economic Community  
Development  
860-270-8160  
[patricia.downs@po.state.ct.us](mailto:patricia.downs@po.state.ct.us)

Anne Foley, Chair  
Senior Policy Advisor  
Office of Policy and Management  
860-418-6268  
[anne.foley@po.state.ct.us](mailto:anne.foley@po.state.ct.us)

Karen Foley-Schain  
Executive Director  
Children's Trust Fund  
860-418-8763  
[karen.foley-schain@po.state.ct.us](mailto:karen.foley-schain@po.state.ct.us)

JoAnn Freiberg  
Consultant for School Climate,  
Character Education and Bullying  
State Department of Education  
860-807-2041  
[joann.freiberg@ct.gov](mailto:joann.freiberg@ct.gov)

Sylvia Gafford-Alexander  
Project Director  
Department of Social Services  
860-424-5058  
[sylvia.gafford-alexander@po.state.ct.us](mailto:sylvia.gafford-alexander@po.state.ct.us)

David Guttchen  
Director of Policy Development and  
Planning Division  
Office of Policy and Management  
860-418-6286  
[david.guttchen@po.state.ct.us](mailto:david.guttchen@po.state.ct.us)

Mary Marcial  
Programs and Treatment Director  
Donna Cupka (for Mary Marcial)  
Department of Correction  
860-692-7493  
860-692-6831  
[mary.marcial@po.state.ct.us](mailto:mary.marcial@po.state.ct.us)  
[donna.cupka@po.state.ct.us](mailto:donna.cupka@po.state.ct.us)

John McCarthy  
Legislative Liaison  
Department of Labor  
860-265-6524  
[john.mccarthy@po.state.ct.us](mailto:john.mccarthy@po.state.ct.us)

Karen Ohrenberger  
Director  
Department of Mental Health and  
Addiction Services  
860-418-6900 / 860-418-6826  
[Karen.ohrenberger@po.state.ct.us](mailto:Karen.ohrenberger@po.state.ct.us)

Julia O'Leary  
Deputy Director of Regional Services  
Connecticut Judicial Branch  
860-721-2186  
[Julia.oleary@jud.ct.gov](mailto:Julia.oleary@jud.ct.gov)

Deanna Paugas-Lia  
Director of Prevention  
Department of Children and Families  
860-550-6637  
[Deanna.paugas-lia@ct.gov](mailto:Deanna.paugas-lia@ct.gov)

Christine Pollio  
Legislative Affairs  
Department of Mental Retardation  
860-418-6066  
[Christine.pollio@po.state.ct.us](mailto:Christine.pollio@po.state.ct.us)

Jon Swift  
Office for Workforce  
Competitiveness  
860-258-4302  
[jon.swift@po.state.ct.us](mailto:jon.swift@po.state.ct.us)

Pamela Trotman  
Planning Specialist  
Office of Policy and Management  
860-418-6359  
[Pamela.trotman@po.state.ct.us](mailto:Pamela.trotman@po.state.ct.us)

**APPENDIX D**

**STATE OF CONNECTICUT**

**AGENCY PREVENTION REPORT**

November 2006



**A REPORT TO THE CHILD POVERTY AND PREVENTION  
COUNCIL**

## **I. Background**

### **State Prevention Council**

The State Prevention Council was created under Public Act 01-121, An Act Concerning Crime Prevention and a State Prevention Council to evaluate and promote prevention work in the State of Connecticut. In essence, the mandate was to establish a prevention framework for the state, develop a comprehensive state-wide prevention plan, offer recommendations to better coordinate existing and future prevention expenditures across state agencies and increase fiscal accountability.

The Council met regularly to ensure that the requirements of the public act were implemented in a comprehensive manner. The membership of the Council included representatives from the Office of Policy and Management, the Chief Court Administrator, and the Commissioners of the departments of Children and Families, Education, Mental Health and Addiction Services, Mental Retardation, Public Health and Social Services.

One of the main tasks of the Prevention Council was the development of a statewide prevention plan. The Council conducted research, analysis and deliberated extensively during the planning and development phase of the plan. The plan included four major recommendations that served to advance formation of comprehensive approaches for prevention within the state. The recommendations were to:

- increase public awareness of the value of prevention
- strengthen state and local networks involved in prevention
- improve data collection on prevention programs
- share and implement best practices

The Council strongly felt that these recommendations when implemented would provide the Council with the information and tools necessary to effectively evaluate and analyze prevention initiatives in the state and set priorities for future prevention programming. The State Prevention Plan was submitted to the General Assembly in 2003.

As stipulated in the public act, the Governor's 2003-2005 Biennium Budget packet included a prevention report with recommendations for appropriations for primary prevention services administered by state agencies that served on the State Prevention Council. The report was released in February 2003.

In 2003, the legislature enacted Public Act 03-145, An Act Concerning the State Prevention Council and Investment Priorities, which required the Council to continue its work to implement its recommendations to foster the development and implementation of a comprehensive and coordinated statewide system of prevention in Connecticut. Implementation of these recommendations served to increase the awareness of the value of prevention. In January 2004, the Prevention Council's progress report was submitted to the General Assembly. This report

highlighted statewide prevention initiatives within the policy domains of Early Childhood Development and Youth Development and its relationship to the four recommendations.

In accordance with the stipulations set forth in the public act, the Council submitted its final prevention report in March 2004. The report highlighted the accomplishments and outcomes for statewide prevention initiatives.

### **Child Poverty Council**

In the Spring of 2004, the Connecticut legislature enacted Public Act 04-238, An Act Concerning Child Poverty establishing a Child Poverty Council. The Council was charged with recommending strategies to reduce child poverty in the State of Connecticut by fifty percent (50%) within ten years.

The legislation required that the Council consist of the following members or their designees: the Secretary of the Office of Policy and Management, the President Pro Tempore of the Senate, the Speaker of the House of Representative, the Minority Leader of the Senate and the Minority Leader of the House of Representatives, Commissioners of the Department of Children and Families, Education, Higher Education, Labor, Mental Health and Addiction Services, Mental Retardation, Public Health, Social Services, Corrections, Transportation, Economic and Community Development, Health Care Access, and Child Advocate, chairperson of the State Prevention Council, Executive Director of the Children's Trust Fund, the Executive Director of the Commission on Children, and the Commission on Human Rights and Opportunities.

The Council engaged in numerous strategies to gather the appropriate data to assist in the formation of its recommendations. To that end, the Council presented its first report to the Legislature in January 2004. The report contained 67 recommendations to reduce child poverty in Connecticut by fifty percent over a ten year period. The recommendations were organized under six major objectives:

- enhance families' income and income-earning potential;
- help low income families build assets;
- enhance affordable health care, housing, child care and early childhood education;
- support safety net programs for families with multiple barriers;
- enhance family structure stability; and
- further study child poverty issues and solutions.

In July 2005, the legislature enacted Public Act 05-244, An Act Concerning the Implementation of the Recommendations of the Child Poverty Council. This public act made the executive director of the Commission on Human Rights and Opportunities a member of the Child Poverty Council and required the Council to meet at least twice a year to review and coordinate state agency efforts to meet the goal of reducing child poverty by 50% by June 30, 2014. The Council's annual implementation reports to the legislative committees included progress made toward meeting this goal. The Council continued its work to develop strategies to implement, monitor and report on the implementation of the recommendations.

It is important to note that a number of the Council's recommendations were proposed by Governor Rell and enacted by the legislature in FY 2006-07.

In January 2006, the Child Poverty Council submitted a report on progress made towards the implementation of the plan to meet the child poverty reduction goal and the extent to which state actions were in conformity with the plan.

### **Child Poverty and Prevention Council**

In June 2006, the Connecticut legislature enacted Public Act 06-179, An Act Concerning State Investments in Prevention and Child Poverty Reduction and the Merger of the State Prevention and Child Poverty Councils.

This public act requires the newly formed Child Poverty and Prevention Council (CPPC) to adhere to provisions of the previous councils and imposes additional responsibilities relating to prevention services. The CPPC is comprised of members from both the Child Poverty and State Prevention Councils. In 2006, the Chief Administrator was added to the Council.

The public act directs the Child Poverty and Prevention Council to:

- Establish prevention goals, recommendations and measure prevention service outcomes to promote the health and well-being of children and their families.
- Report to the Governor and various legislative committees on the state's progress in prioritizing expenditures for prevention services in budgeted state agencies with membership on the council including:
  - Summarizing measurable gains made toward the child poverty and prevention goals established by the CPPC.
  - Providing examples of successful interagency collaborations to meet the child poverty and prevention goals established by the CPPC.
  - Recommending prevention investment and budget priorities.

The public act also requires each state agency with membership on the council that provides prevention services to children and families to submit an agency prevention report to the CPPC by November 1, 2006 and November 1, 2007 and must be included in the Council's report to the Governor and legislature. Each agency report must include at least two prevention programs.

This report represents the first State Agency Prevention Report in response to the legislative reporting requirement cited above.

## **II. Development of State Agency Prevention Reports**

In July 2006, OPM convened a subcommittee meeting with representation from each of the state agencies represented on the CPPC. The purpose of the meeting was to discuss reporting requirements, responsibilities of subcommittee members and the process for submission of the state agency prevention reports. Agencies participating were: the Office of Policy and Management, Departments of Children and Families, Education, Higher Education, Labor, Mental Health and Addiction Services, Mental Retardation, Public Health, Social Services, Corrections, Transportation, Economic and Community Development, Office of Workforce Competitiveness, Children's Trust Fund, Judicial Branch, and the Office of Health Care Access.

At the initial subcommittee meeting, OPM proposed an overall approach for the development of the state agency prevention report, which was adopted by subcommittee members. Each agency represented on the Council designated one staff person to serve as the single point of contact for their agency. The contact person distributed all requests for information from OPM to the appropriate division within their agency and forwarded the responses to OPM.

For the purpose of this report, the subcommittee agreed to use the definition of prevention found in the public act:

*Prevention means policies and programs that promote healthy, safe and productive lives and reduce the likelihood of crime, violence, substance abuse, illness, academic failure and other socially destructive behaviors.*

This definition spans multiple fields and encompasses many types of prevention services. In an effort to focus the scope of the agency's prevention report, the subcommittee agreed to refine this broad definition and report on primary prevention programs that serve children 0-18 and their families. Primary prevention refers to programs designed to prevent or eliminate at risk behavior before a problem occurs and promotes the health and well-being of children.

OPM developed and distributed to the state agencies a report form to capture all relevant prevention data needed to complete the prevention report.

## **III. State Agency Reports**

This section of the report represents an array of primary prevention services that provide intensive, comprehensive and family-centered resources and support that reduces or eliminates high risk behavior and promotes the health and well-being of children and families. Each state agency was given the option to select and report on two or more primary prevention programs that positively impact children aged 0-18 and their families.

Each report includes the following:

- a brief description of the purpose of prevention programs
- the number of children and families served

- long-term goals, strategies and outcomes to promote the health and well being of children
- a statement on the overall effectiveness of prevention within the agency
- methods used to reduce disparities in child performance and outcomes by race, income level and gender

The departments of Corrections, Labor, Higher Education, Economic and Community Development, Office of Health Care Access, Office of Workforce Competitiveness, and the Judicial Branch, determined that their prevention programs did not meet the definition of primary prevention, and therefore, no reports from these agencies are included in this report.

The state agency prevention programs included in this report are as follows:

**Children’s Trust Fund**

Sex Abuse Project  
 Family Empowerment Initiative  
 The Help Me Grow Program  
 The Kinship and Grandparent Respite Fund  
 Nurturing Families Network  
 The Parent Trust Fund  
 Shaken Baby Syndrome Prevention Project

**Department of Children and Families**

Positive Youth Development Initiative  
 Youth Suicide Prevention  
 Shaken Baby Syndrome Prevention Project

**Department of Education**

Even Start  
 Family Resource Centers  
 Early Childhood Programs/School Readiness  
 Head Start Services & Enhancement

**Department of Mental Health and Addiction Services**

Best Practices Initiative  
 Local Prevention Council Programs

**Department of Mental Retardation**

Family Supports  
 Birth to Three

**Department of Public Health**

Captain 5 Day Nutrition Education  
 Immunization Program

**Department of Social Services**

Fatherhood Initiative  
 Family Supportive Housing

**Office of Policy & Management**

Norwich Reintegration Education  
 Neighborhood Youth Center

## Children's Trust Fund

**Program Name:** Sexual Abuse Project

**Program Description:** This pilot program trained teachers in every school in East Hartford and spoke with hundreds of parents and others interested in preventing childhood sexual abuse. The Child Sexual Abuse Prevention Project at ChildPlan, Inc. grew out of the work of the Trust Fund's Childhood Sexual Abuse Prevention Coalition in 2003. The project builds upon the work of the coalition by developing strategies to prevent child sexual abuse by focusing on involving adults throughout the community in these efforts.

**Number of children and families served:** 425 professionals and 400 parents were served during 2005- 2006.

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**Program Name:** Family Empowerment Initiatives

**Program Description:** Family Empowerment Initiatives include 8 prevention programs that assist high-risk groups of parents with children of various ages. The programs are co-located in various settings including a school, a substance abuse center, a prison, a domestic violence shelter, a child guidance center and a public housing project where families may be addressing other issues.

These programs help families to address a whole range of issues including parenting and family relationships.

**Number of children and families served:** 647 children and families were served during 2005 – 2006.

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**Program Name:** The Help Me Grow Program

**Program Description:** The Help Me Grow Program is a prevention initiative that identifies and refers young children with behavioral health, development and psychosocial needs to community-based services. The program bridges the gap between children with early signs of developmental problems and the services designed to address them. The program serves children who may not be eligible for the state's Birth to Three or preschool special education programs, yet are still at risk for developmental problems.

**Number of children and families served:** 9,345 children and families served since January 1, 2000.

**Program Name:** The Kinship and Grandparents Respite Fund

**Program Description:** The Kinship and Grandparents Respite Fund awards small grants to orphaned or abandoned children and the court-appointed relative guardians they live with. The

Trust Fund provides funding to eight probate courts to administer the program. The grants provide for a range of activities including tutoring, camp, fees for a variety of programs and extra-curricular experiences, clothing, eyeglasses and other basic necessities and respite for the caregivers.

**Number of children and families served:** 2,018 children and families serviced from July 5, 2005 through June 6, 2006.

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**Program Name:** Nurturing Families Network (NFN)

**Program Description:** This program operates out of 25 of the twenty-nine birthing hospitals in the state and in 10 community centers in the city of Hartford. NFN provides education and support for all interested new parents and intensive home visiting services for parents identified as most at risk. The NFN reaches more than 4,000 first time families each year and has offered home visiting services to approximately 3,243 vulnerable families at risk of abusing, neglecting or abandoning their children. The program is expanding to eight neighborhood service areas in the City of New Haven and is expecting to reach an additional 250 vulnerable families through its home visiting services. The home visitors become involved during the mother's pregnancy and continue working with the family, on average, for nineteen months. The home visitors teach child development and help the family to bond with and take hold of their responsibility to their child. Seventy percent (70%) of the time fathers are involved. Home visitors support the parent to finish school, to secure a job, and to find and utilize the services of a pediatrician. They connect families to WIC, and to counselors and others in the community who can help. The Network also offers intensive group support to parents and extended family members. The program teaches the family appropriate expectations for their children and fosters empathetic understanding and strategies for enhancing the well being of children. Approximately 600 families have participated in the Nurturing Program each year.

**Number of children and families served:** 24,155 children and families served since the program began.

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**Program Name:** The Parent Trust Fund

**Program Description:** The Parent Trust Fund provided 29 grants to offer classes to parents to help improve the health, safety and education of children by training parents in leadership skills and by supporting the involvement of parents in community affairs.

**Number of children and families served:** 577 parents were served during 2005 – 2006.

**Program Name:** Shaken Baby Syndrome

**Program Description:** The Shaken Baby Prevention project trained hospital based medical professionals and community service providers throughout Connecticut on integrating a national

model of prevention into their practice. The training program has been widely accepted into many local high schools' health and well-being curriculum. Three regional trainers provide outreach, education and support to the community on preventing shaken baby syndrome.

**Number of children and families served:** 550 participants have attended presentations during 2005-2006.

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**Long-Term Agency Goals:** The goal of the Children's Trust Fund is to prevent child abuse and neglect and to ensure the positive development of children.

The funds appropriated to the Children's Trust Fund are used to support community efforts that assist families. The community programs are designed to engage families before a crisis occurs – to actually keep abuse and neglect from happening.

This strategy is working. The programs supported by the Children's Trust Fund are making a difference in the lives of children and their parents while reducing the number of families that enter the state child welfare system.

**Strategies:** To achieve its goal the Trust Fund:

- Conducts research to better understand and assess areas of risk for child abuse and neglect, finds the most effective ways to assist families, and develops strategies for improving the skills of service providers.
- Funds broad-based prevention efforts in communities that have been shown to address known risk factors for child abuse and neglect, including poverty, substance abuse, domestic violence, and social isolation.
- Funds programs that include a strong focus on matters that effect the well being of children including improving parent-child bonding and interaction, parenting skills and family relationships, healthy living and health care access, and developmental monitoring.
- Offers a range of program services to meet the needs of all families.
- Trains human services staff in prevention approaches and strategies to engage and assist culturally diverse and vulnerable families.
- Supports a network of agencies that work together to support families around their multiple needs.
- Increases public awareness and participation in efforts to prevent child abuse and neglect.

**Outcomes:**

- Reduced rate and severity of child abuse and neglect
- Improved parent –child interaction and parenting skills
- Connection to health care providers, high immunization rates
- Gains in household stability, education, employment
- Less financial hardship, access to more resources
- Enhanced family relationship and parent well-being
- Increases in developmental monitoring and access to services

- Enhanced child well being over time.

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

- The incidence and severity of child abuse and neglect in the high-risk families served by the Trust Fund is much less than expected.
- The evaluation on its Nurturing Families Network (NFN) shows the incidence of abuse and neglect to be well below that of high-risk families not participating in this type of program; 3% compared to 19%.
- The immunization rate for two-year old children whose families are involved in the program is 93% compared to 73% for two years olds with similar demographic background on Medicaid.
- A significant percentage of the parents are completing high school, becoming employed and moving out of financial hardship.
- The percentage of mothers establishing independent households increased from 53% to 93% in the second year of program involvement. This is a significant outcome, likely to ensure the future safety of children, given the high number of mothers who were living in abusive or violent or potentially violent households at the start of their program involvement.
- Families are also improving parent-child relationships as well as parenting capacity, attitudes and behavior.

Other research on home visiting shows that the early intervention reduces rates of tobacco and alcohol use, episodes of running away, behavioral problems, arrests, convictions, and sexual promiscuity among teenagers whose families had been reached in this way.

Research on other Trust Fund efforts have found that health care providers have increased their use of developmental surveillance and referrals of at risk youth following training.

**Methods:** The Trust Fund uses intensive home visiting, developmental surveillance and early identification of developmental delays and behavioral problems, and parent engagement to reduce racial and economic disparity.

**Intensive multi-focused home visiting:**

Several studies have found that home visiting services reduce disparities in child performances and outcomes by race and income level.

One study, conducted by the Missouri Department of Elementary and Secondary Education, found that children enrolled in preschool - whose families participated in a home visiting program - scored significantly higher on all measures of intelligence, achievement, and language ability than children in the comparison group whose families did not receive home visiting services.

The parents who participated in the home visiting program were mostly young, poor, undereducated, single heads of household. Their children shattered the conventional wisdom that they would perform poorly in school. The children did as well as the national norm for children their age - with roughly 15% exceeding the national norm. The children out performed a comparison group of children from wealthier and more stable families not considered at risk for poor outcomes (study available upon request).

How does Help Me Grow reduce disparities by race, income level and gender...?

The National Research Council's report *Neurons to Neighborhoods* (Shonkoff and Phillips, 2000) and RAND's analysis of early childhood interventions, *Investing in Children*, (Karoly et al, 1998) indicate that high quality early intervention programs can have very positive results for those children receiving services. These included increases in short and long term academic achievement, reduction in grade retention rates, and reductions in special education referrals and reduction in teenage pregnancy.

The Help Me Grow program offers universal access to anyone in Connecticut who has concerns about their child's learning, behavior or development. Thousands of families have been connected to critical early intervention programs. Help Me Grow provides training to child health providers on developmental screening and connection to services. The Help Me Grow staff has visited over 50% of Connecticut's pediatric and family practices. Based on this research project, funded through the Commonwealth Fund, referrals for early intervention have doubled. In addition, Connecticut is the only state that provides universal access to an on-going child development monitoring system called *Ages & Stages*. Anyone in the state can access this free service.

**Other:** Child abuse and neglect is at the root of many of the problems children face. Children who are abused or neglected are at high risk for developmental and behavioral problems, health issues, learning disabilities and cognitive delays.

Abused or neglected children are more likely to become involved with the child protection and juvenile justice systems and to become involved with the departments of Social Services, Corrections and Mental Health as adults.

Children fare best when they are nurtured by parents who provide for their needs and help through difficult times growing up. And yet we find that most of the families who participate in Trust Fund programs are ripe for a crisis. More than half of the parents served were abused themselves as children, most are poor and have a limited education and more than half are teenagers – who are just growing up themselves.

As a result, many of the mothers are having difficulty bonding with their babies and meeting the needs of their infants. In Connecticut there are thousands more families who struggle with the demands of parenting and who are in the high range for abuse potential.

It is critical that families are reached before a crisis occurs. Child abuse and neglect must be prevented.

While prevention is a relatively new field, research demonstrates that the strategies employed by the Children's Trust Fund can help more families and more children have a better life. By preventing child abuse and neglect we have a better chance of keeping children safe in their homes, able to perform well in school and have a productive future.

### **Department of Children and Families**

**Program Name:** Positive Youth Development Initiative

**Program Description:** The Department funds 6 agencies, all using evidence-based or best practice models, to provide positive youth development and family strengthening programs. The Bureau staffs bimonthly technical assistance meetings. An independent evaluator is assisting the Department, in partnership with the providers, to develop common outcomes for this initiative, gather data and monitor effectiveness.

**Number of children and families served:** Approximately 803 children and their families were served in SFY 2005-2006.

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#### **Long-Term Agency Goals:**

- An increase in the social-emotional skills of children through a universal prevention program/strategy;
- An increase in support and opportunities for young people through enrichment and/or recreation;
- An increase in bonding of children to their parents, school and peers; and
- An increase in the engagement of/and communication with families.

**Strategies:** The Positive Youth Development Initiative promotes approaches that help young people grow into competent, healthy adults by providing them with opportunities to build skills, help their communities, and form healthy relationships with others. The youth development approach defines goals or outcomes, based on the capacities, strengths, and developmental needs of youth. Therefore youth must be included in any planning sessions, committees or coalitions that are going to make decisions directly affecting them. Similarly the diversity of gender, culture, ethnicity, religion, economic status, etc. in the target group must be recognized and represented in the planning process.

**Outcomes:** Increase student and parental life skills thereby reducing risk level and increasing the probability of youth success in school and future endeavors through the sustained implementation of universal and indicated evidence-based prevention programs for youth and families statewide. This is a new initiative and possible outcomes are yet to be determined.

The possible outcomes under discussion within the agency include the following:

- Completion/graduation from program
- Decrease in drug use / delayed initiation of use
- Decrease in aggression/ violence
- Increase in positive peer network
- Increase in internal locus of control for youth and parents
- Increase in knowledge of & ability to identify and control moods including anger
- Increase in young persons' self-efficacy
- Increase in school bonding
- Improvement in attendance
- Improvement in graduation rate
- Improvement in grades
- Decrease in DCF involvement
- Increase in youth involvement in their "passion"
- Increase in parental skills (e.g., coping, monitoring, communication, discipline) and their application
- Increase in parental involvement with school
- Increase in help-seeking behavior by youth and parents
- Decrease in perceived isolation by families

**Measure of Effectiveness:** One measure is the integration of prevention throughout the Department. DCF Prevention Liaisons have been established in all Area Offices and facilities and meetings are held monthly.

**Methods:** All services must be provided in a context that is child centered, family-focused, strength based and culturally competent.

**Program Name:** Suicide Prevention

**Program Description:** CT Youth Advisory Board was legislatively established in 1989 within the Department of Children & Families. The membership is comprised of volunteers, community and state agency representatives with the goal of preventing suicide among children & youth. This goal is accomplished through statewide awareness campaigns and training.

**Number of children and families served:** 271 people were trained in SFY 2005-2006.

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**Long-Term Agency Goals:**

- Increase public awareness of the existence of youth suicide and means of prevention;
- Make recommendations to the Commissioner of the Department of Children and Families for the development of state-wide training in the prevention of youth suicide;
- Develop a strategic youth suicide prevention plan;
- Recommend interagency policies and procedures for the coordination of services for youth and families in the area of suicide prevention;
- Make recommendations for the establishment and implementation of suicide prevention procedures in schools and communities;
- Establish a coordinated system for the utilization of data for the prevention of youth suicide;
- Make recommendations concerning the integration of suicide prevention and intervention strategies into other youth focused prevention and intervention programs

**Strategies:**

**Promote Awareness That Suicide Is Preventable and That Mental Health Is Important To Overall Health**

- Promote a public awareness campaign that promotes the adult role in facilitating the mental health of children and youth
- Use non-traditional service providers and community partners to develop appropriate messages and strategies to reach diverse populations
- Enhance and facilitate training for children and youth, parents and caregivers, professionals on child development, substance abuse, coping skills, life skills, mental health issues, conflict resolution, competition and stress relieving strategies
- Promote awareness among adults of key male and female methods of suicide attempts and completions among children and youth
- Promote awareness of issues specific to children and youth who may be victimized by their peers because they are perceived to be not acceptable.

### **Promote, Develop and Implement Effective Prevention Strategies**

- Facilitate more early mental health prevention and intervention such as early childhood services and specialized nursery schools
- Encourage providers to discuss firearm safety with caregivers and include in client assessment
- Promote participation of schools and local agencies in local systems of care
- Expand after school and other positive youth activities
- Increase awareness of the significance of self-mutilating and cutting behaviors among children and youth.

### **Promote Improved Access to Behavioral Health Care**

- Conduct rapid assessment and planning of care for children, youth and their caregivers
- Ensure that clinical care is provided in the least restrictive environment
- Ensure timely access to behavioral health care
- Provide increased community-based services
- Reduce over-utilization of out of home care
- Promote system changes to expand the scope of services in schools
- Assess utilization of school-based mental health and substance abuse services
- Ensure that caregivers and gatekeepers are educated about Husky and Medicaid coverage for children and youth

### **Promote the Provision of Quality Behavioral Health Care**

- Promote support of the appropriate use of clinical behavioral health interventions prior to the use of psychotropic medications
- Increase knowledge of the efficacy of the use of multiple psychotropic medications in children
- Increase collaboration between state agencies- education, public health, mental health and addiction services, judicial, children and families, mental retardation and social services
- Maintain and implement measures to ensure family/caregiver input is solicited, respected and heeded at the treatment, planning and evaluation level
- Develop and implement effective transition plans with participation of parents/caregivers and community service providers.

**Outcomes:** Through the work of the Interagency Suicide Prevention Network, the state now has a five-year plan in place. We are now entering the implementation stage. Of the above referenced strategies, the Board has identified four to be the focus for the coming year and outcomes measures will be aligned with these. These four are:

- Enhance and facilitate training for children and youth, parents and caregivers, professionals on child development, substance abuse, coping skills, life skills, mental health issues, conflict resolution, competition and stress relieving strategies
- Promote participation of schools and local agencies in local systems of care
- Ensure timely access to behavioral health care

- Increase collaboration between state agencies- education, public health, mental health and addiction services, judicial, children and families, mental retardation and social services

**Measure of Effectiveness:** One measure is the integration of prevention throughout the Department. DCF Prevention Liaisons have been established in all Area Offices and facilities and meetings are held monthly.

**Methods:** Cultural competency is incorporated into the designing and implementation of all training and awareness campaigns. Target populations for training include high risk groups such as Gay, Lesbian, Bisexual and Transgender youth.

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**Program Name:** Public Awareness Campaign; Training of DCF workers and providers on strategies to calm crying babies and stop toddlers' temper tantrums and educate young people in the Department's facilities about the dangers of shaken baby syndrome.

**Number of children and families served:** Training was provided on baby calming strategies to over 400 providers and 100 parents. Technical assistance was provided and audio-visual materials were provided to the Department's four facilities in order to develop prevention education for young people in the Department's care.

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**Long-Term Agency Goals:**

- Reduce the incidence of shaken baby syndrome
- Increase the bonding of parents and young children.

**Strategies:** Since crying is a known trigger for shaken baby syndrome, the Department is working to disseminate baby calming strategies to the general population, and in particular to parents who may be at greater risk for the perpetration of shaken baby syndrome.

**Methods:** In partnership with the Department's Research Scientist feasible outcomes are being developed.

**Measures of Effectiveness:** Resources were unavailable to conduct a formal evaluation of the series of trainings conducted in the Spring of 2005. However, very positive anecdotal information has been received from both DCF staff and community providers regarding the use of these strategies with their clients after attending the training.

**Methods:** Simultaneous translation in Spanish was available for the parents' training

## Department of Education

**Program Name:** Even Start Family Literacy Program

**Program Description:** Even Start provides intensive “family literacy services” to help break the cycle of poverty and illiteracy by improving the educational opportunities of low-income families by integrating early childhood education, adult literacy or adult basic education and parenting education into a unified family literacy program.

Even Start is contained as part of Title I, Part B Subpart 3 of the Elementary and Secondary Education Act (ESEA) reauthorized as the “No Child Left Behind Act of 2001” Public Law 107-110.

**Number of children and families served:** 238 Children and 194 Families for fiscal year 2005-2006.

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**Program Name:** Family Resource Centers

**Program Description:** Family Resource Centers are based on the "Schools of the 21st Century" concept, as developed by Dr. Edward Zigler, Director of the Zigler Center in Child Development and Social Policy at Yale University. This concept envisions comprehensive, integrated, community-based systems of family support and child development services located in public school buildings. By strengthening effective family management practices and establishing a continuum of childcare and support services for parents and children in need, Family Resource Centers work to provide the best possible start for all children and families regardless of race, ethnicity, and socio-economic status. Centers provide a common location for families to take advantage of a range of services, which can be tailored to meet the unique needs of families from diverse backgrounds and cultures.

**Number of children and families served:** 18,416 (average number of families enrolled monthly)

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**Program Name:** Early Childhood Program (School Readiness)

**Program Description:**

- To significantly increase the number of accredited and/or approved spaces for young children in order to provide greater access to high-quality programs for all children;
- To significantly increase the number of spaces for young children to receive full-day, full-year child care services to meet family needs and to enable parents to become employed;

- To establish a shared cost for such early care and education programs among the state and its various agencies, the communities and families and;
- To enhance the quality of programs providing school readiness or child day care services.

**Number of children and families served:** The number of children served in priority and competitive districts combined for the 2005/2006-grant year is 7,525 children. It is unknown how many families were served.

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**Program Name:** Head Start Services and Enhancements

**Program Description:** Head Start is a federally funded program that is supplemented by the state. It is a comprehensive program that serves children 3-5 and their families. It is a child focused and family centered program that has the overall goal of increasing the social competence of young children in low-income families. Social competence means the child's everyday effectiveness in dealing with his or her present environment and later responsibilities in school and life. Head Start offers opportunities and support for families to grow and change based on their strengths, needs and interests. State funding provides more parents opportunities to work, attend education and/or job training programs to help them attain self-sufficiency. The state supplement increases the number of children who attend Head Start programs, the number of children who have the opportunity to attend full-day and full-year programs and extended-day and extended-year programs. It provides increased opportunities for children to enhance their language, literacy and mathematical skills.

**Number of children and families served:** 6,628 children (and their families which are not counted in this number)

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### **Long-Term Agency Goal**

*The narrative below represents draft language developed by The Connecticut State Board of Education for a five-year (2006 – 2011) comprehensive plan for education. Included is the “implementation plan with appropriate goals and strategies to achieve resource equity and equality of opportunity, increase student achievement, reduce racial, ethnic and economic isolation, improve effective instruction, and encourage greater parent and community involvement in all public schools of the state.” The vision is to create “a superior education for Connecticut’s 21<sup>st</sup> century learners.” Final approval of this draft plan is expected in the fall 2006. The narrative language below reflects the proposed wording.*

Working with the education community, the State Board of Education has put forth a vision and a mission for public education in Connecticut, and has identified seven core values that reflect its beliefs and form the basis for an organizational structure and culture that will strengthen State Department of Education employees' interactions and relationships with all internal and external colleagues. The seven core values listed below are embedded in the Board's vision and mission

and will guide the entire education community as it works to achieve the Board's goals and objectives:

*Collaboration:* We work in meaningful partnerships to learn, to make decisions, and to share information, talents and energy to achieve our goals.

*Diversity:* We value, actively pursue and are strengthened by diverse perspectives. Our varied cultural backgrounds, beliefs and points of view are essential to achieve our mission.

*Innovation:* We generate and support new ideas and approaches that achieve individual and organizational excellence.

*Integrity:* We are honest, ethical and respectful.

*Leadership:* We advocate for and advance our vision. We inspire and empower our colleagues to achieve it.

*Responsibility:* We are dedicated to individual and organizational performance that builds and maintains public trust and confidence. We are accountable for fulfilling our commitments and expectations.

*Responsiveness:* We are timely, thorough and accurate.

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## **Long-Term Agency Goal # 1**

Goal: Increase student achievement.

Student achievement is directly related to high quality instruction. The student achievement gaps in Connecticut are unacceptable. There are gaps between genders, racial, ethnic and socioeconomic groups, as well as gaps in expectations for students from differing backgrounds. We must expect all students to achieve at high levels and make certain that expectations for students and rigor of curriculum are equal in urban, suburban and rural schools. We will increase student achievement by working with our state, federal and local partners. We must ensure in Connecticut that our definition of achievement extends beyond core subject areas so students can be successful in the 21<sup>st</sup> century.

### **Strategy and Methods**

- Develop and provide model curriculum.
- Review curriculum in low performing districts for rigor and alignment to state standards; require state-approved revisions.

- Provide training on implementation of standards-based model curriculum and monitor implementation of curriculum in low-performing districts.
- Increase training for educators in curriculum and teaching strategies that emphasize contributions and perspectives of different ethnic and cultural groups.
- Increase collaboration/communication with preparation programs to align preparation and pre-service training with research-based standards.
- Provide training on effective instruction to meet needs of all students, including English Language Learners (ELLs) and students with special needs.
- Provide training on the use of technology to meet the needs of all students.
- Develop partnerships with higher education and local entities to recruit and retain diverse educator workforce.
- Promote use of formative assessments as part of all instruction and course offerings.
- Expand alternative routes to certification.
- Explore use of technology to expand access to high quality educators.
- Accelerate recruitment of minority candidates into teaching.
- Convene leadership committee with representative stakeholders to recommend design and content of program.
- Use data from pilot sites at Cooperative Educational Services (CES) and Connecticut Association of Schools (CAS) to provide input for design and content.
- Create repository of test items and electronic delivery systems and analysis system.
- Align test items with model curriculum.
- Provide a data warehouse and tools for analysis.
- Provide technical assistance on analyzing data and using results to improve student achievement.
- Use State Education Resource Center to identify and publicize best practices.
- Collaborate with higher education, high school credential programs and business to define PK-16 student competencies.

- Align Connecticut college placement tests with defined student competencies.
- Incorporate 21<sup>st</sup> century skills and content into curriculum and instruction in middle and high schools.
- Provide guidelines on modifying middle and high schools to meet the needs of students, such as smaller learning communities, alternative schedules, and access to online learning opportunities.

## **Outcomes**

- Provide quality, standards-based, culturally responsive and relevant curriculum for all.
- Ensure educators (teachers and administrators) provide relevant, meaningful and engaging instruction to meet needs of all students.
- Develop and support nontraditional pathways to meet anticipated educator shortages.
- Develop and implement statewide induction program to attract, support and retain high-quality administrators.
- Develop and implement a formative assessment system.
- Assist district and school personnel to collect and analyze data to inform decision-making.
- Implement Vanguard School Improvement Model.
- Ensure students are well-prepared for higher education and the workforce.

## **Measure of Effectiveness**

- Significant increase in number of students in low-performing districts scoring at or above proficiency and goal in reading, writing, math and science.
- Increased proportion of students scoring at or above proficiency and goal on Connecticut Mastery Test and Connecticut Academic Performance Test; decreased gap between subgroup performance.
- Decreased drop-out, expulsion and suspension rates among all subgroups of students.
- Increased graduate rates among all subgroups of students.
- Increased diversity in educator workforce.

- More high quality teachers in every classroom.
- Sufficient numbers of educators to meet shortage areas.
- All new leaders have access to induction program.
- All educators use formative assessments to evaluate students' progress frequently throughout school year.
- All districts have access to and knowledge of resources to analyze formative and summative assessment results and other data to improve instruction.
- All educators have access to repository of best practices.
- More Vanguard Schools.
- More students demonstrate competencies that enable them to successfully transition to higher education or work.
- More students taking science, technology, engineering, math, world language, and advanced courses.
- Increased participation and successful completion of a higher education degree.
- Increased student achievement.

### **Long-Term Agency Goal # 2 and # 3**

Goal: Achieve resource equity and equality of opportunity; reduce racial, ethnic and economic isolation.

These two goals are closely linked. All students should have the same opportunities and access to human, material, and fiscal resources regardless of where they attend school. In addition, each student should have the opportunity to learn from and connect with others of different racial, ethnic and economic backgrounds. The State Board of Education will facilitate greater access to resources and choices; address issues of over-identification of subgroups in special education; foster culturally responsive learning environments; continue magnet school, charter school, and Open Choice programs; and seek expanded funding to fully support these initiatives.

### **Strategy and Methods**

- Increase resources to provide full-day kindergarten, and focus initial efforts to increase capacity in high-need districts.

- Focus initial efforts to serve neediest 3- and 4-year-olds.
- Recruit, prepare and certify high-quality preschool teachers.
- Increase physical space to accommodate additional preschool programs.
- Expand existing student data collection system to include data for all students in public and private preschool programs.
- Develop kindergarten assessment to determine school readiness.
- Evaluate effectiveness of preschool programs.
- Advocate for extended school year and extended school day programs for students who need additional assistance.
- Advocate for before- and after-school programs where extended day programs not available.
- Advocate for summer programs that offer academic and cultural enrichment where extended year not available.
- Provide models for reducing “out-of-school” suspension programs.
- Use state-of-the-art technologies as part of all instructional and course offerings.
- Provide on-line learning opportunities.
- Provide teaching and learning opportunities through Connecticut Education Network (CEN).
- Provide guidance and technical support to districts on components of physically safe and healthy learning environments.
- Promote implementation of Healthy and Balanced Living Curriculum Framework.
- Promote implementation of nutrition, health and behavioral guidelines.
- Provide guidance and technical support to districts on prevention of substance abuse, sexually transmitted diseases and related concerns.
- Provide guidance and technical support to districts on components of emotionally safe and healthy learning environments.

- Promote efforts to provide information and technical support on positive school climate to pre-service and in-service educators.
- Assist districts in increasing and fostering strong personal connections among school community members, especially between adults and students.
- Provide legal guidance to educators and students surrounding Connecticut anti-bullying and sexual harassment legislation.
- Increase number of courses offered and number of schools offering courses.
- Increase funding to pay fees associated with these programs.
- Increase awareness of opportunities for participation and funding.
- Increase program and course offerings, such as Advanced Placement, honors, dual/concurrent enrollment such as UConn, International Baccalaurate.
- Provide information, technical assistance, and professional development.
- Develop relationships with other countries to increase teacher exchange programs.
- Integrate international awareness in subject areas and career development.
- Provide resources through general funding of all educational programs (revised Education Cost Sharing funding formula).

## **Outcomes**

- Provide full-day kindergarten to all.
- Provide quality preschool programs to all.
- Extend opportunities for learning in PK-12 for students in high-needs districts.
- Explore alternatives to meet the needs of underperforming student groups.
- Provide physically safe and healthy learning environments for all.
- Provide emotionally/socially safe and healthy learning environments for all.
- Expand access to all forms of advanced course/program offerings.
- Expand world language and international awareness education instruction across all Connecticut schools to begin in early elementary grades.

- Expand magnet, charter and Open Choice programs.

### **Measure of Effectiveness**

- More high-quality, full-day kindergartens offered in state.
- Increased school readiness.
- Decreased suspension and expulsion rates.
- More students attend preschool; all high-poverty students attend preschool.
- More certified/qualified teachers in preschool settings.
- Comprehensive student database used to track students from preschool through high school.
- More students ready for kindergarten.
- Kindergarten curriculum aligned to Connecticut preschool curriculum framework.
- Decreased preschool expulsion rates.
- More high-needs districts on extended-day and/or extended-year schedule.
- Increased enrollments in summer school programs where extended year not available.
- More students exposed to and engaged in new academic and cultural experiences.
- Increased graduate rates.
- Decreased drop-out, suspension and expulsion rates.
- Increased achievement of *all* students.
- More teachers use effective strategies to meet needs of diverse student population.
- More diverse perspectives that represent multiple points of view emphasized in the curriculum.
- Decreased number of black and Hispanic students identified as special education.
- Increased accommodation of students with diverse learning styles.

- More school communities fully-informed about and protected from physical hazards and allergens.
- More school communities fully-informed about violence prevention (physical).
- More school communities fully-informed about making healthy choices with respect to exercise, nutrition, and life choices about risky and healthy behaviors.
- More school communities fully-informed about strategies to diminish substance abuse and other related risky behaviors.
- More school communities fully-informed and protected from all forms of peer cruelty (male and female bullying behaviors in verbal, emotional, social, intellectual, physical and cyber arenas) and violence prevention.
- More training provided to educators for creating positive and respectful school culture and climate; comprehensive violence prevention and intervention.
- All students have at least one significant adult in school as their advocate.
- More school communities fully-informed about letter and spirit of anti-bullying and sexual/racial harassment legislation.
- Reduction in incidents of bullying and sexual/racial harassment.
- Increased participation of needy students in various forms of advanced courses and programs.
- More students earn “3+” on Advanced Placement examinations.
- More schools offer world languages.
- Increased enrollments in world languages.
- Increased sequence lengths in world languages.
- International competition integrated in career development design.
- Students in all districts to have access to choice programs.

**Long-Term Agency Goal # 4**

Goal: Encourage greater parental and community involvement in all public schools in the state.

The State Board of Education recognizes that education is a shared responsibility throughout a student's life. Schools, families and communities all contribute to student success, and the best results come when all three work together. School-family-community partnerships are formed to support student success and help adults coordinate their efforts to promote learning. The State Board of Education will provide leadership in developing and promoting school-family-community partnership programs that contribute to success for all students. Partnerships must engage multiple community stakeholders and recognize, respect and address families' diverse interests, needs and talents, as well as economic and cultural differences.

### **Strategy and Methods**

- Align pre-service training with National Council for Accreditation of Teacher Education (NCATE) standards on partnering with families and communities.
- Provide professional development to school and district staff in developing effective school-family-community partnerships based on the State Board of Education standards.
- Provide incentives to schools and districts to establish a permanent infrastructure to support Action Teams for Partnerships, which include community organizations, business sector and faith-based groups.
- Provide training and technical assistance for development and implementation of district parent involvement policies.
- Disaggregate data in adult education reporting system to determine number of adult learners who are parents of school-age children and provide access to programs and services.
- Increase capacity of adult education system and Family Resource Centers to meet literacy needs of parents.
- Increase resources to establish parent reading clubs in sites that receive School Readiness funds.

### **Outcomes**

- Engage families and communities meaningfully in success of all students.
- Develop literacy skills of parents; help parents support children's literacy development.

### **Measure of Effectiveness**

- School and district action teams trained for school-family-community partnerships with outcome-oriented action plans.

- Increased parent participation in the planning and improvement of school programs.
- Increased support to parents for supporting children's learning at home.
- Improved district policies and consistent implementation.
- Improved student attendance.
- Increased homework completion.
- Increased attendance at parent-teacher conferences.
- Increased number of parents of children in School Readiness programs that support children's learning and development.
- Increased number of parents with improved literacy skills and high school credentials.

### **Department of Mental Health & Addiction Services**

**Program Name:** Best Practices Initiative

**Program Description:** 13 statewide funded projects that apply science and research-based programs to populations across the life cycle. These science-based community prevention programs are designed to enhance the lives of adults and children and encourage family, peers, neighbors and others to become involved.

Program components usually include education and information, opportunities to develop life and professional skills and individualized service plans. The programs target services to meet the needs or concerns of the population being served and vary in length, intensity, approach and content.

**Number of children and families served:** 6,847

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**Program Name:** Local Prevention Council Programs

**Program Description:** Increase public awareness of Alcohol Tobacco and Other Drugs (ATOD) prevention and stimulate the development and implementation of local prevention activities primarily focused on youth through 120 local municipal and town councils serving the 169 towns and cities in Connecticut.

**Number of children and families served:** 460,376 (this number includes professionals and community members as we are unable to break out the children and families separately.

**Long-Term Agency Goals:**

- Provide cost-effective, research based, developmentally appropriate prevention services that promote the health & well-being of children and families
- Increase partnerships with state and local agencies to develop, implement, evaluate and diffuse effective prevention programs and strategies that focus on youth and families
- Increase the cultural ability of prevention program providers to work effectively with youth and parents from culturally, economically and geographically diverse populations

**Strategies:**

- Fund programs based on needs identified by communities
- Implement program standards to monitor the service system
- Develop partnerships with state and local agencies by participating committees and advisory boards
- Increase funding of evidence-based programs that focus on families, early childhood and youth development
- Assess the prevention needs for youth and families across the state
- Provide training and technical assistance to the DMHAS prevention providers on cultural competency

**Outcomes:**

- Increased number of evidence-based programs that focus on youth and families
- A more refined quality assurance process that assesses effectiveness and fidelity of implementation of prevention programs
- An integrated state plan that supports families and communities in youth and early childhood development
- Increased partnerships with state and local agencies
- Increased number of providers trained and receiving technical assistance on cultural competency

**Measure of Effectiveness:** In the last 3 years the DMHAS Prevention unit has increased by 50% the number of evidence-based programs that focus on youth and their families. With the increase in staff, there were also increases in the number of Prevention partnerships between DMHAS and other state and local agencies. Several plans have emerged from these partnerships, most notably the Early Childhood Partners, Strategic Prevention Framework and a policy recommendation to align substance abuse prevention and social and academic development through school community and family partnerships. The DMHAS Prevention Training Collaborative has also increased the number of courses offered to providers.

**Methods:** DMHAS provides Prevention services aimed at increasing the health & wellness of children and their families through funding and assessing its pool of over 160 non-profit providers statewide. To address disparities, DMHAS contracts with the Multicultural Leadership Institute (MLI), a statewide resource in the provision of cultural competent mental health and substance abuse prevention services to assure that all products, activities and services are culturally competent.

**Other:** Where possible, the DMHAS Prevention unit shares lessons learned and program outcomes and accomplishments with the field at national meetings and conferences.

## **Department of Mental Retardation**

**Program Name:** Birth to Three

**Program Description:** The Department of Mental Retardation is the lead agency (17a-248 C.G.S.) for the Birth to Three program which is also operated under the provisions of Part C of the Individuals with Disabilities Education Act. This is the same federal law that governs special education for children ages 3-21.

The mission of the program is to strengthen the capacity of families to meet the developmental and health-related needs of their infants and toddlers who have delays or disabilities. The program ensures that all families have equal access to a coordinated program of comprehensive services and supports that:

- foster collaborative partnerships
- are family centered
- occur in natural settings
- recognize current best practices in early intervention
- are built upon mutual respect and choice

Birth to Three seeks to assist families to ameliorate delays in their infants' or toddlers' development that are identified early or to prevent secondary delays or disabilities. We work with families to ensure that their children are ready for Kindergarten at age five.

The federal law requires that two groups of children receive services 1) those with developmental delays and 2) those with diagnosed conditions expected to lead to a developmental delay without the benefit of early intervention. The state is given quite a bit of latitude in defining both of those groups. The federal law also allows states to serve children who are at environmental risk for delay, although Connecticut has not chosen to include those children yet.

Early intervention services must be delivered in natural environments, and for children of this age, that is typically the home, although services can be delivered in any setting that the child and family typically frequent, such as at child care. Most services are delivered by occupational, physical, and speech therapists along with early childhood special education teachers, although there are many other professionals and paraprofessionals who can be service providers as well.

**Number of children and families served:** In FY 2006, 7,971 children were newly referred for evaluation. 8,586 eligible children and their families received services during some portion of the fiscal year which equated to approximately 4,000 on any given day. The one-day count represents 3.1% of all Connecticut children under the age of three.

**Long-Term Agency Goals:** To ensure that children with developmental delays or who are at-risk of developmental delays are ready for Kindergarten.

**Strategies:** Family-centered early intervention services are delivered in natural environments as early as possible to as many Connecticut infants and toddlers who have disabilities or developmental delays or who are at risk for developmental delays.

**Outcomes:**

- Children receive early intervention services as early as possible
- Children's development is improved
- Families feel more confident and competent to facilitate their children's development
- Fewer children need special education services by Kindergarten

**Measure of Effectiveness:**

- percent of children under the age of three served (currently 3.1% - 11<sup>th</sup> nationally compared to all other states)
- percent of children under the age of 12 months served (23<sup>rd</sup> nationally compared to all other states)
- percent of infants and toddlers served who demonstrate: 1) improved social-emotional skills, 2) acquisition and use of knowledge and skills, and 3) use of appropriate behaviors to meet their needs (data not yet available)
- percent of families served who report that early intervention services have helped the family help their children develop and learn (data under analysis, not yet available)
- percent of children served who have exited the program and who do not need to receive special education services in Kindergarten (49%)

**Methods:** All children that meet the eligibility criteria are eligible – irrespective of race, income level, gender, or town of residence. The program does not specifically target groups of children for services. However, by including all children with significant developmental delays, Birth to Three is working to teach families and other caregivers to facilitate the child's development so that they can "catch up" to their typical peers by Kindergarten. Therefore, we are actually concentrating on reducing disparities between children with developmental delays and their typically developing peers.

The focus of services is in teaching the family and caregiver(s) ways to facilitate the child's development during naturally-occurring routines and activities. Birth to Three uses a coaching process to help the caregiver feel more confident and competent in assisting the child's development. Since each child's Individualized Family Service Plan is individualized for that

child and that family, and since the focus of the plan is on the family's priorities for their child and themselves, the family's ethnicity and income level will be addressed because it affects that family's priorities and need for services.

As services begin, children are assessed using any one of three curriculum-based assessments. This allows the Birth to Three provider to summarize the child's development at entry which is then compared to the development at exit to track developmental progress. Use of this type of assessment also helps the family track their child's development.

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**Program Name:** Family Supports

**Program Description:** The Department of Mental Retardation (DMR) provides Family Supports which assist families to care for their children who have mental retardation. Most families who have children with mental retardation need extra support to help them to care for their children at home. Family supports include goods, services, resources, and other forms of assistance that help families to successfully parent their children who have mental retardation. Family Supports help families to stay together and to maintain their children in the family home. When children grow up in a nurturing family home, they are more likely to live healthy, safe and productive lives.

**The department provides two primary Family Support programs, Individual and Family Grants and Respite at DMR Respite Centers.**

**Individual and Family Grants**

Individual and Family Grants are cash subsidies provided for the purpose of assisting individuals and families to defray extraordinary disability-related expenses. The provision of Individual and Family Grants acknowledges the extra effort and commitment of families who have children with disabilities that have an extraordinary financial impact on the family. The provision of Individual and Family Grants assists families to purchase items and services that are not otherwise reimbursable through insurance or available from other sources. The cash subsidies may be used to purchase supports that include, but are not limited to, in-home supports, behavioral supports, nursing, medical or clinical supports, temporary assistance, crisis support, skill training, family training, leisure services, transportation, support coordination, respite and assistance to access community supports. The maximum grant amount is \$5,000 per individual or family per fiscal year. For families who have children with mental retardation, Individual and Family Grants support the child to remain in the family home and help to prevent out of home placement. A total of 3,463 families received Individual and Family Grants in FY 2006. This number includes 1,587 families of children under age 18.

**Respite Services**

Respite is the temporary care of a person with mental retardation for the purpose of offering relief to the family. It is a service that allows the family to have time to reenergize, deal with emergency situations, or engage in personal, social, or routine activities and tasks that otherwise may be neglected, postponed, or curtailed due to the demands of caring for a child who has mental retardation. The goal of respite services is to support the continued presence and

participation of individuals who have mental retardation within the family homes and to prevent out of home placement.

The Department of Mental Retardation provides respite through ten regional Respite Centers. DMR Respite Centers are specifically designed to provide planned and scheduled relief to families. The three DMR regions provide overnight respite throughout the year from Thursdays through Tuesdays and are open twenty-four hours a day, seven days a week for up to eight weeks during the year, including summer months or school vacations. Respite Centers are operated by DMR staff who have skills needed to work with children and adults who have mental retardation and their families.

In total, DMR Respite Centers served 1,133 persons who have mental retardation in FY 2006, including both children and adults. There were a total of 484 children served in DMR Respite Centers in FY 2006.

**Number of children and families served:** 1,617 served in fiscal year 2006.  
(Most children who received Respite Services also received Individual and Family Grants)

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**Long-Term Agency Goals:** The Department of Mental Retardation serves over 15,000 individuals who have mental retardation including 3,055 children under the age of 18. This number does not include children who do not have mental retardation and are served in the Birth to Three System. While most children live with their families, about 252 or eight percent of children served by DMR live in other residential settings. The department's long term prevention goal is to support families to care for their children in the family home and to prevent out of home placement.

**Strategies:** Most families who have children with mental retardation need extra support to help them to care for their children at home. DMR provides Family Support to assist families to care for their children at home. Family Supports include goods, services, resources, and other forms of assistance that help families to successfully parent their children who have mental retardation. The Department of Mental Retardation plans to continue to provide Family Supports, including Individual and Family Grants and Respite. Within available resources, the department will expand the number of families served with Family Supports.

In addition to the Family Support services offered by the department, DMR continues to pursue the development and implementation of Home and Community Based Services Waivers which offer services in the community as an alternative to institutional care. The department continues to expand the range and amount of services available under the waivers that assist families to care for their children within the family home. These services include personal services, respite, home and vehicle modifications, family training and consultative services.

In FY 2006, the department established a position of Lifespan Coordinator within the Central Office to coordinate children's services, as well as services to elderly individuals who are served by DMR. The initial focus of this position is on children's service, including expanding the availability and ensuring the quality of supports provided to children and their families.

**Outcomes:** Specific outcomes to measure the success or effectiveness of the Family Supports provided by DMR include the number and percentage of children who live in family homes rather than in out of home placements.

**Measure of Effectiveness:** The percentage of children served by DMR who lived in their family homes has remained consistent over the last six years. The percentage of out of home placements has not increased since October 2000 and has remained at eight percent.

**Methods:** DMR Family Support services are available to children and their families regardless of race, income level or gender, however families with significant income levels may be liable for a portion of the cost of the respite stay.

**Other:** The Department of Mental Retardation's vision and guiding principles for children with mental retardation are as follows:

**Vision:** All children with mental retardation grow up with the love and nurturing of their families. Families identify and receive the individually designed supports they need to raise their children in their local communities. Communities embrace children with mental retardation and their families and include them in all aspects of community life.

**Guiding Principles:** The following guiding principles were identified by focus team members as critical ingredients in providing supports to children and their families.

▪ **Children Grow Best in Families**

A "whatever it takes" approach should be adopted to keep children with their families. Families should receive the support they need to raise their children at home. When a family is not able to provide full time care for their child, arrangements should be made to share the care of their child with others who will provide a nurturing family home. When a child is unable to live with his or her family, even part-time, a permanent home should be provided for the child that balances the family's wishes with the best interests of the child. It is essential that children maintain strong relationships with their families. Families' bonds with their children should be maintained whenever possible.

▪ **Families Know their Children Best**

Families have primary responsibility for the well being of their children. Families should have information about available options, services, and resources that will enhance their abilities to make informed choices. Support staff should listen to families and respect their decisions.

▪ **Supports Are Responsive to the Needs of the Entire Family**

Families are the constant in their children's lives. Children should be supported in the context of their families with services that are tailored to the unique family circumstance.

▪ **Supports Are Family-Directed**

Families should drive the planning process and have a strong voice in designing, selecting, and evaluating the supports and services they and their children receive. Families should have the tools and resources they need to be successful in directing their supports.

- **Supports Are Delivered in a Culturally Competent Manner**  
The culture of the family influences the choices they make and will accept. Supports should be delivered in the family's language and in ways that are consistent with a family's cultural preferences. Supports should be provided by a culturally competent workforce that understands the diverse needs of families.
- **Services and Supports Are Individualized, Flexible, Far-reaching, and Responsive to Changing Needs**  
No two families are alike in their strengths, challenges, or aspirations. Families should have access to a full range of options including in-home and community supports that are uniquely tailored to their needs. Supports should be easily accessible and sufficiently available to make a difference. Supports should be available before a crisis arises, but if an emergency does arise, families want some sense of security that help will be there when they need it. Supports should be flexible to meet the changing needs of families in a timely way.
- **Families and Children Receive Supports and Services in Their Community of Choice**  
Families want their children to be welcome participants in their own communities. They want their children to be able to access the same formal and informal supports available to children who do not have disabilities. Assistance should be available to help families to use and strengthen their natural supports, connect with their communities, and develop new resources. Families should be assisted to reach out to other families for networking, and to work on community building and workforce development issues. Supports should promote the integration and inclusion of children with mental retardation in the daily life of the community.
- **Supports Are Designed to Maximize Families' Competencies**  
Families should be supported to make decisions about needed supports and services and to direct the provision of those services. Professionals and others should promote the competencies of families and provide any tools necessary to assist families including leadership, networking, and advocacy skill development that will prepare families to advocate for new or enhanced supports.

### **Department of Public Health**

**Program Name:** Captain 5 A Day Nutrition Education Program

**Program Description:** This program targets parents, pre-school children, and teachers in Head Start and School Readiness (SR) programs. Workshops are provided to teachers to enable teachers to integrate nutrition education into their lesson plans and curriculum. Workshops are provided to parents to assist parents' success in feeding healthy food to their children. Developmentally appropriate activities and strategies are used to maximize the program's impact on children

**Number of children and families served:** 3,800 preschool and 7,000 high school children and their caregivers in fiscal year 2005.

**Program Name:** Immunization Program

**Program Description:** The State of Connecticut Immunization Program's mission is to prevent disease, disability and death from vaccine preventable diseases in infants, children, adolescents, and adults through surveillance, case investigation and outbreak control, vaccination, monitoring of immunization levels, provision of vaccine, and professional and public education.

- **Number of children and families served:** According to the latest National Immunization Survey (fiscal year 2005) 84.8 % of the states' two year olds were up to date on their immunizations comprised of a series of 4 doses of DTP, 3 doses of Polio, 1 dose of MMR, 3 doses of HiB, 3 doses of Hepatitis B, and 1 dose of varicella vaccines (4:3:1:3:3:1). This rate is the highest in the country. Connecticut's childhood immunization has remained among the top five nationally since the 1990's, was ranked third in 2005, and has a projected rate of 92.8 for 2006

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**Long Term Agency Goals:** The Department of Public Health (DPH) works proactively to protect the health and safety of the people of Connecticut and to prevent disease and promote wellness through education and programs such as prenatal care, newborn screenings, immunizations, nutrition and supplemental foods, AIDS and sexually transmitted disease awareness. Reducing health disparities in maternal and child health remains one of the agency's highest priorities. DPH selected its prevention programs for inclusion in this report based on a focus on children birth to age eighteen. These initiatives also impact the families of these children, either directly or indirectly. The selected programs are preventive in nature, provide education and information to families that promote healthy behaviors, attempt to reduce crime and violence, promote academic success, and discourage socially destructive behaviors.

**Strategies:**

- Implement disease prevention and health promotion of women, infants and children including children with special health care needs
- Identify and nurture community-based health and prevention initiatives through public and private partnerships
- Provide funding to community-based providers to implement prevention programs at the local level, including school-based and community health centers
- Through Community-Based Health Centers, assure the availability and accessibility of comprehensive primary and preventative health care and other essential public health services for low-income uninsured and vulnerable children and families in underserved areas
- Conduct surveillance activities to continuously monitor the effectiveness of the agency's prevention initiatives
- Collaborate with other state agencies to cut across agency boundaries and combine programmatic and funding efforts to improve outcomes
- Establish and coordinate the DPH's Virtual Children's Health Bureau to capture the overarching programs and initiatives throughout the agency

- Provide community-based abstinence-only education to 9-14 year old youths, including parental/guardian involvement whenever possible
- Promote the use of asthma management plans by health care providers and parents of asthmatic children, address the early identification of children with asthma and work to develop a state asthma plan and enhance asthma surveillance activities
- Provide nutrition education to parents, pre-school children, and teachers in Head Start and School Readiness programs, and provide workshops to enable teachers to integrate nutrition education into their lesson plans and curriculum, and to educate parents on feeding healthy food to their children
- License and regulate child day care facilities and offer resources and technical assistance to providers
- Improve the quality of care children receive in licensed child day care programs by revising Connecticut's licensing standards to be more in line with national standards and provide technical assistance to licensed programs
- Work with organizations such as the Child Day Care Council and the CT After School Network to develop draft regulations, staff training, and assure inspection goals are met in accordance with state statutes
- Ensure that state-of-the-art emergency medical care is available for all ill or injured children or adolescents, and that pediatric services are well integrated into an emergency medical service system
- Prevent disease, disability and death from vaccine preventable diseases in infants, children and adolescents through surveillance, case investigation and outbreak control, vaccination, monitoring of immunization levels, provision of vaccine, and professional and public education
- Conduct comprehensive lead poisoning prevention programs to reduce the risk of lead exposure
- Screen all newborns for genetic and hearing disorders prior to hospital discharge or within seven days of birth to help prevent severe health and developmental consequences
- Through Oral Health initiatives, increase entry into long-term comprehensive dental services for Medicaid, SCHIP, and other underserved children and develop a best practice model for sealant programs
- Make available to sexual assault victims and their families free and confidential services such as crisis intervention, support and advocacy, survivor groups, 24-hour hotline, and emergency transportation
- Through collaborative effort between Injury Prevention Program and CT Safe Kids, provide child passenger safety workshops to health care and childcare professionals to increase provider capacity as effective educators on child passenger safety
- Provide a variety of services to adolescents to reduce the transmission and incidence of selected sexually transmitted diseases
- Address all risks associated with the use of tobacco products focusing on youth, pregnant women, disparate populations and environmental tobacco smoke
- Provide nutrition education and supplemental food to eligible women, infants, and children through the WIC and Nutrition Programs
- Provide professional education, technical assistance and program development targeted toward youth violence prevention

The role of DPH is to address prioritized needs and gaps in services for the target populations. Services provided by community-based programs include case management, outreach, disease prevention, education, and the empowering of MCH populations about health and health-related issues. The combination of ongoing assessments, quarterly reporting data, technical assistance meetings and site visits assist DPH in determining priorities.

**Outcomes:**

- 1.8 million newborns have been screened prior to hospital discharge and 941 identified with genetic disorders to allow treatment to be promptly initiated to avert complications and prevent irreversible problems
- Inception of newborn hearing screenings at birth in 2000 has identified 360 babies with hearing loss, with the average age of diagnosis dropping from 2 ½ years to 2 months, and in 2005, Connecticut conducted hearing screenings on 99% of newborns
- Coordinated prevention and intervention efforts with parents and health professionals as partners lead to improved health and school readiness
- Revision of child day care regulations with improved health and safety standards, staff training opportunities, number of technical assistance opportunities conducted, and the number of inspections and investigations completed
- Every child, their parents, and all pregnant women in Connecticut will have access to comprehensive, preventive, continuous health care
- All children will have access to affordable, healthy, safe, and developmentally-appropriate early care and education with comprehensive support services that facilitate effective transitions from birth to Kindergarten
- All families will have access to the information and resources they need to raise healthy children, and parents will be involved as partners in the planning of early childhood services
- Effective local or regional early childhood collaborative structures will ensure the provision of integrated services
- A state level infrastructure with community representation will guide, support, and monitor implementation of a comprehensive, integrated system of services for children and families
- Data integration among agency programs will allow for seamless retrieval of information

**Measure of Effectiveness:** Infant Mortality – programming within DPH to reduce infant mortality is aimed at the period before conception, along with the prenatal and postnatal periods.

- From 1981 to 2003, Connecticut’s infant death rate fell from 12.0 to 5.3 deaths per 1,000 live births

Births to Teens – State programs serve pregnant and parenting teens and provide intensive case management services with emphasis on promoting positive pregnancy outcomes, positive parenting and breastfeeding.

- In Connecticut from 1993-2003, the birth rate for teens dropped from 38.8 to 25.8 infants born per 1,000 female teens

Prenatal Care – DPH strives to improve access to prenatal care through several strategies, such as supporting sites for primary care and free pregnancy testing at family planning clinics.

- In Connecticut in 2004, 87.5% of infants were born to women who began receiving prenatal care in the first trimester

Title V programs Comadrona, Healthy Start, Healthy Choices for Women and Children, Fetal Infant Mortality Review and Right From the Start provided outreach to and identification of pregnant women to promote early entry into prenatal care

Breastfeeding – DPH promotes breastfeeding as a social norm in the state due to the positive maternal and infant health effects

- The estimated rate for breastfeeding in Connecticut has improved from 68.7% to 69.3%

**Methods to Reduce Health Disparities:** Reducing disparities in maternal and child health indicators remains one of the major challenges facing the public health community, and DPH utilizes multi-level strategies that include:

- Addressing health disparities by targeting low-income families and encouraging them to participate in screenings, prevention activities such as immunizations and oral health, and HUSKY
- Improving the number and capacity of providers in underserved communities by functioning as liaison in the recruitment and retention of primary health care professionals through a collaboration with the DPH Primary Care Office and the Connecticut Primary Care Association
- Increasing the knowledge base on causes and intervention to reduce disparities by analyzing data on health care practices and use across racial and ethnic groups
- Utilizing the DPH Office of Multicultural Health to raise public and provider awareness of racial/ethnic disparities in health care
- As resources permit, consider addressing the recommendations of the Connecticut Health Foundation's Policy Panel on Racial and Ethnic Disparities which include:
  - Collect and integrate racial and ethnic data to its statewide planning efforts and publish a report on the key findings
  - The Office of Health Care Access and DPH should require health care organizations, including providers and payers, to collect data on each patient's primary language in health records and information systems, and post signage in the languages of the patients they serve
  - Establish a certification program for all medical interpreters to ensure cultural competence and quality service

- Establish a system for monitoring and enforcing PA 00-119 regarding linguistic access in acute care hospitals

## **Department of Social Services**

**Program Name:** Fatherhood Initiative

**Program Description:** The purpose of the Fatherhood Initiative Program is to promote and facilitate positive interaction between fathers and their children thereby increasing the parent child bond that contributes to optimal growth and development for children. The Initiative also facilitates and supports social and emotional connections between fathers and their children, which has been shown to increase financial support for children of non-custodial, separated, and divorced fathers.

This Initiative is operationalized through contracts with five geographically dispersed agencies.

Intervention strategies and tactics used by Fatherhood Initiative providers aim to prevent child poverty, child abuse and neglect, absentee fathers, intergenerational poverty, and youth violence among children of program participants. The agencies provide a range of services including preparation for employment, job search, life skills training, case management, parenting skills and education for parenting. Program participants are multi-ethnic, multicultural, working income, no income, and marginal income men, many of whom have had some involvement with the criminal justice system, DCF, and DSS.

In October 2006, the Fatherhood Initiative was awarded a competitive grant of one million dollars per year, for five years, by the Department of Health and Human Services, Administration on Children and Families, Office of Family Assistance.

The program receives oversight from a multi-agency, multi-disciplinary steering committee.

**Number of children and families served:** Approximately 400 fathers will be served annually.

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**Specific long term goals for the Department are:**

- To provide structured ongoing programs and activities that support the development and retention of parenting (fathering) skills among non-custodial, divorced, and fathers with shared custody;
- To reduce the level of poverty among children living in households in which the father is absent;
- To support and facilitate healthy child development by providing programs and services for Fatherhood Initiative program participants that contribute to healthy father-child relationships;
- To promote and support co-parenting, regardless of marital status;

- To foster and facilitate, through various community based programs and services, economic self-sufficiency for Fatherhood program participants and their children;
- To provide programs and services that increase the vocational skills and employability of program participants; and
- To provide community based programs and services that sustain co-parenting and successful father-child relationships.

**Specific intended outcomes of DSS' prevention efforts include but are not limited to:**

- Among Fatherhood program participants, a decrease in the number of unemployed and underemployed program participants;
- Increase in the number of children who have healthy relationships with their fathers;
- Increase in the number of gainfully employed non-custodial fathers who contribute to the financial support of their children;
- Decrease in the number of single female headed households who are totally dependent on entitlements;
- Among non-custodial fathers and single mothers, increased awareness of the pivotal role that men play in normal healthy child development and positive psycho-social/educational outcomes for children;
- Increase in voluntary child support payments; and
- Increase in the number and rate of voluntary paternity acknowledgement by unmarried fathers

**Strategies:** Strategies developed to achieve the goals and intended outcomes are:

Contract with five geographically dispersed agencies with expertise and knowledge about fatherhood, non-custodial parenting, co-parenting, cultural and ethnic factors in parenting, and proven ability to work with low/no income men;

- In collaboration and partnership with contracted agencies, identify best practices for developing, supporting, and/or improving father-child relationships and parent to parent relationships;
- Provide non-custodial fathers and other Fatherhood program participants with life skills training;
- Provide non-custodial fathers and other Fatherhood program participants with employment training and job placement;
- In partnership with contracted agencies, support and facilitate job development and job retention among Fatherhood program participants;
- Develop and provide knowledge and skill driven father-child activities that foster and support healthy father-child relationships;
- Educate fathers and mothers about the importance of male parent involvement in the lives of children; and
- Develop strategies and practices that, whenever possible, connect unmarried fathers to the gestation/birth process, parenting roles and responsibilities prior to the birth of the child.

**Outcomes:** Specific outcomes that may be used to measure the success or strategic effectiveness of the Fatherhood Initiative may consist of:

- Longitudinal comparison of changes in parent-child relationships, rate and extent of co-parenting (regardless of marital status), and rate of job retention among Fatherhood program participants from ethnic/cultural minority communities;
- Increase in the actual number of early pre-post birth paternity acknowledgements; and
- Positive changes in the rate of voluntary child support payments.

**Measure of Effectiveness:**

- Rate and extent of voluntary and involuntary child support payments among program participants;
- Consistent ongoing employment;
- Reduction in the rate of unemployment and underemployment among program participants;
- Reported rate of co-parenting among program participants;
- Rate of voluntary paternity establishment and acknowledgement among unmarried fathers;
- Actual rate of pre-post birth involvement of unmarried fathers;
- Changes in pay rates/income among program participants; and
- Number of households evidencing an increase in income, resulting in a reduction in child poverty, as a result of the receipt of financial support from non-custodial, divorced, separated, and/or co-parenting fathers.
- Other measures of effectiveness will result from the completion of the grant related evaluation, currently under development.

**Methods:** In progress, however, greater emphasis is being placed on addressing the impact of ethnicity, income, and gender on performance outcomes.

**Program Name:** Family Supportive Housing

**Program Description:** The DSS Family Supportive Housing Program is composed of two separate components. The overall purpose of the program is to prevent future homelessness among families and to secure and maintain family stability. The newest initiative or component is the Family Supportive Housing Program. It is designed to create permanent and affordable housing opportunities for adults and families who are homeless or at risk of becoming homeless, especially those families evidencing a history of consistent and persistent homelessness due to mental illness, substance abuse, and/or family violence. In order to address some of these systemic, personal, and interpersonal causes of homelessness, this initiative offers supportive services to program participants. DSS provides housing subsidies from its Section 8 or State Rental Assistance (RAP) program for the housing component and funds the supportive services component through an appropriation.

The second initiative is a joint collaboration between DSS and the Department of Children and Families (DCF). The Department provides Section 8 and RAP housing

subsidies to DCF families who are participants in the Recovering Families Program. This DCF program supports the reunification and maintenance of stability within these families. DCF provides program oversight and the funding for the contracted supportive services.

**Number of children and families served:** The Family Supportive Housing Initiative aims to have 500 supportive housing units in use within the next five years. The 500 units will include 25 units of supportive housing for families during the current biennial budget period and a proposed increase to 75 family units during the next biennial budget. The department has provided Section 8 and State RAP housing subsidies for over 400 DCF families; the budget provides another 100 subsidies this fiscal year.

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**Specific long-term goals for the Department are:**

- To provide structurally sound, habitable, safe, affordable apartments combined with health care, social service support, and employment services;
- To develop strategies and tactics that support the reintegration of families with chronic health challenges into the community by addressing their basic needs for housing and ongoing support;
- To prevent or reduce the rate of homelessness among families with children; and
- To support and facilitate family stability and reunification in order to increase self-reliance and self-sufficiency among at-risk families and their children.

**Outcomes:** Specific intended outcomes of DSS' prevention efforts include but are not limited to:

- Decrease in the number of families who are homeless or housed in shelters
- Reduction in number of emergency room visits and hospital inpatient stays.
- Increase in the number of families who become self-reliant and less dependant on public entitlements.

Reduction in the rate and incidence of relapse within those families with substance abuse issues.

- Increase in the number of employed heads of households currently receiving support from DSS.
- Improve the health, employability, earning capacity, self-sufficiency, and other social-economic outcomes for families experiencing homelessness.
- Improve developmental and educational outcomes for the children of such families through connections to early childhood education and child care programs as well as more stable involvement in K-12 educational programs.

**Strategies:** Strategies developed to achieve the goals and intended outcomes are:

- In collaboration with shelter providers and community based social service agencies, identify families who are consistently and persistently homeless.
- Develop guidelines for programs and services.
- Create an RFP, review proposals and select service providers for the supportive services component.

- Develop and maintain a multi-media outreach campaign designed to educate the community.
- Identify opportunities and create services, including day care/early care, that can be delivered on site or in close proximity to the housing units.
- Encourage sponsors of family projects to establish relationships early on in the project planning with child care and early childhood education providers within the community to secure designated “slots” for children from the supportive housing project.

**Measure of Effectiveness:**

- Housing occupancy – rate and duration.
  - Number of episodes or incidence of repeat homelessness among program participants;
  - The degree or extent to which the person’s mental health status remains stable as evidenced by cooperating with treatment plans, in-patient care, number of emergency room visits, observation of social service staff, etc.
  - The degree or extent to which the person remains drug/substance free as evidenced by self- report, hospitalization, observable signs of substance use.
  - Consistent ongoing employment
  - Changes in Income and changes in job or work status. Average monthly income; receipt of SSI/SSDI or other public benefits;
  - Severity of existing chronic health conditions (pre and post housing occupancy service receipt), evidence of well child care, preventive health care visits, hospitalizations (pre-post assessment)
  - Incidence or rate of involvement with the criminal justice system including arrests, number of days incarcerated, etc.
  - Evidence of connections/networking within the community
  - Client-participant feedback via an objective data collection instrument.
  - Using the individualized care or service plan, measurable improvements based on the client contract for needed services.
- Reported changes in parent-child or family relationships.

The current data collection system used by DSS and its partner agencies indicates that primary prevention programs are meeting stated goals and objectives.

**Methods:** In progress, however, greater emphasis is being placed on addressing the impact of ethnicity, income, and gender on performance outcomes.

## Office of Policy and Management

**Program Name:** Neighborhood Youth Center

**Program Description:** The Neighborhood Youth Center Program is designed to increase the range and extent of positive experiences for at-risk urban youth ages twelve through seventeen years. Research findings on delinquency and substance use prevention consistently show that positive youth development approaches work best to prevent these undesirable behaviors in youth. Currently, 12 centers in six cities (Bridgeport, Hartford, New Britain, New Haven, Norwalk and Waterbury) are supported by the Neighborhood Youth Center Program with federal dollars from the U.S. Department of Education.

**Number of children and families served:** An average of 644 youth each day of operations during January – March 2006.

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**Long-Term Agency Goals:** Promote positive youth development and thereby reduce crime, delinquency and urban violence.

**Strategies:** The Neighborhood Youth Center Program supports specific local initiatives to increase positive experiences for youth ages 12 through 18 years. Neighborhood Youth Centers **must** include the following seven components.

1. Neighborhood Center Setting  
(safe, appropriate, accepting, accessible and open regular hours)
2. Neighborhood Center Staff  
(qualified, supervised and supported)
3. Neighborhood Youth Center Program  
(appropriate to the age, maturation level, gender, culture, and community needs of its youth clients)
4. Parent Involvement  
(in planning the program initially and on an on-going basis)
5. Youth Involvement  
(many viable opportunities for youth input into the planning and management of the center)
6. Applicant Agency  
(knowledgeable about and actively involved in the neighborhood)
7. Evaluation  
(participation in evaluation efforts)

**Outcomes:** Outcomes that the Office of Policy and Management uses to measure the success of the Neighborhood Youth Center Program include youth's **Satisfaction with the Center, Achievement Motivation, Attitudes Toward School, Peer Self Efficacy and Level of Substance Use**. In addition, process improvement data; such as **Attendance, Demographic Information** and youth's **Perceptions of Supports and Opportunities** within the programs at the centers; is collected. Summaries of these data

are shared with the directors of the centers who can then work on program improvement plans with technical assistance provided by youth development experts.

**Measure of Effectiveness:** The findings from the outcome evaluations suggest that involvement with the Neighborhood Youth Center Program has a positive influence on youth's attitudes towards school. It also appears that the staff and directors of the Neighborhood Youth Centers derived information of value from their participation in the process evaluation. The collection and interpretation of youth perception data and the development of implementation plans with expert consultation resulted in tangible and positive changes in youth's experiences of the programs. See the full evaluation reports at <http://www.opm.state.ct.us/pdpd1/grants/NYC.HTM>.

**Methods:** Neighborhood Youth Center Programs are required to provide programs that are appropriate to the populations they serve.

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**Program Name:** Norwich Pilot Reintegration Education Program (PREP)

**Program Description:** PREP is designed to successfully reintegrate juvenile offenders back into school following their release from adult and juvenile detention, the Connecticut Juvenile Training School, Department of Children and Families' residential placements, and the Department of Correction.

PREP had three primary objectives: (1) to promote information sharing among various public and private agencies involved in the lives of youth; (2) to create a single point of contact within the Norwich Public Schools for youth leaving detention or placement; and, (3) to implement short-term academic programs to increase the likelihood that youth will complete their education.

**Number of children and families served:** a total of 21 students were referred to the Program for the period of October 2004-December 2005 (the initial goal was to serve 10 students per year).

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**Long-Term Agency Goals:** Successfully reintegrate juvenile offenders back into school following their release from adult and juvenile detention, the Connecticut Juvenile Training School, Department of Children and Families' residential placements, and the Department of Correction

**Strategies:** Establishing a single point of contact and providing short-term alternative education services.

**Measure of Effectiveness:** Central Connecticut State University (CCSU) conducted an evaluation of PREP; the evaluation focused on ‘process measures’ to determine how closely the Norwich PREP followed the program model and to what success it had in achieving its stated goals and objectives. The CCSU findings were that:

- The Norwich PREP successfully achieved both of its primary goals (to provide a single point of contact and to provide short and long term academic support services for students).
- A re-entry center was established at Norwich High School with a PREP coordinator.
- The PREP coordinator became a valuable resource for the entire school; she helped refer PREP and non PREP students to outside agencies for additional services.

Overall, the Norwich PREP is following the PREP model and has achieved the goals that were stated in the school district’s grant proposal. The study was not able to conclude whether this program has produced long term successes, however, the evaluators were confident that this program will be successful if it maintains its current level of implementation.

## Appendix E

### ENDNOTES

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