Connecticut General Statute (C.G.S) Section 17a-6e

Report on the Department of Children and Families' Racial Justice Data, Activities and Strategies

February 15, 2022

DCF COMMISSIONER DORANTES' STATEMENT

As this pandemic rages on, DCF has remained open and responsive to Connecticut's children and families. We recognize the (im)perfect storm of the coronavirus, racial unrest and economic instability have hit some communities harder than others. As a result of the confluence of those three factors, the navigation of day to day experience can look quite different from town to town. CT has a unique make up of urban centers, suburban rims, rural areas and tribal lands. Each geographic distinction presents its own interpretation of the 'new normal' coming into focus.

By the middle of 2021, the CT General Assembly sent Senate Bill 1 declaring Racism a Public Health Crisis in our state to Gov Lamont for signature. Our Governor established a Commission on Racial Equity in Public Health. This 28-member commission is made up of subject matter experts from across all three branches of government and includes recommendations from key stakeholder groups. By the end of the calendar year, the commission had its inaugural meeting. As I represent the work of this Department by being appointed to this body, I recognize the enormous responsibility we have before us while at the same time, share with enormous pride, the unrelenting work of DCF's Racial Justice efforts.

DCF's statewide racial justice workgroup (SRJWG) has continued its work during this pandemic ---sometimes hosting more attendees virtually than we had when we could meet in person. In between workgroup meetings the leaders from all DCF divisions get support, coaching and consultation to refine the racial justice initiatives that each leader of the Dept has been working on. Overall our racial justice evolution is now encased in our Safe & Sound framework of safety science as we continue to nurture the experiences of our staff and constituents served. The Strategic Planning Division has been busy helping to define the measurement metrics while the Child Welfare Division uses the Child Stat performance improvement process to determine which initiative will be considered for scale-up. At last count, there were over 30 change initiatives following the PDSA model. Plan, Do, Study, Act[1]- is a framework used to assess small tests of change as systems undergo various times of change.

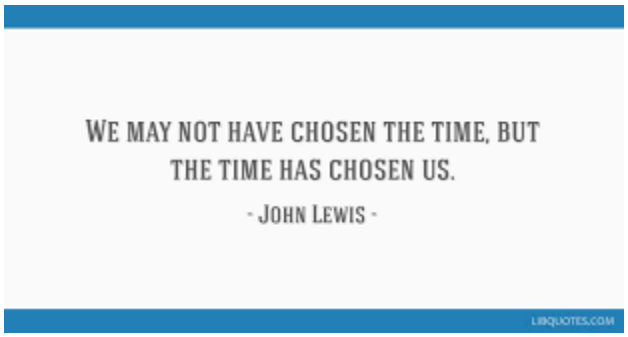
There are change initiatives underway in divisions across Operations, Administration, Legal and External Affairs. All supported as a means of helping DCF become a more racially just agency with outcomes intended to eliminate disparity and promote equity. The action-oriented goal of anti-racism work calls for systems to not sit passively by while marginalized communities experience disproportionate outcomes. Anti-racism work is being reflected in a conscious effort to ensure safety of children, preservation of family bonds, racially aware service delivery and incorporation of the voices of community members with lived-expertise. Along with the SRJWG, DCF is thankful for the support and reviews of the regional and statewide advisory councils (RACs / SAC) that we often consult with to stay on track.

[1] **Plan Do Study Act (PDSA)**
The Plan do study act is an iterative, four-stage problem solving model used for improving a process or carrying out change. The PDSA cycle is a systematic series of steps for gaining valuable learning and knowledge for the continuous improvement of a product or process. It is also known as Deming cycle, as Dr. Edward W Deming popularized the concept. Mr. Walter A. Shewart introduced him to this concept

The question remains," How will we know if our efforts are truly making a difference for all families?" The Strategic Planning division, along with graduate students from the University of CT's (UCONN) Master of Public Administration program have worked diligently to update our pathways data according to the new census report. Upon review of key decision points in comparison to the racial group's representation in the CT population, we must continue to ask ourselves if these metrics are reflecting the experience of families receiving our interventions. Are there other decision points to consider at this juncture?

Some very direct conversations are underway to enhance our partnership with a cadre of predominantly Black churches in an effort to call-out and acknowledge experiences of Black congregants in relation to child welfare themes. Our Faith-Based initiative also includes reigniting the ***Queen Esther foster care*** recruitment project. In addition, DCF is crafting a consultation hub model using the **Urban Trauma**[2] Framework. This clinical approach allows for greater attention to the unique perspective of minoritized families. We have a duty to meet communities 'where they are' with honesty, transparency and an earnest desire to continue to hold ourselves accountable.

Our journey has not been easy. We find ourselves in 2022 servicing communities that have historic mistrust of systems. It is our collective responsibility to address that -- not theirs. Our work continues while sharing ideas with other jurisdictions across the country as CT DCF has made its mark. The journey is far from over and we understand the assignment.



[2] https://maysaakbar.com/urban-trauma

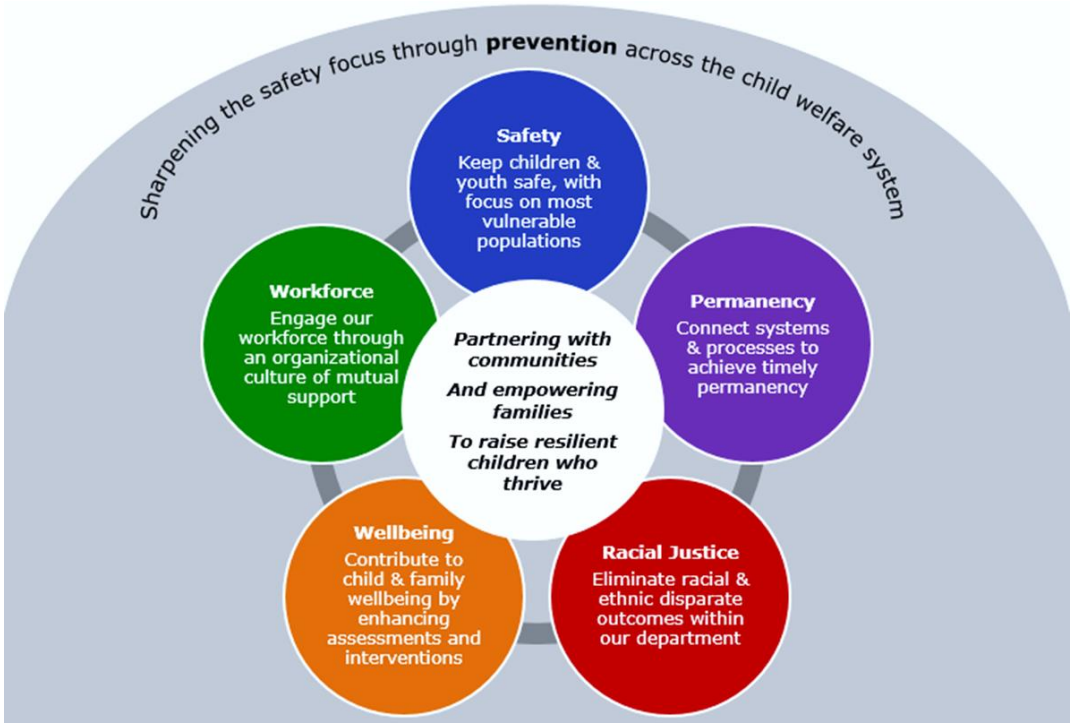
TABLE OF CONTENTS

DCF OVERVIEW:

The Connecticut Department of Children and Families (CTDCF/Department) is the Child Protective Services (CPS) agency in the state of Connecticut. Pursuant to legislative mandate, in addition to CPS, the Department is responsible for prevention, education under USD II, and children's behavioral health services.

DCF's mission is: "Partnering with communities and empowering families in order to raise resilient children who thrive". The Department continues its efforts to sharpen the safety focus through prevention across the child welfare system. The mission is supported by the following 5 bold strategic goals (figure 1) 1: Safety, 2: Permanency, 3: Racial Justice, 4: Wellbeing, and 5; Workforce. As part of the larger child welfare system, the Department works in partnership to ensure a holistic understanding of what children and families need. The 5 identified goals are compensatory, integrated and support the overall mission of the Department.

Figure 1: Department of Children and Families Strategic Goals:

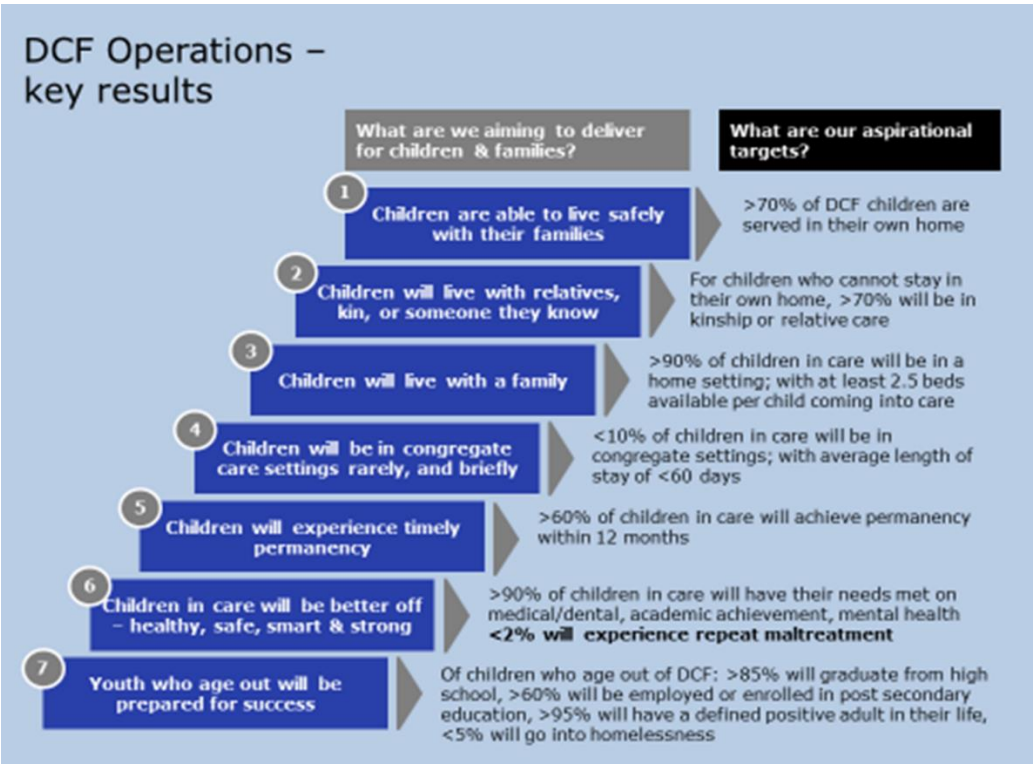


The Department takes pride in its organizational values and works with purpose to ensure that all employees and partners contribute to the overall vision. The Department's workforce intervenes with passion seeing this line of work as a calling, and more than just a job. In addition, The Department prioritizes practice and strives to deliver high quality service. The Department values people by seeing the humanity in everyone and continually works to bring out the best in colleagues and the families and children that are served.

The mission is grounded in a core set of 7 Aspirational Targets (Figure 2) that drive the Department's Strategic Goals for how to best meet the needs and serve Connecticut's children and families. CTDCF

believes that children do best when living safely at home with their family of origin. When living at home with a parent is not reasonably safe, the best alternative is to live with relatives, kin, or someone that they know who can provide a safe and nurturing home. If no family member can provide a suitably safe home that meets the child's needs, the child should receive care and services in an appropriate foster home or a setting that is able to meet their need in a timely manner. If it's absolutely required, children who need to be in congregate care settings will have a brief stay. When and if a child is to enter the Departments care, the Department will work towards achieving timely permanency, ensure that their medical, dental, academic achievement and mental health needs are meet, while at the same time ensuring that older youth are prepared to successfully transition out of the Departments car and assist in identifying a positive adult that will continue to provide support and guidance.

Figure 2: Department of Children and Families 7 Aspirational Targets (Key Outcomes)



CTDCF has implemented several strategies in SFY 2021 to enhance efforts to achieve the Key Results and Aspirational Targets. For example, in striving to keep children safe at home, the agency engaged in the following efforts: submitted the Family First Prevention Plan, Careline front door screening was enhanced to improve accuracy in decision making, and cases opened for an Investigation/FAR or continued services improved quality of safety decision making and quantity. Statewide initiatives were implemented to ensure that the Department increased its efforts for Children living with Relatives/Kin: Quality Parenting Initiative, Caregiver Practice Model and Kinship Navigation. In addition, CTDCF continues to emphasize that congregate care should be only be used for treatment of unmet need, not placements. CTDCF"s utilization of congregate is one of the lowest in the country gaining national attention. There are also several statewide efforts currently underway to address timely permanency.

Commitment to Anti-Racism

In 2021, CTDCF remained committed to the stance of becoming an anti-racist organization whose beliefs, values, policies and practices achieve racially just and equitable outcomes. As we examine and redesign the CTDCF as an authentically anti-racist agency, our progress will be apparent in its structures, policies, practices, norms, and values. CTDCF has acknowledged that child welfare has ongoing systemic racist structures embedded (i.e. policies, practices and programs) and we recognize that intentional action will assist us in moving the needle on the agency's strategic goal of Racial Justice. As a nation, we continue to navigate the global pandemic which unfortunately has highlighted further the racial disparities and racial inequities that existed well before the pandemic surfaced. These times have elevated the need to address these inequities not only in the child welfare system but in other systems across society as well. As a Department, we will continue to look at the impact of the pandemic on the families and children we serve and ensure that we identify ways of addressing their needs.

In 2020, as part of the Departments' Anti-Racist Framework. CT DCF established 4 grounding principles to guide us in achieving these goals. Figure 3 below outlines each guiding principle and how the Department is defining itself moving forward.

Figure 3: DCF Guiding Principles, Value and Foundation:

Becoming an anti-racist organization is a key part of our identity. As an anti-racist organization, CTDCF will decisively identify, discuss and challenge issues of race and culture and the impact(s) they have on our agency, our families, our community, and ourselves. We do this in order to identify and correct any inequities found within the agency and in the provision of our services. The Department continues its commitment to move from Equity to Justice to further ensure that services are individualized and based on a comprehensive assessment of child and family's strengths and needs. In partnership with providers, the family, youth and children, in a developmentally appropriate manner, shaped by clients' racial, cultural, and linguistic self-identification and needs, the Department hopes to move closer to achieving its goals. Striving for Institutional Transformation is our goal as we do not want to make small transactional changes but rather make the changes that fundamentally transform how we work with children, families, the

communities we serve, and one another. This will be evident in the several change initiatives that continue to move forward across the Department.

BACKGROUND AND CONTEXT

In 2021, Connecticut was ranked as the sixth wealthiest state in the United States with a household median of $78,833 [3] which is slightly lower than the national median of $79,900. The population in CT as of July 1, 2021 was estimated to be 3,605,597; slightly under what is was in 2020. Despite being ranked as one of the wealthiest states CT also struggles with poverty specifically in urban areas and eastern rural communities. The National poverty rate was estimated to be 11%, with CT falling slightly under at 9.7%. The U.S. Census Bureau's federal poverty level for a family of four in Connecticut was estimated to be $26,500 [4]. Like many other states, the COVID-19 pandemic has not only disrupted the everyday lives of our children, it has also exacerbated our nation's greatest moral disgrace: child poverty.

The poverty rate for people under the age of 18 increased nationally from 14.4% in 2019 to 16.1% in 2020 [5]. Information for the poverty rate for children in CT and other data disaggregated by race remains pending, however historically, systemic racism and institutional barriers have made children of color particularly vulnerable to child poverty. Black and Hispanic children experience some of the highest poverty rates in the country, and 71 percent of children in poverty in 2019 were children of color [6]. Due to the struggles that families experienced during this pandemic, many were hopeful that the Child Tax Credit (CTC) offered to families through the American Rescue Plan in 2021 would assist families overcome some of the struggles experienced. The Center on Budget and Policy Priorities conducted a study that found that 93% of families in CT whose household income was $35,000 or less spent the assistance on basic needs (food, utilities, rent/mortgage, clothing) and educational costs (books, supplies, tuition, tutors, afterschool programs, transportation) [7]. The future of the CTC is unknown at this time and therefore all who encounter CT families will need to find effective ways to support families who are struggling financially. These are not families who should be brought to the attention of CTDCF. Reports made to the Department should be made on the basis that children are in potential harm of abuse and neglect that cause concern for their safety and not because of poverty.

Poverty and its connection with child maltreatment have been well documented to allow for better understanding about the impact of poverty on the field of child protection services and the ultimate impact on the delivery of services. In an article written by Paul DiLorenzo [8], he poses questions about the role that poverty and race have on the lives of the families served. One of the questions he posed was: *Are there points of intersection with poverty, race, generational trauma, parental substance abuse and mental health disorders and our (child welfare system) responsibility for child safety, permanency and well-being?* As noted in previous reports, CTDCF is continuing to explore the answer to this question, suggesting that poverty is sometimes mistaken as maltreatment, causing families to be reported for concerns of abuse and neglect. Finding the right balance to ensure the safety and well-being of the children we serve is of great importance and should continue. In CT, of the family cases accepted in Federal Fiscal Year (10/1/20-9/30/21) 85.3% of calls received identified allegations of neglect which is where concerns of poverty often fall.

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[3] H.Alas, *The 10 Wealthiest States in America | Best States | US News* , March 2021.
[4] Retrieved from: U.S. Census Bureau QuickFacts: United States).
[3] Retrieved from: Income and Poverty in the United States: 2020 (census.gov)
[6]Children's Defense Fund (CDF). 2020. "Child Poverty in America 2019: National Analysis," p. 1. Washington, DC: CDF. https://www.childrensdefense.org/wp-content/uploads/2020/12/Child-Poverty-in-America-2019-National-Factsheet.pdf
[7] C. Zippel, 9 in 10 Families With Low Incomes Are Using Child Tax Credits to Pay for Necessities, Education | Center on Budget and Policy Priorities (https://www.cbpp.org/) October 2021.
[8] Dilorenzo, Paul. Three Conversations Child Welfare Systems Should Have to Start 2022, Retrieved from imprintnews.org, January 2022

The impacts of COVID-19 have continued to challenge families throughout the nation; the State of Connecticut is no different. While the nations' racial civil unrest was much more prevalent in 2020 with the murder of George Floyd, the racial inequities have not diminished and remain. Families continue to fear for their overall well-being, health, and for their economic and financial stability. The Social determinants of health, at times referred to basic human needs is defined by the United States Centers for Disease Control and Prevention (CDC) as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks [9]. Areas of focus are economic stability, housing, education, health care, social and community relationships. There is no doubt that COVID 19 has impacted these areas for families across Connecticut and this is to remain at the forefront when it comes to supporting the families and children we serve.

While some aspects of disproportionality and disparities across CT's child welfare system and critical pathways are impacted by external factors, such as those described above related to poverty, the Department is committed to ensuring that all areas and divisions within the Department also work on reducing the racial disparities seen within the agency. As noted earlier, the overarching mission of CTDCF anti-racist work is to examine and redesign the Department as an authentically anti-racist agency. CTDCF has been focused on the issue of racial justice for over a decade, with its formal journey beginning in 2005 as a participant in the national Breakthrough Series Collaborative focusing on disproportionality and disparities sponsored by Casey Family Programs. After receiving technical assistance and undergoing a series of leadership and organizational changes, CTDCF renewed its focus on addressing issues related to Racial Justice in 2011. Today, with the support and leadership of Commissioner Vannessa Dorantes, along with her administration, eliminating racial and ethnic disparate outcomes and achieving Racial Justice within the Department has been explicitly included as one of the five strategic agency goals, as noted above in Figure 1. As this shift is taking place, outcomes for children, families, and staff of color will demonstrate decreases in disparities.

A Culture of Safety

A culture of safety is one in which our values, attitudes, and behaviors support psychological and physical safety for staff, and the families and children we serve. As a culture of safety, *CT Safe and Sound Culture* is rooted in principles of respect, trust, candor, equity and racial justice. When this is put into action, this enables us to be engaged, supportive, accountable and open to learning. It empowers us to make sound decisions and competently provide services that help children and families achieve safe and healthy outcomes. At various times throughout 2021, the Department began to see how Safe and Sound Culture has begun to take root in our everyday interactions with how our staff engage each other and how they advocate for the families they serve.

CTDCF is mindful that this work is hard and often painful for some therefore CTDCF is committed to cultivating and sustaining an environment that is supported and grounded in the context of the Department's Culture of Safety, Safe and Sound as referenced above. There are 5 main principles that are being branded as the "5R's" (Figure 4) that will provide a framework for our work within a culture of safety and racial justice.

[9] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved January 2022 from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Figure 4: The Five Rs of Safe and Sound:

As 2021 unfolded, CTDCF furthered its efforts to cultivate and nurture a Safe and Sound culture throughout the agency as it actively engaged leaders of all offices, divisions, and programs to lift racial justice efforts. These leaders were charged with using their data and local racial justice teams to identify an opportunity for improvement: A Change Initiative. Leaders proposed their initiatives and then dove into the work of testing their strategies, practices or tools. The Racial Justice Leads (the designated leaders of the statewide racial justice work) mapped the Change Initiatives to the 7 Key Aspirational Targets/Outcomes noted above and began to offer facilitated discussions that reflected and modelled the spirit of our Safe and Sound culture.

These discussions were held periodically and offered peer support and consultation focused on each of the 7 Key Results. They acknowledged and celebrated the ongoing racial justice and equity work teams had been doing since the formal implementation of the Change Initiatives in January 2021 and provided an opportunity for shared learning across divisions, facilities and area offices. The group consultations calls also time for critical thinking to ensure that the course of action identified was going to make a difference qualitatively and quantitatively; with the overall goal of moving needles across the state in the ultimate effort to eliminate disparities and achieve racial justice.

CTDCF and its efforts to reduce racial and ethnic disparities requires collaboration with all community stakeholders and multiple areas. Such efforts to address racial inequity will require vision, commitment and partnership. CTDCF partnered with Dr. Maysa Akbar to offer intentional technical assistance to several of our leaders from across the state. Dr. Maysa Akbar is a groundbreaking psychologist, best-selling author, and healer. Dr. Akbar is a thought leader and expert in racial trauma, ally-ship, diversity, equity, and inclusion. She is an engaging and dynamic speaker who is sought by corporations, philanthropies, nonprofit organizations, urban school districts, and social service agencies in their efforts to promote antiracism and advance racial equity. She brings insight, courage, and passion to her conversations with communities of color and white communities alike.

The report that follows is a continuation of trends and efforts captured by CTDCF for the time frame falling under State Fiscal Year (SFY) 2021 (July 1, 2020 - June 30, 2021) and/or calendar year (CY) 2021 (January 2021-December 2021). For a more detailed history of DCF's journey on addressing racial inequities please refer to the initial submission dated February 15, 2019 and/or the CTDCF Racial Justice website for further information and to review previous submissions. The information captured in this report will illuminate the Department's rich array of data that is being used to inform strategies to eliminate disproportionality and disparate outcomes across key decision points. In addition, this report will highlight a few of the racial justice change initiatives occurring across the state that are already demonstrating promising results.

CTDCF's FAMILY FIRST PREVENTION SERVICES ACT (FFPSA) PLAN:

CTDCF continues to look forward to the implementation of the Family First Prevention Services Act (FFPSA) that was passed and signed into law in February 2018. CT DCF is hopeful that Family First will create a new child and family servicing system that puts the prevention of maltreatment at the forefront, separates poverty and child neglect with a focus on racial equity while also enhancing and sustaining child safety and child and family well-being[10].

Connecticut presented a prevention plan of time-limited services and programs to include mental health and substance abuse prevention and treatment services and in-home parent skill-based programs as well as kinship navigator services. Prevention services will be for eligible children or youth candidates for foster care, pregnant or parenting youth in foster care, and the parents or kin caregivers of those children and youth. Connecticut is on track to have an approved plan that will serve those families who come to the attention of the child welfare agency and develop support for families "upstream," resulting in families being diverted from involvement with the child welfare agency. Connecticut will take a phased approach to service delivery. The Initial phase will begin with prevention services offered to Known-to-DCF children and families and the Voluntary Care Management. The intermediary phase will be the development of the Care Management Entity, and the second phase will be services to the Community Pathways children and families.

There are four core components of Connecticut's Family First Prevention Services Plan. The first core component is the implementation of a child-specific prevention plan for in-home cases that meet the eligibility criteria. The second core component is a continuous safety management plan to assess family needs, and services are refined to address the need. The third core component is the creation of a Care Management Entity to manage family cases receiving services outside of DCF. The fourth core component of Family First will be expanding the service array of evidence-based practices to support Connecticut's families better and prevent unnecessary out-of-home care. Connecticut's final core component is the reduction of abuse and neglect reports. Connecticut views Family First as not just an opportunity for system transformation and change but an opportunity for families to receive the needed services earlier.

Currently, Connecticut's Family First Prevention Services Plan is before the Children's Bureau and is pending final approval. CTDCF had two very productive calls with the Children's Bureau as part of the submission process, presenting an innovative plan for the community pathway population whereby eligible families unknown to DCF will have access to Family First services and programs. While we await approval, DCF has begun implementation, reconvening three strategic workgroups: Infrastructure, Policy, and Practice (IPP), Continuous Quality Improvements (CQI), and Workforce Development (WD). With an eye on the overall program development, the IPP workgroup will focus on the Family First policy, practice changes, and the development of the child-specific prevention plan. Family First's CQI workgroup, informed by a recent gap analysis that summarizes the prevention services and service gaps, will ensure that Connecticut is contracting for the appropriate type and number of evidence-based practices and programs needed for the identified candidacy populations. This workgroup will engage diverse stakeholders to ensure that the CQI evaluation process has a racial justice perspective. Finally, the Workforce Development workgroup will kick off an agency-wide Family First Awareness Campaign in February 2022 to introduce a trauma-informed, intentional racial justice perspective Family First Prevention Services training for DCF caseworkers and the provider workforce.

[10] TRANSFORMING CHILD WELFARE: PRIORITIZING PREVENTION, RACIAL EQUITY, and ADVANCING CHILD AND FAMILY WELL-BEING, KRISTA THOMAS, PH.D and Charolette Halbert, PUB.POL>)

RACIAL/ETHNIC DISPROPORTIONATILITY ACROSS THE CT CHILD PROTECTION SYSTEM:

The Department disseminates and uses its data, routinely disaggregated by race, ethnicity and other demographics, to identify areas of strength and opportunities for improvement. Cross-examining its data from a racial justice perspective better allows for further opportunity to ensure that the Department provides quality, equitable, and outcome driven care for the children and families in Connecticut.

CTDCF continues to have strong data infrastructure that is accessible to all staff in order to support the evaluation of its practices and outcomes through a racial justice lens. The Department has deliberately invested in capabilities that allows us to disaggregate most reports by race and ethnicity. This provides agency leaders the ability to observe trends, which then inform strategies to eliminate the racial and ethnic disparate outcomes within CTDCF. This report will touch upon key data points captured in the pathways data set that are considered key components in the Departments efforts.

A foundational tool created in 2013 that has been consistently used by the Department, is the "Racial/Ethnic Disproportionality Across the CT Child Protection System Data" referred often as the "CTDCF Pathway Data." (Figure 5 below). This data set graphically presents the distribution, by race/ethnicity, of children served across Connecticut child protection system at key decision points. The data that is included in the DCF pathways is compared to the child population in CT that stemmed from the U.S. Census Bureau. The Department received the results from the 2020 U. S. Census Bureau and now has updated information and more accurate data on the demographics and population of the families and children served in CT. The CT DCF Office of Performance Management and Evaluation conducted a comparison of 2010 and 2020 Census of the child population and they found that the overall child population declined by 9.8%. The Hispanic/Latinx child population increased by 20% and the Black child population declined by 7%. The child population for Other increased by 39% while the White children population decreased by 10%.

The demographics of Connecticut have noticeably changed between 2010 and 2020. One specific change was in the increase in both the Hispanic and Other populations, and a decrease in White. Several explanations for these results were offered by CT Data Collaborative. They indicated that falling birthrates of White, increasing birthrates of Hispanic and Asian women, a cultural shift towards multiracial identities, and changes to the latest census form to better capture such diversity, all contributed to this dynamic. The 2020 Census data was used to create revised comparison data for the previous two years to create more accurate trendlines comparing the state's progress in recent years.

The pathway data are produced for every Region and Area Office in the state and then shared statewide. Along with moving the needles on the DCF Outcomes/Key Results, these are also some of the "needles" that we are striving to move. CTDCF has made the commitment to consistently look at the data set available related to child outcomes to ensure the strategies that are developed address areas of need while being intentional in helping CTDCF become an anti-racist organization.

Figure 5; Statewide Racial/Ethnic Disproportionality Across the CT Child Protection System SFY21:

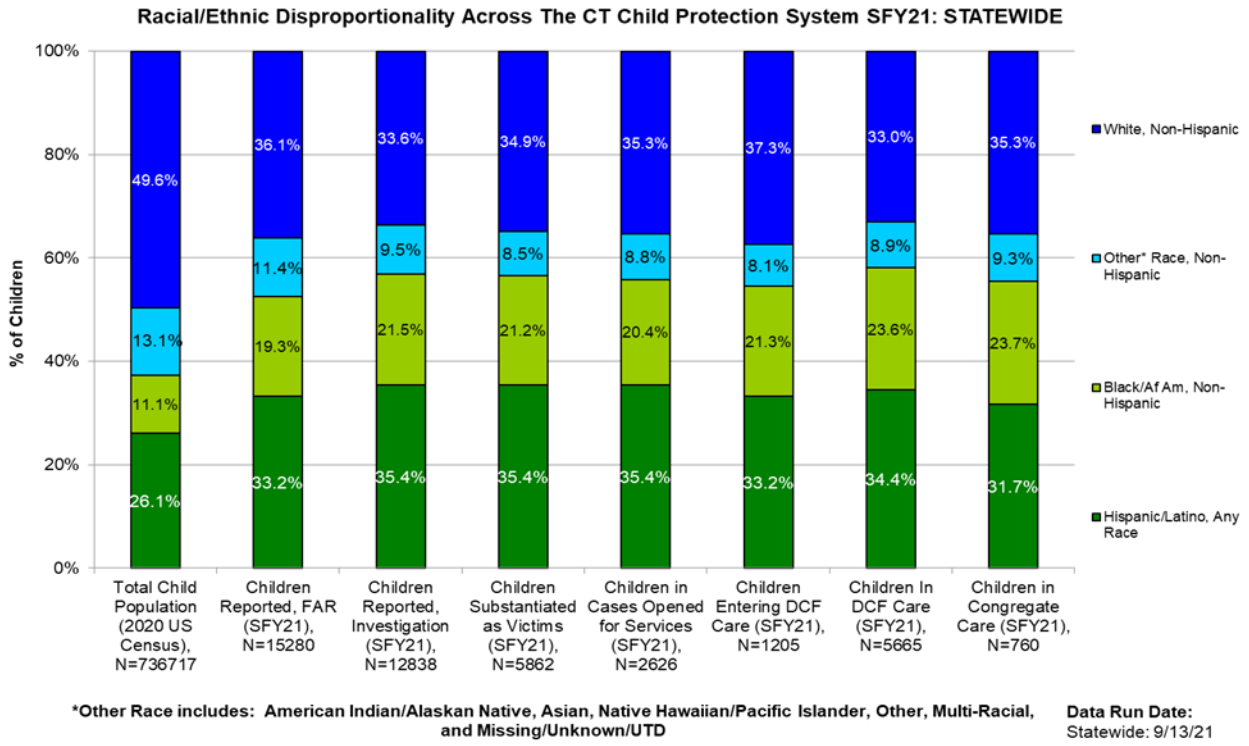


Figure 5 above shows the percentage of each racial group that comprises the CTDCF child population at each stage of involvement (key decision point), in comparison to the general CT child population in the 2020 US Census. Each bar depicts the stage or level of child welfare agency involvement. Further, each segment represents the total unique child population of each race/ethnicity observed for that specific stage. Disproportionality occurs when racial/ethnic groups in the child welfare agency child population are under or over-represented compared to the general child population. The Disproportionality Index is calculated for racial/ethnic groups by dividing the percent of children in the child welfare agency child population who are members of a racial/ethnic group by the percent of children in the general population who are also members of the same racial/ethnic group. Thus, the degree of divergence between the general and child welfare agency child populations represents the extent to which each racial/ethnic group is disproportionately represented at each stage or level of involvement in the agency.

The above data continues to reveal considerable overrepresentation of African American and Hispanic/Latinx children in all areas along the pathway decision points.

Comparing State Fiscal Year (SFY) 2021 pathway data to (SFY) 2020 pathways data indicates that apart from children entering DCF care and in congregate care, there was an increase in disproportionality in most of the decision points for the population that are Hispanic/Latinx children. There is a noted combination of increases and decreases in disproportionality for African American children. For instance, there was an increase in disproportionality of children with cases opened for services and of children in congregate care, and a slight increase of children in DCF care. There was a decrease in children entering care and no significant difference percentage wise in children substantiated as victims, however it should

be noted that total number of children collectively captured in this category decreased by approximately 1300 children. Of note, however, are the decreases for Other Race, Non-Hispanic children in all decision points. There was no significant change in most of the key decision points for White, Non-Hispanic however a very slight increase in children entering care was recorded.

In contrast to the Disproportionality Index, the Disparity Index compares disproportionality between one racial/ethnic group and a reference racial/ethnic group. The Disparity Index is calculated by dividing a racial/ethnic group's Disproportionality Index by the reference racial/ethnic group's (usually White) Disproportionality Index. The results indicate, for example, at what rate Black/African American children are reported to CTDCF in comparison to White children, i.e., "Black/African children are reported to DCF at a rate that is (e.g., 2.5) times greater than White children." Figures 6-Figure 12 shows the Disparity Index trends over the last eight years (SFY13 to SFY21) for each bar in the pathway.

The data indicate that most aspects of the pathway require continued attention to eliminate the observed disproportionality and disparity. Looking at the data via the disparity index trend perspective can clarify the effectiveness of interventions and assist in creating strategies that will ultimately impact the direction of the trend and the outcomes for families and children. The strategies implemented need to be equitable and continuously assessed to ensure that the trends are moving in the right direction. In CTDCF, not only are children of color overrepresented at all stages of the child welfare system (disproportionality) but disparities also continues to exist with Hispanic/Latinx children, Black/African American children and Other Race Non-Hispanic children when compared to White, Non-Hispanic children. African American and Hispanic/Latinx children are more likely to be substantiated for maltreatment, removed from their homes, and remain in care longer than White children.

With respect to accepted FAR reports, in SFY2021 the disparities for children referred to the FAR track significantly increased in comparison to SFY2020, except for a very slight decrease in White and Other Race. This can be interpreted as a positive trend, as in this data set, we hope to see the referrals to FAR trending upward as those families referred to FAR have low risk factors and do not require a determination of substantiation. This makes the assessment more collaborative and less intrusive in nature. While there was an increase in disparity rates in FAR there was also an increase seen in the reports accepted as investigations. Black/African American children were more than 2.75 times more likely and Hispanic/Latinx children are 2 times more likely to be reported for an investigation than White Non-Hispanic children. These are both lower than last SFY20, but reports received were dramatically impacted by COVID-19 mainly because reports made by school personnel make up approximately 29% of the reports made to the Careline. Although reports made to CTDCF continued to be received by law enforcement, medical personnel and other mandated reporters, those were also received at lower rates than prior to the Covid-19 pandemic response. As time progresses, further analysis will need to occur to understand the impact on reporting and the further potential impacts on disparities.

With respect to children being Substantiated as Victims there was little significant change from SFY2020 to SFY2021. There was a very slight increase for Black/African American Children and an increase for Hispanic/Latinx children. There was a slight decrease for children in the Other Race category and this group is now less likely than Whites to be substantiated as a victim. Similarly, in cases opened for services, Black/African American and Hispanic/Latinx saw increases as Other Race decreased and is now less likely than Whites to be opened for services.

Overall, the disparity index continues to be higher for Black children and families at all decision points across the pathway, although some progress is beginning to be seen. Children entering care showed a

significant decrease for Black/African American children from SFY2020 to SFY2021 although a disparity still exists in comparison to White children. For Hispanic/Latinx children there was a less significant decrease from SFY2020 to SFY2021. Other Race saw a decrease and continued its trend from 2020 of being less likely to enter DCF care than Whites. This could partly be due to the impacts of COVID-19 and/or the work done by staff to reduce the number of children entering care. Additional analysis will be needed to understand why this occurred.

Figure 6: Disparity Index Trends: SFY 2013-2021

Please note the yellow dotted lines denote the switch to using 2020 Census data. The years left of the line (2013-2018 use 2010 Census data while the years to the right on the line (2019-2021) use 2020 Census data for comparison Thus, the years prior to 2019 should not be compared directly to 2019-2021.

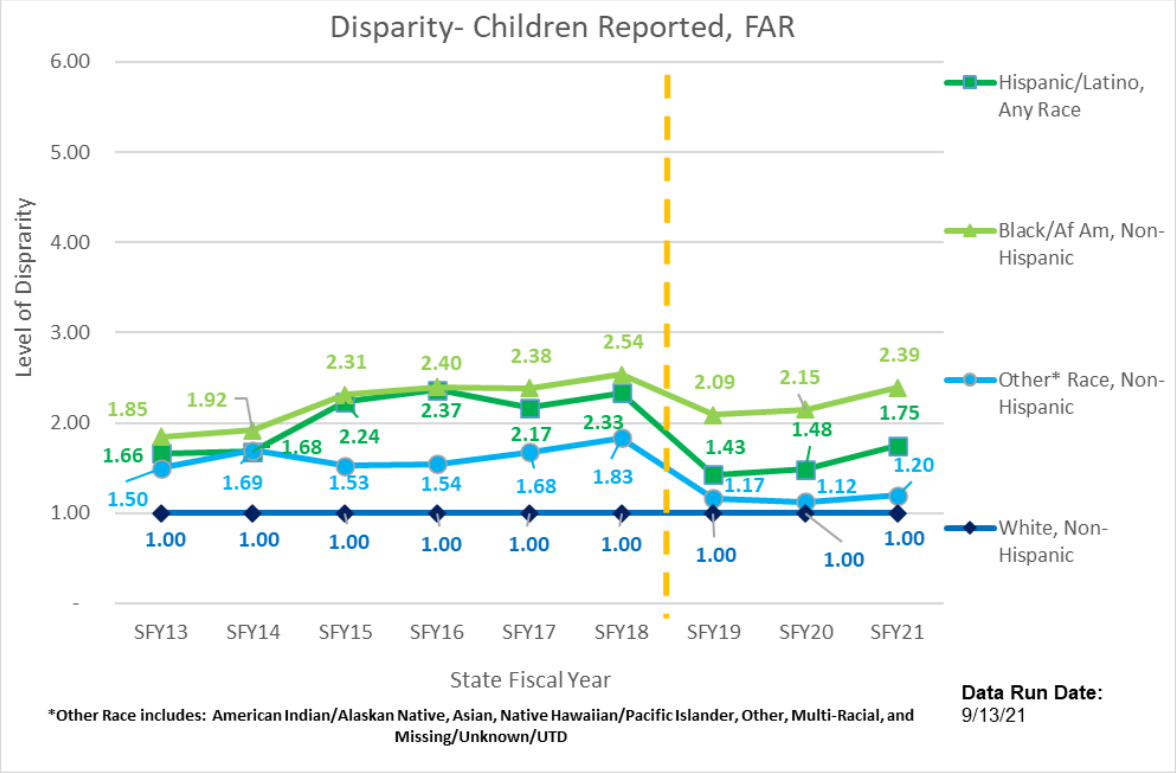


Figure 7: Disparity Index Trends: SFY 2013-2021:

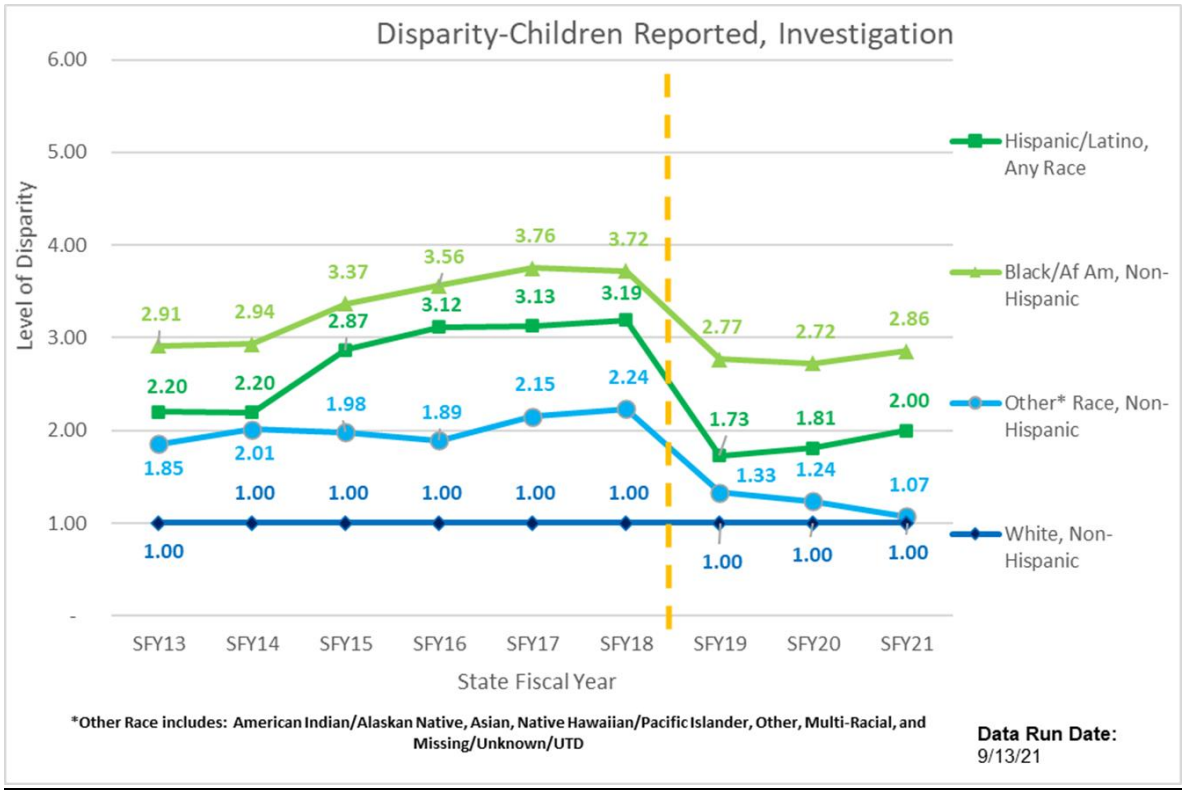


Figure 8: Disparity Index Trends: SFY 2013-2021:

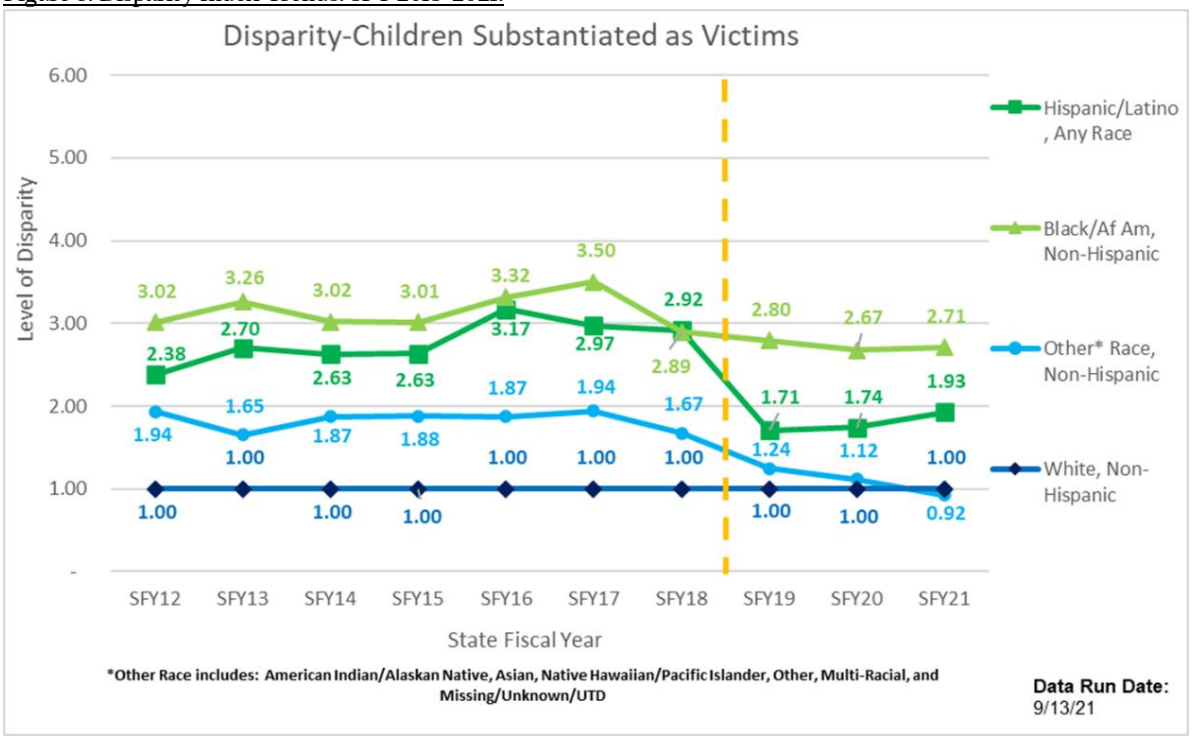


Figure 9: Disparity Index Trends: SFY 2013-2021:

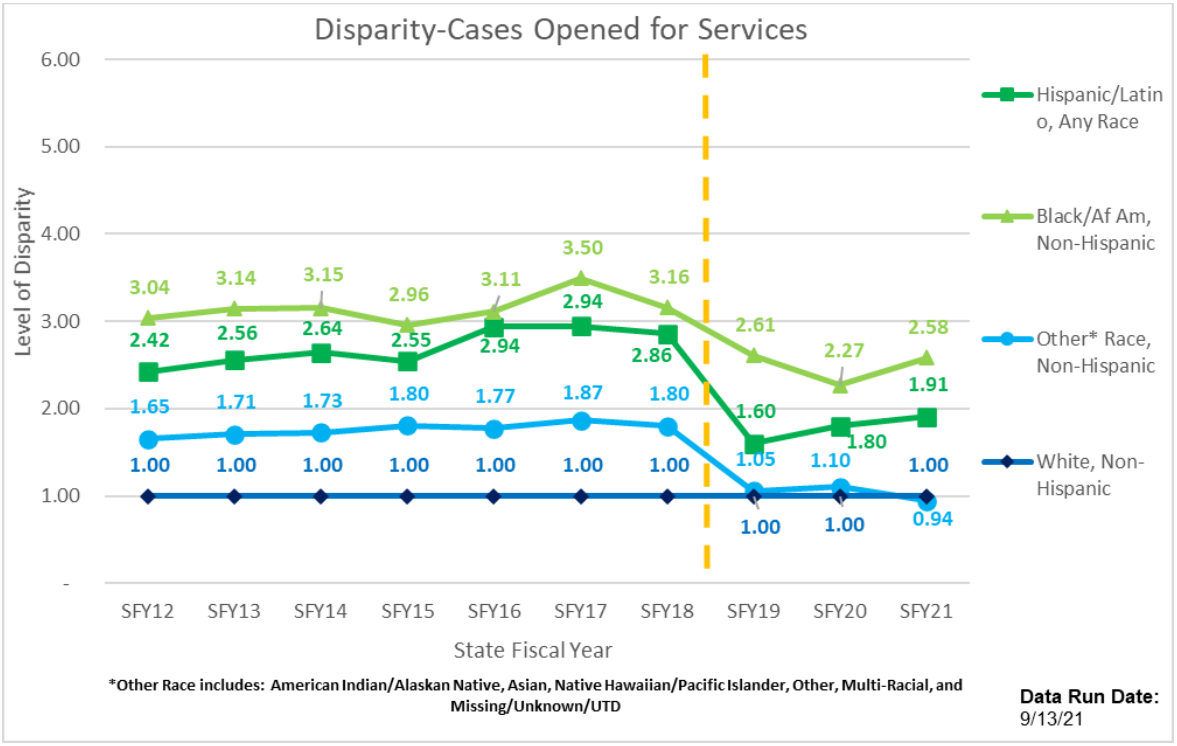


Figure 10: Disparity Index Trends: SFY 2013-2021:

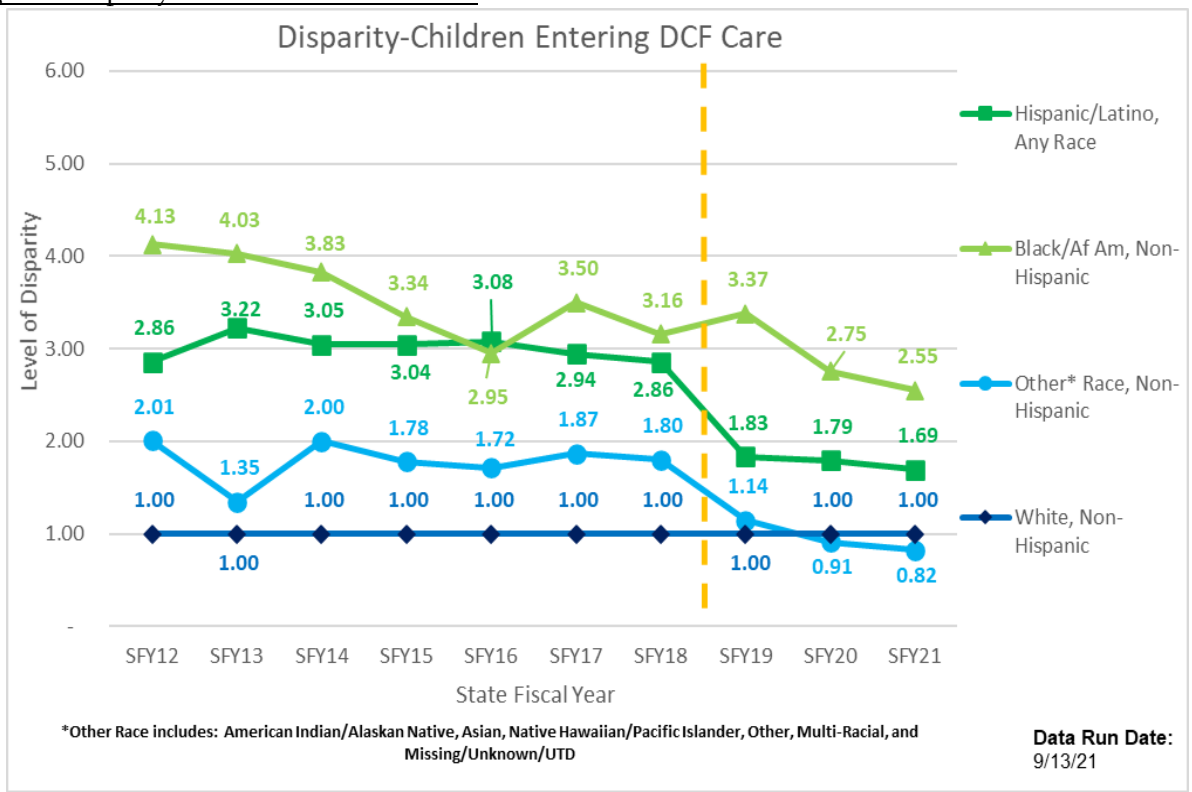


Figure 11: Disparity Index Trends SFY 2013-2021

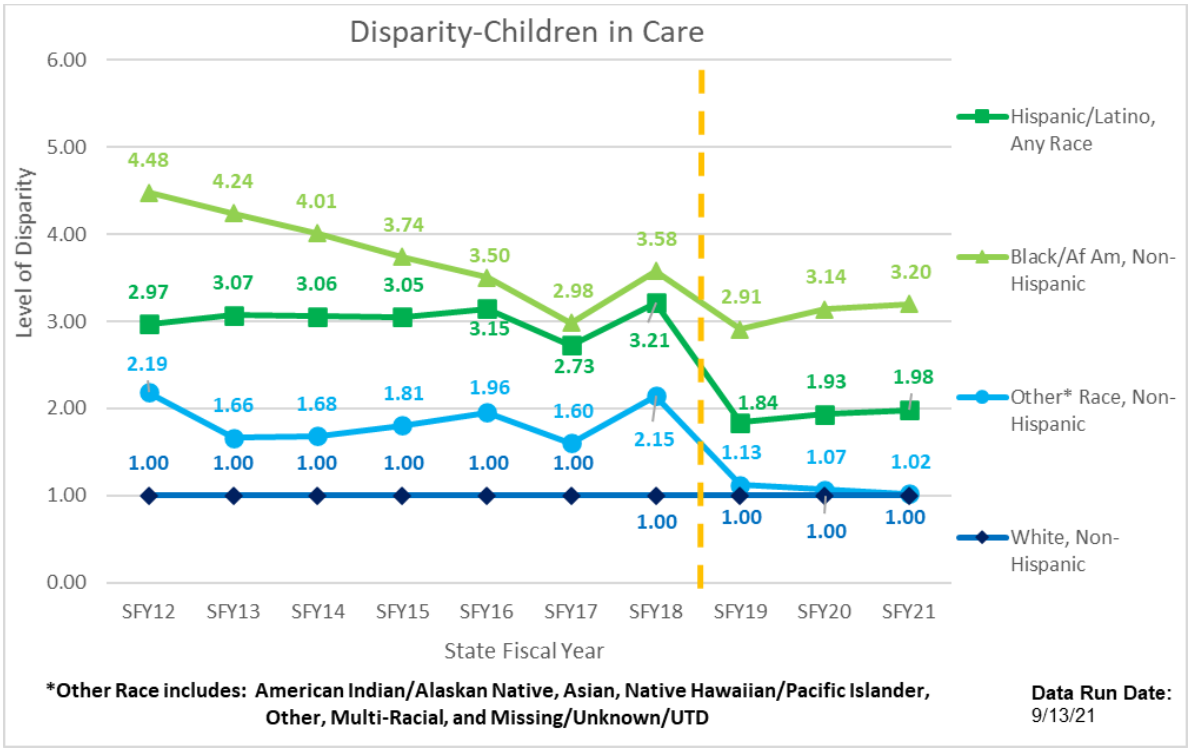
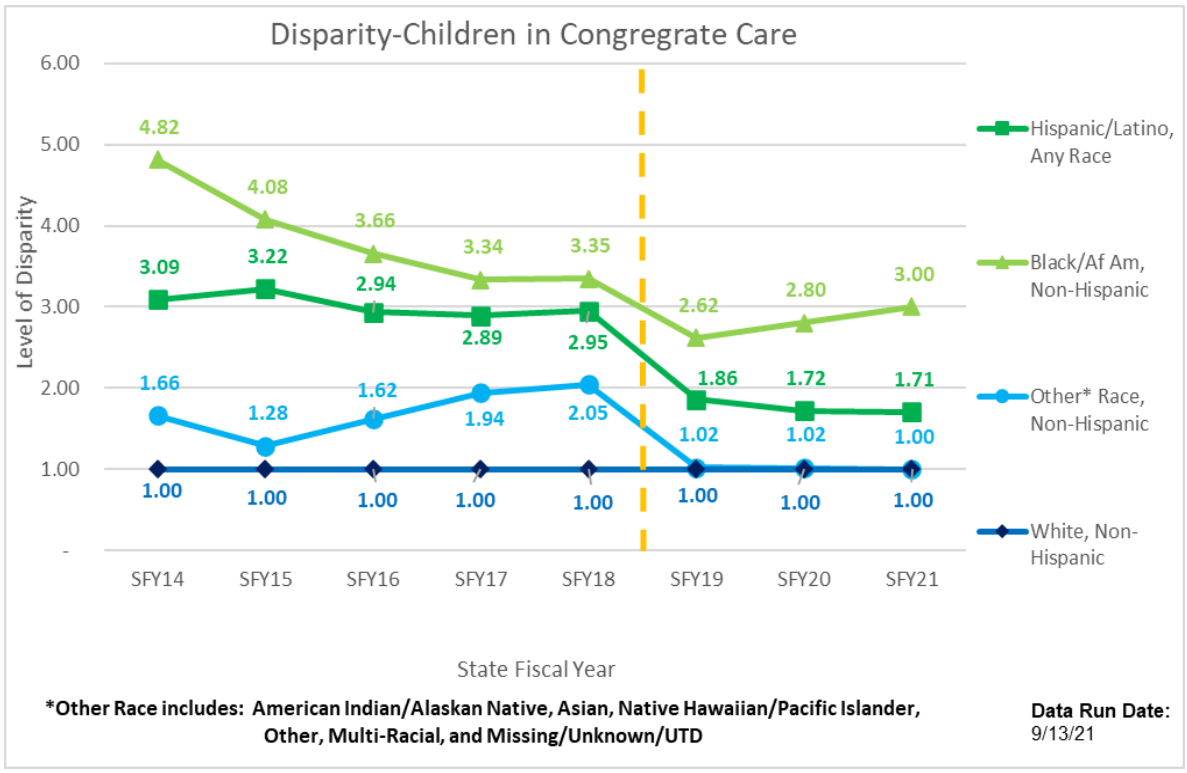


Figure 12: Disparity Index Trends SFY 2013-2021



Collectively, the Disproportionality and Disparity Index Trend data demonstrate that the Department must engage in further exploration of the specific sectors of the pathway to identify opportunities to reverse emerging trends of increased overrepresentation and disparity. Moreover, these trends when coupled with other contextualizing data, offer insights into some factors that may impact the experiences and outcomes for families and children of color. Our anti-racist work and racial justice initiatives are being constructed to address these trends as we continue to strive to eliminate disparities and achieve racial justice for all children and families served by CTDCF.

IMMIGRATION PRACTICES

The Department's Director of Immigration Practices provides consults on an ongoing basis for immigrant families that are being served by the CTDCF. The Department is certainly seeing more undocumented case participants across the board, especially in the Norwalk and the Danbury Area Offices. The subjects of these consults vary, but mostly the questions posed are around potential legal solutions regarding DCF clients' immigration statuses as well as access to mental health and medical services for those who do not have health insurance. Due to the questions and the increase in consultations, there have been 10 half day trainings in DCF area offices and another 13 such trainings in community agencies, colleges and universities throughout Connecticut. In addition, there is a monthly Immigration Practice Training available through the DCF Academy for Workforce Development for DCF employees and community providers. The subjects of this training concern legal remedies, health care resources, the dynamics of the migration process, the effects of complex trauma on engaging immigrants and the various community agencies which assist immigrants. This training is routinely updated as immigration law changes frequently.

The Department has limited data on our undocumented families. The division of Performance Management has been informed and is looking for ways to mitigate this. Many families that come to the attention of the Director of Immigration Practices are for undocumented people from Latin America who have very little access to any kind of health care. There is a concern related to the possibility of repeat maltreatment in this context, as well as inappropriate referrals to DCF because the resources are so limited.

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES:

For the past seven (7) years through the Substance Abuse and Mental Health Services Administration (SAMHSA, federal System of Care) grant, DCF has assisted and supported over fifty (50) organizations and hundreds of individuals in an organizational and individual self-assessment on how well they meet the needs of racial, ethnic and linguistic needs of all those they serve. The framework the Department has developed and used with a small group of volunteer and paid champions is based on the *National Standards for Culturally and Linguistically Appropriate Services or CLAS Standards.*

The National CLAS Standards aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities. The National CLAS Standards are a set of fifteen (15) standards that help organizations advance and sustain culturally and linguistically appropriate services. The National CLAS standards incorporate several principles including:

- fostering cultural competence;
- building community partnerships;
- collecting diversity data;
- provider planning and evaluation benchmarks;

- reflection of respect and diversity; and
- ensuring language access to all communities.

The work and process was developed into a step by step CLAS Toolkit known as the *Advancing Health Equity and Racial Justice in Children's Behavioral Health*. The CLAS Toolkit allows administrators to lead and support their staff through what may at times be a difficult self-assessment process. It is our hope that agencies and their remarkable staff can continue the difficult work to correct inequities in all health care but especially in children's behavioral health[11].

In September 2021 the CLAS regional Learning Communities began again. Every region, except for Region 1, has held at least one Learning Community meeting. Attendance is as follows:

- Region 2 held on 10/27/21 with 7 people in attendance
- Region 3 held on 9/30/21 and 10/28/21 with 10 people in attendance at each
- Region 4 held on 9/13/21 with 19 people in attendance
- Region 5 held on 11/1/21 with 18 people in attendance
- Region 6 held on 10/27/21 with 16 people in attendance

The 5th cohort of the new grant started in November 2021 with 5 agencies participating

- United Services
- Wheeler Clinic
- FAVOR
- Bridges Healthcare Inc
- United Community and Family Services

There were 4- ***Introduction to CLAS Standards*** sessions since 7/1/21 to recruit providers into the cohorts with 82 people in attendance. We currently have four organizations that have committed to our next cohort which should begin in February of 2022.

CHILD SAFETY PRACTICE MODEL:

In October 2020, the Department established a contract with Taylor Consultants to develop CT's Child Safety Practice Model, with a specific emphasis on approach, interactions, and decision-making in the midst of the COVID-19 pandemic. When developing safety practice models, many jurisdictions focus their work internally, but we decided to be much broader in our view and include our external partners in helping us keep children **safe** in the community. The model aligns with our core values around engagement of families, building upon the family's protective factors and capacities, and **keeping children safely** at home whenever possible. The model is specific to CT and builds upon our existing policies and practice guides with key features intended to refine and strengthen our safety assessment and safety planning practices. Additionally, the model is designed to promote greater consistency in language and understanding of safety both internally and externally as well as promoting greater equity in decisions. The model is built upon the following guiding practice commitments that provide the context for assessing safety and safety planning:

1. Safe and Sound Culture & Safety Science
2. Commitment to Equitable Safety Outcomes & Racial Justice
3. Comprehensive Assessment, Resources, Tools, & Protocols

[11] https://www.plan4children.org/connecting-to-care/culturally-and-linguistically-appropriate-services/

4. Supervision and Consultation to Inform Critical Thinking
5. Community Partners shared understanding
6. Comprehensive Service Array focused on Safety
7. Supports for Kin, Foster, and Adoptive Families
8. Dedicated safety attention for Young Adults

The four objectives of the model are as follows:

- Increasing consistency of safety related language;
- Increasing consistency of decisions and outcomes;
- Clarifying expectations for DCF staff and community-based partners; and
- Increasing understanding of applied safety concepts

The model focuses on the ABCD paradigm, which will be become our way of thinking about child safety and a strategy of collecting critical information to help inform our safety decisions in real time. The model focuses attention on the following areas that we believe are critical to assessing child safety:

- A= Adult parental protective capacities
- B= Behaviors that are harmful
- C= Child Vulnerability
- D= Dangerous Conditions

Although the model builds from our strong safety practices, including the continued use of our revised SDM Safety Assessment and Considered Removal Child and Family Team Meetings, there will be new features that will be designed to enhance skill building and development, facilitate information sharing, and promote critical thinking. Practice Profiles, a tool developed by the National Implementation Network (NIRN) identifies specific skill sets along a continuum from beginning level to advanced that will help operationalize the model and serve as a foundation for training and supervision.

Beginning in May 2021, the model was presented to various stakeholders, including the state's Advisory Groups at the local and statewide levels, and Focus Groups were held with consumers (parents, foster parents and youth) to gain broader community feedback about our safety practices and the model. Beginning in April, front-line staff were trained on the model and efforts are underway to develop a plan for external training, including contracted services, credentialed providers, other state agencies and advisory groups, and mandated reporters.

SERVICE ARRAY ANALYSIS:

CTDCF continues its commitment to ensuring that the provision of services to families and children are culturally, linguistically, socially and economically relevant and symbiotic to the demographics of our children and families. The Department also ensures that all providers provide a detailed description on their agency's knowledge, expertise and understanding of diversity (including, but not limited to: racial, ethnic, gender and gender identity, sexual orientation, culture, linguistic, immigrant, disabilities, and religion) as it relates to the provision of services prior to the implementation of any service.

Since 2016, the Department has maintained that all Requests for Proposals (RFP's) include explicit language stating the requirement that Department-funded services be responsive to diverse cultural health beliefs and practices, experiences of racism, preferred languages, health literacy and other communication needs. In 2019, the Department furthered this mission by requiring applicants in a Department RFP process to demonstrate in their proposals:

§ Their knowledge of the cultural makeup and dichotomy of the geographical regions they are proposing to serve;

§ The challenges the applicant has experienced and the strategies they have utilized to engage families in a culturally responsive manner; and

§ The applicant's commitment to cultural and linguistically competent care through the diversity of their organization and staffing composition.

This section of each RFP is worth 15 points towards the overall scoring and award of a contract with the Department. In addition, the Department remains committed to ensuring that its service providers deliver effective, equitable, understandable, trauma informed and respectful quality care. The services delivered must be responsive to diverse cultural health beliefs and practices, experiences of racism and/or other forms of oppression, preferred languages, health literacy, and other communication needs. Applicants must demonstrate throughout their responses, that the children and families receiving services in their program are approached, engaged and cared for in a culturally and linguistically competent manner, including but not limited to: cultural identity, racial and/or ethnic, religious/spiritual ascription, gender, physical capability, cognitive level, sexual orientation, and linguistic needs. Within a broad construction of culture, service provision must also be tailored to age, diagnosis, and developmental level, geographical, economical, and educational needs.

In 2021, through partnership with Casey Family Programs, the Contracts Division furthered its efforts by establishing formal technical assistance to small, urban-led community providers. The goal of this effort is to build capacity within these smaller community-based providers to help them meet the states' requirements so that they can become funded services providers for children and families in their own communities. This initiative offers a 5-topic group learning collaborative, as well as individual assistance to providers looking to expand or begin collaborating with the Department on service provision to children and families. The learning series (group sessions) targets five specific areas commonly a struggle for small providers:

1. Basic Branding
2. Basic Record Keeping
3. Financial Statements
4. Contract Development
5. DCF 101

Two cycles of the services have been offered thus far, and total attendees are:

1. Basic Branding: 27
2. Basic Record Keeping: 23
3. Financial Statements: 17
4. Contract Development: 13
5. DCF 101: 26

Part of this initiative is also 1:1 technical assistance to providers. Since the initiatives' inception, and since formal implementation, **HEDCO** (a company designed to assist small business with growing their business and our community partner on the RJ Initiative to successfully engage minority led, urban provider agencies to our service array) has worked with five different providers (some are still in process)

on a variety of self-identified issues (e.g., Business Plan Development, Business Structure, Branding, Finance Review, Basic Record Keeping, etc.). CTDCF is getting ready to move into the third cycle of this effort and plans to add a few additional topics to target some of the issues identified in the previous two cycles.

The Department continues to maintain a data collection and reporting system to support the monitoring and oversight of its contracted services. This system, the Provider Information Exchange (PIE), encompasses multiple programs across the state and contains multiple data elements that allows the Department to track and monitor utilization, outcomes and the quality of services delivered. These data are reportable by key client demographics, including age, gender and race and ethnicity.

As the COVID-19 pandemic unfolded, the Department shifted its contracted service continuum to a virtual model of service provision in almost all cases, although the service provider network maintained the capacity to provide in-person services in emergency situations. Throughout the pandemic, the Department engaged in frequent discussions with its contracted providers regarding the efficacy of virtual service provision as well as when and how to reengage back to in-person models of care. In preparation for this step, the Department engaged its provider network in a collaborative Continuity of Care (COOP) Service Model Plan development process. The premise of service model COOP plans is to ensure that each of the 80 service types available to children and families across Connecticut through a contract with DCF can remain operational in the face of an emergency- finite or prolonged, and that each will operate in a standardized consistent model, regardless of geographical location. Each of CTDCF's contracted services now has a COOP plan that identifies all of the components of the service, which can be temporarily transitioned to a virtual model of service then breaks an emergency situation into 4 phases and identifies how each component of the service type will be provided in each phase (virtually, in-person or suspended). While these plans loosely mirror the State phases of an emergency, they are designed to be fluid enough to allow for deviation from the overarching State-delineated phase if required by safety factors for children. Additionally, the plans were not specific to the COVID-19 pandemic, but rather any emergency that might be realized by the State in the future.

The implementation of the COOP plans allows DCF, with one communication, to establish an emergency phase for all providers, of all services, from all 330 individual programs across the State. This ensures consistency and standardization of service provision from providers of like service type which provides continuity to our children and their families while also ensuring that data for this timeframe can be analyzed through the same lens. It also ensures CTDCF's ability to remain committed to quality assurance efforts as staff can be made aware of CTDCF's expectations during an emergency and can monitor accordingly.

Results Based Accountability (RBA) Performance Outcomes for all POS Contracts: The Department has committed to ensuring that all contracted community programs contain RBA measurable performance outcome measures. As part of that effort, the Department's Service Outcome Advisory Committee (SOAC), comprised of CTDCF staff from all continuums- regional staff, social workers, system program directors, program coordinators, fiscal staff, contract management staff, Academy for Workforce Development staff, clinical staff and various other staff throughout the Department, as well as provider and consumer representatives, have begun an in-depth review of each contracted service type to develop Performance Outcome Measures for each of the 80 service types (330 programs) under contract with the Department. This initiative utilizes a standardized, comprehensive process that includes subject matter experts, the current provider network and consumers to develop standard performance outcome measures that target the key performance indicators of the service type, provide consistency across the DCF service array and establish measurable and attainable goals for all contracted providers, inclusive of a measurable Racial Justice performance outcome measure for every service type.

This work, once completed, will provide the framework, in conjunction with the service coordination process, to perform in-depth analysis of each contracted service type, on an annual basis to include review of statistics, performance measures, capacity and utilization trends, effectiveness of services, fiscal analysis and anecdotal information from workers who use the programs, to determine what works within the level of care, and what could be done better and how the Department can enhance the service to provide better outcomes for Connecticut's children and their families.

The Systems' Division continues to focus on enhancing our service system to better meet the needs of children and families by promoting strong engagement and collaboration within CTDCF and our community partners. In January 2022, the Division celebrated 2 years of Enhanced Service Coordination (ESC) being implemented to all CTDCF Regions. ESC is a needs focused consultation model to ensure that service referrals are focused on services that best align or match the identified needs for a family.

Since launching statewide and throughout the pandemic, the ESC Service Coordination team has continued to focus on ensuring timely referrals through ongoing outreach and consultation with staff and service matching for four of the Department's parenting support services: Intensive Family Preservation (IFP), Reunification and Therapeutic Family Time (RTFT), Parenting Support Services (PSS) and Child First. We refer to these as our ESC Services for purposes of this report.

Throughout the pandemic, the Division has helped DCF navigate the impact that COVID-19 has had on our families, staff, and providers by maintaining ongoing communication and collaboration with DCF staff and providers to support continuity of services. Furthermore, despite COVID-19 challenges, the Systems' Division partnered with Divisions across DCF and the provider network to ensure minimal interruptions to service delivery. The Division has provided integral support to our larger CTDCF system, including social workers and providers, by helping facilitate triaging protocols for face to face contact, navigate staffing shortages, and other COVID-19 related challenges for internal and external partners.

The Systems' Division continues to participate in monthly statewide meetings convened by DCF Program Leads for the four ESC services to discuss program service delivery, capacity, waitlist, and staffing. ESC Service Coordinators Program Leads and providers have led several informational town halls throughout the year to ensure staff were familiar with the four services and how they can meet the needs of families. The ESC Service Coordinators continued to track referrals and assess trends through Regional dashboards. The information is then shared with Regional leadership and providers to highlight timeliness, service match, utilization data and support in real-time, data-informed conversations, troubleshoot issues and assess performance.

In 2021, the Systems' Division developed a change initiative that focused on assessing and addressing disproportionality and disparate outcomes in service provision for families referred to the four ESC services. The change initiative promotes broad engagement with CTDCF Regions and Central Office Divisions, provider partners, and across Connecticut's broader child welfare system. Through this effort, the Division is actively assessing multiple factors that may contribute to disproportionality and disparity in service provision for the four ESC services to families with overarching strategies designed to raise awareness of racial inequities. These include Engagement of External Stakeholders with the Implicit Bias Training and Anti-Racist Framework and Engagement of CTDCF Staff and ESC Service Providers to Understand Service Trends.

In 2021, the Division successfully completed training and presentations on CTDCF's Anti-Racist Framework and Implicit Bias training to all IFP/RTFT providers. These activities also included a follow up feedback surveys to identify opportunities to collaborate and determine unmet service provider needs in this work. This will allow us to build future opportunities to use data in collaboration with providers to formulate solutions with shared accountability by analyzing service trends across multiple data points.

In 2022, the Systems' Division will continue to explore expansion of ESC as a needs-focused consultation model to manage referrals for others contracted services at DCF so that similar analyses and provider engagement can promote shared accountability in our journey to transforming CTDCF into an anti-racist child welfare system.

For the purpose of this report and to provide clarity on graphs and data shown, the following definition will assist in understanding the graphs and data presented. Data presented from the service array is primarily collected from DCF-contracted providers of services. See below for descriptions of the charts.

> Caregiver - Client/participant in service. Depending on service requirements and intended clientele, caregiver may mean biological parent, foster parent, or other participant with responsibility to care for a child.
>
> Caregivers serviced - Presents numbers of caregivers in each race/ethnicity group involved with the service, including clients designated as evaluation only and excluding crisis only episodes. Percentages are calculated by dividing number of caregivers in that race/ethnicity group divided by the total number of caregivers served during the fiscal year.
>
> Met treatment goal - Clients designated as such have met all or most of the treatment goals of the program or otherwise received intended benefit(s) of the program as determined by provider. Percentages are calculated by dividing number of caregivers per race/ethnicity group that met the treatment goal by number of caregivers who were expected to complete treatment (excluding evaluation only and excluding crisis only episodes) in each of these race/ethnicity groups.

In April 2012, following the statewide implementation of our Differential Response System, funding was allocated by the legislature to provide continued support to families, who received a Family Assessment Response (FAR). Community Partner Agencies (CPA) were selected through a statewide procurement process in all six DCF regions to further support families and connect them to an array of community supports and resources, designed to promote the safety and well-being of children and their families. The program was designed to connect families to concrete, traditional and non-traditional resources and services, utilizing a Wraparound Family Team approach and philosophy, placing the family in the lead role of their own service delivery. UCONN School of Social Work continues to function as our Performance Improvement Center to evaluate our intake practice, as well as outcomes and service delivery data for the Community Support for Families Program (CSF).

Figure 13: Disposition to Community Support for Families for SFY 2021

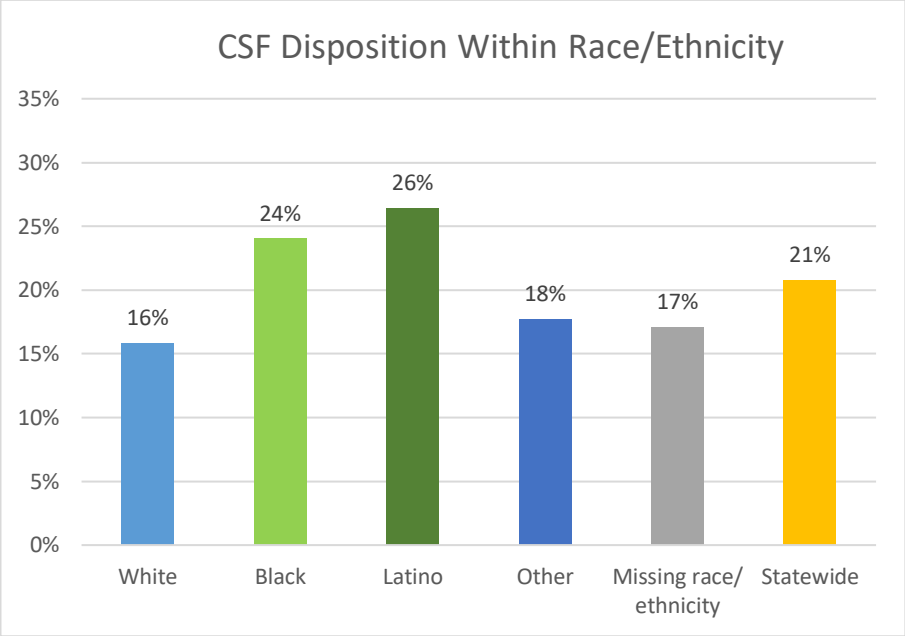
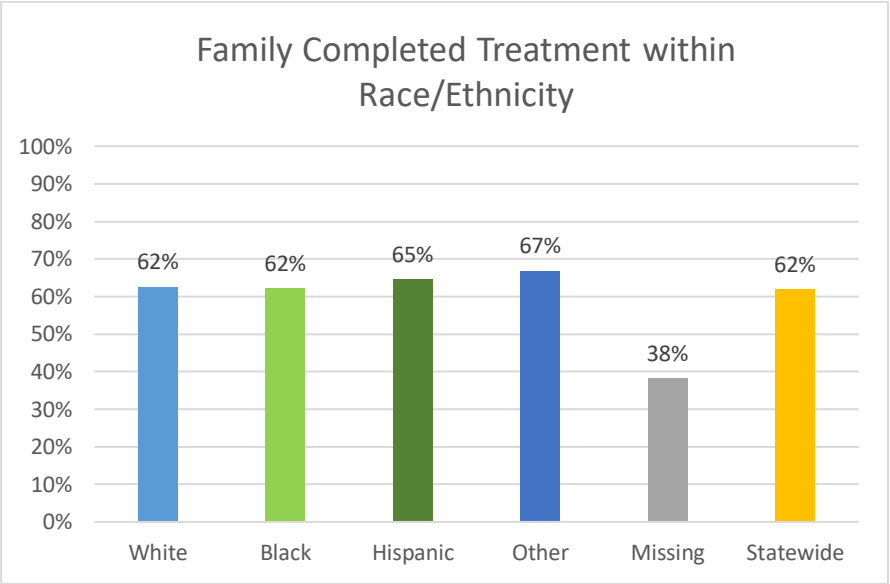


Figure 13 above shows that of all families who received a Family Assessment Response, approximately 21% of families were referred to the CSF program. Variations were noted by race/ethnicity which are as follows: 16% of White families were referred to CSF compared to 24% Black families; 26% Latino families and families of other race groups at 18%. Seventeen percent (17%) of families were missing race/ethnicity information for the primary caregiver. The family is the unit of analysis for the program and as such, the race/ethnicity of the primary caregiver is used in the analysis. While families are being referred to CSF at differing rates by race, these seem to be the "right" families, i.e. those that need the additional support that CSF offers.

Figure 14 below represents the families who completed CSF Treatment by Race/Ethnicity. Overall, 62% of families completed treatment. A significantly lower percentage of families missing race/ethnicity completed treatment compared to families with an identified race.

Figure 14: Families who completed CSF treatment; Race and Ethnicity for SFY 2021



The CSF program has continued to operate during the COVID-19 pandemic. The Community Partner Agencies (CPAs) have implemented a number of provisional practices around limiting in-person visits to protect CSF families and staff from COVID-19 including utilizing telehealth for most visits, checking in with families by phone in between video conferences, providing PPE to families and staff when in-person visits are necessary, doing curbside/front porch visits when possible, and providing gift cards for goods needed. Since service delivery has had to rely mostly on telehealth, it is important to understand the barriers for families to utilizing this service.

Looking for areas of systemic racial injustice is critical; therefore, UCONN's research agenda prioritizes analyzing and assessing potential racial disproportionality/disparities. UCONN will examine disproportionality and disparity at key decision points of our intake practice including substantiation, central registry, safety and removal decisions, and case disposition. UCONN will continue to evaluate outcomes of families who are referred to the CSF program through a racial justice lens.

As required, CTDCF will continue to submit our annual legislative report relative to our FAR and the CSF Program, inclusive of rates of subsequent reports and substantiations though a racial justice lens. Assessing racial disproportionality and disparity in the Connecticut child welfare system will help inform our collective efforts to reduce racial disproportionality/disparity.

INTEGRATED FAMILY CARE and SUPPORT PROGRAM (IFCS):

In partnership with Beacon Health Options, CTDCF established a program in early 2020 to empower and strengthen families as well as remove the stigma of CTDCF involvement for families accessing CTDCF funded services to address their needs. The development of the program was a result of a budget option submitted under CTDCF's prior administration following a review of data, specifically looking at the high rate of unsubstantiated case transfers to ongoing services. The program was developed in the belief that families would be better served in their own community without CTDCF involvement and aligns well with the FFPSA and our prevention mandate. Integrated Family Care and Support (IFCS) was designed to engage families while connecting them to concrete, traditional and non-traditional resources and services in their community, utilizing components of a Wraparound Family Team Model approach. The length of service provided is 6-9 months based on the family's level of need and willingness to engage in

services with an option to extend the length of service if needed. Families who meet the eligibility criteria can be referred to the program. Outcome Measures for the program focus on engagement, family satisfaction, reduction in child maltreatment and several performance indicators and will be evaluated through a racial justice perspective.

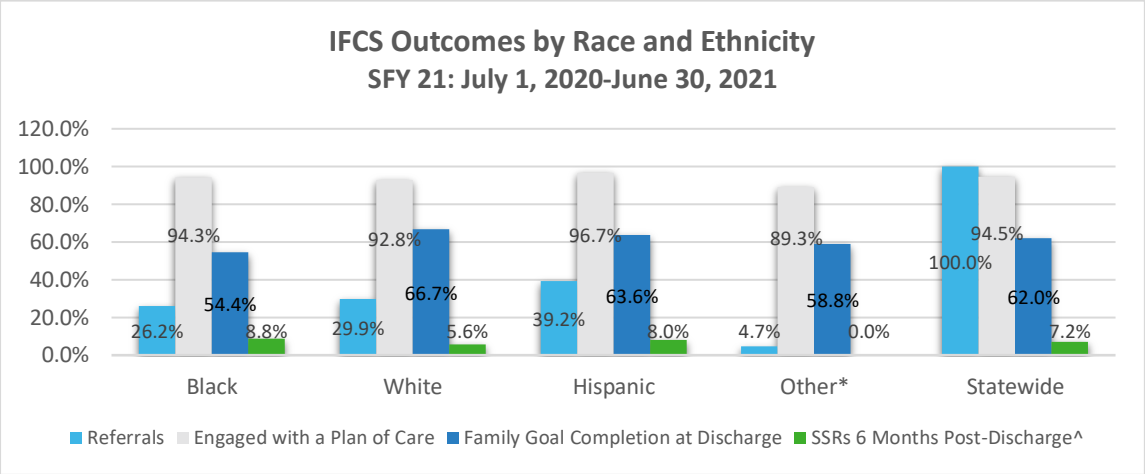
By the end of SFY 2021, nearly 1,168 referrals were made to the IFCS program. IFCS is designed to be community based, working directly with families in their homes. Care Coordinators and Peer Support Specialists live in the communities they serve, and reflect the racial, ethnic, and language that are predominate within the regions. Unfortunately, health and safety factors related to the spread of COVID-19 limited face-to-face interactions from mid-March 2020 to July 2021. The program quickly pivoted, and enhanced engagement efforts through innovative problem solving and by leveraging available technology. These efforts successfully re-envisioned what care coordination under the Wraparound approach could look like during a pandemic. Beacon's IFCS team supported families of all races and ethnicities to turn limitations into opportunities and helped support families to meet their goals and kept children at home safely in their communities.

The Central Office Program Lead continues to meet with Beacon Health Options staff on a monthly basis to review referrals, address programmatic issues, review data, and develop data reports. Regional CTDCF/IFCS staff meet regularly to foster relationships between CTDCF/IFCS staff, address case specific concerns, promote communication, and ensure the needs of families are addressed during the COVID-19 pandemic. CTDCF will continue to work closely with Beacon Health Options and regional staff to assess and evaluate service delivery, child and family outcomes, as well as outcomes through racial justice and equity.

Race and Ethnicity data is captured only for the primary caregiver of the families referred to IFCS. Figure 15 below represents several of the IFCS outcomes by race and ethnicity[12]. The breakdown of race and ethnicity for the 909 referrals received within the timeframe indicated are as follows: 29.9% White, Non-Hispanic, 26.2% Black/African American, Non-Hispanic, 4.7% Other Race, Non-Hispanic, and 39.2% Hispanic/Latino, Any Race.

[12] *The race and ethnicity categories in figure 15 are represented according to DCF's request and are different than the categories Beacon uses for reporting. For the Hispanic Origin category, DCF interprets a null value in both the Hispanic checkbox and ethnicity field as Non-Hispanic. Therefore, null values for ethnicity have been categorized as Non-Hispanic.*Other includes American Indian/Alaskan Native, Asian, Native Hawaiian/Pacific Islander, Other, Multi-Racial, and Missing/Unknown.*

Figure 15: IFCS Outcome by Race and Ethnicity for SFY2021



As shown in Figure 15, the percent of caregivers who engaged in the program, as defined by developing a plan of care, was similar for all groups; with Hispanic caregivers engaged at a slightly higher rate and Other caregivers at a lower rate. The biggest variation in rates among the demographic populations was for the goal completion outcome. There was a lower percent of Black caregivers completing goals at discharge compared to the statewide rate and, despite the lower rate of care plan development, White caregivers had higher rates of goal completion. As indicated in the notes below, rates for subsequent substantiated reports (SSRs) 6-months post-discharge are somewhat misleading due to the overall number of SSRs being less than 10. The total number of SSRs 6 months post-discharge was only nine through 6/30/21. This very small *n* size greatly skews the rates and makes it difficult to compare and include in any analysis on disparities, as a difference of one greatly changes the percent.

Due to the timing of the IFCS start, the program does not have a full calendar or state fiscal year of data to compare this current data against and is unable to provide trends analysis. In addition, without pre-COVID-19 service data it is difficult to measure the impact of COVID-19 on service delivery. However, reporting of race and ethnicity rates by referred, engaged status, and program outcomes will continue to occur on a quarterly basis. Ongoing monitoring of race and ethnicity rates by outcomes will continue to guide programmatic efforts in the year ahead.

INTENSIVE FAMILY PRESERVATION (IFP):

This service provides an intensive in-home service designed to intervene quickly in order to reduce the risk of out of home placement and or abuse and/or neglect. Services are available to families 24 hours per day, seven days a week with a minimum of 2 home visits per week including a minimum of 5 hours of face-to-face contact per week for 4-6 months. Staff work a flexible schedule, adhering to the needs of the family. A standardized assessment tool is used to develop a treatment plan and to focus the intervention based on the needs of the family. As needed families are linked to other therapeutic interventions and connected with basic needs such as housing, education and employment needs including making connections with non-traditional community supports and services. The target population for this service includes CT DCF active in-home and Integrated Family Care and Support (IFCS) cases. This service is delivered when there is an emerging removal concern for children from birth through 17 years of age.

Figure 16: Number of Caregivers served by (IFP) in SFY 2021 by Race/Ethnicity

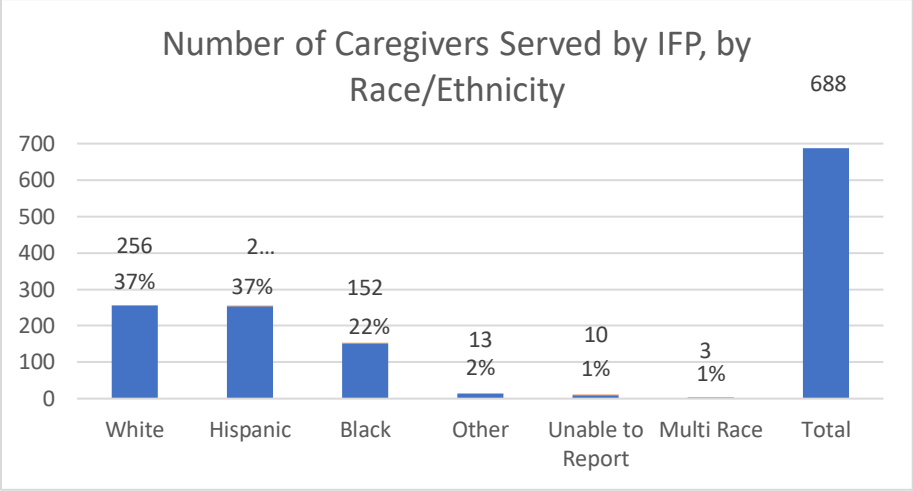
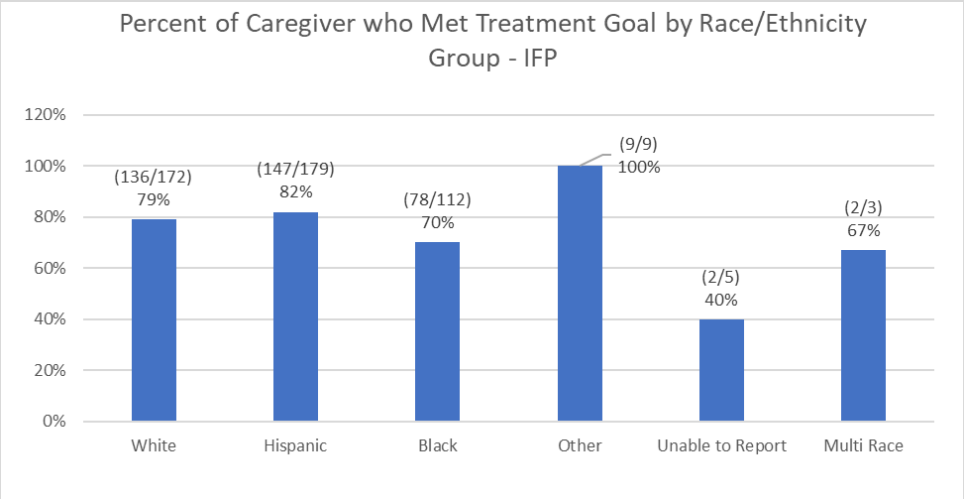


Figure 16 (above) shows the number of caregivers who received IFP services in SFY 2021 broken down by race. In SFY 2021, there were a total of 688 caregivers serviced by IFP, **representing a decrease in caregivers since SFY 2020,** when 817 caregivers were served. White caregivers make up the highest proportion of caregivers served. There were 10 (1%) caregivers in which race/ethnicity was noted as "Unable to Report." In comparing SFY 2021 to SFY 2020, the percentage of White, Black and Hispanic families served all increased by 1%, 2% and 2 % respectively.

The Department examined the percentage of caregivers served by IFP that met the treatment goal across different racial/ethnic groups (Figure 17 below). In SFY 2021, 374 caregivers met their treatment goal for IFP services, of the 480 caregivers who expected to complete treatment during the fiscal year. Caregivers expected to complete treatment are a subset of all caregivers served, as all individuals' participating in services (688, picturized in the chart above) start at different moments in the year, and thus may be expected to continue in programming for longer than the fiscal year. In comparing SFY 2021 to SFY 2020, the percentage of Black caregivers who met the treatment goal decreased by 9 percentage points. The percentage of Hispanic caregivers who met their treatment goal increased by 11% points.

Figure 17: Percentage of Caregivers Served by IFP who Met Treatment Goals in SFY 2021 by Race/Ethnicity:



REUNIFICATION AND THERAPEUTIC FAMILY TIME (RTFT):

Reunification Readiness Assessment, Reunification Services, and Therapeutic Family Time are designed for caregivers with children (from birth to age 17) who were removed from their home due to protective service concerns. These three service types are available to caregivers as three separate components based on the needs of the family. Families can be referred for this service immediately following a child's removal from the home or at any time during their placement. Reunification Readiness Assessment uses a standardized assessment tool to ultimately render a recommendation regarding parental and child readiness to reunify. Reunification Services also uses a standardized assessment tool to develop the service plan, delivers a staged reunification model to support families throughout the reunification process, adopts the Wraparound Model design to engage the family and build their networks of support, delivers Therapeutic Family Time uses the Visit Coaching Model, to restore parent/child attachment and facilitate permanency planning and emphasizes a continuity of relationships. Visit Coaching is incorporated into all three service types offered by the RTFT service. The target population includes only those families whose children in out of home placement or cannot return home without services. Families to be served include biological and adoptive caregivers referred by CTDCF and includes CTDCF active caregivers only. For all services except Therapeutic Family Time, the permanency goal for the referred child must reunification.

Figure 18: Number of Children served by Reunification and Therapeutic Family Time (RTFT) in SFY 2021 by Race/Ethnicity:

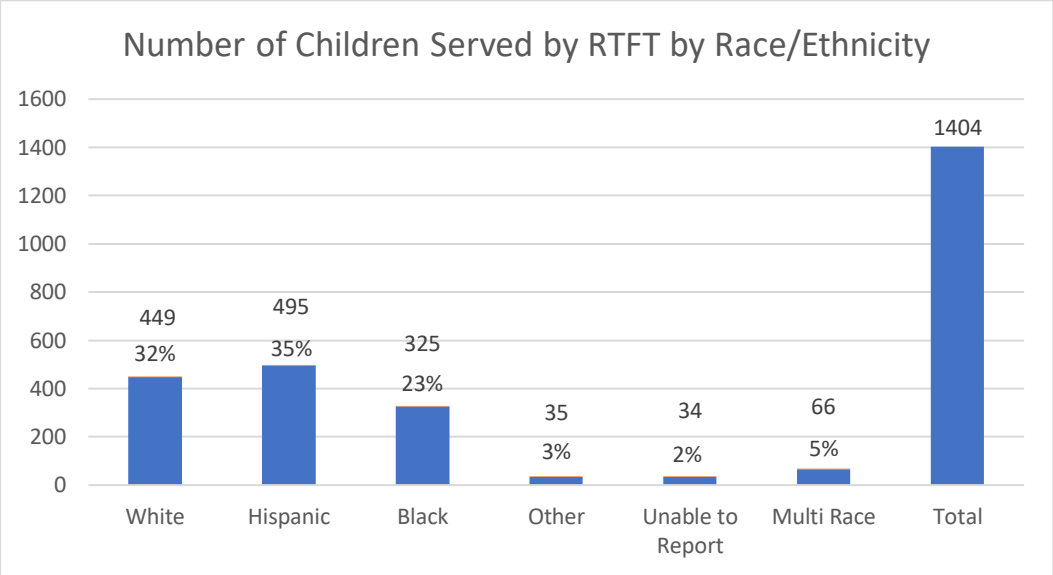


Figure 18 (above) shows the number of children who received RTFT services in SFY 2021 broken down by race. For SFY 2021 there were a total of 1404 children served by RTFT, a substantive increase since SFY 2020, when 1124 children were served. Hispanic children make up the highest proportion of children served. There were 34 (2%) children in which race/ethnicity was noted as "Unable to report." In comparing SFY 2021 to SFY 2020, Black children served slightly decreased by 1 percentage point. The percentage of White and Hispanic children increased by less than 4 and 5 percentage points respectively.

The Department examined the percentage of children that met the treatment goal across different racial/ethnic groups (Figure 19 below). In SFY 2021, 906 children met their treatment goal for RTFT services compared to 1116 children who were expected to complete treatment. The percentage of Black children who met the treatment goal decreased by 1 percentage points from SFY 2020 to SFY2021. The percentage of Hispanic and White children who met their treatment goal increased by 6% and 2% percentage points respectively.

Figure 19: Percentage of Children served by RTFT that Met Treatment Goal in SFY 2021 by Race/Ethnicity:

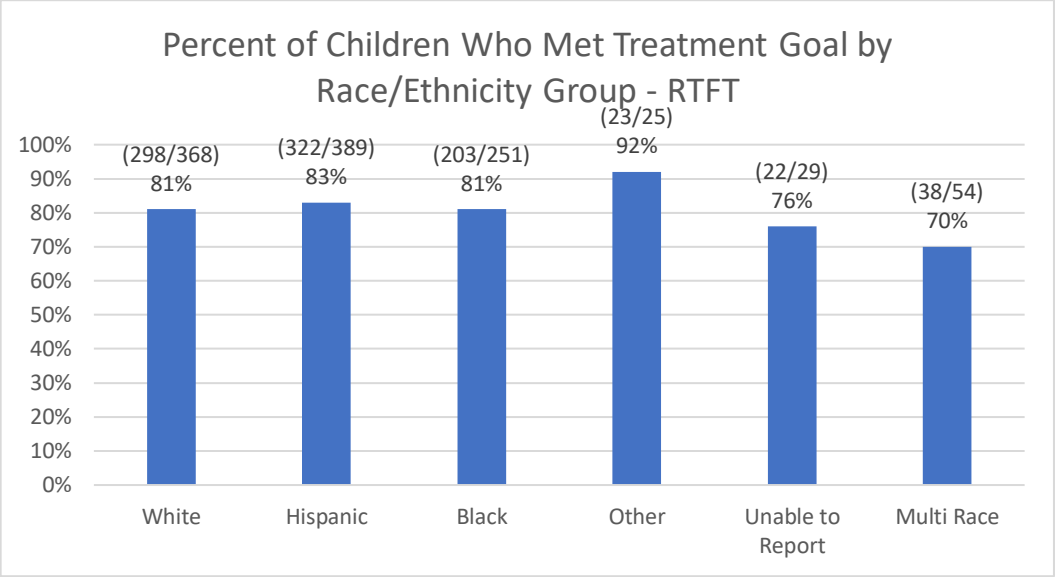
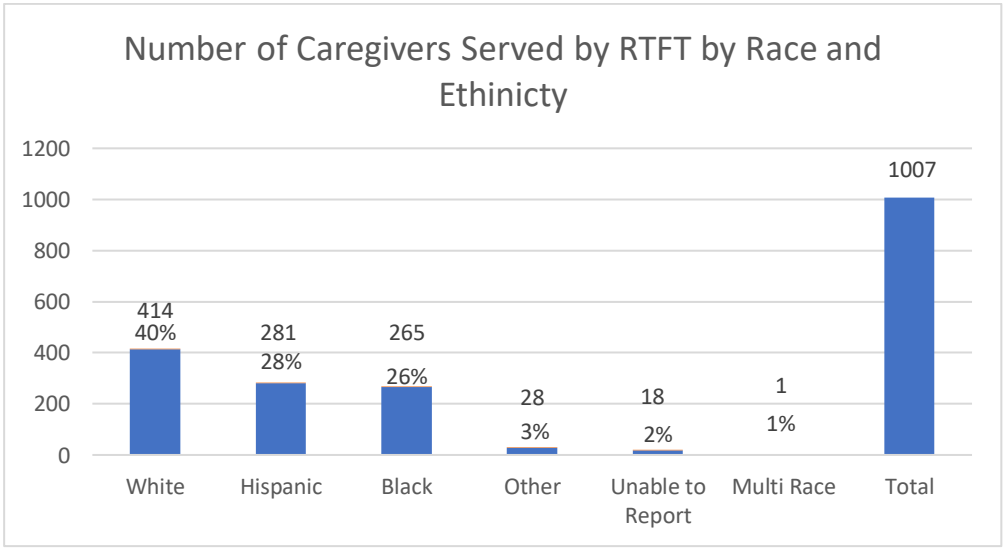


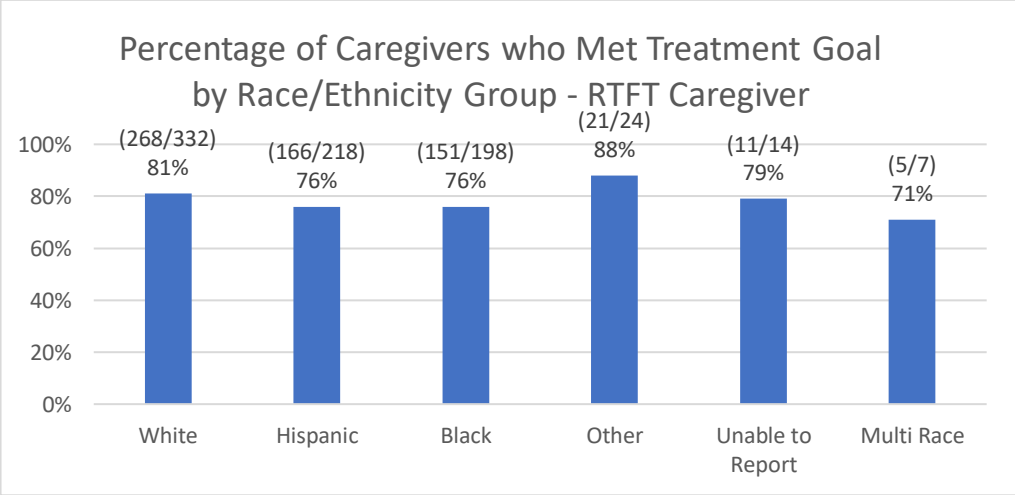
Figure 20 (below) shows the number of caregivers whom received RTFT services in SFY 2021 broken down by race. For SFY 2021 there were a total of 1007 caregivers served by RTFT, representing a substantive increase since SFY 2020, when 814 caregivers were served. White caregivers make up the highest proportion of caregivers served. There were 18 (2%) caregivers in which race/ethnicity was noted as "Unable to report." In comparing SFY 2021 to SFY 2020, White caregivers represented an increase of 2 percentage points. The percent of Black caregivers decreased by 2 percentage points and Hispanic caregivers remained the same as the prior fiscal year.

Figure 20: Number of Caregivers Served by Reunification and Therapeutic Family Time (RTFT) in SFY2021 by Race/Ethnicity:



The Department examined the percentage of caregivers served that met the treatment goal across different racial/ethnic groups (Figure 21). In SFY 2021, 622 caregivers met their treatment goal for RTFT services out of the 793 expected to complete treatment. In comparing SFY 2021 to SFY 2020, White caregivers represented an increase of 2 percentage points. The percent of Black caregivers increased by 1 percentage points and Hispanic caregivers decreased by 2 percentage points.

Figure 21: Percentage of Caregivers served by RTFT who Met Treatment Goals in SFY 2021 by Race/Ethnicity:



PARENTING SUPPORT SERVICES (PSS):

This service utilizes the evidenced-based models of Triple P (Positive Parenting Program®) of the University of Queensland, and Circle of Security Parenting to provide an in-home and virtual parent education curriculum along with support and guidance so that parents with children 0-17 years of age can become resourceful problem solvers and be able to create a positive and safe home learning environment for children to develop social, emotional, and cognitive strengths. Within the multi-tiered Triple P system, this service will use Triple P's Level 4 Standard and Level 4 Standard Teen courses. In addition to Triple P, this service will provide short term case management supports to help parents fully utilize the parenting services. Priority is given to parents involved with CT DCF. Caseload permitting and in consultation with the CT DCF area office, providers may serve parents referred by other community providers.

Figure 22: Number of Families served by Parenting Support Services (PSS) in SFY 2021 by Race/Ethnicity:

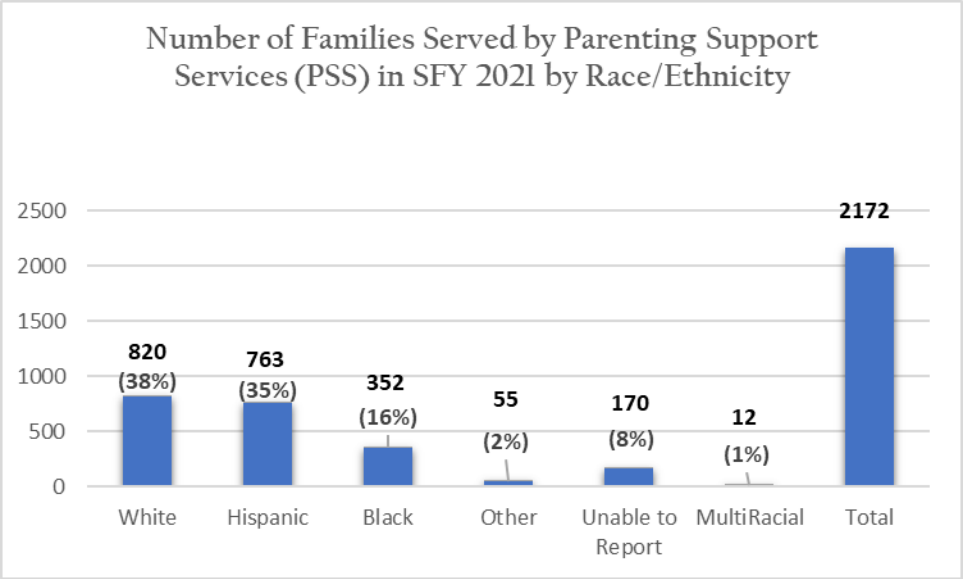
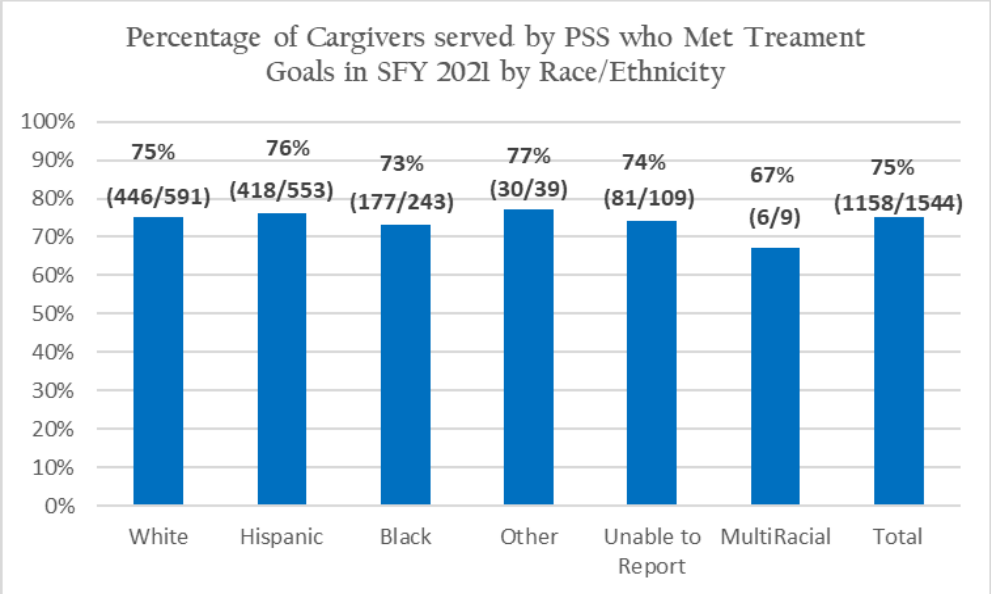


Figure 22 (above) shows the number of caregivers who received PSS services in SFY 2021 broken down by race. For SFY 2021 there were a total of 2172 families served by PSS, representing a substantive increase in caregivers since SFY 2020, when 1514 families were served. White caregivers make up the highest proportion of caregivers served. There were 170 (8%) families in which race/ethnicity was noted as "Unable to report." In comparing SFY 2021 to SFY 2020, Black caregivers represented a slightly larger percentage of those served. The percentage of Hispanic/Latinx and White caregivers slightly decreased.

Figure 23: Percentage of Caregivers served by PSS who Met Treatment Goals in SFY 2021 by Race/Ethnicity:



In Figure 23 (above) The Department examined the percentage of caregivers that met the treatment goal across different racial/ethnic groups. In SFY 2021, 1158 parents met their treatment goal for PSS services of the 1544 expected to complete treatment. In comparing SFY 2021 to SFY 2020, the percentage of Black and Hispanic parents who met treatment goals decreased by 4 and 3 percentage points respectively. The percentage of White parents who met treatment goals increased 4 percentage points.

CHILD FIRST (CF)

Child First provides home based assessment, family plan development, parenting education, parent-child therapeutic intervention, and care coordination/case management for high-risk families with children under six years of age in order to decrease social-emotional and behavioral problems, developmental and learning problems, and abuse and neglect.

Figure 24: Number of Caregivers served by Child First (CF) Services in SFY 2021 by Race/Ethnicity:

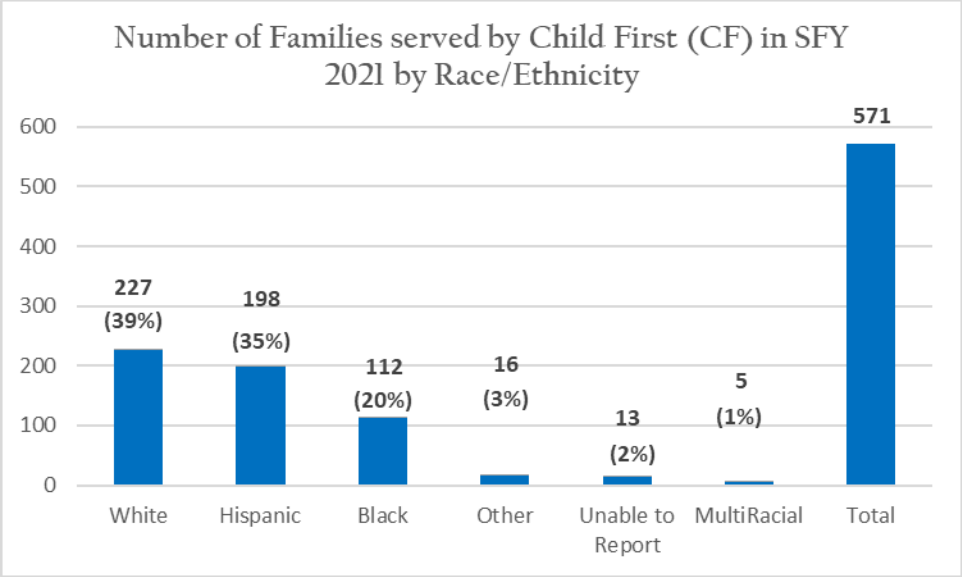
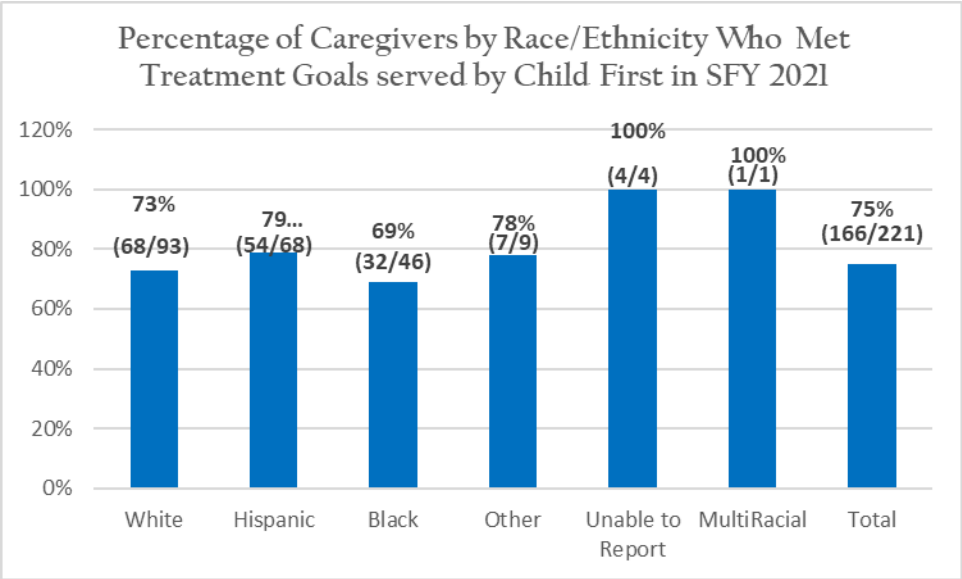


Figure 24 (above) shows the number of caregivers whom received CF services in SFY 2021 broken down by race. For SFY 2021 there were a total of 571 caregivers served by CF, representing a substantive increase in caregivers since SFY 2020, when 478 caregivers were served. White caregivers make up the highest proportion of caregivers served. There were 13 (2%) caregivers in which race/ethnicity was noted as "Unable to report." As In the previous fiscal year, White caregivers made up the largest proportion of caregivers served compared to other race/ethnicity groups.

Figure 25: Percentage of Caregivers served by CF who Met Treatment Goals in SFY 2021 by Race/Ethnicity:



The Department examined the percentage of caregivers served that met the treatment goal across different racial/ethnic groups. In SFY 2021, 166 caregivers met their treatment goal for CF services, of the 221 expected to complete treatment. In comparing SFY 2021 to SFY 2020, the percentage of Hispanic caregivers who met treatment goals increased, while White and Black caregivers who met treatment goals decreased.

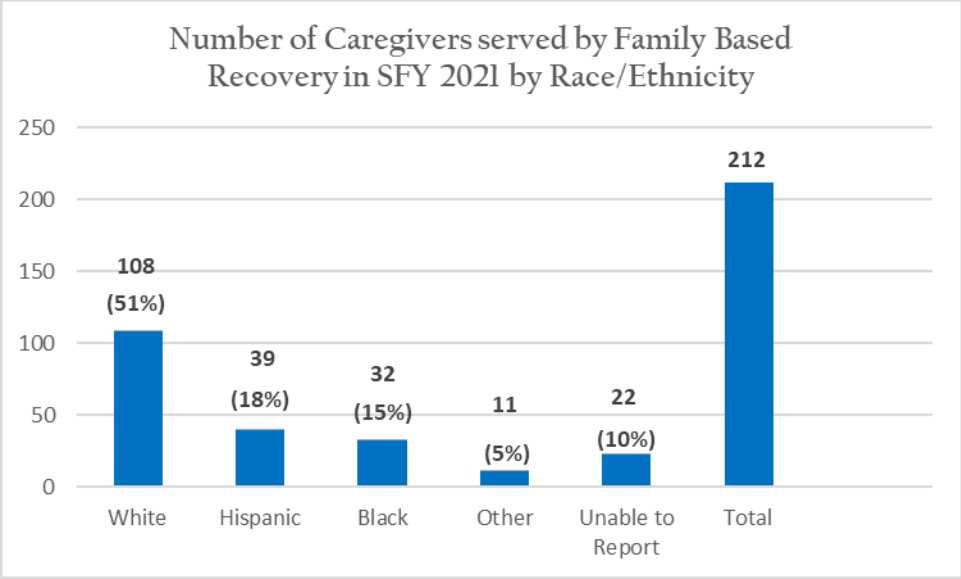
FAMILY-BASED RECOVERY (FBR)

Family Based Recovery (FBR) is an intensive, in-home clinical treatment program for families with infants or young children (birth to 5 years old inclusive) who are at risk for abuse and/or neglect, poor developmental outcomes and removal from their home due to parental substance use. The overarching goal of the intervention is to promote stability, safety, and permanence for these families. Treatment and support services are provided in a context that is family-focused, strength-based, trauma-informed, culturally competent, and responsive to the individual needs of each child and family.

Target population for FBR is parents/caregivers who meet both of the following admission criteria: Substance use within the last 30 days which meets criteria for a substance use disorder and an index child from birth to 5 years old inclusive that resides with the parent/caregiver or will be imminently reunified. Length of service for FBR is on average between 6 and 12 months based on the clinical needs of the parent/caregiver. FBR offers the following services:

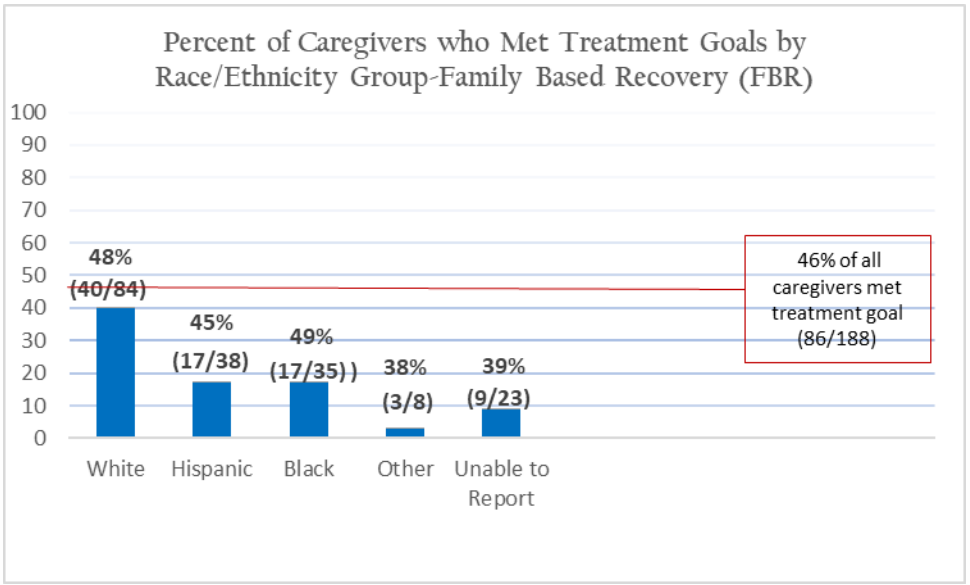
There were 235 FBR referrals received between July 2020 and June 2021 including 23 referrals that ended up being evaluation only and did not need FBR treatment, leaving at total of 212 caregivers served. Of these 212 caregivers, 32 (15%) of caregivers admitted in FY 2021 were African American, 39 (18%) were Hispanic, 108 (51%) were Caucasian, 11, (5%) identified as Other, and 22 (10%) did not have race/ethnicity identified. There were 188 FBR discharges between July 2020 and June 2021.

Figure 26: Number of Caregivers served by Family Based Recovery (FBR) in SFY2021 by Race/Ethnicity:



The Department examined the percentage of caregivers that met the treatment goals across different racial/ethnic groups (Figure 27). As noted below the data shows that 17 (49%) of African American clients, 17(45%) Hispanic clients, 40 (48%) of White clients, 3 (38%) of clients who identified as Other, and 9 (39%) of clients without an identified race/ethnicity completed treatment.

Figure 27: Percentage of Caregivers served by Family Based Recovery (FBR) who Met Treatment Goals SFY 2021 by Race/Ethnicity:



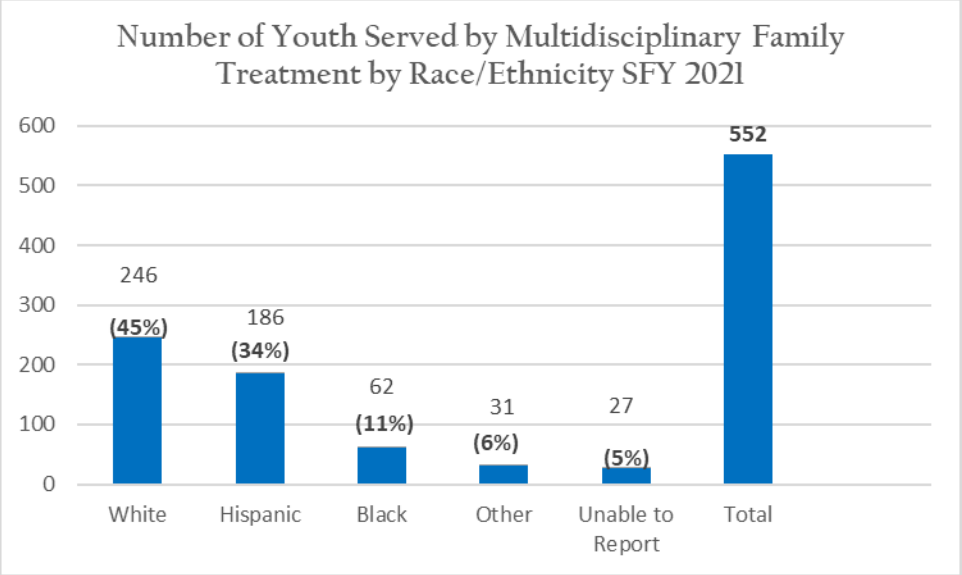
MULTIDIMENSIONAL FAMILY THERAPY (MDFT)

Multidimensional Family Therapy (MDFT) is an evidence-based in-home treatment model whose objectives are to eliminate the adolescent's substance use and delinquent behaviors, and improve mental health, school, and family functioning. MDFT improves family functioning, as well as the adolescent's coping, problem-solving, and decision-making skills. MDFT is available to children and adolescents ages of 9-18 (and their parent/caregivers), who presents with substance use and/or complex behavioral health needs. Referrals are accepted from any source such as: the parent/caregiver, DCF, hospital, school, probation/court, police, or community provider. MDFT services last an average of 5 months. MDFT provides weekly sessions of individual therapy with the child/adolescent, therapy with the parent(s), and family therapy to address child/adolescent and family issues specific to this child/adolescent. Interventions also focus on promoting communication and relationship-building among the family members. Providers provide 24-hour emergency and crisis intervention services to children and/or adolescent and their families. Local emergency mobile psychiatric services should not be used as common practice by providers.

There were 602 MDFT admissions between July 2020 and June 2021 including 50 referrals that ended up being evaluation only and did not result in an MDFT recommendation. Resulting in a total of 552. Admissions have decreased since March 2020 due to the state's COVID public health emergency.

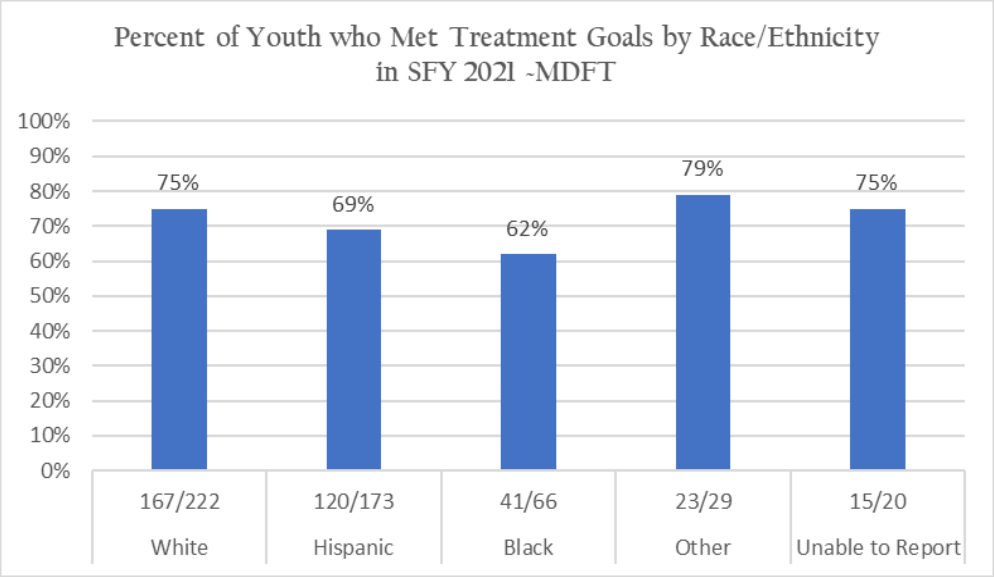
As noted below in figure 28: 62 (11%) of youth admitted in FY 2021 were African American, 186 (34%) were Hispanic, 246 (45%) were Caucasian, 31 (6%) identified as Other, and 27 (5%) did not have race/ethnicity identified.

Figure 28: Number of Youth Served by Multidisciplinary Family Treatment (MDFT) SFY2021 by Race/Ethnicity:



In SFY 2021 366 (72%) of the youth completed and met treatment goals (Figure 29). Of the youth that completed and met treatment goals 41 (62%) were African American youth, 120 (69%) were Hispanic youth, 167 (75%) of Caucasian youth, 23 (79%) were youth who identified as Other, and 15 (75%) of youth were categorized without an identified race/ethnicity.

Figure 29: Percentage of Youth served by MDFT who Met Treatment Goals for SFY 2021 by Race/Ethnicity:



In general, for the identified services captured above the differences observed from SFY 2020 to SFY 2021 were not major shifts. However, it should be noted that efforts to address the decreases observed in referrals, engagement and met treatment goals occurred in partnership with CTDCF and external partners. As mentioned earlier in this report, ESC Service Coordinators, Program Leads and providers have led several informational town halls throughout the year to ensure staff were familiar with the services and how they can meet the needs of families.

FATHERHOOD ENGAGEMENT SERVICES (FES):

The purpose of this CTDCF-contracted program is to enhance the level of involvement of fathers in their CTDCF case planning and provision of services, strengthen fathers' positive parenting skills and to assist CTDCF with refining best practices working with fathers. CTDCF data highlights insufficient engagement of fathers resulting in unmet standards for assessment and needs met. While the Department's family strengthening practices are inclusive of fathers, intentional focus is needed to ensure that fathers are encouraged and supported to be as involved as mothers.

Fatherhood Engagement Services ("FES") provides intensive outreach, case management services and 24/7 Dad© group programming. Case management services will help to mitigate barriers to more effective engagement through assessment of needs, advocacy, and linkage to supports and services, while 24/7 Dad© services will teach skills and characteristics to strengthen the father's parenting relationship. There is an additional FES team providing outreach to incarcerated fathers designed to link them to their local FES provider.

During 2021, and beginning with FES, DCF embarked on a journey to develop Performance Outcome Measures for all contracted services. The finalized measure for FES included targeted racial justice metrics. These will be incorporated into future data collection and will become available for review and utilized for refined program assessment.

The below charts capture the outcomes for fathers served by FES in calendar year 2021. The total number of fathers referred to FES program during the year was 448. Of those, 231 were served and closed during

the year, 69 refused the service and 148 were enrolled and remained open for services into 2022. The below slides capture outcomes for the 231 fathers served and closed during the year.

Engagement rate shows the percent of fathers by race and ethnicity who accepted the service and were enrolled in FES.

Figure 30: Engagement Rate of Fathers enrolled in Fatherhood Engagement Services (FES) in SFY21 by Race/Ethnicity

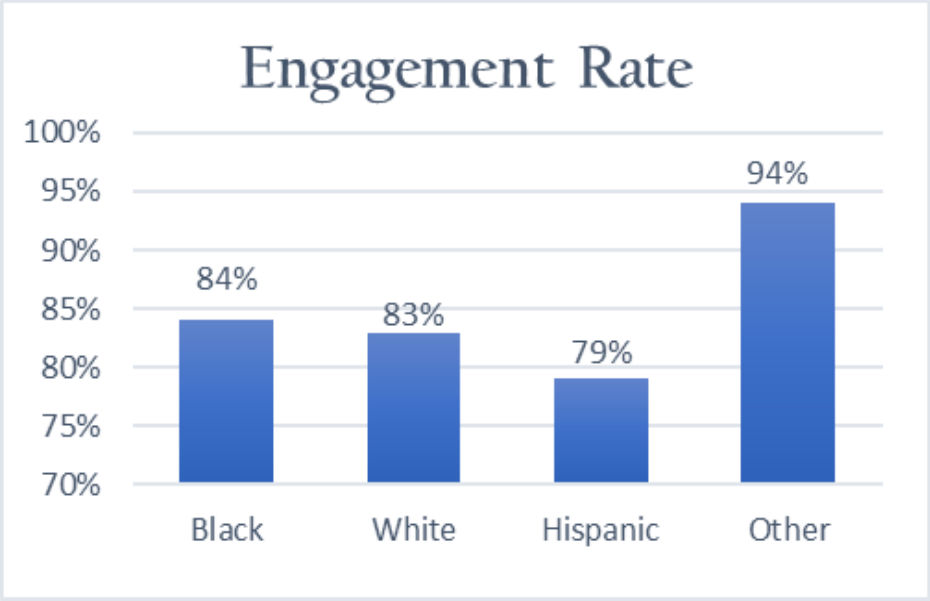
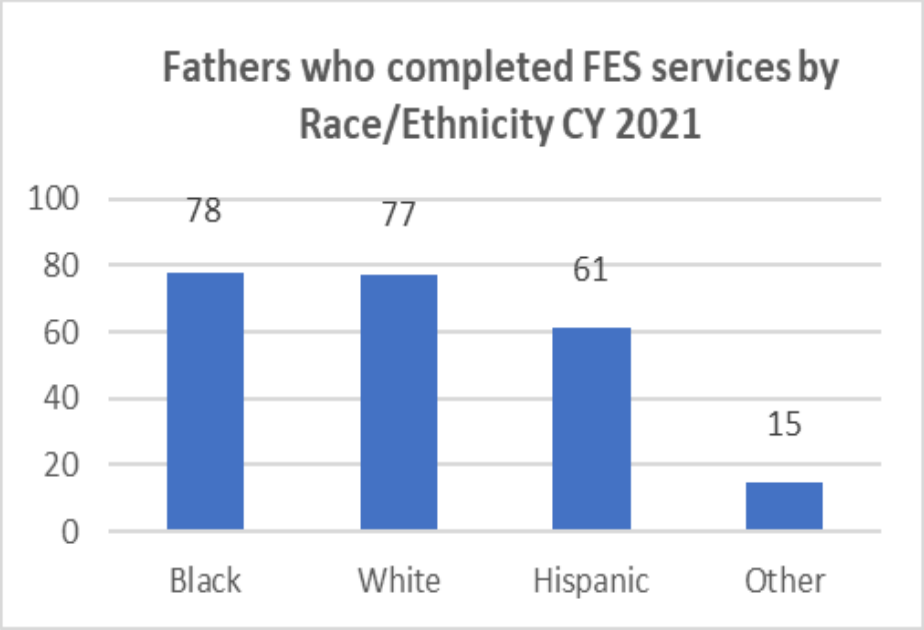
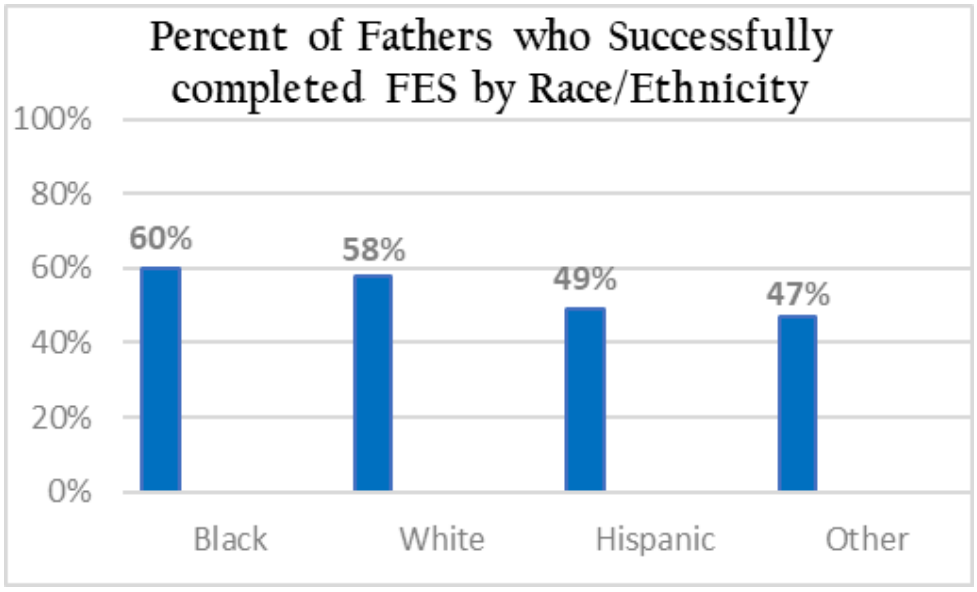


Figure 31: Fathers who completed FES services by Race/Ethnicity for Calendar Year 2021



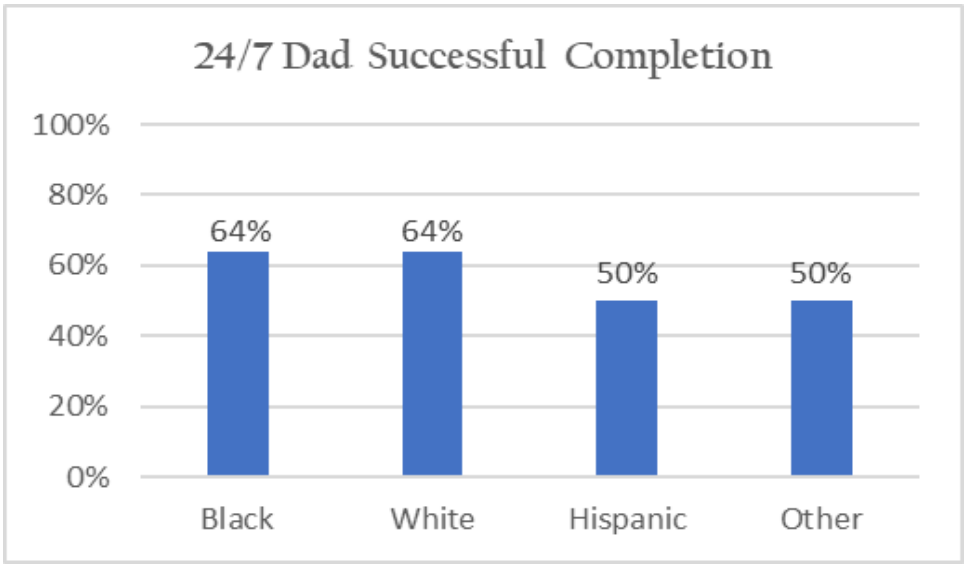
2021 saw a 10% drop in successful program completion from the prior years. Providers reflected on the impact of COVID and distanced service provision as major barriers. Hispanic fathers continue to lag in completion rate by 10%. Lack of Spanish speaking staff in some areas has been cited. Providers report that COVID has exacerbated the difficulty in recruiting bilingual employees.

Figure 32: Percent of Fathers served who o successfully completed in CY 2021 by Race/Ethnicity:



Similarly, there was a 10% dip in successful completion of the 24/7 Dad curriculum.

Figure 33: Percent of Fathers served who successfully completed 24/7 Dad in CY 2021 by Race/Ethnicity:



Fatherhood Engagement Leadership Team (FELT)

The engagement of fathers is instrumental in reducing the disparities seen with children of color. Studies have shown that when fathers are engaged children are able to be reunified with their birth families more often and have shorter stays in the foster care system. Engaging fathers early in the process can even eliminate the need for placement entirely. CTDCF utilizes a centralized structure, Fatherhood Engagement Leadership Team (FELT), to guide its approach to strengthening practice in all facets of our work with fathers. The structure is anchored by local FELTs in each office, comprised of DCF staff members, community providers and fathers, meeting monthly to identify barriers to father engagement and develop mitigating strategies. They are organized under the Statewide Fatherhood Engagement Leadership Team (SFELT), where they meet bi-monthly with representatives from other divisions within DCF as well as the Solnit's. The goal is to improve the outcomes for children and families involved with DCF by engaging fathers as equal caretakers in case planning and service delivery. To achieve this, the FELTs are oriented to address workforce attitudes and beliefs regarding fathers served by DCF, identify agency practices which present barriers to father engagement and employ strategies to mitigate, create community partnerships to support DCF's efforts around fatherhood and elevate culture of father importance. All efforts and activities are guided by and in alignment with DCF's 7 Aspirational Goals (Key Strategies) and the department's Racial Justice mission to become an anti-racist organization.

In the spring of 2021 DCF embarked on a partnership with My People, a Hartford agency with expertise in fatherhood engagement, to advance the FELT structure, modeled after the Fathers and Continuous Learning in Child Welfare Breakthrough Series Collaborative (BSC). Guided by the Collaborative Change Framework (CCF) the FELTs have begun functioning in the Plan Do Study Act (PDSA) process, initiating small tests of change to effectuate improved engagement. Each FELT completed the BSC's Fatherhood Self-Assessment tool based on the 5 domains of the CCF. Following those results, they have begun developing initiatives designed to address barriers to father engagement. These initiatives, or " PDSAs" in BSC language, have focused on various aspects of case practice, including utilization of search tools to locate out of reach fathers, case consultation triggers where father was not full involved, and supervision prompts to ensure fathers were receiving appropriate attention and assessment by assigned Social Workers. All PDSAs are developed with metrics to assess effectiveness of the initiative. Those found to be effective will be scaled up. It should be noted that the 2nd domain of the Fatherhood CCF concerns racial equity for men of color in the child welfare system and has been a major focal point for initiative development.

Each SFELT meeting also involves a topical presentation and discussion. These have included Leonard Burton Advancing Equity in Fatherhood Programs and Abdul Rahmann I. Muhammad's Moving from Engagement to Inclusion and Equity. Locally, Mr. Muhammad has provided 24 hours of consultation and 13 hours of training to DCF office FELTs, workgroups and leadership on strategies and training topics including: Turning 50 Barriers to Fatherhood Engagement into 50 Opportunities for Fatherhood Engagement, 21 Levels of Fatherhood Engagement and 10 Steps to Working with Fathers Beyond Engagement.

Related but adjacent to the FELT work, DCF offices continue to elevate father importance in other ways including the hosting of a father forum, provider open house where a father with lived experience addressed the audience, and outreach to incarcerated fathers for input and perspective. The Hartford Office, using private dollars commissioned a mural for the building depicting fathers.

These sustained efforts appear to be paying dividends. A review of Administrative Case Review metrics concerning such areas as social worker assessment of fathers' needs, social worker visitation with fathers, and continuity of father/child relationship all show statewide improvement.

STATEWIDE CHANGE INITIATIVES:

The Department is part of the bigger child welfare system that is responsible for ensuring the best outcomes for all children and families served. The Department recognizes however that work is still needed within the agency to address disproportionality and disparities and CTDCF continues to be committed to doing its part.

In 2020, Commissioner Dorantes charged CTDCF's Senior Leaders, across every division and function, to develop and refine concrete Change Initiatives, with associated metrics under their identified sphere of influence. There are currently 28 separate Change Initiatives occurring across Divisions, Area Offices, and Facilities. The Change Initiatives have been intentionally aligned with the 7 Key Results/Outcomes, noted earlier in this report, along with the Racial and Ethnic Disproportionality across the CT data set. Areas of focus for these change initiatives include (but are not limited to): Mandatory review of Central Registry placement when registry poses barrier to placement; Reduction in the number of children entering foster care, specifically children of color; Looking at relative/kin placement with a disparity lens; Implementation of racial justice equity assessments (RJEA) and consultations; Continued Promotion of Racially Justice Health Equity Plans and the implementation of the National CLAS Standards, Reduction of Disproportionate Substantiations of Black Child Victims; Process for Expedited Review of Barriers for Placement and Childcare (brief description captured below), Minority Business Provider Engagement and Statewide Implicit Bias Training. As one can observe in the examples provided, the 7 Key Aspirational Goals are at the forefront of the strategies implemented. It is the hope that with this intentional focus, CTDCF will decrease and ultimately move towards eliminating the racial disparities seen throughout the agency.

HIGHLIGHTS OF SELECT CHANGE INITIATIVES:

CTDCF's Legal Division developed a statewide racial justice Change Initiative that created mandatory reviews of Central Registry placement when their status on the Registry poses a barrier to placement, licensure, family arrangements or otherwise limits an adult's access to a child. Persons of color are disproportionately represented on the Central Registry in contrast to White perpetrators of abuse/neglect. The goal in developing this policy was to target DCF's aspirational Key Result 2: Children who must come into care will be placed with kin whenever possible and appropriate. Data tracking for the new policy began in August 2021 and by December 2021 had begun to show very promising results. There has been a total of 46 central registry reviews done for appellants of color. Overall, 89% (41) resulted in a central registry reversal, often allowing children to remain with family in a safe kinship placement.

Another statewide Change Initiative that was implemented was offered by CTDCF's Academy for Workforce Development related to Implicit Bias Training. While CTDCF understands that providing implicit bias training as a stand-alone strategy/practice has not demonstrated a reduction in disparities, it does recognize implicit bias training as an important, supplemental strategy to reinforce other strategies that reduce bias in decision making while keeping children safe. Below you will find an overview of this Change Initiative along with some preliminary findings.

Overview of Implicit Bias Training Change Initiative: Every individual has a certain level of implicit bias that affects choices. We believe that to best serve our families, it is imperative to understand our current biases. Recently, the Academy for Workforce Development required Implicit Bias Training to be completed by all DCF staff to reduce the effect of bias. If bias can be removed from the decision-making process of our staff, DCF services will become more equitable. Specifically, we hope the Implicit Bias Training will shift Pathways Data to reduce disparities between children of color and children who are White. Below is a list of possible factors influenced by implicit bias within DCF:

1. DCF cases being accepted
2. Cases being substantiated
3. Cases being opened
4. Children coming in for care
5. Children remaining in care past 12 months
6. Children Being reunified

The Implicit Bias Training of the Trainers began on 10/8/2020 and was completed o 12/8/2020. The Academy trained 68 staff as Implicit Bias trainers. These 68 staff were then responsible to train the Implicit Bias curriculum to their office/division/facility. During this timeframe, 2,507 DCF staff were trained in Implicit Bias.

The Academy collaborated with St. Joseph University to develop three surveys that were distributed to quantify the results of the Implicit Bia Training. The first survey was sent three days before the training to gauge current knowledge and feelings about implicit bias. The second survey was sent two weeks after the training to determine what the staff learned. The impact survey was conducted two months after that training but only taken by supervisory and management staff.

Pre-Survey: 2,507 staff members took the training and there was a 55% return rate of the pre-survey responses.

Post-Survey: 2,507 staff members took the training and there was a 31% return rate of the post-survey responses.

Impact Survey: DCF has a total of 426 supervisors/ managers and there was a 34% return rate of the impact survey responses.

Implications: There was a positive outcome on staff who took the implicit bias training. More staff members were compelled to provide feedback of the training and how it reduced their own biases when working with the families on their caseload. Similarly, the managers provided feedback on how they envisioned their staff reducing implicit bias.

Pre & Post Survey Explained: A significant change in responses between the pre and post surveys

- More staff members became aware of the Pathways data
- More staff members were able to define the term privilege in the context of identity and bias
- More are aware of their biases/stereotypes
- More unlearned biases previously held
- Staff identified more with providers after the implicit bias training
- More staff agreed that clients should be matched with staff they identify with

Impact Survey Explained: For all questions, a large majority of supervisors agreed that there were positive shifts in defining, recognizing, and discussing implicit bias in supervision around cases. However, a lesser majority of respondents indicated that staff was more aware of the Pathways data, with more than a third noting no change. Perhaps Pathways data should be promoted more regularly to increase awareness.

Focus Group Analysis: January 2021 to December 2021:
The Academy and St. Joseph University collaborated and held five implicit bias focus groups that consisted of a diverse population including Area Office Staff, Central Office Staff and Non-Case Carrying Staff.

Theses focus groups were a 90-minute discussion via Zoom that asked questions about how participants experienced the Implicit Bias training and its impact on their work in the subsequent months.

During this timeframe, the Academy and St. Joseph University will continue to analyze and transcribe the transcripts collected from the focus groups to gather themes that will guide our efforts in becoming an anti-racists child welfare agency. The preliminary data suggested the following next steps:

- Coaching for supervisors to hold a universal conversation on implicit bias during all supervisions
- Exploring education for our mandated reporters on implicit bias and its impact on the child welfare system
- Developing marketing tools that reinforce the value and importance of becoming an anti-racist child welfare agency

Finally, in efforts to achieve an anti-racist child welfare agency, the Academy has committed to ensure our trainers are knowledgeable in the topics of cultural responsiveness, racial justice, and anti-racism practice. Our first step in trying to achieve this effort is to have all our trainers trained in the full two-day Pre-Service Advancing Anti-Racism within Child Welfare Practice Training. The expectation will be that the trainers observe this training to prepare themselves to train the full two-day curriculum to our pre-service staff. There will not be a teach-back component to this shadowing experience, instead, all the trainers will be invited to attend a Debriefing /Q&A session after they observe the material. These Debriefing/Q&A sessions will continue monthly until they are no longer requested.

2022 STRATEGIES TO ELIMINATE DISPROPORTIONALITY AND DISPARITES:

While tremendous efforts have been made across the agency to address the noted concerns, along with bringing awareness to staff regarding the structural and institutional racism that exists in institutions such as CTDCF, the trends in the pathway data shows only slight changes from previous years. There could be several reasons as to why there hasn't been larger improvement in the Racial and Ethnic Disproportionality across CT data, including changes in data analysis (Census data), impacts of the COVID-19 pandemic, internal factors (e.g., practice) or external factors. One external reason could be the continued need to collaborate with community stakeholders as children are served by multiple programs and sister agencies within our communities. For example, reports made to the CTDCF Careline (our "front door") on children/families of color are disproportionate which immediately puts families of color at a disadvantage. CTDCF is committed to identifying, strategizing and implementing efforts internally and externally in order to achieve positive outcomes for all children and will continue to modify any strategy not meeting the goals identified.

It is critical that the Department use the pathways data and the 7 Key Aspirational Goals to determine which programs/change initiatives are effective in reducing racial disproportionality for our families and then implementing what works from those programs into those that are lacking. It is the hope that CTDCF will be able to identify additional change initiatives that could be scaled up and implemented statewide to redesign CTDCF as an authentically anti-racist agency. We recognize that becoming racially just is an ongoing process and through our Safe and Sound organizational culture, intentional engagement of caregivers, youth and staff we will be strengthened, and our outcomes will also reflect this evolution. It is anticipated that the continued work of refining our change initiatives to ensure movement both quantitatively and qualitatively will show substantial results in the future.

Community involvement and partnership is essential to assist the agency in reaching its goals. Several providers have joined the Departments' commitment in addressing Equity and Racial Justice within their own organizations as well and the Department is looking to create a community academy that promotes and enhances racial justice efforts in a deeper way.

As the Department continues its journey, it is the hope that by focusing on goals collectively as an agency and streamlining the work that is being done across the state, that the trajectory for a child of color on the decision point's pathway can be changed.

The Department recognizes that having conversations related to race and equity is not always easy and that creating an environment in which those difficult conversations can occur, and flourish is critical in order to achieve our Racial Justice goals. While these conversations are important more important is the focus must remain on the outcomes and ensuring that the strategies that are implemented move the outcomes in the intended direction. Efforts to cultivate the Safe and Sound Safety Culture within the Department will continue so that leaders at all levels can strive to balance systems and individual accountability and embed open communication, transparency and continuous learning and improvement throughout.

Specifically, over the course of 2022, the Department will focus on key areas of policy, practice, and partnerships in intentional ways. In terms of policy; when created, reviewed or updated will be done so using a racial equity impact analysis perspective. The Policy and Practice subcommittee (who is supported and accountable to the Statewide Racial Justice Workgroup) will offer support and consultation as needed.

The racial justice work done in 2022 will be focused on two major areas. The first will be an important exploratory process to better understand the Department's challenges related to achieving the federal government's targets for timely permanency for children placed in out-of-home care. CTDCF has seen improved rates for Hispanic and Whites in last 2 years and a decline for Black and Other in last 2 years. Overall no group is trending toward the standard goal and therefore the agency will need to take a closer look as to why that is. One thing to keep in mind is that for many cultures, "family" is defined much more broadly than a biological parent, such that children placed with kin may very often be in "stable" living situations with their "own family" and we will need to understand what barriers exist within family dynamics that doesn't allow for timely permanency. This narrative must be explored more thoroughly as part of the Department's anti-racist frame to better reflect the way Black, Latinx, and other cultures define and experience relational and emotional permanency.

While continuously honoring the need for keeping child safety, permanency, and well-being in the forefront, this practice exploration will begin with a deep dive into both the kinship care and permanency data to better understand what the numbers are telling us about who is in kinship care, by race and ethnicity, and who is/is not achieving timely permanency. From these analyses, we will then begin to unravel the narratives related to safety, permanency, and well-being to better articulate if these goals are, in fact, in conflict, or if CTDCF may be achieving both federal targets, simply using a racially just narrative that better suits the children and families of color in CT.

The second practice area that will be of focus is a statewide scaling up of one of the most promising Change Initiatives: the use of a Racial Justice and Equity Tool (RJET) and associated practice. This tool has been utilized by several area offices but has been used for a variety of practice areas. The purpose is to build in specific questions about social influencers of equity (formerly known as "social determinants of health") that allow workers to consider a family's context, opportunities, and barriers at a systems level. The tool

and process also ask specific questions about the impact of racism and bias on a family's experience as well as exploring the worker's own beliefs about the family. By doing this in a structured, supported, team-based, and supervised way in the Safe and Sound Culture, direct conversations can be had that result in improved identification of services for families. Equally critical is the fact that these authentic and direct conversations about bias, race, opportunity, and equity result in improved decisions with, for, and about families and children, all while maintaining safety as the central focus. One region has seen promising outcomes using this tool, and they will serve as peer supports and mentors to other leaders in the state as this tool and process is spread more broadly. Support and coaching will also be provided by the Racial Justice Leads and there will be quarterly meetings to share successes, challenges, and questions. As the practice is being expanded, policy considerations and formal training will be developed to ensure consistency in process and, most importantly, to ensure that the process is resulting in the same positive improvements in outcomes across the state.

The final goal area for 2022 will focus on partnerships. These partnerships will be developed and deepened at the system level as well as at the community level. At the system level, CTDCF will work to share its trainings and facilitated dialogues with schools, health care partners, and law enforcement. Much of the dialogue will center around the front door and the issues described above related to differences between poverty, maltreatment, and neglect, specifically for children and families of color. The partnerships will strive to create common understanding along with the co-identification of alternatives in the community that are better suited to serve these children and families. We know that many children and families have needs, but many of these needs are best met within the community and without state government CTDCF involvement. The more we can collaborate with other systems who impact the lives of children and families of color, the closer we will be to eliminating disparities and achieving our racial justice goals.

Taken together, this work will help the Department continue its work on many fronts, from the way we interact with children and families, to the way we partner with the community and key system stakeholders, to the way the work is captured in policy and reflected in data.

The Department will continue to work with its Statewide Racial Justice Workgroup and its Subcommittees, the Central and Area Office Diversity Action and Racial Justice Teams along with key stakeholder groups to implement and monitor the above strategies and further enhance the change initiatives for every division. Further, these strategies will be evaluated and refined as may be needed to support integration and nexus with those proposed outcomes.