



Rhode Island Department of Children, Youth & Families



Images from the 2005 Rhode Island Heart Gallery; a collaborative effort of DCYF, Adoption Rhode Island and local photographers.

Annual Report for Fiscal Year 2005



For the first time in at least a decade, I am pleased to share with you the Annual Report of the Rhode Island Department of Children, Youth and Families (DCYF). The purpose of the Annual Report for Fiscal Year 2005 is to summarize DCYF's statutory authority and responsibility, our mission and vision and our efforts to ensure the safety, permanency and well being of every child and family who comes in contact with the Department. Our hope is for this document to illustrate the programs and practices we have undertaken in our everyday efforts to help improve the lives of young Rhode Islanders.

I firmly believe that the citizens and elected officials of Rhode Island have the right to hold DCYF accountable for our successes and our mistakes. While this report is not designed to provide all of the information we have to share, it is designed to show progress on broad measures, help you draw conclusions about the direction of DCYF and help you determine what other questions need to be asked.

Since my arrival in March 2005, I have directed our efforts at achieving five key objectives:

- Keeping all children and youth safely at home or in as close proximity to home as possible;
- Fully implementing family-centered and community-based practice;
- Increasing our ability to focus on families by developing more efficient work processes, beginning to reduce caseloads and ensuring that the agency's support services are focused on providing aid and assistance to front line staff;
- Developing strong and effective partnerships with families, the Family Court, community providers and community leaders; and
- Reforming our Juvenile Corrections Programs into state-of-the art facilities and programs which focus on ensuring that youth returning to Rhode Island's communities have the skills, knowledge and experience necessary to lead productive lives.

This report provides you with an overview of our activities to achieve these objectives. It also identifies outcomes related to these objectives and key next steps we plan to undertake during Fiscal Year 2006. I understand that this report may not answer all of your questions about our operations, but I trust that, through the 2005 Annual Report, we will begin to provide you with the information you need to measure our progress.

I hope that you find this a helpful tool in holding DCYF accountable for carrying out our mission and mandates. I look forward to your comments, questions, feedback and constructive involvement in helping us to make sure that children can live safely in their homes, neighborhoods, schools and communities. Thank you.

Sincerely,

Patricia H. Martinez

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Director

Agency Overview

DCYF is the single state agency with statutory authority and responsibility to support the State's public policy of protecting children and ensuring that children and families are provided with the supports they need to succeed. We are designated as the principal state agency to mobilize the human, physical and financial resources available to plan, develop and evaluate a comprehensive and integrated statewide program of services designed to ensure the opportunity for children to reach their full potential. Rhode Island is one of a small group of states that integrate the three major public responsibilities for troubled children, youth and families – Child Welfare, Children's Behavioral Health and Juvenile Corrections – in one agency.

DCYF's Key Public Policy Responsibilities

- **Child Welfare,**
- **Children's Behavioral Health**
- **Juvenile Corrections**

The Department has four (4) main divisions: Office of the Director and Support Services [Management and Budget, Office of Practice Standards, Legal Services, Human Resources, Licensing and Adoption Services, and Management Information Services (MIS)], Child Welfare (Child Protective Services, Intake, Family Services and Adoption Support), Juvenile Corrections (The Rhode Island Training School For Youth and Juvenile Probation and Parole) and Children's Behavioral Health and Education (Contracts and Program Standards, Placement Services, Care Management Teams, Community Services, and Grants and Program Evaluation). In partnership with the RI College School of Social Work, the Department also co-manages the Rhode Island Child Welfare Institute which provides training and staff development services for Department staff.

DCYF Family Service Regions

- **Providence (City of Providence)**
- **East Bay (Barrington, Bristol, East Providence, Jamestown, Little Compton, Middletown, Newport, Portsmouth, Tiverton and Warren.)**
- **Southern (Charlestown, Coventry, East Greenwich, Exeter, Hopkinton, Narragansett, New Shoreham, North Kingstown, Richmond, South Kingstown, Warwick, Westerly, West Greenwich and West Warwick)**
- **Northern (Burrillville, Central Falls, Cranston, Cumberland, Foster, Glocester, Johnston, Lincoln, North Providence, North Smithfield, Pawtucket Scituate, Smithfield and Woonsocket.)**

and Parole) and Children's Behavioral Health and Education (Contracts and Program Standards, Placement Services, Care Management Teams, Community Services, and Grants and Program Evaluation). In partnership with the RI College School of Social Work, the Department also co-manages the Rhode Island Child Welfare Institute which provides training and staff development services for Department staff.

In 1994, as part of our effort to increase our ability to address the needs of families within their own communities, the Family Services component of the Child Welfare Division decentralized into four (4) regions (see insert). Juvenile Probation offices are co-located with the Providence, East Bay and Northern Regions with additional

Juvenile Probation and Parole offices located in Cranston, Wakefield, Newport, Warwick, Woonsocket and in the Providence Public Safety Complex. The Rhode Island Training School for Youth is located at the Pastore Complex in Cranston.

Vision, Mission and Guiding Principles

Our Guiding Principles:

Our Vision:

As active members of the community, we share a vision that all children, youth and families reach their fullest potential in a safe and nurturing environment.

To fulfill our mission, we believe that:

- The family, community and government share responsibility for the safety, protection and well-being of children through a system of care which is family-centered and community-based;

- A system of care for children who require our intervention should be school-linked, integrated across all DCYF divisions and among external partners, and culturally relevant with emphasis on prevention and early intervention;
- When the natural family is unable to care for a child/youth it is our responsibility, in as timely a manner as possible, to ensure the child/youth is provided permanency in his/her life in a safe, stable and nurturing environment which can include adoption, guardianship or independent living;
- All children and youth should be transitioned from public care with the supports, skills and competencies necessary to ensure stability and permanency;
- Families and DCYF Staff, foster families and service providers are partners in the provision of timely and appropriate high quality care and must possess the requisite knowledge, attitude and skills;
- Partnership requires open, honest and respectful communication fostering an awareness of the quality of services and clear and agreed upon authorities and responsibilities;
- Staff at all levels should be held accountable to a professional code of conduct;
- As an invaluable resource, staff are entitled to a safe, supportive work environment that fosters professional development;
- Quality improvement is an on-going process, utilizing best practices and external and internal performance standards aligning research, policy, evidence-based practice, training and outcome evaluation;
- To support the system of care, fiscal accountability should be ensured through performance-based budgeting, increased efficiencies and revenue enhancements.

Our Mission:

To assist families with their primary responsibility to raise their children to become productive members of society; to realize our obligation to promote, safeguard and protect the overall well-being of culturally diverse children, youth and families and the communities in which they live through a partnership with families, communities and government; to maximize the safety, permanence and well-being of the children, youth, families and communities we serve.

Fulfilling our Mission and Meeting our Vision

Family Centered Practice

Like many state children's services agencies, the Department has been criticized for placing too great an emphasis on placing children who need social, emotional and educational supports in group care settings, including costly residential treatment centers. This focus results in fewer community-based prevention services being developed and maintained and, in turn, results in fewer children and their families being able to stay in or near their homes, schools and communities.

Family Centered Practice respects the family's strengths and different methods of coping

Over the last several years, the Department has worked to increase the state's capacity to safely maintain children in their own homes and communities. We advanced this effort in 2002 by more fully embracing the principles of Family Centered, Culturally Competent Practice. We have joined with our community partners

to promote the following family centered principles:

- Recognizing that the family is the constant in the child's life, while the service systems and personnel within those systems fluctuate. (This recognizes that 'family' may have many interpretations, but maintaining a child's connection to his/her family holds significant meaning in their lives.)
- Facilitating collaboration between and among professionals at all levels of well-being.
- Recognizing and respecting the racial, ethnic, cultural, sexual orientation, special needs and socioeconomic diversity of all families.
- Recognizing family strengths and individuality and respecting different methods of coping.
- Sharing information between DCYF staff and parents on a continuing basis and in a supportive manner.
- Facilitating family-to-family support and networking. (This includes parent support organizations, interactions between concurrent planning families, foster families, adoptive families, biological families and extended family relationships.)
- Understanding and incorporating the developmental needs of infants, children and adolescents and their families into service delivery systems.
- Designing accessible service delivery systems that are flexible, culturally competent, community-based and responsive to family needs.

We cannot succeed in strengthening families without strong partnerships with schools, government, faith institutions and other key facets of the community

All of these efforts are designed to ensure the safety, permanency and well-being of every child and family we serve. Family-Centered and Community-Based Practice serves as the foundation for all of our work with children, youth and families.

Program Improvement Plan

Since 2001, state child welfare agencies have been engaged with the Children's Bureau in implementing a new approach to accountability for state child welfare systems designed to assess administration, practice and results for children and families – the Child and Family Service Reviews (CFSR). This approach begins with statewide assessments using data on outcomes that agencies are trying to achieve for their clients and families, followed by on-site reviews and interviews with an array of stakeholders. The next stage of this process is the development and implementation of a program improvement plan (PIP) based on the findings from the review.

Combined, the CFSR and PIP comprise a new paradigm to child welfare systems grounded in outcome-based measures and data-driven decisions intended to inform evidence-based practices and evaluate system-wide efforts. Both the CFSR and the PIP center on seven outcomes that support the goals of safety, permanency, and well-being. Program Improvement Plans respond to the findings of the CFSR.

The Rhode Island CFSR was conducted during the week of March 8, 2004. The period under review was from October 1, 2002 to March 8, 2004. Based on the CFSR findings, Rhode Island is collaborating with the regional Administration for Children and Families (ACF) to develop a PIP where 14 critical items are to be identified for improvement.

The 14 critical items identified will specifically address fundamental practice changes aimed at achieving national outcomes. Four items originate from Safety Outcomes, 8 items originate from Permanency Outcomes and 2 items originate from Well Being Outcomes. The 1st quarter is anticipated to include 34 action steps and 63 benchmarks. When approved, the full Program Improvement Plan (PIP) will be available at http://web.dcyf.org/docs/pip_final.pdf.

Implementing our Goals

Most children involved with DCYF are provided services in their own homes and communities or with relatives. On a daily basis during FY 2005, DCYF staff provided

GOAL 1 - Create a community-based, family-centered service system

GOAL 2 - Establish a continuum of high quality, culturally relevant placement resources in proximity to each child's home

GOAL 3 - Promote adoption or other planned living arrangement when reunification is not achievable

GOAL 4 - Transition all children and youth from public supported care with the supports, skills and competencies in place to ensure stability and permanency

GOAL 5 - Enhance the capacity of employees, foster parents and providers to deliver high quality care to children and families

direct services to about 5,959^{a,b} children and their families. About 2,962^a (50%) of these children remained at home and approximately 774^a (13%) lived with relatives^c.

DCYF also funds community-based

programs which provide services to children and their families without that family or child having to become directly involved with the Department. These children are not included in the daily approximations noted above. On a daily basis during FY 2005, the DCYF-funded community-based programs provided services to approximately 798^a children. These

services included Comprehensive Emergency Services (CES), Children’s Intensive Services (CIS) and Youth Diversionary Program (YDP) services. This brings the total daily number of children served either directly by DCYF staff or by these community-based providers to approximately 6,757^a.

However, a significant number of children receiving direct services from DCYF continue to be placed in non-relative foster homes, group homes, residential treatment centers, and the Rhode Island Training School. During FY 2005, each day approximately 772^a (13%) lived in non-relative foster homes, 834^a (13%) lived in residential programs and 207^a (3%) lived at the RI Training School for Youth. Approximately 477^a (8%) had other living arrangements including, but not limited to, psychiatric hospital, medical hospitals, prisons, independent living and Job Corps.

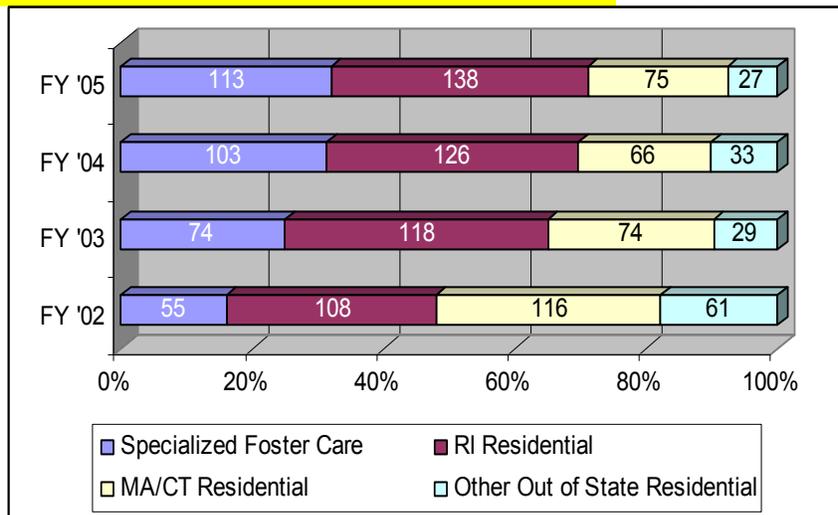
During FY 2005, approximately 63% of the children served directly by DCYF lived with their families or a relative.

The Department deeply believes that the key to our success with children and families is to reduce the numbers of youth placed outside of their homes and increase the number of youth who remain at home and receive services through community agencies.

Reducing Out of State Placements

A vital component of our efforts to keep children as close to their home communities as possible is our focus on re-shaping our use of what are known as Purchase of Service (POS) Placements. This helps us with ensuring that the child’s needs are being addressed in the most appropriate treatment setting possible.

Chart 1: POS Care: Reduction and Redistribution Fiscal Year Annual Averages 2002-2005



DCYF POS Placements include four main categories:

- Rhode Island-based Specialized Foster Care,
- Rhode Island-based Residential Treatment Centers, Nearby Out of State Residential Treatment Centers in Massachusetts and Connecticut and Distant Residential Treatment Centers in Other States.

Due to their distance from the youth’s home community, out-of-state placements are

generally viewed as less able to focus on the needs of the family as a whole and as less likely to reconnect the youth to their schools and community programs. While the total average number of youth in POS during FY 2005 (353) as compared to the total average for FY 2002 (350) is about the same, there has been a significant shift from out-of-state care to in-state care. In FY 2002, 42% (177) of youth placed in POS were placed out-of-state, but in FY 2005, only 29% (102) of POS youth were placed out-of-state.

During this same period, the percentage of youth in Specialized Foster Care POS doubled from 16% (55) in FY 2002 to 32% (113) in FY 2005. Specialized Foster Care settings allow a youth to live in a family setting, if appropriate to the youth's educational needs, and allow a youth to remain in a public school setting, often their own school in their home community.

These figures clearly show that as a state we are doing a better job of making sure that, when children do need to be provided services outside of their home settings, this is being done as close to home as possible.

Eliminating Night to Night Placements

“Night to Night Placement is defined as “the temporary placement of a child or youth in a program for a purpose other than the intended purpose of the program”. Eliminating the use of Night to Night Placements is key to our efforts to ensure that children needing out-of-home care are placed in the most appropriate and stable settings possible. It is a complicated issue which has troubled the Department for nearly two decades. Numerous efforts, including the imposition of a now longstanding Federal Court Consent Decree, have been made over the intervening years to reduce and eliminate the use of Night to Night Placements.

Over the past several years the Department has taken a multi-pronged approach to addressing Night to Night which seems to have had some degree of success. These efforts include:

- Expansion of our ability to review the ongoing placements of children in out-of-home care to ensure that they remain in such care only as long as necessary through our Care Management Teams (CMTs) and our utilization management contract with Placement Solutions. This allows for services to become available more quickly for other children who are in need of such services;
- An increase in the number of emergency group home (also known as Shelters) beds; and
- With Governor Donald Carcieri’s leadership, a focus on increasing the number of available foster homes.

**Chart 2: Night to Night Placement
FY 2003- FY 2005 Weekly Average by Month**

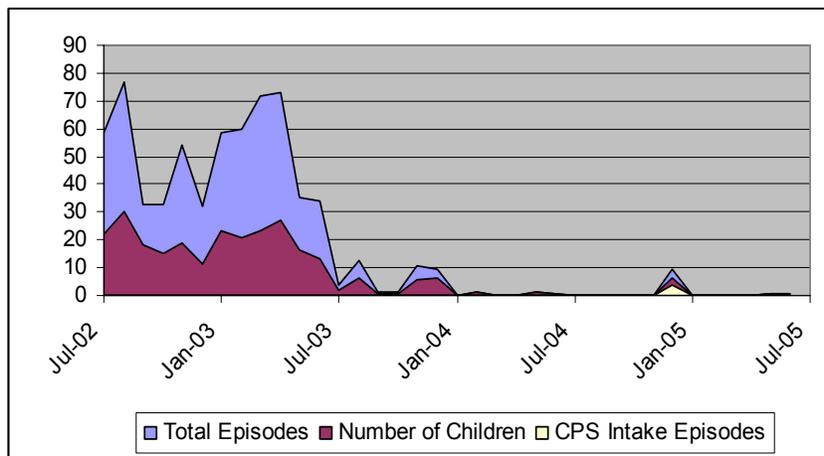


Chart 2 shows the tremendous success of these multi-pronged efforts. In FY 2003, the number of children placed on Night to Night status each week ranged from 3 to 38. This dropped in FY 2004 to a range of 0-12 and in FY 2005 it further decreased to a range of 0-3 children placed on Night to Night status each week. Even more significantly, the average number of children placed on Night to Night status each week dropped from (twenty) 20 in FY 2003 to two (2)

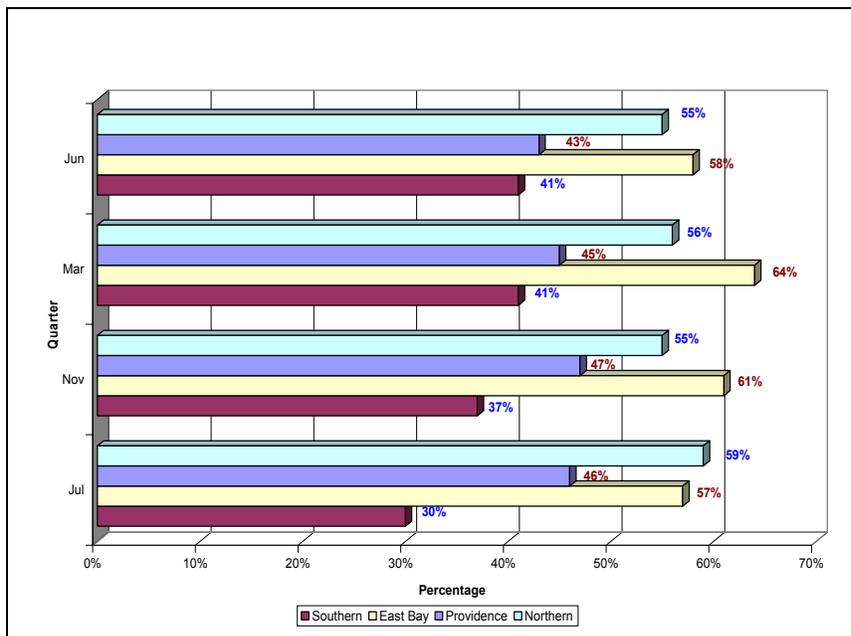
in FY 2004 and to less than one (1) in FY 2005. At the same time, the number of Night to Night episodes^d dropped sharply from 2,650 total episodes in FY 2003 to (sixteen) 16 total episodes in FY 2005.

While we are pleased with these results, we know that containing Night to Night is an ongoing process. We are beginning to see signs of stressors on the system of care which raise concerns in this area. This includes the effects of the Family Court’s Truancy Court Program and the court orders for the placement of these youth into DCYF residential programs. This use of our placement systems reduces the availability of these slots for youth who are in the care and custody of the Department due to abuse/neglect, behavioral health or juvenile delinquency reasons.

Regionally Based Foster Homes

One measure of how well we are truly embracing Family Centered Practice is how effective we are in making sure that, when children are in need of out-of-home care, we ensure they are provided that care in the least restrictive setting that is in their own community or as

**Chart 3: Rhode Island 2005 Fiscal Year by Quarters
Percentage of All Foster Children Placed In Their Own Region**



close to that community as possible. The more effective we are at achieving this goal

then the more successful we will be at keeping children connected to their families, schools and communities.

Unless a child has clinical needs requiring a more intensive treatment focused setting, we strive to place children who require substitute care into foster homes or other home-like settings.

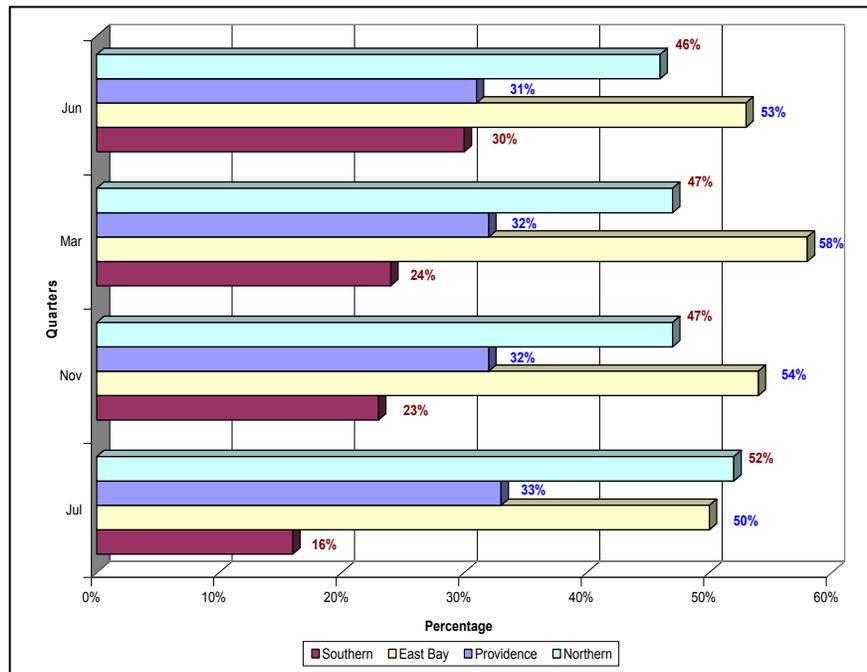
In determining foster home placement, we

make every effort to place the child according to the following placement priorities:

1. Relative’s home; or
2. Home of a family friend; or
3. Non-relative foster home in child’s home community; or
4. Non-relative foster home in community nearby to child’s home community; or
5. Non-relative foster home in a community distant from the child’s home community.

Over the past year the Department has increased our focus on placing children in the homes of relatives or foster homes closer to home. We have just begun to collect the data needed to track our progress in this area. Charts 3 and 4 provide a baseline against which we will measure our progress in future years. Chart 3 displays the percentage of all children placed in foster care who are placed in their own Region. While this does not get us down to the “placement in home community” measure, it does help us see whether or not we are moving in the right direction. This chart, however, does not control for the children who are placed with relatives who live outside of the child’s “home” region (e.g., a Providence child may be placed with a relative who

**Chart 4: Rhode Island 2005 Fiscal Year by Quarters
Percentage of Non-Relative Foster Children Placed In Their Own Region**



being placed in their “home” region from the 1st quarter to the 4th quarter. No region showed significant gains.

Chart 4 attempts to control for the “placement with relative” phenomena by showing only the percentage of non-relative foster placements within a child’s “home” region. This chart also shows need for improvement in the manner in which we develop foster home resources for children in our care. The Southern Region again shows a significant decline between the 1st and 4th quarters in the percentage of children placed in non-relative foster homes that are within the region. The East Bay Region shows a slight decline while the Northern and Providence Regions are relatively static.

It is clear from this baseline data that the Department needs to continue to focus our efforts on recruiting families who can be a foster family to children who are from their own or nearby communities. This will allow us to ensure that more children stay connected to their home school district, are provided services by local agencies, have more opportunities to stay connected to their biological families and have the chance to be involved with community recreational, sports and cultural activities.

Children's Intensive Services

In addition to addressing the needs of children who come to our attention due to abuse and neglect or involvement with our juvenile justice system, DCYF is responsible for meeting the behavioral health needs of children throughout the State of Rhode Island. While

“New” CIS Model Goals

- **Provide intensive clinical services and supports to the child and family**
- **Help avoid preventable inpatient psychiatric admissions**
- **Support the timely return of children to the community**
- **Provide community-based supports to children with acute needs**

children and their families are often involved with us for a combination of abuse/neglect, juvenile justice and/or behavioral health reasons, many times a family's first contact with DCYF is because the severity of their child's behavioral health needs is beyond the ability of the family to

address on their own. Our goal is to reduce the need for families to become formally involved with DCYF through ensuring the availability of quality children's behavioral health services within our communities.

One program intended to provide effective community-based behavioral health services and which the Department has funded for nearly 20 years is the Children's Intensive Services Program (CIS). CIS is a community and home-based behavioral health program designed to meet the needs of children with serious emotional and/or behavioral disturbances (SED) and

designed for children presenting with mental health issues that put them at risk for more restrictive living arrangements, including settings which may be out of the home and/or out of their

“New” CIS Continuum of Care Services

- **Crisis Stabilization/Assessment/Intervention**
- **Medication Evaluation & Management**
- **Outpatient Treatment (individual/family/group therapy)**
- **Therapeutic Case management**
- **Service Coordination**
- **Other Therapeutic Supports (Assessment, Recreation, etc.)**

community (e.g., juvenile justice placements, psychiatric hospitalization, etc.).

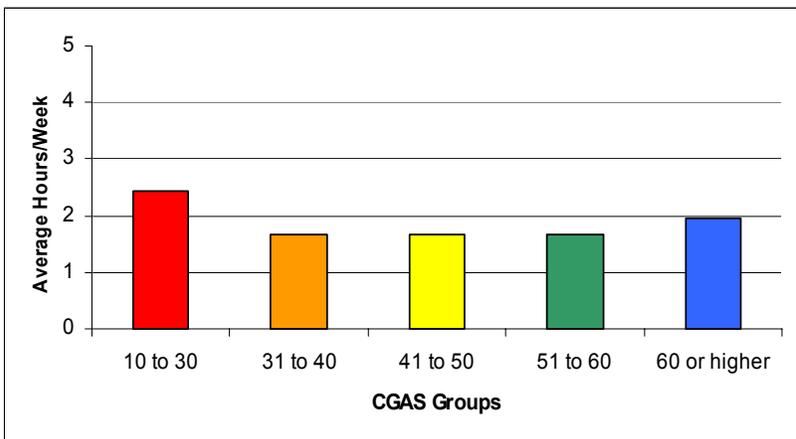
The “new” CIS model was developed out of a concern by many that the “old” model wasn't achieving the desired outcomes of helping families with their children in their own homes and communities. Following a lengthy planning process which involved parents, providers, and community advocates, DCYF promulgated the standards for the “new” CIS model in September 2003 and launched these on April 1, 2004.

The focus of CIS is on the child in his/her social environment so that the treatment is individualized to provide an optimal combination of services and case management activities to address the multiple, complex needs of the child and family. It is primarily family focused but inclusive of school and community. It is designed to address the needs of the child within the context of his/her environment.

The Department conducted two evaluations of the CIS program within the last five years. One evaluation focused on the “old” CIS model and was conducted using data from February 2002 through June 2003. This evaluation was used to inform the Department and key stakeholders in the development of the standards for the “new” CIS model launched on April 1, 2004. The Department conducted an initial evaluation of the “new” CIS model from April 1, 2004 through March 31, 2005.

During the first year of the “new” CIS model, CIS providers served more than 2,400 children who on average were at a higher level of psychiatric need than children enrolled in the “old” model. Approximately 10% of children enrolled in the “new” CIS were admitted directly from psychiatric hospitals. Both models used the Modified Child Global Assessment Scale (M-CGAS) at admission

Chart 5: “Old” CIS Model - Average Number of Service Hours Provided Per Week as Compared to M-CGAS Scores



and discharge to help determine the child’s level of functioning and the clinical needs of the child (the lower the M-CGAS score, the lower the child’s level of functioning). The mean M-CGAS score for children enrolled in the “old” CIS model was 51.9 while the mean score for those enrolled in the “new” CIS model during the first year of operation was 44.

The evaluation of the “old” CIS model in part found that there was little variation in the intensity of the delivery of services as compared to the clinical needs of the child (see Chart 5). This shows that children on average received between 1.5 -2.5 service hours per week

- “New” CIS Levels of Care**
Level 1 – Crisis Intervention
Level 2: Standard Care
Level 3: Intermediate Care
Level 4: Maintenance Care

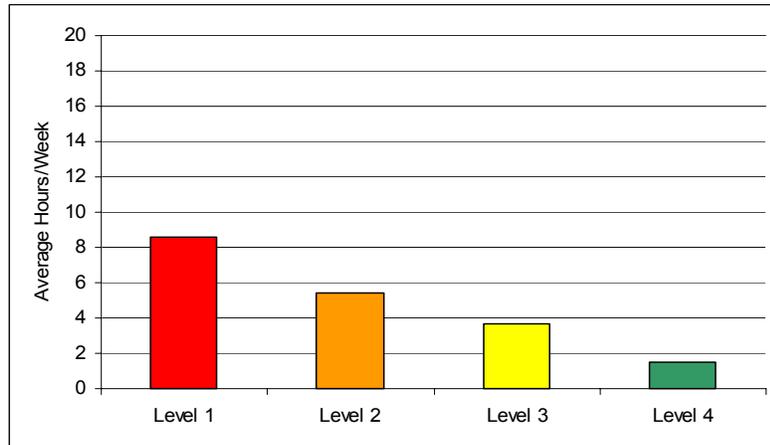
regardless of their functioning level as measured by the Modified Child Global Assessment Scale (M-CGAS)^e. The expectation however was that children with more acute and intense clinical needs would require more service hours while children with more stable clinical needs would require fewer service hours.

The “new” CIS model incorporates four levels of care: Level 1 – Crisis Intervention, designed for children with M-CGAS scores in the 10-30 range; Level 2 – Standard Care, designed for children with M-CGAS scores in the 31-40 range; Level 3 – Intermediate Care, designed for children with M-CGAS scores in the 41-50 range; and Level 4 Maintenance

Care, – designed for children with M-CGAS scores in the 51-60 range^f. Chart 6 shows that in the “new” CIS model, Level 1 clients received more than twice as many service hours per week than did Level 4 clients. At each level, 50% of the children in the program received at least the median number of hours of service per week.

The Department has incorporated additional assessments into the “new” CIS model so that we can more effectively evaluate the strengths and weaknesses of this model. This includes the Ohio Scales^g and the Child and Adolescent Functional Assessment Scales (CAFAS)^h. Both of these scales are nationally accepted and validated assessment tools for working with children and adolescents. The data from these

Chart 6: “New” CIS Model - Average Number of Service Hours Provided Per Week based on CIS Level



assessments during the initial evaluation provides the Department with a baseline against which to measure in the future. However, preliminary CAFAS results show significant improvement from admission to discharge with the average admission score being 89 and the average discharge score being 55 (in CAFAS, the higher the score, the higher the level of impairment). This shows that children who were admitted with moderate to severe impairment were discharged with minimal to moderate impairment.

The Department is encouraged by the findings in the preliminary evaluation of the “new” CIS model. We believe it is providing, and will continue to provide, a significant community-based resource for families to access when a child is exhibiting behaviors associated with serious emotional disturbance and mental illness. In turn we view CIS as a major part of our continuum of care and our efforts to ensure that children with significant mental health needs do not have to leave their homes in order to obtain quality care and treatment.

Juvenile Corrections: RI Training School and Community Corrections

The Department’s Division of Juvenile Corrections plays an integral role in helping to restore safety to schools, neighborhoods and communities where safety is of concern and to ensure that all of Rhode Island’s communities become safe communities. On any given day, the DCYF Probation and Parole Officers supervise approximately 1,383^a youth on probation and parole who are living in our communities. At the same time, the staff of the RI Training School work with an average of 207^a youth daily. The focus with each of these groups of youth is to prepare them to live in their own communities in a manner that is safe and productive.

As part of our ongoing effort to continuously improve our juvenile corrections services, several years ago the Department began a process to redesign how we deliver these services.

This led to the development of two key programs – Safe Streets Providence and Project HOPE.

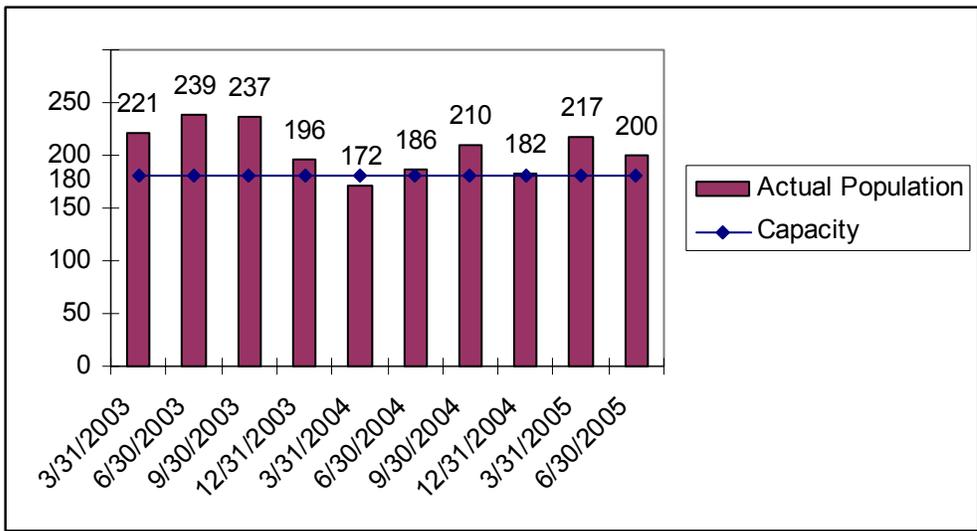
Safe Streets Providence (which has since been expanded to the Pawtucket/Central Falls area) has proven to be a highly successful, intensive supervision model for high-risk youth and young adult offenders who have been released from the RI Training School or the ACI. DCYF leads this program in partnership with the Department of Corrections and the local police departments. Juvenile and Adult Probation Officers work with smaller caseloads during the hours when these young people are at a higher risk of re-offending. They concentrate on helping these young men and women to re-connect to their community, schools and families in a positive way.

Communities Participating in SAFE Streets Program

- Providence
- Pawtucket
- Central Falls
- Cumberland

Project HOPE, modeled after the Department’s Child and Adolescent Service System Program (CASSP), is another very successful juvenile corrections program which concentrates on youth who are ready to leave the RI Training School and who are identified as having serious emotional disturbance issues. Training School staff collaborate with community providers and other community partners to develop and implement an effective transition plan which emphasizes positive re-connections to the youth’s family, neighborhood and community. This plan is put into effect prior to the youth’s departure and supported in the community by community-based agencies.

Chart 7: FY 2004 & FY 2005- RITS Daily Population v. Capacity



While these programs have proven effective, we know

they are not enough. The capacity of the Training School stands at 181 while we continue to have an average of 207^a youth assigned to the Training School on any given

day. Training School census data (see Chart 7) shows a daily census range of 172-239 youth throughout FY 2005. Our physical plant is one of the last remaining barriers to our being able to be released from the nearly thirty year old Federal Court Consent Decree. The conditions of the buildings are poor and the layout of the campus limits our ability to conduct effective programming.

We recognize that we cannot become a truly family-centered and community-based agency without significant reforms in our juvenile corrections services. With this understanding, several years ago the Department embarked on a comprehensive plan to redesign this component of the agency. In collaboration with our staff, community partners, Governor Carcieri and the General Assembly, we developed and are implementing a plan to build a state-of-the-art male youth detention center for pre-adjudicated males; a state-of-the-art Youth Development Center for those high-risk offenders who require some time in a locked, secure and structured setting; a state-of-the-art and separate program for female offenders; and up to seven Community Transition Homes to be located in various communities throughout the state.

These programs share a common vision: they are designed to ensure that youth involved with the State's juvenile justice system have safe environments in which to live that focus on helping them re-shape their lives so that they can return to their home communities and become productive members of society. This vision provides continuity of care from pre-adjudication through discharge and aftercare; holds youth accountable for their actions;

Common Vision for RI Juvenile Corrections Programs

- **Safe communities and safe Programs**
- **Youth are held accountable**
- **Continuity of care across all levels**
- **Gender-based programming**
- **Opportunities provided for youth to develop skills, knowledge and emotional strength needed to succeed.**

ensures that the differing needs of male and female offenders are addressed according to the principles of gender specific programming; and aims to give these young people opportunities to develop the skills, knowledge and emotional strength they need to be successful.

FY 2005 has focused primarily on laying the groundwork for achieving this vision. We have had meetings with key political leaders and community stakeholders in Pawtucket, Central Falls, Warwick, Providence and other communities that are critical to our success. We have invited community

members to several meals at the Training School so they can meet our youth and learn firsthand the challenges they face. We have secured the funding necessary to build the physical plants for these new programs and identified some potential sites for the new Detention Center, the Youth Development Center and the Female Offenders' Program.

We see many more significant steps being taken in FY 2006, including the beginning of construction on the three main programs. We anticipate the need for some additional statutory changes in relation to local zoning ordinances for us to be able to site the Community Transition Homes. However, we continue to be highly excited about the positive effect this reform will have on our system, on our youth and on our communities.

Community Engagement

The Department continued in FY 2005 to more effectively integrate our efforts with the efforts of the communities and families we support. Director Patricia Martinez and Deputy Director Jorge Garcia spent much of the first six months meeting with providers, advocates,

foster parents and other stakeholders to hear from them first hand what they see as the Department's strengths and challenges. These insights will prove to be invaluable in moving us forward toward a more family-centered and community-based agency.

Director Martinez has also focused on finding ways to work more collaboratively with the Rhode Island Family Court. At the same time, she is ensuring that the Court understands and works with us on issues affecting our ability to operate successfully, such as the amount of time DCYF social caseworkers and probation officers spend in Court and the unanticipated impact the Truancy and other Specialty Courts have on our ability to ensure that the needs of all of the children and youth in our care are being met.

Department Staff are involved in well over 100 external committees and commissions. We are not able to list all of these in this report but do want to highlight some key efforts:

- Each of our Regional Offices continued to focus on engaging more effectively with their communities. Paula Fontaine, East Bay Regional Director, is an active member of the

<p><u>A Sampling of DCYF Involvement</u></p> <ul style="list-style-type: none"> • RI Children's Cabinet • Governor's Council on Behavioral Health • Legislative Commission on Child Care • CHILDSpan Advisory Board • Local CASSP Collaboratives • Sexual Offender Management Task Force • RIDE Transition Council • RIDE 21st Century School Advisory Committee • Newport Partnership for Families • NHPRI Advisory Committees • Washington Co. Coalition for Children • Woonsocket Child Abuse and Neglect Task Force • Child Abuse and Neglect Prevention Network
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Newport Partnership for Families and has met with the staff and faculty of several school districts in the region in an effort to find ways to work more effectively together;

- Janice Contillo, Northern Regional Director, works closely with a group of providers and stakeholders from Woonsocket to focus the work of DCYF with these agencies more effectively and to better support foster parents in the region;
- Suzan Morris has developed several new partnerships with stakeholders in Washington and Kent Counties which have proven to be effective in coordinating DCYF's efforts with these agencies;
- John Farley, former Providence Regional Director, set the groundwork on developing visitation alternatives at several community agency sites throughout Providence and Anne Lebrun-Cournoyer, the new Regional Director, has embraced and expanded this effort;
- Stephanie Terry, CPS Administrator, Vince McAteer, Chief Investigator for CPS, and Ed Albanese, Chief Casework Supervisor for CPS have each stepped forward in providing trainings and consultations to community providers, school districts and others on the

work of DCYF and how we can help with engaging families in community-based services earlier in an effort to reduce the likelihood they will become formally involved with DCYF.

- Our Division of Children's Behavioral Health and Education Division developed and implemented the Family and Youth Partnership. As well, they have continued to develop our longstanding Youth Advisory Board which is composed of youth who have been or are in residential care. These committees, composed of youth and families who

have used our services, have proven to be invaluable assets in helping us move to a more family-centered agency.

- Our Division of Juvenile Corrections held numerous meetings with community stakeholders in relation to our reform efforts. Division staff hosted many state leaders and members of the General Assembly who wanted to see the conditions of the Training School first hand. They have continued to set the standard for the recruitment of staff which reflects the diversity of the state by holding informational sessions in the neighborhoods of our larger communities.

Moving Ahead

This report has outlined for you the immediate goals of DCYF; our vision, mission and guiding principles; and a summary of our successes in FY 2005 as well as our continued challenges. We are an agency committed to becoming a national leader in working with children and families who are in need of the support of the state. We have made great strides, but know that we have much more work to do. Our goals for FY 2006 include the following:

- Building a stronger in-state infrastructure of community-based and residential programs so that we can continue to reduce our reliance on out of state programs;
- Developing and implementing a family assessment process consistent with the principles of family-centered practice which will give us a more comprehensive understanding of the strengths and challenges each of our families and their children face;
- Developing a Program Improvement Plan that is acceptable to the Federal Government and which, more importantly, aims at improving our ability to keep children safe in their homes, neighborhoods and schools; facilitating the implementation of the principles and practices of family-centered practice; more effectively integrating the various operational divisions of the Department; and bringing us closer to truly partnering with our community providers and other community institutions;
- Redesigning our Licensing Division to ensure that foster families and providers are guided through the licensing process as expeditiously as possible while also ensuring that the homes and providers we license are safe homes for children and are held to high standards of practice;
- Developing and implementing licensing standards for outpatient Children's Behavioral Health programs;
- Developing and implementing emergency services standards which improve our ability to ensure that families have the upfront support they need when a child is facing a behavioral health crisis;
- Breaking ground on the new Youth Detention Center and the new Youth Development Center;

We are an agency committed to becoming a national leader in working with children and families who are in need of the support of the state.

- Identifying and beginning the construction of a new site for our Female Offender Program;
- Developing and implementing a more coordinated approach to engaging with parents, families, communities, providers and federal, state and local elected officials.

We know that we cannot accomplish these goals without the support and assistance of the people of Rhode Island. We look forward to working with you to achieve our vision of safe homes, safe schools, safe neighborhoods and safe communities.

Additional Resources

The Department has numerous resources available to the public and to public officials that can assist you. This includes links to services as well as numerous publications – studies, reports, policies and regulations – available for you to use. Below are some web links for you to use to access these resources:

Web Links

DCYF Website: <http://www.dcyf.ri.gov>

Rhode Island Program Improvement Plan:

http://web.dcyf.org/docs/pip_final.pdf.

Frequently Asked Questions about DCYF:

<http://www.dcyf.ri.gov/questions/index.htm>

Studies, Reports and Regulations:

<http://www.dcyf.ri.gov/docs/index.htm>

Resources and Services:

<http://www.dcyf.ri.gov/link.htm>

RITS & IESE Partnership (The RITS & IESE Partnership reflects collaborative work between the Rhode Island Training School (RITS) and Brown University's Institute for Elementary and Secondary Education (IESE):

<http://www.brown.edu/Departments/IESE/RITS/>

Child Abuse and Neglect Hotline

To report suspected child abuse and/or neglect, please call 1-800-RI CHILD (1-800-742-4453). Any person making such a report may choose to keep their identity anonymous.

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Acknowledgements

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Endnotes

^a These counts are based on an average derived from using end of the month point in time data.

^b These counts exclude children living in subsidized or non-subsidized adoption.

^c This includes both children living with relatives who are not receiving foster care payments as well as relatives receiving foster care payments.

^d A night-to-night episode is defined as the placement of a single youth on a given night in a program for other than the intended use of that program. The number of episodes per week is usually greater than the number of individual youth placed on night-to-night status that week. Each night a youth is in night-to-night placement is counted as a separate episode. For example, if an individual youth is placed for three consecutive nights, this is counted as three (3) episodes.

^e The Modified Child Global Assessment Scale, or M-CGAS, is a numeric scale (1-100) used by mental health clinicians and doctors to rate the general psychological and social functioning of children under the age of 18. A higher M-CGAS score translates to a higher level of functioning while a lower score translates to a lower level of functioning.

^f In the new CIS model, there are set expectations for providers to follow in regard to the minimum number of direct clinical service hours per week to be provided to a client in each level. Level 1 clients are expected to receive at least 6-14 hours; Level 2 clients should receive 2-10 hours; Level 3 clients should receive 2-5 hours; and Level 4 clients should receive .5-1 hour with an additional 2 hours of case management each month.

^g The Ohio Youth Problems, Functioning, and Satisfaction Scales (Ohio Scales) are instruments developed to measure outcomes for youth ages 5 to 18 who receive mental health services. It should be noted that the Ohio Scales were developed primarily to aid in the tracking of service effectiveness.

^h The Child & Adolescent Functional Assessment Scale (CAFAS) is a rating scale, which assesses a youth's degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems.