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Assessing **Utilization and Measurement** in Practice:

An Analysis of *Department of Children & Families* Provider Survey Data

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EXECUTIVE SUMMARY

This report examines the data collected under Special Act 24-24 (SA 24-24) with the intent to assess the functioning of Connecticut's Department of Children and Families' (DCF) contracted service array and identify gaps in service availability. While the Act seeks to increase transparency around utilization, funding, and program outcomes, analysis of provider-reported data reveals substantial limitations in comparability and completeness.

Across 261 programs representing 59 service types, key utilization and outcome measures are frequently missing or inconsistently defined. These gaps limit cross-program comparability and complicate interpretation of the collected data. Importantly, missing data does not indicate lack of service activity; rather, it most frequently reflects a structural misalignment between standardized reporting requirements and the operational realities of diverse service models.

Where the data are most consistent—provider narrative responses—a clear and repeated pattern emerges. Providers rarely describe reduced demand for services. Instead, they describe constrained capacity: chronic workforce shortages, increased case acuity, mismatches between referred needs and program scope, referral pathway breakdowns, and practical barriers that make it difficult for families to engage. In this context, underutilization is best understood as a signal of system strain rather than diminished need. These patterns are consistent with a Social Determinants of Health framework, which locates many drivers of family well-being upstream, within the economic, social, and environmental conditions that shape daily life.

The findings point to four aligned policy priorities: (1) strengthening data definitions, interoperability, and governance; (2) helping to support providers through payment that reflects the true cost of care and career supports that minimize barriers to entry into the field; (3) reducing economic barriers for families so referrals translate into real access; and (4) resourcing these recommendations equitably.

INTRODUCTION

Understanding how systems are meeting needs is fundamental to affirming that they are acting in the collective interest of those whom that system is designed to serve. Special Act 24-24 (formerly House Bill 5428) reflects the Connecticut General Assembly's recognition that visibility into Connecticut's Department of Children and Families' contracted service array is essential to strengthening the state's behavioral health, child welfare, and prevention systems.

SA 24-24 requires DCF to report detailed information on the utilization, expenditures, referrals, and outcomes of its contracted programs.[i] The Act outlines a broad set of metrics intended to illuminate where services are reaching children and families, where and why capacity is constrained, and where unmet need persists.

In practice, however, the legislation presumes a level of data consistency and standardization across DCF's diverse provider network that does not yet exist. The initial data release required under SA 24-24 represents a substantial effort by DCF and its contracted providers to compile information across hundreds of programs and service types. However, the resulting data, submitted through individual program-level forms, vary widely in completeness and consistency. As a result, the dataset in its original form is difficult to analyze holistically and cannot, on its own, support many of the system-level questions the statute seeks to answer.[ii]

Rather than generating new data, this report responds to the Legislature's intent by reconstructing DCF's original submission into a unified dataset from which meaningful insights can be drawn. This report is not an audit of DCF or its providers, nor is it a performance evaluation of individual programs. Instead, it offers an analytic reinterpretation designed to make the SA 24-24 dataset usable for system-level learning, while clearly documenting where the collected data falls short of the statute's measurement goals.

Legislative Intent & Measurement Framework

Functionally, SA 24-24 requires DCF to collect data elements intended to create a comprehensive picture of the agency's contracted service array. While each of these items are enumerated as distinct reporting requirements, together they are intended to help tell a larger story about how the system operates and where utilization patterns are reflective of structural constraints rather than reduced need.[iii] Done well, these data support capacity planning and reveal where unmet needs are most acute, enabling policymakers and stakeholders to target improvements where they matter most.

This legislation required DCF to submit a report to the Connecticut General Assembly by February 1, 2025, including data from fiscal years 2023 and 2024. SA 24-24 captures program-level information related to:

- *Program Participation and Utilization:* Measures in this domain are designed to describe the reach and capacity of DCF's contracted service array. They are intended to show how many children and families are served, how fully programs use their contracted capacity, and how many referrals programs receive as well as how often and why referred children and families may go unserved.

- *Funding and Expenditures:* These financial indicators connect service delivery to the state's fiscal investments. These measures help identify where resources are being allocated. They include total allocations and expenditures, and whether contracts include

the critical infrastructure needed for program efficacy such as staff training, data collection, and quality assurance procedures.

- *System Characteristics and Service Context:* These items describe how the system is organized, capturing the geographic areas served by each program, whether programs are third-party billable, and whether a DCF open case is required to receive a specific service. They help to contextualize access and reveal gaps in availability of services.

In practice, the dataset produced through SA 24-24 does not yet support that full system-wide utilization analysis. Across 261 programs representing 59 service types, many key quantitative measures are missing, inconsistently defined, or not comparable across fundamentally different service models. Rather than forcing conclusions where the dataset cannot reliably sustain them, this report focuses on the components that provide the strongest and clearest analytic insight.

Specifically, the report examines two foundational components of the dataset:

1) *Missingness and Data Quality:* The extent, distribution, and nature of missing data reveal systemic issues in reporting infrastructure and a lack of definitional clarity. Patterns of missingness highlight where definitions were unclear or where other barriers prevent standardized reporting. These gaps help explain why most statutorily required metrics could not be analyzed and point towards the areas where future data collection and system improvements may have meaningful impact.

2) *Program Narrative Responses on Utilization and Referrals:* Across all submitted forms, the narrative fields were the most consistent and analytically rich component of the dataset. Providers described common challenges, indicated similar needs, and illustrated what cannot be explained with the quantitative fields alone. Their narratives offer grounded insight into the functioning of programs within DCF's service array.

In these areas, the report presents descriptive summaries. These findings are included to highlight the array of available information. This report centers program narratives as the most reliable lens for understanding system functioning in the current data landscape.

Why Visibility & Transparency Matter Now

Visibility and transparency are related but distinct conditions, both necessary for public accountability. Visibility refers to the state's capacity to see how its service systems are functioning in practice. It encompasses whether data exist, whether they are sufficiently complete and comparable, and whether they meaningfully reflect how services are accessed, delivered, and constrained across populations and geographies. In this report, visibility is about whether the structure and quality of available data allow policymakers and the public to identify where services reach families, where capacity is constrained, and where unmet need persists.

Transparency, on the other hand, refers to the extent to which that information is accessible, interpretable, and accountable to external audiences. Transparency requires not only that data be made public, but that they are presented in ways that are understandable, contextualized, and accurate, with clear definitions and limitations. Without transparency, even visible systems cannot be meaningfully evaluated or used to inform public decision-making.[iv] Together, visibility and transparency are mutually reinforcing.

These distinctions matter now because DCF's contracted service array is a core component of Connecticut's child welfare and children's behavioral health continuum, and because the

conditions that once ensured public accountability for much of that system have fundamentally changed. The formal end of federal court oversight under the Juan F. consent decree in 2022 marked substantial progress for the agency relative to the conditions that prompted the original lawsuit.[v] With this exit, however, Connecticut also lost the protections that were in place to ensure DCF's budget and staffing levels are maintained. The state additionally no longer benefits from the guaranteed data collection and reporting provided by the Federal Court Monitor, creating gaps in public transparency relative to the child welfare mandate. The subsequent erosion of DCF's data reporting infrastructure additionally inhibits visibility into parts of the system.

This shift also comes at a moment of substantial public investment in the statewide children's mental and behavioral health continuum. Over the past several legislative sessions, Connecticut has enacted major policy packages aimed at strengthening access to an array of children's mental and behavioral health services in the state[vi], expanding access to crisis response services[vii], and addressing longstanding workforce and reimbursement challenges.[viii] Maintaining and protecting those investments requires measurement systems that can credibly show where services are reaching families, where capacity is constrained, and where the service ecosystem is not functioning as intended.

Understanding the importance of this work now also requires clarity about the role that DCF plays in families' lives. While most closely associated with caring for children in out-of-home foster care, most of the agency's work takes place far earlier in families' trajectories. Tens of thousands of referrals are made to DCF each year, but only a subset result in investigations, and an even smaller share enter foster care placement.[ix] In Connecticut, DCF serves as the state's lead agency for children's behavioral health, with responsibility for overseeing and coordinating a statewide continuum of community-based service. For the vast majority of families, interaction with DCF centers on stabilization, support, and prevention.

In 2024 alone, DCF received 67,795 reports through its Careline[x], accepting 31,911 for further action. During that year, DCF served 4,052 families in their homes and 4,155 children in out-of-home care.[xi] DCF staff assess each child and family's circumstances to develop individualized case plans, aligning service referrals and supports to meet identified needs across multiple domains of family wellbeing.

This work depends on a broad and interconnected continuum of contracted services including mental health treatment, substance use recovery supports, medical services, youth mentoring, parenting programs, crisis response, and other community-based interventions. These services are not interchangeable. Families rarely experience need in a single category, and access to and effectiveness of one service can depend on the availability of others.

In a broader context of rising behavioral health needs,[xii] persistent workforce constraints[xiii], and overlapping family stressors,[xiv] the state's ability to see where services are available—and where they are not—is a substantive policy issue. When visibility is limited, unmet need is more challenging to identify, and patterns related to utilization become more difficult to interpret.

These challenges are especially consequential for children involved with the child welfare system. This population is more likely to experience elevated trauma exposure frequently resulting in complex clinical and higher service intensity needs. In practice, the same structural limitations that are challenging for any child-serving system can have outsized effects on children who've already experienced increased adversities.[xv]

Visibility and transparency, in this context, directly impact the State's capacity to align services with need, to support providers operating under strain, and to ensure that systems designed to protect children and families are functioning equitably and effectively.

DATA CONTEXT

Data Sources & Coverage

In order to meet the requirements of SA 24-24, DCF issued data requests to its network of contracted providers.[xvi] DCF currently has 89 total service types and 345 unique contracts.[xvii] Some organizations hold multiple unique contracts, providing services across multiple service types. A total of 261 programs responded to the SA 24-24 data collection effort, representing 59 distinct service types. The raw data released by DCF in their report included reporting from **66%** of DCF's overall available service types, and includes data representing approximately **75%** of DCF's contracted service providers.[xviii] **Table 1** summarizes the number of programs reporting data across service types.

Table 1: Count of Programs Reporting, by Service Type[xix]

Service Type	Count of Programs	Percent of Total
C-KIN	6	2.30%
CARE COORDINATION	8	3.07%
CAREGIVER SUPPORT TEAM	4	1.53%
CHILD OUTPATIENT SERVICES	4	1.53%
COMMUNITY SUPPORT FOR FAMILIES	6	2.30%
EARLY CHILDHOOD SERVICES - CHILD FIRST	9	3.45%
EXTENDED DAY TREATMENT	11	4.21%
FAMILY BASED RECOVERY	5	1.92%
FATHERHOOD ENGAGEMENT SERVICES	4	1.53%
FOSTER CARE SUPPORT GROUPS	2	0.77%
FUNCTIONAL FAMILY THERAPY	4	1.53%
FUNCTIONAL FAMILY THERAPY-FOSTER CARE	10	3.83%
HYPE	5	1.92%
INTENSIVE FAMILY PRESERVATION	8	3.07%
INTENSIVE TRANSITION CARE MANAGEMENT COORDINATION	2	0.77%
IPV-FAIR (INTIMATE PARTNER VIOLENCE- FAMILY ASSESSMENT INTERVENTION RESPONSE)	6	2.30%
JUVENILE REVIEW BOARD	2	0.77%
MOBILE CRISIS INTERVENTION SERVICES	5	1.92%

MULTIDIMENSIONAL FAMILY THERAPY (MDFT)	10	3.83%
MULTIDISCIPLINARY EXAM TEAM (MDE)	6	2.30%
MULTIDISCIPLINARY TEAMS (MDT)	9	3.45%
MULTISYSTEMIC THERAPY (MST)	4	1.53%
MULTISYSTEMIC THERAPY BUILDING STRONGER FAMILIES (BSF)	5	1.92%
MULTISYSTEMIC THERAPY-PROBLEM SEXUAL BEHAVIOR (PSB)	3	1.15%
OUTPATIENT PSYCHIATRIC CLINIC FOR CHILDREN	17	6.51%
PARENTING SUPPORT SERVICES	9	3.45%
PERMANENCY & PLACEMENT SERVICES PLANNING (PPSP)	2	0.77%
QUALITY PARENTING CENTERS	11	4.21%
RESIDENTIAL TREATMENT CENTER	3	1.15%
REUNIFICATION & THERAPEUTIC FAMILY TIME	7	2.68%
SAFE-FR	11	4.21%
SSTRY (SUBSTANCE SCREENING, TREATMENT, AND RECOVERY FOR YOUTH)	2	0.77%
STTAR	6	2.30%
SUBACUTE STABILIZATION CENTER	2	0.77%
THERAPEUTIC FOSTER CARE	2	0.77%
THERAPEUTIC GROUP HOME	17	6.51%
TLCC	2	0.77%
TRANSITIONAL SERVICES EMERGING ADULTS	2	0.77%
URBAN TRAUMA CENTER	3	1.15%
URGENT CRISIS CENTER	4	1.53%
WORK TO LEARN / LAUNCH	5	1.92%
CAFAF	1	0.38%
CARE MGMT ENTITY - ICC	1	0.38%
CROSSROADS - YAS	1	0.38%
FATHERHOOD ENGAGEMENT SERVICES (DOC)	1	0.38%
FIRST EPISODE PSYCHOSIS	1	0.38%
INTEGRATED FAMILY CARE & SUPPORT	1	0.38%
LITERACY BASED MENTORING	1	0.38%

MULTIDIMENSIONAL FAMILY THERAPY-R (MDFTR)	1	0.38%
MULTISYSTEMIC THERAPY EMERGING ADULTS (EA)	1	0.38%
MULTISYSTEMIC THERAPY-BSF-IPV	1	0.38%
PREVENTION CARE MANAGEMENT ENTITY (PCME)	1	0.38%
START PROGRAM	1	0.38%
SUPPORTING HOUSING FOR FAMILIES	1	0.38%
SURVIVOR CARE	1	0.38%
TRANSITIONAL PEER SUPPORT	1	0.38%
VOLUNTARY CARE MANAGEMENT	1	0.38%
WENDY'S WONDERFUL KIDS	1	0.38%
YOUTH LINK MENTORING	1	0.38%

Limitations of the Dataset

As part of this analysis, we assessed not only the content of the provider-submitted data, but also its completeness, consistency, and alignment with the requirements of SA 24-24. This serves two purposes: (1) to evaluate the practical implications of data quality on interpretation and (2) to examine how fully the current dataset supports the legislation's broader goals.
All values in the report are taken directly from DCF provider submissions, not from verified administrative records. In many cases, providers even adapted the reporting form to align with their existing definitions, workflows, or contractual arrangements. While these adaptations were reasonable and necessary at the program level, they limit comparability across services and constrain the extent to which conclusions can be drawn at the aggregate level.

Several limitations are especially important for interpretation, including:

Inconsistent Interpretation of Reporting Categories: Programs applied different interpretive assumptions when completing reporting fields, due to a lack of definitional clarity on the SA 24-24 program form. For example, some programs reported total program expenditures, while others reported total expenditures specifically from DCF funds. These differences in interpretation of the reporting requirements greatly limit consistent use and cross-program comparison.

Non-Comparable Metrics Across Service Types: DCF's contracted service array includes programs with fundamentally different structures, and not all service types generate the same programmatic metrics. Some, for instance, may serve parent-child dyads or sibling groups; some are time-limited treatment programs, others provide episodic crisis response, ongoing support for caregivers, or systems coordination. As a result, the collected measures are not relevant to every program. When a measure does not map onto a service model, missing reporting should be interpreted as a limitation of metric fit rather than a lack of service activity.

Geographic Scope Reporting Impacts Comparability: Providers reported geographic scope using widely varying formats and levels of specificity (e.g. single towns, lists of towns, DCF region(s), multi-region areas, and statewide service areas). Because these categories are not standardized, and because services are delivered through different modalities (in-home, clinic-

based, hospital-based, hybrid, etc.) the dataset does not support precise geographic comparisons or a comprehensive mapping of service gaps across communities.

For each statutorily required item, **Table 2** identifies what data were required, the measurement intent behind the statutory language, as well as what data were actually collected.

Table 2: Alignment of Special Act 24-24 Requirements with Collected Data

Special Act 24-24 Reporting Item:	Measurement Intent:	Data Collected:
(1) participation in each department program	To show how many children, youth, and families were served by each DCF-funded program in the two most recent fiscal years.	Counts of clients and/ or cases served by each program during SFY 2023 and 2024.
(2) program quality controls in place	To determine whether and what quality assurance activities are included in DCF's contracted procurement rate.	Binary indicator identifying whether quality assurance costs were included in procurement-rate budgeted costs.
(3) program expenditures in relation to utilization	To compare what DCF spent on each program relative to how that program was used, assessing cost in relation to service volume.	Dollar amounts for: total program allocations, total program expenditures, and calculated spending per case.
(4) department funding and expenditures by account	To detail how DCF allocates funds across its accounts to support contracted programs.	Dollar amounts allocated by account (e.g., salaries, benefits, overhead, training).
(5) the percentage of contracted utilization and whether utilization is increasing or decreasing and, for any decline in utilization or utilization that falls below eighty-five per cent of the contracted expectation, the reasons for the decline or low utilization, including an evaluation of whether the trend	To identify the share of contracted capacity used each year, determine whether utilization is increasing or decreasing, and document reasons for low or declining utilization.	Contracted and actual utilization counts for each fiscal year; narrative explanations describing reasons for year-over-year change.

reflects decreased need for the service or workforce limitations		
(6) the number of referrals to each contract and the reasons that referrals go unserved, which may include reasons such as staffing vacancies, the fact that the program met capacity or that the client did not meet the admission criteria	To measure demand for each program and understand why referrals may go unserved.	Referral counts for each program and SFY; narrative explanations for unserved or declining referrals
(7) for each contracted service, whether procurement rates include costs for staff training, data collection or quality assurance expectations	To determine whether program contracts include funding for staff training, data collection, and quality assurance.	Binary indicator for inclusion of staff training, data collection, and quality assurance within procurement rate costs (inclusive of the quality assurance item [statutory item 2])
(8) for each contract, whether the service is billable under Medicaid	To determine whether contracted services can be billed to Medicaid.	Binary indicator (Y/N) reporting whether services were identified as “third-party billable,” reflecting a broader definition of billability
(9) for each contracted service, whether a child or family was required to be in the department's care or custody as a criteria for referral or admission	To clarify eligibility criteria by identifying whether an open DCF case is required for engagement with the service.	Binary indicator denoting whether an open case DCF is required for engagement with a specific program.
(10) for each contract, the geographic scope for delivery	To identify the geographic area (region, county or counties, town, multi-town area, county, or planning region) served by each contracted program.	Text entered geographic scope for each program.

(11) for each service, information concerning achievement of contracted service expectations regarding attainment of treatment goals based on initial assessment	To determine whether clients or cases achieve treatment goals based on initial assessment.	Providers' reported counts of clients/ cases receiving an initial assessment, clients/cases eligible for treatment, clients/cases achieving the treatment goal, percent achieving contracted treatment expectations (Actual), Percent achieving contracted treatment expectations (Contracted benchmark)

FINDINGS

Missing Data

Before discussing what can be shown with the data available, it is essential to understand what is not visible in the current dataset. Missing data is not simply a technical limitation of this report; rather, it is itself an important finding. Throughout this report, missing data or "missingness" refers to instances in which a program did not report a usable value for a required SA 24-24 reporting field.

Across programs, missingness is substantial but patterned rather than random. On average, approximately 17% of required fields are missing across the dataset. This means that more than half of the form fields have missing values for between 15 and 30% of programs. *These gaps do not stem from provider noncompliance or disengagement*. Instead, they reflect structural differences in how programs operate, how core concepts are defined and understood across service types, and how different programs' internal systems are configured to report certain forms of information.

These patterns collectively illustrate the challenge of understanding utilization and unmet need within a service system that is highly diverse, adaptive, and unevenly equipped for data collection. **Table 3** shows the frequency of missing values for each form field collected under SA 24-24.

Table 3: Summary of Missing Data, by Reporting Item

Measurement Field	N Missing	N Present	% Missing
Contracted program utilization for SFY 2023	75	186	28.74
Actual program utilization in SFY 2023	35	226	13.41
Contracted utilization for SFY 2024	66	195	25.29
Actual program utilization in SFY 2024	24	237	9.20
Actual vs contracted utilization % for SFY 2023	71	191	27.20
Actual vs contracted utilization % for SFY 2024	65	197	24.90
Number of referrals received in SFY 2023	42	219	16.09
Number of referrals received in SFY 2024	27	234	10.34
Clients receiving evaluation only in SFY 2023	63	198	24.14
Clients receiving evaluation only in SFY 2024	51	210	19.54
Clients receiving services in SFY 2023	30	231	11.49
Clients receiving services in SFY 2024	21	240	8.05
Clients completing treatment plan in SFY 2023	59	202	22.61

Clients completing treatment plan in SFY 2024	54	207	20.69
Total clients served in SFY 2023	59	202	22.61
Total clients served in SFY 2024	52	209	19.92
Cases receiving initial assessment in SFY 2023	47	214	18.01
Cases receiving initial assessment in SFY 2024	35	226	13.41
Cases eligible for treatment in SFY 2023	46	215	17.62
Cases eligible for treatment in SFY 2024	32	229	12.26
Cases achieving treatment goals in SFY 2023	53	208	20.31
Cases achieving treatment goals in SFY 2024	40	221	15.33
Total program allocations in SFY 2023	67	194	25.67
Total program allocations in SFY 2024	63	198	24.14
Total program expenditures in SFY 2023	37	224	14.18
Total program expenditures in SFY 2024	32	229	12.26
Expenditures per case in SFY 2023	73	188	27.97
Expenditures per case in SFY 2024	65	196	24.90
DCF funding allocated for salaries in SFY 2023	36	225	13.79
Expenditures on salaries in SFY 2023	32	229	12.26
DCF funding allocated for salaries in SFY 2024	30	231	11.49
Expenditures on salaries in SFY 2024	27	234	10.34
DCF funding allocated for employee benefits in SFY 2023	48	213	18.39
Expenditures on employee benefits in SFY 2023	32	229	12.26
DCF funding allocated for employee benefits in SFY 2024	43	218	16.48
Expenditures on employee benefits in SFY 2024	27	234	10.34
DCF funding allocated for overhead costs in SFY 2023	58	203	22.22
Expenditures on overhead in SFY 2023	41	220	15.71
DCF funding allocated for overhead costs in SFY 2024	51	210	19.54

Expenditures on overhead in SFY 2024	36	225	13.79
DCF funding allocated for staff training in SFY 2023	67	194	25.67
Expenditures on staff training in SFY 2023	59	202	22.61
DCF funding allocated for staff training in SFY 2024	60	201	22.99
Expenditures on staff training in SFY 2024	47	214	18.01
Indicator that staff training is included in the procurement rate for SFY 2023	27	234	10.34
Indicator that staff training is included in the procurement rate for SFY 2024	24	237	9.20
Indicator that data collection is included in the procurement rate for SFY 2023	33	228	12.64
Indicator that data collection is included in the procurement rate for SFY 2024	30	231	11.49
Indicator that quality assurance expectations are included in the procurement rate for SFY 2023	33	228	12.64
Indicator that quality assurance expectations are included in the procurement rate for SFY 2024	30	231	11.49

Missingness Across Data Elements

Some of the highest missingness appears in measures that sit at the center of SA 24-24's intent. Contracted utilization targets are missing for roughly one quarter of programs in both years; 28.7% of programs in SFY 2023 and 25.2% in SFY 2024. Provider narratives indicate that, for some programs, a contracted utilization target does not exist in a meaningful way. Certain services are not client-serving, do not operate on a fixed number of slots, or are structured around availability rather than enrollment. In these cases, utilization cannot be calculated as a percentage of contract maximum because no such maximum is defined. For example, hotline-based services may track contacts or calls rather than discrete clients or cases, making traditional utilization metrics inapplicable.

Measures comparing actual to contracted utilization represent a core indicator of service use under SA 24-24. These fields are intended to assess whether contracted service capacity is being fully used, underutilized, or exceeded. Despite their central role in the statute, these measures exhibit elevated missingness, affecting 27.2% of programs in SFY 2023 and 24.9% in SFY 2024.

The prevalence of missingness that appears across these fields highlights a mismatch between a standardized reporting system and the operational realities of different service models. Without clearer differentiation by program type, utilization data may inadvertently over-represent only the services that fit the referrals and clients model while obscuring other service types that play critical roles in prevention or system coordination.

Likewise, measures intended to capture progression through services, including the count of clients receiving only an evaluation, and clients achieving treatment completion show elevated levels of missingness across both years. As with some of the core components of utilization, these metrics are not universally applicable across all service types. Some programs do not conduct formal assessments, do not provide time-limited treatment, or do not define completion in a standardized way.

Several key financial reporting fields also show a high degree of missingness. Values for total program allocations are missing for 25.7% of programs in SFY 2023 and 24.1% in SFY 2024. Notably, allocations and expenditures specific to staff training also show persistently high missingness. In SFY 2023, 25.7% of programs did not report training allocations, and 22.6% did not report training expenditures, with only modest improvement in SFY 2024. This pattern is striking given the policy importance of training as one critical component of workforce development and may reflect ambiguity about how training costs are defined, budgeted, or embedded within broader rate structures rather than tracked as stand-alone line items.

Implications of Missing Data

Missing values should not be interpreted as evidence that services were unused, unnecessary, or ineffective. Rather, these patterns reveal where the reporting framework was not equipped to capture the full scope of DCF funded services.

These findings also provide important context for the analyses that follow. Understanding what data are currently available, and where they are not, helps clarify what can reasonably be concluded for the current report and where future improvements are needed. In this way, missing data serves not only as a limitation, but as a guide for building and strengthening systems of measurement that accurately and equitably reflect how children and families experience the system.

Taken together, these limitations informed a deliberate methodological choice. Because of substantial missingness, inconsistent interpretation of key fields, and limited cross-program comparability, comprehensive quantitative analyses were intentionally excluded from this report.[xx]

Narrative Response Patterns

Program narratives are the most analytically valuable component of SA 24-24, because they provide context that the quantitative fields cannot. On the program form, respondents were asked to explain (1) declines in utilization or utilization significantly below contract, and asked to provide reasons for the decline or low utilization including whether trends reflect decreased need or workforce limitations, and (2) explain why referrals went unserved.[xxi] These narrative fields were analyzed together because providers' responses showed substantial conceptual overlap and routinely described the same underlying constraints across both questions.[xxii]

Of the total 261 programs that submitted a form for the SA 24-24 data collection effort, 180 included a written narrative response describing reasons for decreased utilization. 156 programs included a narrative response providing a contextual explanation for reasons referrals may have gone unserved. 213 programs in total provided narrative data, responding to one or both of the narrative prompts. Responses varied in length and detail, but collectively provide a system-level view of recurring constraints that shape access and service delivery across DCF's contracted service array.

The patterns below summarize themes that providers most frequently raised when asked to explain low utilization or unserved referrals. Code frequencies reflect how often a theme appears across program narratives, not the magnitude of the issue in any one program, nor the quality of services provided. Themes are best read as indicators of recurring constraints within the service array and most narratives describe multiple, interrelated factors rather than a single challenge or cause.

Table 4: Top Substantive Themes in Program Narratives[xxiii]

Top Substantive Themes in Program Narratives	Programs Reporting	Percent of Programs
Workforce Constraints	100	46.95%
Client Engagement Barriers	93	43.66%
Client Needs Mismatch	63	29.58%
Referrals System Issues	53	24.88%
Metric Notes	35	16.43%

Across narratives, the most common themes are clustered into five broad categories: *workforce constraints; client engagement barriers; mismatch between referred needs and available services; referral pathway and process issues; and notes on metrics*. These constraints frequently co-occur. This suggests shared structural issues rather than isolated program-level problems. Read together, the narratives describe interconnected pressures that compound across stages of service access and delivery.

Workforce Constraints

Workforce challenges were the most frequently cited barrier to meeting contracted utilization and accepting referrals. Providers across the continuum described difficulty recruiting, hiring, credentialing, and retaining staff at the levels needed to operate at contracted (or otherwise optimal) capacity. In many narratives, workforce shortages functioned as the binding constraint on capacity. Programs described reducing caseloads, pausing admissions, limiting service hours, or narrowing geographic coverage when staffing fell below necessary, safe, or specific thresholds for program quality.

Within the narratives, providers described prolonged vacancies and hiring delays driven by competition with better compensated settings. These responses additionally detailed the layered constraints related to clinical staffing: licensure requirements, specialized expertise, and supervision capacity. Where programs rely on licensed clinicians, staffing instability could depress operational capacity even when demand remained high, because clinical coverage cannot be easily or meaningfully substituted with non-licensed roles. These issues were especially pronounced among home-based service providers.

Providers additionally noted that their capacity for service delivery is shaped not only by workforce challenges, but also by extended onboarding timelines and the time required to train and onboard new staff. Training requirements, whether agency-specific or tied to evidence-based model fidelity, extended onboarding timelines and reduced active capacity. Several programs described training periods lasting multiple months, during which new hires are unable to work to the capacity of another full-time staff member, resulting in a lag between hiring and

restored capacity. Multiple programs noted that this process is necessary to maintain program quality, despite the limitations it creates in the short term.

While staffing constraints were widespread, a smaller number of providers reported a recent stabilization or improvement in staffing, but they still described this as tentative or vulnerable to workforce pressures.

Importantly, many narratives framed low utilization not as reduced need, but as reduced operational capacity. In other words: there was need and demand for the service but the workforce infrastructure required to deliver it consistently was unstable. Workforce instability directly limits the state's ability to deliver services. When programs cannot hire, credential, or retain staff quickly enough to meet program or contract requirements, unmet need grows. In this context, underutilization is a reflection of staffing constraints and the strain created by chronic labor force instability.

Client Engagement Barriers

The second most common theme reflected barriers to initiating or sustaining participation after referral to a program. Program narratives frequently described difficulty reaching families, missed appointments, and disengagement after initial outreach. These narratives did not frame engagement as a matter of motivation or compliance. Rather, program narratives described engagement as predictably shaped by social determinants of health, the overlapping and compounding constraints faced by families such as transportation limitations, unstable work schedules, caregiving demands, and housing instability. When these conditions are unstable, participation in voluntary services becomes logistically fragile, even when need remains high.

Engagement challenges surfaced more often in narratives from programs that did not require an open DCF case. Participation in these programs is not mandated and depends more heavily on family availability, trust, perceived benefit, and the contextual constraints mentioned above. This pattern suggests that low utilization may be indicative of friction in the service connection and follow-through, not low or declining service need.

These narratives underscore a key point. Families experiencing multiple, overlapping stressors are often asked to navigate complex service systems at precisely the moment their capacity is most constrained. Missed appointments, disengagement, or declined services frequently reflect cumulative burden rather than lack of need.

Client Needs Mismatch

A third major pattern that emerged from the program narratives was a persistent mismatch between the clients' needs and the services available from DCF contracted providers. Programs frequently described referrals that were appropriate in intent (i.e. families or youth clearly need support) but that did not align with the clinical scope, intensity, eligibility criteria, or operational design of the receiving program. In most cases, the mismatch was not about whether a family needed services, but whether the specific service to which they were referred could reasonably meet the needs presented.

Program narratives often pointed to situations in which youth required a higher level of care, a different modality, or more intensive supervision than their program was designed to provide. Responses describe receiving referrals for youth with complex co-occurring needs, elevated safety risks, or clinical profiles outside of a program's scope even when that program is operating with capacity.

Providers also described an increase in overall case acuity that strained existing service models. Higher-acuity cases were characterized as more time-intensive, requiring lower caseloads, greater clinical expertise, and more coordination across systems. Even when staffing levels were relatively stable, programs reported serving fewer clients because each case required substantially more time and attention. In this way, higher acuity functions as a latent capacity constraint.

Narratives further suggest potential pressure points at both ends of the service continuum. Several programs described receiving referrals that were too acute for outpatient services, while others noted challenges serving youth stepping down from inpatient or residential settings when outpatient intensity was insufficient to sustain stabilization.

These patterns suggest system-level inconsistencies in assessment and level-of-care (LOC) determination processes. For Medicaid-enrolled youth, formal LOC processes are often administered through Carelon Behavioral Health as part of managed care authorization. However, for youth outside of Medicaid or outside of those referral pathways, LOC determination processes appear less standardized. Inconsistent assessment pathways can result in referrals that are well-intentioned but poorly aligned with program scope.

Referral System Issues

A fourth major theme involved the referral process itself, how referrals are generated and how they move through the system. Unlike workforce constraints, which limit a program's operational capacity to deliver services, referral system issues concern how clients move into and through the service array. Program narratives described experiencing inconsistent referral flow or receiving referrals that were incomplete, misrouted, or poorly aligned with eligibility criteria.

A recurring subtheme was the importance of knowledge continuity across the service array. Service narratives suggested that effective referrals rely on stable familiarity with what services exist, who they serve, and how to access them, particularly for specialized programs where alignment between program and service provider is essential. When referring entities experience turnover and loss of institutional knowledge, providers described a higher likelihood of misrouted referrals and less consistent referral flow.

These findings suggest an opportunity to strengthen care coordination infrastructure across the continuum. Enhanced care coordination could improve referral accuracy, reduce delays caused by misrouting, and preserve institutional knowledge about program scope and eligibility amid staff turnover within referring entities. Strengthened coordination mechanisms—particularly those that facilitate real-time communication between referring staff and receiving providers—may reduce both open capacity and unmet need that arise from referral friction rather than service scarcity.

Breakdowns in referral pathways can simultaneously create open capacity and unmet need, undermining service array efficacy and reach overall. Inconsistent referral quality, eligibility alignment, program fit, and institutional knowledge loss increase the likelihood that families' referrals to services result in delays in access at families' most critical moments.

Metric Notes

Notably, the fifth most prominent coding theme was the loose category of "metric notes" wherein providers were providing context for better understanding the data that they had provided on the form or providing reasons why they were unable to provide specific data points as requested. The prevalence of these notes is analytically meaningful. It indicates that providers were not

simply “missing” data, many were actively signaling the limits of fit between the reporting framework and operational realities.

In other words, the program form contains two forms of information at once: the values as reported by program-level respondents, and the contextual guidance those respondents offered about how those values should be interpreted.

Program respondents’ metric notes reveal that missing data often reflects misalignment between reporting frameworks and operational reality, rather than noncompliance or a failure to collect appropriate data. This finding reinforces a central theme of the report—measurement is not only a technical exercise, but also a series of decisions that shape what information is visible and ultimately governable.

Summary of Findings

The findings of this report point to a consistent and consequential pattern: apparent underutilization within DCF’s contracted service array is rarely driven by reduced need. Instead, providers describe a set of structural conditions that constrain whether services can be delivered and accessed as intended.

First, overall missingness shows clearly that the SA 24-24 reporting framework is not well aligned with the operational realities of a highly diverse service array. *These missingness patterns reinforce a critical distinction between data gaps and service gaps.* Measures central to the Act’s intent—such as contracted utilization targets and treatment completion—are not uniformly applicable across program models, and in many cases lack consistent definitions. These gaps underscore the limits of standardized metrics when applied to services that vary widely in structure, intensity, and purpose. In this context, missing data is not simply a limitation; it is evidence of where system infrastructure and measurement design require further development.

Second, provider narratives offer a coherent and system-level account of how these constraints operate in practice. Across programs, providers rarely cited diminished demand for services. Instead, they described how workforce instability restricts capacity, how higher-acuity cases require more intensive and time-consuming intervention, how referral pathways struggle to consistently match families to appropriate services, and how families’ material constraints shape engagement. These challenges frequently co-occur, compounding one another across stages of service access and delivery. Read together, the narratives depict a system in which need is present—but increasingly difficult to meet under current conditions.

Importantly, these patterns are not isolated or novel. The challenges identified here—workforce instability,[xxiv] access barriers driven by economic hardship,[xxv] and fragmented data systems[xxvi]—have been documented by providers, advocates, researchers, and state agencies for years. What this analysis adds is not a new diagnosis, but a clear demonstration of how these conditions manifest within the service array. These findings reflect a system operating under sustained structural strain. Meaningful understandings of utilization, and any policy actions that follow, require attention to the financial and economic conditions and also components of system design that determine whether services can be delivered at scale, sustained over time, and accessed by those who need them most.

POLICY RECOMMENDATIONS

Connecticut has taken meaningful steps in recent years to expand children's behavioral health services and strengthen the continuum of supports available to families. SA 24-24 represents a constructive step toward increasing transparency and understanding how the state's contracted service array is functioning. The findings of this report build on that, showing that utilization patterns are shaped less by reduced need than by the conditions under which services are delivered and accessed.

The recommendations below focus on continuing to build the measurement and data infrastructure needed to make the service array visible and transparent; paying for services in a way that can sustain staffing and capacity; building family economic security by providing the practical supports necessary for meaningful stability; and resourcing programs in ways that promote broader equity.

The findings in this report are consistent with existing research and with what many stakeholders in the field have long observed. As a result, many of the policy recommendations that follow mirror those advanced by other organizations and experts as well as advanced by us in the past. Rather than offering prescriptive new policies, this report seeks to strengthen the case for shared priorities by grounding them in an economic framework and highlighting relevant revenue mechanisms to make them more attainable.

(1) Build data infrastructure to increase visibility and transparency.

Measurement determines what becomes visible in public systems. In child-serving systems, where unmet need carries lifelong consequences, decisions about what is measured, how it is defined, and whose experiences are captured are not neutral technical choices. These decisions shape how resources are allocated, which needs are recognized, and how systems are held accountable.

The findings of this report demonstrate the limits of measurement in the absence of strong, coordinated data infrastructure. The SA 24-24 data reveal widespread gaps in completeness and comparability, gaps that fundamentally constrain the state's ability to understand where needs persist and how individuals experience and interact with public systems over time.

Just as children's risks and needs do not occur in isolation, data used to understand outcomes for children, youth, and families must move beyond isolated systems. Recent work by the TCB and its partners has provided a comprehensive assessment of Connecticut's children's behavioral health data infrastructure and the conditions required for effective system improvement. That analysis underscores a core reality also reflected in this report: no single agency or dataset can capture the full experience of children and families who interact with multiple public systems over time. Instead, meaningful oversight and improvement depend on intentional data sharing, linkage, and governance across child welfare, behavioral health, education, health care, and related systems.[xxvii]

Connecticut has recently made substantial investments in foundational data assets, including upgrading administrative systems, building public data repositories[xxviii], fostering analytic partnerships, and establishing the Children's Behavioral Health Data Workgroup within the TCB.[xxix] This work is inclusive of DCF's ongoing investments in data infrastructure. DCF has been investing in strengthening its data systems, committing about $500,000 in 2024 to

improving its Provider Information System (PIE) and is preparing to launch the CT-KIND platform aimed at improving data integration and quality.[xxx]

This report builds on a growing body of evidence[xxxi] showing that the priorities that have already been identified are necessary to make statutory reporting meaningful and public accountability achievable

Policy actions to strengthen visibility and transparency include:

- **Expand cross-agency data visibility** across child welfare, behavioral health, education, and health systems to support a whole-child, whole-family view of service access and outcomes.

- **Improve timeliness of access to data**, including reducing delays between service events and availability of usable information for oversight and planning

- **Strengthen public reporting**, including publishing more DCF system-level data through the Connecticut Open Data Portal, and creating additional[xxxii] agency specific public-facing dashboards.

- **Strategically utilize program data to strengthen service delivery,** including for the use of site-specific quality improvement efforts from the lens of equitable access, quality, and outcomes of care.

- **Advance equity-centered data governance**, ensuring that integrated data systems explicitly examine disparities in access, utilization, and outcomes, while also protecting privacy and informed consent.

These actions would help ensure that data collected through state systems can be translated into timely, comparable, and publicly accessible information that supports meaningful accountability– and ultimately better access to services and improved outcomes for children and families. Strengthening data governance and quality is also a prerequisite for the responsible adoption of advanced analytics and artificial intelligence moving forward.

(2) Increase funding for behavioral health services and support the nonprofit workforce.

Connecticut's child welfare and behavioral health systems depend on a network of service providers to deliver care, treatment, and provide support and prevention services across the state. While this report highlights the need to start with more visibility and transparency, our findings also make clear that service availability and utilization are shaped not only by demand, but by whether providers can recruit, retain, and sustain a qualified workforce under existing funding structures.

Paying for services in a way that reflects their true costs—including staffing, training, administrative requirements, and data reporting expectations—is essential to maintaining capacity and service continuity. Over time cumulative financial pressures on providers contribute to program closures, mergers, or reductions in service availability even while need remains high.

Recent analysis by CHDI documents a persistent workforce shortage driven by reimbursement rates and grant funding that have failed to keep pace with inflation and the true cost of delivering high-quality care—particularly in community-based settings serving the highest-need children.

Providers report high vacancy and turnover rates, rising caseloads, and escalating burnout, resulting in long waitlists and delays in care even as behavioral health acuity among children increases.[xxxiii] These conditions are also reflected in the SA 24-24 findings, where providers frequently cited workforce limitations as the primary reason services were unutilized or referrals went unserved.

Supporting providers is about creating stability within the service ecosystem that families are referred into, so that referrals can meaningfully translate into access. It is foundational to system performance and sustainability.

Policy actions to stabilize the provider service ecosystem include:

- **Standardize and strengthen cross-system level-of-care (LOC) determination processes.** DCF should assess the consistency of LOC assessment pathways across Medicaid and non-Medicaid populations to improve referral accuracy and ensure youth are matched to clinically appropriate services at initial referral. Strengthening standardized, cross-system LOC determination processes would serve two purposes. At the individual level, it would increase the likelihood that youth are matched to clinically appropriate services on the first referral. At the population level, aggregated LOC data would provide actionable insight into where the service array lacks capacity relative to documented need and acuity trends.

- **Increase reimbursement rates and create a transparent rate-setting process.** Increase Medicaid reimbursement for children's behavioral health services to reflect the actual cost of high-quality care[xxxiv],, and establish a systematic, inflation-responsive rate-setting methodology with regular public documentation. Strengthen parity enforcement and align state grants and private insurance practices so reimbursement and grant funding support competitive compensation and required service components.

- **Make immediate, time-limited investments in recruitment and retention.** Create multi-year emergency workforce stabilization grants to child-serving behavioral health providers, with clear requirements that most funds be used directly for recruitment and retention (e.g., wage supplements, sign-on/retention bonuses, loan supports, schedule flexibility). Prioritize providers serving high-need and underserved populations and require basic reporting on staffing outcomes (vacancies, turnover, diversity) tied to funding.

- **Remove administrative barriers to entry and retention.** Reduce or eliminate unnecessary licensure and entry costs (including no-cost associate licenses) and streamline administrative requirements in state contracts that do not add value to care quality. Convene cross-state and stakeholder work to identify alternatives to licensing exams that produce inequitable pass rates while preserving quality and portability, and simplify insurance participation burdens that discourage providers from accepting coverage.

- **Grow and diversify the workforce pipeline.** Expand and target tuition assistance, loan repayment, and training supports for child-serving behavioral health roles (including prescribers and non-clinical roles), prioritizing BIPOC and bilingual candidates and documented shortage areas. Develop and fund a statewide recruitment/marketing strategy and use pipeline data (enrollment, completion, placement) to adjust investments over time.

- **Expand the youth and family peer support workforce.** Create a statewide implementation plan—led by a peer support workgroup with majority youth/family membership—to expand training, certification, career pathways, and paid roles for youth and family peers. Expand Medicaid/insurer reimbursement and dedicated funding so peers can be hired at scale to improve engagement, reduce disparities, and complement clinicians' work.

- **Expand prevention and early intervention through community-based organizations.** Develop a statewide plan and budget to strengthen community-based prevention/early intervention (e.g., schools, primary care, faith-based groups, youth programs), including culturally responsive approaches and clear referral pathways. Fund scalable, low-cost models that reduce stigma, identify needs earlier, and connect families to the right level of care—while monitoring access and equity across communities.

(3) Increase financial supports for families.[xxxv]

Family economic security is foundational to child and family well-being and deeply intertwined with child welfare system involvement. This relationship is well described by a social determinants of health (SDOH) framework, which locates many drivers of family well-being within the economic, social, and environmental conditions that shape daily life.[xxxvi] When families lack access to stable housing, reliable transportation, or food security and other basic supports, even well designed clinical and family support services are harder to access and less likely to succeed. These constraints shape whether families can attend appointments, remain engaged in services, and meet reunification or stabilization requirements.

Economic hardship is closely intertwined with contact with the child welfare system and other public systems, not as a single causal pathway, but as a condition that increases exposure to stressors, reduces resources that buffer stress and support follow-through with services. In practice, material hardship shapes whether families come to the attention of public systems in the first place, and also impacts what happens after involvement begins. Foster care placement is most closely associated with the accumulation of adversities, which are more difficult to mitigate under conditions of economic instability.[xxxvii] Likewise, families living with poverty-related constraints face additional hurdles in completing service plans—barriers that can delay stabilization and reunification.[xxxviii]

This recommendation comes at a particularly important time as recent analysis from CT Voices shows that even prior to recent federal funding cuts, poverty and near-poverty rates, especially for children, are high and have increased in recent years.[xxxix] Meanwhile the majority of adult residents, particularly those with children, report having difficulty paying usual household expenses.[xl] Strengthening the social safety net is not peripheral to child welfare and behavioral health investment; it is often upstream of the crises that bring families into contact with multiple public systems. By reducing poverty-related stressors and material hardship, economic stability can lower the likelihood of preventable system involvement and reduce prolonged family separation driven by poverty-related constraints rather than safety concerns.

Policy actions to strengthen family economic security include:

- **Protect SNAP and Medicaid in the face of federal cuts.** Recent CT Voices analysis shows that the impact of federal cuts from H.R. 1 to the state budget amount to over $1 billion dollars in FY26 and will be substantially more in subsequent years.[xli] These cuts will negatively impact families, especially those with children.

- **Expand access to basic logistical supports for families involved with or at risk of contact with the child welfare and other public systems.** Increase availability of transportation assistance, housing stabilization supports and protections, food access, reliable communication (e.g. phone and internet access). Meaningful progress in one or combination of these would help to alleviate material hardships that lead to deeper or sustained involvement with the child welfare system.

- **Create a CT Child Tax Credit (CT CTC).** Creating a permanent, well-designed CT CTC will support the economic well-being of Connecticut's low- and middle-income families with children. This includes helping to reduce both poverty and inequality and will increase the ability of low- and middle-income families with children to make ends meet.[xlii] To provide the most support for families and children in poverty and near poverty, a CT CTC would include the following key design features: full refundability, no income floor, no income-based phase-in, and no cap on the number of children. This is a direct supportive measure that helps to alleviate economic hardship and support long term family economic stability.

- **Sustain the CT Earned Income Tax Credit (EITC).** A growing body of evidence indicates that economic supports can play a meaningful role in impacting child welfare system involvement and preventing foster care placements.[xliii] Studies examining refundable state Earned Income Tax Credits (EITCs) find reductions in foster care entry rates following implementation, with effects emerging over time. Longitudinal analyses suggest that these reductions are not immediate but accrue several years after families begin receiving benefits, highlighting the importance of sustained economic support in mitigating conditions that precipitate child welfare involvement.[xliv]

- **Defend CT Baby Bonds.** Protect funding for the Connecticut Baby Bonds program, which was fully implemented in 2023 as a structural investment in closing the racial wealth gap—a key driver of child poverty.[xlv] Sustaining this fund is essential to realizing the program's long-term impact on economic mobility and intergenerational equity.

(4) Adjust Revenue and Spending Controls to Resource Policy Recommendations

Meaningful improvements to data infrastructure, service provider stability, and family supports, require reliable and sustained public investment, which will come at a cost to the state. Public supports such as Medicaid, housing assistance, TANF, and SNAP, provide a measurable and significant impact on reducing poverty in the state,[xlvi] which ultimately work to reduce the probability of interaction with DCF. Since the passage of H.R. 1, these programs face deep funding cuts from the federal government in addition to greater cost-shift onto the states that are designed to force states to shrink enrollment.

To sustain the access at current levels or offer expansion of these public supports, and fund any or all of the previous policy recommendations, Connecticut can implement revenue options that

support investments into children and families without raising taxes or shifting costs onto those least able to bear them.

Policy actions to adjust revenue and spending controls include:

- **Increase auditing capacity to reduce the state's tax gap.** Connecticut suffers a tax gap of $4 billion.[xlvii] The tax gap is the difference between the total amount of taxes owed by individuals and businesses, assuming full compliance with the law, and the amount that is voluntarily paid on time. Connecticut's tax gap remains so large due to lack of capacity at DRS to investigate and enforce compliance. In fact, the state's audit rates are exceptionally low at just 0.39%. Connecticut's ability to fund public services depends not just on how the tax code is written, but on whether it is enforced. Hiring more tax auditors at the Connecticut Department of Revenue Services would reduce the underreporting of non-wage income and could pay for programs that support family economic security in the long term. **Reducing the tax gap by 10 percent would raise an estimated $400 million in revenue per year on average in FY 2026 and FY 2027. [xlviii]**

- **Adjust the volatility cap.** Changing the threshold using a 5-year or 10-year inflation-adjusted moving average frees up more, needed revenue. The purpose of the volatility cap is to limit the impact on the budget of year-to-year fluctuations in two volatile revenue sources; however, as originally designed, the volatility cap had two major flaws that made it excessively restrictive (in that the threshold was set too low and it was indexed to an economic indicator with no meaningful relationship to the volatile taxes covered). A more effective solution is to set the threshold using an inflation-adjusted moving average of the volatile revenue. **Using a 5-year moving average would free up an estimated $926 million in revenue in FY 2026 and $1.2 billion in FY 2027.[xlix]**

- **Adjust the spending cap.** The purpose of the spending cap is to stabilize the budget and long-term finances by limiting the growth in spending. As discussed in previous reports from CT Voices, the current design has made the spending cap excessively restrictive. In fact, Connecticut's state and local spending level as a percentage of state personal income is below the average for all 50 states and New England states, demonstrating that the state has capacity to responsibly increase its spending.[l] Adjusting the spending cap's definition of increase in inflation to more accurately reflect changes in the cost of living and adjust the spending cap's definition of general budget expenditures to use allowable appropriations rather than authorized appropriations.

These actions are reasonable measures the Legislature can take to increase revenue that could resource the policy recommendations enumerated in this report and more. Fiscal policy is child welfare and children's behavioral health policy because it fundamentally determines whether the state can maintain the service ecosystem families are being referred into.

CONCLUSION

Special Act 24-24 is an important attempt to make a complex service ecosystem visible and increase public transparency. The reported data shows both what is possible and where existing visibility is still needed. It demonstrates clearly that a statewide continuum cannot be understood through a single, uniform template unless reporting expectations are designed to match the realities of how services actually operate.

The most consistent information in this release is the repeated insight that providers offer about what shapes program access in practice. These narratives describe pressure points that shape whether care is deliverable and reachable: staffing instability, rising complexity of children's needs, misalignment between referrals and program scope, and the practical realities of family life that make participation difficult even when services exist. Those realities do not manifest as measurable utilization, as intended by the Act, but they largely determine whether utilization can happen.

For this reason, the policy implications of these findings are best understood as being interconnected. Transparency requires definitions and systems that support comparability. Capacity requires rates and workforce structures that make staffing sustainable over time. Access requires reducing the real-world costs families bear when they try to engage. None of these can be addressed in isolation, and none are durable without sustained public investment.

The implications of these findings extend beyond data quality alone. Improving outcomes for DCF-involved families will require not only expanding services but ensuring that the systems designed to support them are sustainably resourced, transparent to the public, and responsible to the lived realities of those they serve.

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APPENDIX

Appendix Item A: Special Act 24-24 Provider Reporting Form (Sample)[li]

Program Name:						
Geographic Location Covered:						
DCF open case needed for referral or admission?	(N/Y)					
Is Program 3rd Party Billable?	(N/Y)					
Program Utlization	**SFY 2023**			**SFY2024**		
	Contracted	**Actual**	**Actual vs. Contracted %**	**Contracted**	**Actual**	**Actual vs. Contracted %**

Referrals to Program (cases)	**SFY2023**	**SFY2024**
Referrals		
Clients receiving evaluation only		
Clients receiving services		
Clients completing treatment plan		

Narrative explanation for the reasons that referrals go unserved

Are treatment goals being attained?	**SFY2023**	**SFY2024**	
[Cases] receiving initial assessment			
[Cases] eligible for treatment			
[Cases] achieving treatment goal			
Percent achieving contracted treatment expectation: Actual			Definition of contracted treatment expectation: Percent of [cases] achieving treatment goal of those eligible for treatment.
Percent achieving contracted treatment expectation: Contract			

Total Program Expenditures	**SFY 2023**	**SFY2024**
Total Program allocations		
Total Program expenditures		
Total Clients Served		
Expenditures per [case]		

DCF Funding and Expenditures by Account		**SFY 2023**		**SFY2024**	
Expense Account Series Name	**Account number**	**Funding**	**Expenditures**	**Funding**	**Expenditures**
Salaries					
Benefits					
Overhead					
Training					
	Total				

Are factors below included in procurement rate (budgeted costs) (Y/N)	**SFY2023**	**SFY2024**
Staff training	Y/N	Y/N
Data collection	Y/N	Y/N
Quality assurance expectations	Y/N	Y/N

Appendix Item B: Detailed Methods

Data Transformation Process:

The data used in this analysis were extracted directly from the Excel appendixes provided in DCF's Special Act 24-24 report.[lii] In the appendix file, each worksheet represents a single service type and contains one or more program-level forms pasted sequentially.

Because these forms were not structured for analysis, the first step was to flatten them into a single machine-readable dataset. Each program form became one observation (one row) and every field from the program forms became a variable (one column). All text fields were imported verbatim in order to preserve providers' original entries and maintain traceability from the final dataset back to the original forms.

The resulting dataset required extensive cleaning and standardization. Key steps included:

- Variable Standardization and Metric Reconstruction: Variable names, value labels, and units of measurement were standardized. Where providers supplied both raw counts and percentages, percentages were recalculated from raw counts to ensure internal consistency. Binary values (e.g. Y/N, yes/no, 0/1) were normalized to a common coding scheme.

- Program-Provider Alignment: Program names were reconciled across worksheets and mapped to provider organizations. This allowed analysis at both the program and organization levels, and enabled separate examination of single-program providers.

- Service Type Grouping: Service types were mapped to broader service categories, consistent with DCF's published service array taxonomy[liii]

- Geographic Standardization: Reported service areas varied widely in format and scale, including individual towns, lists of towns, counties, DCF regions, and statewide designations. Each program's service area was therefore classified by type (e.g. single-town, multi-town, DCF region or regions, Statewide, etc.). This supports limited comparability of scope while acknowledging the underlying inconsistency of the raw entries.

- Assigning Unique Identifiers: Each program was assigned a persistent unique identifier to ensure unambiguous reference across analytic files.[liv]

These steps produced a more unified dataset suitable for descriptive analysis, while maintaining fidelity to the original provider-reported information. The process also surfaced important gaps in consistency and completeness, including missing fields and inconsistent definitional clarity, which are detailed further in the limitations of the data section of the report.

Qualitative Methods:

As part of the SA 24-24 data collection effort, providers were asked to respond in narrative form to two open-ended questions.

1) Narrative explanation for declines in utilization and/or utilization significantly below contract; the reasons for the decline or low utilization; Evaluation of whether the trend reflects decreased need for the service type or workforce limitations

2) Narrative explanation for the reasons that referrals go unserved

Of the 261 programs that submitted forms, a majority provided at least one narrative response. These narratives varied in length and level of detail. Taken together, however, they provide a system-level view of the conditions shaping service access and capacity across DCF's contracted service array.

The unit of analysis was the program-level narrative response. Programs could submit up to two narrative responses (one for each prompt) and some programs responded to only one. Because providers frequently used overlapping language across the two prompts and described the same underlying constraints in response to both questions, narratives were analyzed as a single, integrated body of qualitative data rather than as two analytically distinct datasets.

This decision was grounded in the data itself. In practice, the distinction between "declines in utilization" and "referrals going unserved" was not reliably meaningful at the program level. In many responses, the same sentence served as an explanation for both questions. Treating the narratives separately would have required the imposition of analytic distinctions that are not meaningfully upheld in program narratives.

Coding Approach

All narrative responses were reviewed and coded inductively. Content categories were developed as patterns emerged from the data. Each provider's written response was read in full and assigned one or more thematic codes reflecting the challenges or conditions described.

Codes were refined iteratively as patterns emerged across responses, ensuring that similar concepts were grouped consistently and that distinctions between overlapping themes were applied in a uniform way. Narratives could receive multiple codes, and coding categories were not mutually exclusive, reflecting the interconnected nature of the challenges described. Coding assignments and counts were reviewed for internal consistency before aggregation and analysis.

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[vii] Connecticut General Assembly. (2022). *Public Act No. 22-81: An act expanding preschool and mental and behavioral services for children (Substitute S.B. 2).* https://www.cga.ct.gov/2022/ACT/PA/PDF/2022PA-00081-R00SB-00002-PA.PDF

[viii]Connecticut General Assembly. (2023). *Public Act No. 23-97: An act concerning health and wellness for Connecticut residents (Substitute S.B. 9).* https://www.cga.ct.gov/2023/ACT/PA/PDF/2023PA-00097-R00SB-00009-PA.PDF

[ix] Williams, S. C., Rosenberg, R., & Martinez, V. (2025). *State-level data for understanding child welfare in the United States*. Child Trends. https://www.childtrends.org/publications/state-level-data-for-understanding-child-welfare-in-the-united-states

[x] The DCF Careline is the agency's 24-hour centralized hotline for receiving and screening reports of suspected child abuse, neglect, and requests for voluntary services.

[xi] Connecticut Department of Children and Families. (2025). *Special Act 24-24 – H.B. 5428: Report on program utilization (FY 2023 & FY 2024)*. Department of Children and Families. https://portal.ct.gov/dcf/-/media/dcf/dataconnect/legislative-reports/2025/dcf-special-act-24-24-report.pdf?rev=b3077613d82040ce969ca6ffbbde6db7&hash=B2BDB899A646241DFC249ED82E65D2D3

[xii] American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, & Children's Hospital Association. (2021, October 19). *AAP-AACAP-CHA declaration of a national emergency in child and adolescent mental health*. American Academy of Pediatrics. https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/?srsltid=AfmBOop0LDqeYl4rsECmrvUu00O4-DDXgrfLxpgbW__m0W7IT4GS3rbJ

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[xiii] CHDI (Kelly, Hoge, Lang et al., 2023): *Strengthening the Behavioral Health Workforce for Children, Youth, and Families: A Strategic Plan for Connecticut*

[xiv] O'Brien, P. R. (2024). *Poverty in the U.S. and Connecticut, 2019–2023*. Connecticut Voices for Children.

[xv] Vivrette, R. (2025). *Referrals to child welfare agencies for child maltreatment continue to rise* (Data point). Child Trends. https://www.childtrends.org/publications/referrals-child-welfare-agencies-child-maltreatment

[xvi] A sample SA 24-24 data collection form is included as Appendix Item A.

[xvii] Connecticut Department of Children and Families. (2025). *Special Act 24-24 – H.B. 5428: Report on program utilization (FY 2023 & FY 2024)*. Department of Children and Families. https://portal.ct.gov/dcf/-/media/dcf/dataconnect/legislative-reports/2025/dcf-special-act-24-24-report.pdf?rev=b3077613d82040ce969ca6ffbbde6db7&hash=B2BDB899A646241DFC249ED82E65D2D3

[xviii] A detailed description of data cleaning, transformation, and analytic methods is provided as Appendix Item B.

[xix] For more detailed definitions and descriptions of each children's behavioral health service type referenced in this report, please refer to *Connecticut Service Array: Definitions of Children's Behavioral Health Services* developed by Connecting to Care Connecticut (2025) https://www.connectingtocarect.org/wp-content/uploads/2025/04/CT-Service-array-FINAL.pdf

[xx] Presenting aggregate statistics under these conditions would carry a high risk of misinterpretation, inappropriate comparison, or misuse, while offering limited analytic value.

[xxi] Connecticut Department of Children and Families. (2025). *Special Act 24-24 – H.B. 5428: Report on program utilization (FY 2023 & FY 2024)*. Department of Children and Families. https://portal.ct.gov/dcf/-/media/dcf/dataconnect/legislative-reports/2025/dcf-special-act-24-24 report.pdf?rev=b3077613d82040ce969ca6ffbbde6db7&hash=B2BDB899A646241DFC249ED82E65D2D3data.pdf?rev=1fb20fab6e1f4b2e99da5bd2fed6ab4c&hash=C022D289AB893E6FFA8C39C46D9BD43C

[xxii] Please refer to Appendix Item B for the detailed Methods section.

[xxiii] Percentages reported in the Top Substantive Themes in Program Narratives table are calculated using the number of programs that submitted one or more narrative responses (n = 213) as the denominator, rather than the total number of programs that submitted a SA 24-24 form (N = 261). This approach reflects the analytic population for which qualitative data are available and avoids treating the absence of a narrative response as evidence that a given theme was not present.

[xxiv] Kelly, A., Lang, J., & Hoge, M. (2023). *Strengthening the behavioral health workforce for children, youth, and families: A strategic plan for Connecticut*. Child Health and Development Institute. https://www.chdi.org/application/files/7317/2623/9449/CHDI_Workforce_Strategic_Plan_Report_CT_Plan_4_Children_.FINAL2-compressed.pdf

[xxv] Ruth, L., & Wilson, R. (2022). *Rising out of recession: How Connecticut can support young adults transitioning out of the child welfare system in challenging economic times*. Connecticut Voices for Children.

[xxvi] Farrell, J., Plant, R., Shaw, T., Harburger, D.S., & Zabel, M. (2025). Children's Behavioral Health System Data Infrastructure and Use of Data for System Improvement: Recommendations for Connecticut's Public Child- and Family-Serving Behavioral Health System. Innovations Institute, University of Connecticut School of Social Work. https://innovations.socialwork.uconn.edu/

[xxvii]Farrell, J., Plant, R., Shaw, T., Harburger, D.S., & Zabel, M. (2025). Children's Behavioral Health System Data Infrastructure and Use of Data for System Improvement: Recommendations for Connecticut's Public Child- and Family-Serving Behavioral Health System. Innovations Institute, University of Connecticut School of Social Work. https://innovations.socialwork.uconn.edu/

[xxviii] Connecticut Office of Policy and Management. (2024). *Connecticut State Data Plan 2025–2026: Connecting the people and processes involved with data to promote communication between, and integration of, formerly siloed data across executive branch agencies* [State government report]. https://portal.ct.gov/datapolicy/-/media/datapolicy/p20-win/reports/connecticut-state-data-plan-2025---2026-final-318.pdf

[xxix] Farrell, J., Plant, R., Shaw, T., Harburger, D.S., & Zabel, M. (2025). Children's Behavioral Health System Data Infrastructure and Use of Data for System Improvement: Recommendations for Connecticut's Public Child- and Family-Serving Behavioral Health System. Innovations Institute, University of Connecticut School of Social Work. https://innovations.socialwork.uconn.edu/

[xxx] Connecticut Department of Children and Families. (2025, February 1). *Special Act 24-24 – H.B. 5428: Contracted program data [Data file]*. Department of Children and Families. https://portal.ct.gov/dcf/-/media/dcf/dataconnect/legislative-reports/2025/dcf-special-act-24-24-data.pdf?rev=1fb20fab6e1f4b2e99da5bd2fed6ab4c&hash=C022D289AB893E6FFA8C39C46D9BD43C

[xxxi] Child Health and Development Institute of Connecticut, Inc., & Connecticut Department of Children and Families. (2021, December). *Children's Behavioral Health Plan Implementation: Data Integration Workgroup report*. https://plan4children.org/wp-content/uploads/2022/01/Data-Integration-Workgroup-Report-12.17.21.pdf https://plan4children.org/wp-content/uploads/2022/01/Data-Integration-Workgroup-Report-12.17.21.pdf

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[xxxv] O'Brien, P. R. (2024). *Poverty in the U.S. and Connecticut, 2019–2023*. Connecticut Voices for Children. https://ctvoices.org/wp-content/uploads/2024/10/2024-Poverty-Report.pdf

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[xxxviii] D'Andrade, A. (2021). Poverty's pathways. *Child Welfare, 99*(4), 51–76. https://www.jstor.org/stable/48647842

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[xli] ibid.

[xlii] O'Brien, P. R. (2024). *Overview of the CT Child Tax Credit* (23rd Tax & Budget Forum). Connecticut Voices for Children. https://ctvoices.org/wp-content/uploads/2024/01/CT-CTC-Final_23rd-TBF.pdf

[xliii] Rostad, W. L., Ports, K. A., Tang, S., & Klevens, J. (2020). *Reducing the number of children entering foster care: Effects of state earned income tax credits. Child Maltreatment, 25*(4), 393–397. https://pmc.ncbi.nlm.nih.gov/articles/PMC7377953/

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[xlviii] A full discussion of this policy recommendation is available in: O'Brien, P. R., Ph.D. (2026). *The Case and Policy Options for Connecticut to Offset New Federal Cuts to Public Benefits.* Connecticut Voices for Children. https://ctvoices.org/wp-content/uploads/2026/01/TB-Forum_Offset-New-Federal-Cuts-Report_010826.pdf

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[l] This policy action is detailed comprehensively in O'Brien, P. R., Ph.D. (2024).*Connecticut's Fiscal Controls Options for Responsible Adjustments.* Connecticut Voices for Children. https://ctvoices.org/wp-content/uploads/2024/12/24th-Tax-Budget-Forum-Report-Final.pdf

[li] This figure reproduces is a blank sample of an original SA 24-24 data collection form. Formatting and structural inconsistencies reflect the design of the original instrument and are retained here to accurately represent the source material.

[lii] Connecticut Department of Children and Families. (2025, February 1). *Special Act 24-24 – H.B. 5428: Report on program utilization (FY 2023 & FY 2024)*. Department of Children and Families. https://portal.ct.gov/dcf/-/media/dcf/dataconnect/legislative-reports/2025/dcf-special-act-24-24-report.pdf?rev=b3077613d82040ce969ca6ffbbde6db7&hash=B2BDB899A646241DFC249ED82E65D2D3

[liii] As compiled by Connecting to Care Connecticut. (2025, April). *Connecticut service array: Definitions of children's behavioral health services*. https://www.connectingtocarect.org/wp-content/uploads/2025/04/CT-Service-array-FINAL.pdf

[liv] Numeric codes were additionally assigned to each service type, service category, and provider organization. This creates a stable structure suitable for linking tables in downstream analysis.