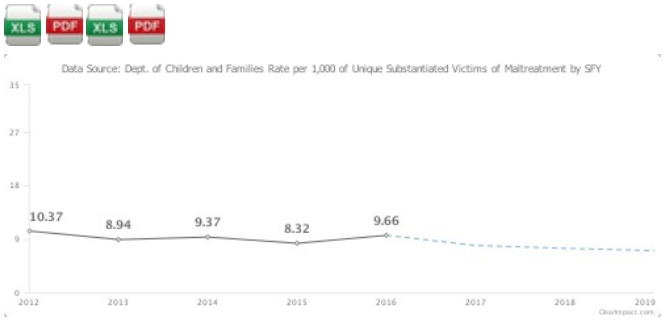
Safe Children Scorecard

Safe Children Scorecard

R SAFE All Connecticut Children Grow Up Safe.

I Headline Abuse, Neglect All Types 0-17



Time Period	Actual Value	Forecast Value	Current Trend	Baseline % Change
2016	9.66	8.46	↗ 1	-19% ↓
2015	8.32	8.32	↘ 1	-30% ↓
2014	9.37	–	↗ 1	-22% ↓
2013	8.94	–	↘ 2	-25% ↓
2012	10.37	–	↘ 1	-13% ↓
2011	12.24	0.00	↗ 3	2% ↑
2010	11.86	0.00	↗ 2	-1% ↓
2009	11.72	0.00	↗ 1	-2% ↓
2008	11.17	0.00	↘ 1	-7% ↓
2007	11.95	0.00	→ 0	0% →

Story Behind the Curve

In Connecticut, abuse includes any malnutrition, sexual molestation, deprivation of necessities, emotional maltreatment or cruel punishment. Children are defined as being neglected when they have been abandoned, are denied proper care and attention, are allowed to live under conditions, in situations, or with associations, that are harmful to their well-being. To further understand what differentiates the two categories, a breakdown and detailed explanation for each type of abuse and neglect can be found on the Connecticut Department of Children and Families (DCF) website.

This indicator is reported as a rate per 1,000 of unique, substantiated victims, calculated by DCF. The state's current reported cases of abuse and neglect have seen a decline in recent years, with 8.32 instances per-1,000 in 2015. The prevalence of reports to DCF for neglect may be related to issues of need such as poverty, unemployment, a general lack of resources, mental health issues and substance abuse. Connecticut's major cities have some of the highest rates of poverty in the nation. In Hartford, 46.1% of the children under 18 live below the poverty line.

Abuse and neglect can have various short and long term impacts on a child's mental and physical health. Some of the negative consequences highlighted by the Child Welfare Information Gateway include: impaired brain development, cognitive difficulties, increased drug/alcohol use, and a variety of physical health issues (lung and liver disease, hypertension, asthma, obesity, etc.). The mental health impacts for

abuse and neglect to children include: anxiety, depression, dissociation, difficulty concentrating, social difficulties and difficulties sleeping and reacting to stress. These issues associated with abuse and neglect can be detrimental to a child's primary education, including their likelihood to attend higher education, and subsequent job prospects.

Policymakers have sought to enhance the reporting of abuse and neglect so that it is accurately recognized and subsequently reduced. Recent bills that have been signed into law include cross-reporting animal cruelty and child abuse, penalties for failing to report child abuse, and revisions to DCF's child abuse and neglect registry. As of April 2012, DCF began responding to low-risk reports through a voluntary Family Assessment Response (FAR) process. Reports handled through a FAR response still contain allegations that meet the statutory definitions of neglect and are assessed for risk and safety, but they do not receive a designation as substantiated or unsubstantiated. This policy has resulted in fewer substantiated allegations since its implementation, but the agency continues to serve as many or more families who may require support in order to safely care for their children.

Partners

- Department of Children and Families
- Office of the Child Advocate
- Child Poverty and Prevention Council
- Department of Social Services
- Community Action Agencies (CAA)
- The Village for Families and Children
- Systems of Care (SOC)/Community Collaborative

Strategy

- Strengthen Connecticut's Differential Response System. (**DCF**)
- Establish Child-Parent Centers (CPCs)to provide comprehensive educational and family support to economically disadvantaged children and their parents. (**CDC**)
- Improve family well-being and to reduce child maltreatment by coordinating services for high-risk families. (**CDC**)
- Implement a shared information system, a standardized data collection system, cross-training, and integrating services across organizations (**CDC**)
- Screen parents of children ages 0–5 in pediatric primary care settings to identify parental exposure to partner violence, mental illness, or substance abuse and provides appropriate referrals. (**CDC**)
- Encourage communities to promote the types of relationships and environments that help children grow up to be healthy and productive citizens so that they, in turn, can build stronger and safer families and communities for their children. (**CDC**)

Strategies contributed by staff from the Department of Children and Families (**DCF**) and the Center for Disease Control (**CDC**).

Comment

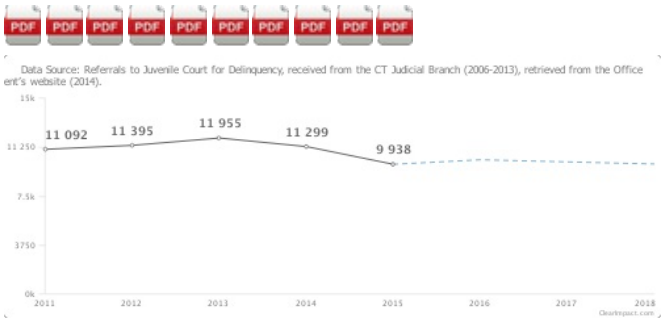
Data source: DCF Office of Research and Evaluation.

Data shows rates (per 1000) of Unique Victims with Substantiated Allegations of Reports Accepted During SFY 2006 through 2011

Data Source: Data provided by DCF, Office of Research and Evaluation. For combined age ranges, the rate per 1,000 children reflects children ages 0 - 17 years old.

Connecticut Department of Children and Families, Office of Research and Evaluation.

Headline Juvenile Delinquency



2015	9,938	10,699	↘ 2	-30% ↓
2014	11,299	11,299	↘ 1	-21% ↓
2013	11,955	–	↗ 2	-16% ↓
2012	11,395	–	↗ 1	-20% ↓
2011	11,092	0	↘ 1	-22% ↓
2010	12,983	0	↗ 1	-9% ↓
2009	9,762	0	↘ 3	-32% ↓
2008	11,414	0	↘ 2	-20% ↓
2007	13,197	0	↘ 1	-8% ↓
2006	14,277	0	→ 0	0% →

Story Behind the Curve

Referrals to Juvenile Court for delinquency in Connecticut have been decreasing over the last decade, even as the age of juvenile court jurisdiction has increased. The age of jurisdiction began including 16 year olds on January 1, 2010 and 17 year olds on July 1, 2012. According to the Judicial Branch, it was anticipated that processing of referrals for of 16 and 17 years olds would double the number of cases handled by the juvenile court annually; however, the result has been far from reality. Connecticut Voices for Children attributes the jurisdictional changes to the Raise the Age law passed in 2007, which created a five-year schedule for implementation of these policy changes. These changes have made a significant impact in the trend, creating brief spikes in the number of referrals as the jurisdiction expanded.

Children and youth referred for delinquency made up roughly 71% of all juvenile court referrals in 2015; totaling 9,938 referrals for 6,633 unique juveniles. The remaining 29% of referrals were for Family with Service Needs (FWSN) complaints; offenses that would not be a crime if committed by an adult (e.g., truancy, running away, beyond control of parent). The vast majority of the delinquency referrals in 2013 were for misdemeanors; just under 67%.

Delinquency referrals in 2015 were overwhelmingly for males at 71% to 29%. As their ages progressed, youth were more likely to be referred. White, Non-Hispanic students just barely made up the majority, with 36%, followed by black (35%), Hispanic (27%), and then Other/Missing Data (2%). As a total trend from 2007-2015, Connecticut Voices for Children claims that the significant decline can be partially attributed to an increase in youth being diverted from juvenile justice towards other interventions.

Once a child or youth has been referred to Juvenile Court for Delinquency the most immediate impact is a higher likelihood of being re-referred (i.e., recidivism). The CT Mirror's report on data collected from the Department of Public Safety shows that sixty percent of youth offenders age 17 and younger will, within two years, offend again or violate probation. Depending on the juvenile's court referral, continued system involvement poses the risk of further adversely affecting the child or youth, as was documented in the *Emily J. v. Weicker* class-action lawsuit about the conditions of confinement in the state detention centers. In addition to these negative impacts, young offenders may have a court record that is not automatically erased (if ever), are often delayed in their schooling, and have limited access to an educational surrogate when identified with a special education need. However, the State of Connecticut has made substantial strides to improve upon the systemic problems that faced the juvenile justice system in the 1990s, particularly with a substantial reinvestment from congregate care to in-home family treatment models.

Beyond Raise the Age, other reforms have been undertaken to ease the reliance on confinement, improve treatment based on race and ethnicity, and expanded the availability of evidence-based treatment programs focused on communities and families. Connecticut Voices for Children notes that the expansion of Juvenile Review Boards and similar programs has played a positive role in diverting youth from court and addressing normative delinquent behavior through preventative, restorative, and therapeutic strategies. Governor Malloy and the Connecticut General Assembly are actively seeking to reform the entire justice system, including juvenile justice, through what has been titled the "Second Chance Society" law signed in July 2015.

Partners

- Judicial Branch Court Support Services Division
- Department of Children and Families

- African American Affairs Commission
- Latino and Puerto Rican Affairs Commission

Strategy

- Increase school referrals to a behavioral health mobile crisis intervention. (**CHDI**)
- Expand a school and community-based restorative justice practices to help to hold students accountable for their behavior, address wrongdoing to victims, and restore relationships, outside of formal juvenile court involvement. (**CHDI**)
- Reduce the number of in-school juvenile arrests among Hispanics. (**LPRAC**)
- Divert *Families With Service Needs* cases away from the Court and into community-based services. (**CSSD**)
- Create/Expand early intervention strategies for juveniles 12 years of age and younger, identified with greater risk for further delinquency or Out-of-Home Placements to prevent recidivism and the child's further penetration into the Juvenile Justice system. (**CSSD**)
- Address trauma experienced by children and youth referred to the court for delinquent and FWSN behaviors by referral to community based treatment centers. (**CSSD**)
- Enhance assessments used to determine the risk and needs of children and youth referred to the court, including trauma and substance abuse screening. (**CSSD**)
- Enhance quality assurance procedures to ensure the quality of client contacts and case planning for children and their families. (**CSSD**)
- Reduce court referrals for school-bsed arrest and reduce the use of the suspension and expulsion by schools. (**CSSD**)
- Support student engagement and success by tracking and reporting truancy referrals by school district and by school in order to reduce chronic absenteeism and provide early identification and intervention to students and families challenged by school attendance. (**CSSD**)
- Better identify need and provide more access to trauma-informed treatment for juvenile justice involved children and families. (**CSSD**)
- Continue community building through Local Interagency Service Teams (LISTs) and Disproportionate Minority Contact (DMC) reduction committees. (**CSSD**)
- Increase school/police training and continue policy/practice changes to reduce DMCs and disparate treatment in the juvenile justice system. (**CSSD**)

Strategies provided by the Judicial Branch Court Support Services Division (**CSSD**), the Child Health and Development Institute of Connecticut, and the Latino and Puerto Rico Affairs Commission (**LPRAC**)

Comment

Data Source: Connecticut Judicial Branch, Court Operations

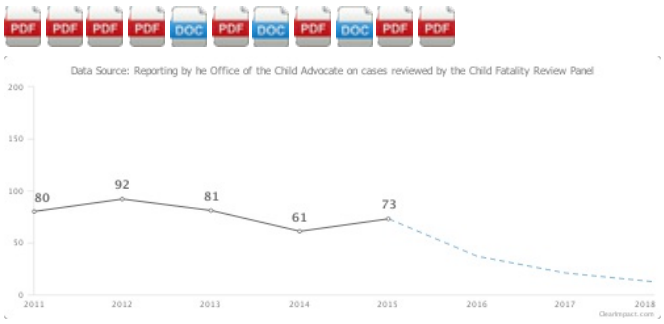
This information reflects on delinquency cases: not FWSN or YIC.

Referrals are broken out by referral type, town of residence, ethnicity, age and gender.

Note: referrals are not unique juveniles so if a juvenile was arrested multiple times in a year, each triggers a new referral.

Age = age at time of offense

Headline Unexpected Deaths



2015	73	50	↗	1	-61% ↓
2014	61	61	↘	2	-67% ↓
2013	81	–	↘	1	-56% ↓
2012	92	–	↗	1	-50% ↓
2011	80	–	↘	3	-57% ↓
2010	132	0	↘	2	-29% ↓
2009	142	0	↘	1	-23% ↓
2008	172	0	↗	1	-7% ↓
2007	146	0	→	1	-21% ↓
2006	146	0	↘	1	-21% ↓

Story Behind the Curve

Data regarding the unexpected deaths of children age's birth through seventeen is provided by the Office of the Child Advocate (OCA). The OCA is statutorily mandated to review all unexpected and unexplained deaths of children in Connecticut. The OCA works closely with the Office of the Chief Medical Examiner (OCME) to review the cause and manner of child fatalities. Reviews of child deaths include both intentional deaths (homicide and suicide) and unintentional deaths (accident and undetermined; which includes Sudden Unexpected Infant Death (SUID)).

Accidents have been the leading cause of unexpected deaths of children for four of the last five years, followed by undetermined deaths. According to OCA, undetermined deaths is a category used by the OCME when, upon the completion of an autopsy, there are no findings of disease, trauma, or obvious injury. Most often, undetermined deaths are infants. For many of these infants there is a risk factor associated with their sleep environment which might include objects in the sleep area such as pillows, blankets, comforters, wedges, or stuffed animals. Also, when an infant is sleeping in a space other than a crib or bassinette such as a chair, couch or adult bed with other adults or children they are at risk for death.

Childhood deaths from accidents occurred across all ages. The leading cause of accidental death for children is related to motor vehicles accidents. In 2015, child deaths associated with motor vehicle crashes included passengers, pedestrians, and drivers. Teen driver fatalities continue to decline.

Historically the second leading cause of unexpected accidental deaths in children has been drowning (natural bodies of water, pools, and bathtubs). In 2015, however, accidental death from positional asphyxia (infant suffocation), was the 2nd leading cause of death for children in Connecticut.

Child homicides did spike in 2012, due to the tragedy at Sandy Hook Elementary School, their occurrence has consistently been the second or third most likely cause of unexpected intentional deaths and occur most frequently in small to large cities. Homicide deaths are most often infants and toddler on one end of the childhood spectrum and teens on the other. Most homicides of children are by people they know, for young children it is most often someone in a caregiving role.

Despite the slight increases in both homicide and undetermined deaths, Connecticut 's child death rate is one of the lowest in the nation. From birth through 17 years old, infants less than one year old, are at the greatest risk of death from intentional and unintentional injuries.

To curb incidence of suicide, DCF established the Connecticut Youth Suicide Advisory Board in 1989, and The Department of Mental Health and Addiction Services (DMHAS) also runs a similar suicide prevention initiative. Efforts through Connecticut's the 1 Word, 1 Voice, 1 Life Campaign, along with the State of Connecticut 2020 Suicide Prevention Plan, supported by prevevention activities with the State Suicide Advisory Board work to keep youth and adults safe . At a legislative level, the Connecticut General Assembly has addressed youth suicide by targeting cyberbullying, school safety plans, and developing a comprehensive children's mental health, emotional and behavior health plan.

When it comes to child deaths from crashes/accidents, the graduated driver's license restrictions (one of the strictest) in country has decreased the number of teen deaths. Also, the CT Department of Motor Vehicles (DMV) has taken on a number of teen driving related initiatives.

The increase in sudden infant death associated with sleeping environment, has resulted in in a campaign with key state agencies taking the lead to bring public awareness to this issue. Legislation was passed by the Connecticut General Assembly to provide parents critical information regarding safe sleep practices.

To address the issue of infant and toddler homicide, a multi-agency working group is currently working on a prevention campaign related shaken baby/abusive head trauma.

Partners

- Office of the Child Advocate
- Connecticut Children's Alliance
- Connecticut Nurses Association
- Department of Public Health
- Department of Children and Families

Strategy

- Implement 'Safe Streets' Programs (**Stamford Youth Services**)
- Reduce teen driving deaths through the DMV Commissioners' advisory group on teen driving safety, community and hospital-based safe driving coalitions, driving schools' training efforts, and the insurance industry efforts. (**OCA**)
- Promote health care providers' education of parents regarding safe sleep for infants. (**OCA**)
- Continue the work of the Connecticut's Suicide Advisory Board (CTSAB) training events and primary prevention efforts throughout the state. (**OCA**)

Comment

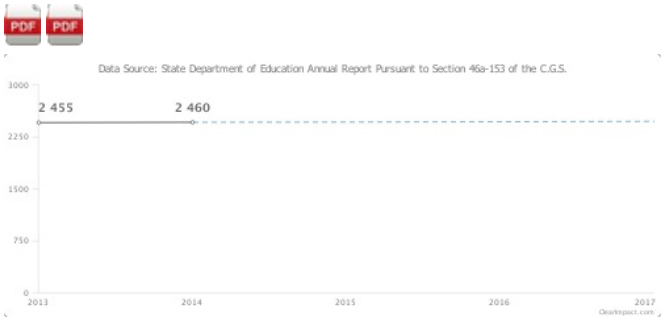
Data Source: Office of the Child Advocate:

An Examination of Connecticut Child Fatalities: A Ten Year Review

January 1, 2001 to January 1, 2011

I Secondary Students Restrained or Secluded in School

2014	2,460	2,460	↗	1	0% →
2013	2,455	–	→	0	0% →



Story Behind the Curve

According to state statutes, restraint in the school setting includes: physical restraint, mechanical restraint, and chemical restraint. Seclusion, in relation to a school environment, is defined as "the involuntary confinement of a student in a room, whether alone or with supervision, in a manner that prevents the student from leaving." Data regarding each student who has experienced restraint and/or seclusion is collected by local or regional boards of education for compilation and analysis by the Connecticut State Board of Education on an annual basis. Since collection of these data points began recently, the current trend is relatively flat; however the data can be disaggregated by gender and race/ethnicity to better understand how the use of restraint and seclusion is weighted.

The most common breakdown of the use and frequency of restraint and seclusion not depicted here is the rate of use amongst students with identified special needs. The Office of the Child Advocate produced a report that highlights the fact that students who have Autism Spectrum Disorders (ASD) are subject to restraint and seclusion most frequently. Both white and female student populations saw an increase in incidences between the two school-year periods. Connecticut is not alone in its increased attention to the use of restraint and seclusion in schools, as the conversation of its purpose and impact has reached a national dialogue.

Seclusion and restraint in schools can become a significant detriment to a child's social and emotional growth. The Healing Hearts Family Counseling Center noted that prior instances of attachment and trauma disorders, including the use of restraint or seclusion by adults can result in further trauma and both short and long term psychological problems. Early and frequent use of restraint and seclusion has the potential to cause Post-Traumatic Stress Disorder (PTSD). As a result, physical restraint or seclusion themselves becomes a recurring psychological trigger in the child, which escalates the frequency and intensity of the violent/self-destructive behaviors that precipitated the restraint or seclusion. This routine then becomes part of the child's everyday school experience. In addition to psychological damage, the use of certain restraint methods and improperly supervised seclusion can cause physical harm. According to the American Occupational Therapy Association, this harm can range from damaged joints and skin irritation, to broken bones and even death. These injuries are not only caused by the type of restraint or the transfer of a child into a seclusion room, but also by the self-harming behavior engaged in by children during the incident. Connecticut, however, has taken multiple steps in recent years to directly combat the use restraint and seclusion in the K-12 system.

In 2012, news of "scream rooms" used by schools in Connecticut prompted the State Department of Education to investigate, and the Committee on Children to respond by requiring annual reporting of children placed in restraint and seclusion. In 2015, the Connecticut General Assembly passed and the governor signed into law significant reforms to restraint and seclusion policies for every school and every child in the state. The law designates face down restraints as life-threatening, limits the use of restraints and seclusion, and increases the training requirements. According to an analysis of laws and policies across the United States, Connecticut "publishes one of the most substantial state data collections." In addition, the report indicates Connecticut has joined many states in closing loopholes, providing safer environments for students who are restrained or secluded, and ensuring better outcomes for children while in school.

Partners

- Department of Education
- Department of Public Health

- Office of the Child Advocate
- African Caribbean American Parents of Children with Disabilities, Inc.
- CT Voices for Children
- National Alliance on Mental Illness
- Center for Children's Advocacy
- Office of Protection and Advocacy for Persons with Disabilities

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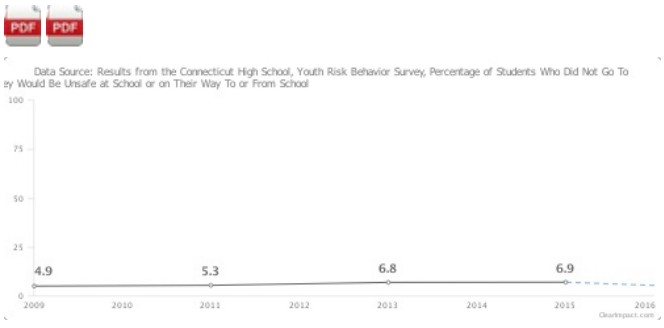
Strategy

- Establish school-wide positive behavior supports and a behavior support strategies
  - Increase predictability and scheduling
  - Increase choice making
  - Appreciate positive behaviors
  - Alter environments by including room arrangement and traffic patterns to accommodate individual needs.
- Monitor systems with the goal of continually improving efficiency and effectiveness.
- Encourage relaxation-based strategies through the creation of cool down or multisensory rooms, as well as teaching relaxation techniques.
- Establish a series of reflective and critical thinking questions that assess a student's anger at others and other people's anger.
- Provide instruction of visualization of a relaxing scenario, progressive muscle relaxation, and autogenic relaxation techniques.
- Train teachers and staff in the Conflict Cycle, the Acting-Out Cycle, and conflict de-escalation strategies.

Strategies collected from "Reducing the Use of Seclusion and Restraint in Schools" by Joseph B. Ryan, Ph.D., Clemson University.

I Secondary High School Students Who Do Not Feel Safe



2015	6.90%	5.46%	↗ 3	-7% ↓
2013	6.80%	6.80%	↗ 2	-8% ↓
2011	5.30%	–	↗ 1	-28% ↓
2009	4.90%	0.00%	↘ 2	-34% ↓
2007	5.50%	0.00%	↘ 1	-26% ↓
2005	7.40%	–	→ 0	0% →

Story Behind the Curve

The Connecticut School Health Survey (CSHS) is conducted biennially and subsequently published by the Connecticut Department of Public Health. The Youth Behavior Component (YBC) survey, which gathers information from students in

grades 9-12, by randomly chosen classrooms, is the source for this indicator. The question asked of these students since 2005 is as follows: "During the past 30 days, on how many days did you **not** go to school because you felt you would be unsafe at school or on your way to or from school?"

The most recent survey results available from 2015 indicate that approximately 7% of students missed school because they felt unsafe. White non-Hispanic students were less likely to miss school because they felt unsafe (4.5%) compared to Black non-Hispanic students (10.7%) or Hispanic students (10.5%). This question was first asked in the 1997 CT YRBS, for which the rate for missing school due to safety concerns was 3.0% of students. Over the course of the survey years 2009-2015, the rates of feeling unsafe at school have statistically increased (from 4.9% in 2009 to 6.9% in 2015). The responses from black/African American (non-Hispanic) students and Hispanic students indicated the most notable increases between 2009 and 2015. A student who does not feel safe in their school has been noted as more likely to engage in more risky behavior, specifically carrying a weapon on school grounds. Other school climate related questions are asked on the YBC, including bullying, being physically threatened or injured on school property, having property stolen or damaged on school property, and access to drugs on school grounds. Positive factors are also asked, such as having an adult at school that a student can turn to when they have a problem.

In recent years, legislation has been enacted by the Connecticut state legislature and signed by the governor to improve safety standards and foster a safe learning environment for students in Connecticut. Three Connecticut school districts currently participating in the Safe Schools/Healthy Students State Project. The project is possible through a federal grant award from the U.S. Substance Abuse and Mental Health Services Administration. The project develops and implements evidence-based programs, effective policies, and innovative strategies that address youth violence and promote the wellness of children, youth, and families. The elements of the project focus on creating safe and violence free schools, as well as promoting mental, emotional, and behavioral health of students and connecting families, schools and communities.

Partners

- Department of Public Health
- Department of Education
- Connecticut Association of School Psychologists
- National Association of Social Workers – Connecticut
- Connecticut Association of Public School Superintendents

Strategy

- Utilize 'Restorative Practices' in schools

- Implement 'Street Safe Programs'

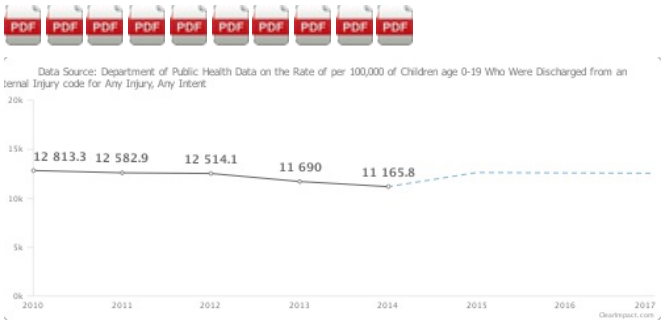
Strategies provided by Stamford Youth Services

Comment

The data source for this information reported is the the Youth Behavior Component (YBC) of the Connecticut School Health Survey (CSHS).

The YBC is an anonymous and confidential school-based survey of high-school students in grades 9 - 12.

I Secondary Emergency Department Visits for Injuries



2014	11,165.80	12,645.25	↘	5	-9% ↓
2013	11,690.00	12,661.64	↘	4	-5% ↓
2012	12,514.10	12,514.10	↘	3	2% ↑
2011	12,582.90	–	↘	2	2% ↑
2010	12,813.30	–	↘	1	4% ↑
2009	12,938.00	–	↗	1	5% ↑
2008	12,902.00	–	↘	1	5% ↑
2007	13,139.00	–	↗	2	7% ↑
2006	12,861.00	–	↗	1	4% ↑
2005	12,319.00	–	→	0	0% →

Story Behind the Curve

The Connecticut Department of Public Health's (DPH) Injury Prevention program collects annual data on the number of recorded emergency department visits for minors ranging from birth to age nineteen. The injuries have a broad variety of categorizations, including at least 19 specific types of injury. These injuries can range from falls, burns and overexertion to assault and poisoning. Overall, the data has seen a gradual decline after a peak in 2007, and shows a continued decline.

The rate of emergency department visits for injury varies by age group. Children aged 0-4 age group had the highest rate for a number of years, followed by the 15-19 age group, then 10-14, and finally 5-9. All age groups saw a decline in injuries requiring an ER from 2013-2014. Unintentional injuries made up 85.6% of all injuries compared to intentional, though both have seen a prominent decline; and males have been consistently more likely to require an emergency department visit versus females. Despite the large gap between white and black instances of injuries requiring an ER, both have seen gradual declines for two consecutive years. In addition, the category of 'Other Race' saw a substantial decline in visits. Other race

includes those not explicitly define, so the decline may also be attributed to greater accuracy on ER reports. Only Hispanic youths saw a slight increase in their rate of visits for injuries.

Emergency department visits for children have two significant consequences that impact a child's overall outcomes. The first is missing time from regular, age-appropriate activities and school days depending on the nature and severity of the emergency department visit. The second, which correlates with the length of stay and type of injury, is the financial cost to families. For many families, these costs and any secondary costs associated with the incident can have a crippling effect on their budget for months, if not years, and divert funds that would otherwise be spent to benefit the child.

Partners

- Department of Public Health
- Department of Children and Families
- Office of the Child Advocate
- Connecticut Poison Control Center
- Connecticut Department of Motor Vehicles
- Connecticut Department of Transportation

Strategy

- Support evidence-based fall-reduction and child safety seat programs.
- Train health care and mental health providers on suicide risk.
- Develop and implement a public education and media campaign about the dangers of prescription drugs that is geared towards the youth.
- Focus programmatic efforts on preventing injuries and deaths related to suicide and violence in CT.
- Advocate for the mandatory use of helmets by bicyclists.
- Train athletes on the importance of and methods for warming up, stretching, taping, using joint braces, etc. to prevent specific injuries.
- Promote use of the CDC's free online courses for health professionals and school coaches, parents, and athletes on preventing, recognizing, and responding to a concussion http://www.cdc.gov/concussion/
- Partner with coaches, educators, athletic and recreational groups to promote use of appropriate protective clothing and equipment for sports and recreational activities: http://www.sde.ct.gov/sde/lib/sde/pdf/publications/concussions/concussions.pdf
- Form partnerships among State agencies and schools to incorporate sports injury prevention into health education programs.
- Promote development and maintenance of playgrounds that meet guidelines for Public Playground Safety.

- Develop a comprehensive home safety program for families and caregivers, focusing on injury risks for children.
- Identify, access, and analyze potential alternative sources of data on causes of and locations of falls for specific age groups, including home, recreational, and sports-related falls.

Strategies contributed by staff from the Connecticut Department of Public Health (**DPH**) and their Injury Prevention Program (**IPP**).

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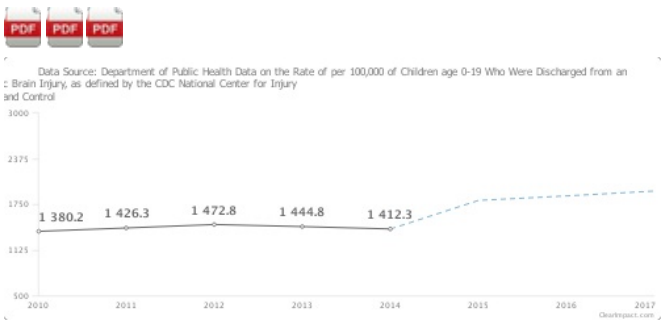
1 Secondary Emergency Department Visits for Traumatic Brain Injury



2014	1,412.30	1,731.00	↘	2	71% ↑
2013	1,444.80	1,591.65	↘	1	75% ↑
2012	1,472.80	1,472.80	↗	2	78% ↑
2011	1,426.30	–	↗	1	73% ↑
2010	1,380.20	–	↘	1	67% ↑
2009	1,410.60	–	↗	4	71% ↑
2008	1,012.30	–	↗	3	23% ↑
2007	990.30	–	↗	2	20% ↑
2006	866.80	–	↗	1	5% ↑
2005	825.30	–	→	0	0% →

Story Behind the Curve

Traumatic brain injuries occur when an individual is struck on the head or strikes their head against an object severely enough to damage the head beyond the scalp and skull. According to the CT Department of Public Health (DPH), the severity of traumatic brain injuries (TBIs) can vary. Mild injuries can cause a brief change in mental status or consciousness, whereas severe injuries result in longer periods of unconsciousness and exacerbate long-term health effects. Between 2005 and 2012, the rates of TBI-related emergency department visits per 100,000 in Connecticut increased overall and among all age groups.

Based upon the data from DPH, the highest rates of TBI-related emergency department visits were among the 0 to 4 year olds. The next highest rates were among 15 to 19 year olds and 10 to 14 year olds were a close third. Overall, males had higher rates of TBI-related emergency department visits compared to females.

Connecticut's Commission on Children provides a variety of resources regarding childhood traumatic brain injuries and has held an open roundtable with the state Department of Social Services, the Connecticut Family Support Council, and the Connecticut Fatherhood Initiative on this issue. Resources include TBI fact sheets, documents from their roundtable discussion provided by various

agencies/organizations, and materials from other organizations. DPH also provides an extensive series of recommendations and external links regarding preventative measures to reduce TBIs. At the state level, the Connecticut General Assembly passed concussion legislation in 2014 that required the State Board of Education to develop a concussion education plan, prohibited school boards from allowing a student athlete to participate in any intramural or interscholastic athletic activity unless the athlete and their parent or guardian receive training on concussions and notification of concussion occurrence. The legislation also established a Youth Athletics and Concussion Task Force to provide additional recommendations to the legislature. The recommendations from that task force led to the passage of new legislation regarding youth athletics. This new language will provide up to date information for parents and youth athletes regarding the signs, risks, and treatments of concussions, as well as the proper procedures to safely return to play after sustaining a concussion.

Partners

- Department of Public Health
- CT Chiropractic Association
- Connecticut Nurses Association
- Parents Concussion Coalition

Strategy

- Educate children, the public, and providers about leading causes of and prevention measures for TBI.
- Educate the public and providers about the effects of TBI including the long term effects associated with head injury.
- Educate the public and providers that concussions are brain injuries and the signs, symptoms and the appropriate treatment for concussions.
- Develop and distribute standardized protocol for post-concussion management.
- Expand partnerships with community agencies serving underserved populations and persons with or at risk of TBI.

Strategies provided by the Department of Public Health (**DPH**)

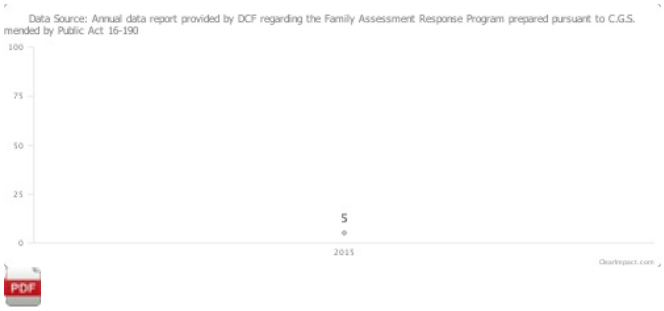
I Development Children who are victims of human trafficking – – – – –

Story Behind the Curve

Partners

Strategy

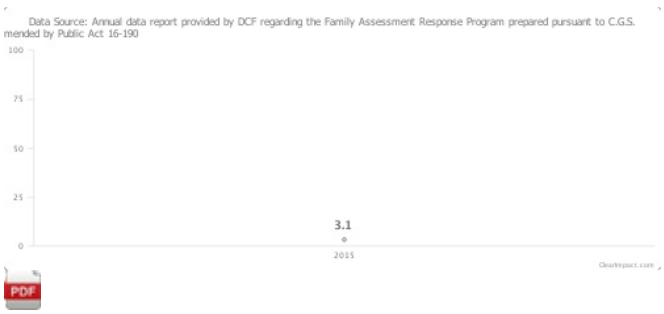
P SAFE Family Assessment Response	Time Period	Actual Value	Forecast Value	Current Trend	Baseline % Change
PM SAFE Families Assigned to Family Assessment Response (FAR) Track	2015	12,829	–	→ 0	0% →
PM SAFE FAR Track - Referred to Community Services (CSF)	2015	17.4%	–	→ 0	0% →
PM SAFE FAR Track- Services Declined, No Safety Factors	2015	23.9%	–	→ 0	0% →
PM SAFE FAR Track - No Further Agency Involvement	2015	40.1%	–	→ 0	0% →
PM SAFE FAR Track- Community Service (non-CSF)	2015	5.0%	–	→ 0	0% →



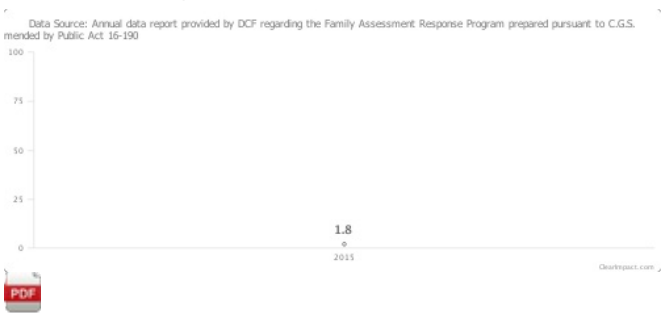
PM SAFE FAR Track - Unable to Complete Assessment | 2015 | 4.0 | – | → 0 | 0% →

PM SAFE FAR Track - Transferred to Ongoing Services | 2015 | 3.8 | – | → 0 | 0% →

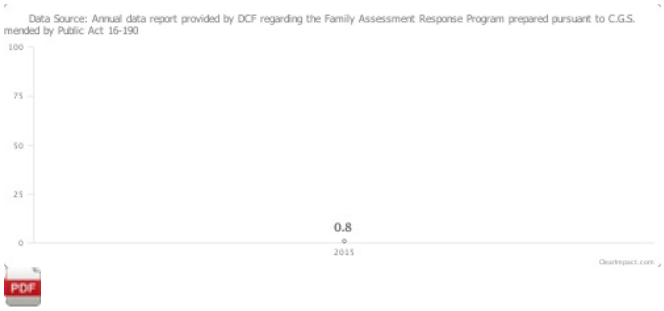
PM SAFE FAR Track - Pending | 2015 | 3.1% | – | → 0 | 0% →



PM SAFE FAR Track - New Report Received (Assessment Closed) | 2015 | 1.8% | – | → 0 | 0% →



PM SAFE FAR Track - Referred to Other Agency | 2015 | 0.8% | – | → 0 | 0% →



PM	SAFE	Families Enrolled in Community Support for Families (CSF)	2015	2,173	–	→ 0	0% →

PM	SAFE	Families Enrolled in Community Support for Families (CSF) - Did Not Engage	2015	317	–	→ 0	0% →

PM	SAFE	Families Enrolled in Community Support for Families (CSF) - Engaged	2015	1,740	–	→ 0	0% →

Data Source: Annual data report provided by DCF regarding the Family Assessment Response Program prepared pursuant to C.G.S.
mended by Public Act 16-190