



# STATE OF CONNECTICUT

## DEPARTMENT OF CHILDREN AND FAMILIES

### Harwinton STAR Home Informational Hearing Committee on Children October 11, 2023

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To: Sen. Ceci Maher, Chair  
Rep. Liz Linehan, Chair  
Sen. Lisa Seminara, Ranking Member  
Rep. Anne Dauphinais, Ranking Member  
Distinguished Members of the Committee on Children

From: Vanessa Dorantes, Commissioner  
Department of Children and Families

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Good afternoon. I am Vanessa Dorantes, Commissioner of the Department of Children and Families. Thank you for the invitation to attend today's forum regarding the Short Term Assessment and Respite (STAR) program in Harwinton operated by the Bridge Family Center. I am accompanied by members of the DCF leadership team to answer questions. DCF has sent a comprehensive response to several questions from committee members that serves as my primary statement on the matter. In addition, we have included a detailed timeline of events that occurred at this STAR home and the actions DCF took to assist the Bridge with serving the girls who were placed there.

Since 1969, the Bridge Family Center has been a valued non-profit provider with several contracts in our service array. They offer many services for the Department including the STAR homes they manage. The Bridge CEO, Margaret Hann, and the Department have worked with local officials over several months to ascertain the scope of issues and work towards a resolution. Examples of our response include; DCF Executive Team meeting with Bridge leadership in response to a community incident in April 2023; the DCF Bureau of External Affairs also coordinated two meetings with emergency personnel, town officials and state legislators in response to expressed concerns. These meetings were held in November 2022 and in July 2023.

To further support stability to this level of care, oversight of STAR program contracts has recently been transitioned within DCF to the Behavioral Health Community Service System division. DCF Behavioral Health division leadership have been meeting with STAR program leadership to assess STAR program resources, referral processes, youth service planning, etc. These discussions will inform the ongoing process of identifying program areas in need of additional resources or modifications. The Department will also continue to work with provider partners to enhance the role of this service type in the larger behavioral health system of care.

According to a 2021 Declaration from the American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, and Children's Hospital Association *"We must identify strategies to meet these challenges through innovation and action, using state, local and national approaches to improve the access to and quality of care across the continuum of mental health promotion, prevention, and treatment."*<sup>1</sup> Here in CT, the legislature has joined in elevating attention to the struggles children and youth have experienced post pandemic. We have collectively seen an increase in the acuity of their needs and behaviors. I implore all listening to also consider another driver for this type of externalized behavior is due to trauma exposure prior to a young person's placement in state custody, which also was exacerbated during the pandemic. No panacea exists. Each child has unique needs which is why together we have built new treatment models and programs to discover and evaluate which service is effective for each child.

As you are aware, our CT system has been challenged in finding the appropriate services for **every** child in need. We serve a small population of children whose acute needs make them vulnerable to predatory victimization and require a more specialized and tailored service array. DCF is committed to evolving our treatment service array to bolster our system with new and innovative programs to support our youth and families.

Rather than repeat previous responses, which the committee has received, my team and I are here to provide further information and are prepared to answer any questions.

Thank you.

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<sup>1</sup> [https://www.aacap.org/App\\_Themes/AACAP/Docs/press/Declaration\\_National\\_Crisis\\_Oct-2021.pdf](https://www.aacap.org/App_Themes/AACAP/Docs/press/Declaration_National_Crisis_Oct-2021.pdf)



Vannessa L. Dorantes  
Commissioner

## DEPARTMENT of CHILDREN and FAMILIES

*Making a Difference for Children, Families and Communities*



Ned Lamont  
Governor

September 22, 2023

Representative Vincent Candelora  
House Republican Leader  
State Capitol  
Room 4200  
Hartford, CT 06106

Senator Ceci Maher  
Co-Chair, Children's Committee  
Room 3100  
Legislative Office Building  
Hartford, CT 06106

Representative Liz Linehan  
Co-Chair, Children's Committee  
Legislative Office Building  
Room 011  
Hartford, CT 06106

Senator Lisa Seminara  
Ranking Member, Children's Committee  
Room 3400  
Legislative Office Building  
Hartford, CT 06106

Representative Anne Dauphinais  
Ranking Member, Children's Committee  
Room 4200  
Legislative Office Building  
Hartford CT, 06106

Rep. Candelora, Sen. Maher, Rep. Linehan, Sen. Seminara and Rep. Dauphinais:

This letter is in response to the inquiries we have received from you regarding the Short Term Assessment and Respite (STAR) program in Harwinton operated by the Bridge Family Center. During the period in question, several divisions of the Department of Children and Families have worked with the provider to strengthen the service provision and continued support of youth.

New admissions to the site remain closed, monitoring continues, and there is a corrective action plan in place through November 2023. The provider gives biweekly updates to the Department and has hired a consultant. It is anticipated that at the end of November determinations will be made on the status of the site as a STAR provider. There will be various options for consideration at that point in

time, including but not limited to, titrating new admissions slowly with an ongoing assessment, permanently reducing the program's bed capacity, continuing unannounced site visits, license revocation, contract termination, etc. The Department is also continuing to meet with all providers of the STAR service type and intends on redefining performance outcome measures in the contract by the end of the year.

Oversight of STAR program contracts has recently been transitioned within DCF to the Behavioral Health Community Service System division. Behavioral Health division staff have been meeting with STAR program leadership and DCF leads to assess STAR program resources, referral processes, youth service planning, etc. These discussions will inform the ongoing process of identifying program areas in need of additional resources or modifications. The Department will also continue to work with provider partners to enhance the role of this service type in the larger behavioral health system of care.

Below are responses to the questions that were contained in the letter dated September 13, 2023, sent by Rep. Candelora, et. al., seeking additional information about the operations at the STAR home and the actions by DCF.

**A description of how the Bridge Family Center was selected to operate STAR and, if it was through a competitive bid process, how many other bids were submitted for consideration?**

A Request for Proposal (RFP) for a Short Term Assessment and Respite (STAR) program was issued in 2006. The Bridge Family Center (The Bridge) was awarded a contract through a competitive process and the Harwinton site was licensed in 2008. A STAR is a program designed to serve DCF-involved youth who are in need of temporary housing and support. Youth are referred directly to STAR programs by DCF Regional Offices and attend school in community based settings. The programs offer respite, assessment, recreation, enrichment, and linkages to discharge resources. The Bridge's contract was renewed on July 1, 2022, and is set to expire on June 30, 2025.

The total annual budget for each STAR is currently \$1,043,351. Providers received a 4% COLA increase in SFY22 and an increase of 5.41% in SFY23. The Bridge was also allowed to retain \$89,475 in surplus SFY22. In addition, the Bridge was awarded a one-time ARPA allotment of \$307,000 in SFY23.

**The extent of the oversight the Department has over the operation of the homes and all temporary housing like this one.**

The Department is the licensing authority for child caring facilities, which includes temporary shelter settings. Licensing visits to these settings occur on a quarterly basis and every two years during the re-licensing process. Increased visits and monitoring also occur as needed and related to the needs of a program. Throughout the height of the COVID pandemic, the licensing team contacted shelters at least three times each week and held scheduled virtual site visits. Face to face licensing visits across congregate sites resumed June 2021.

The Department also oversees the Purchase of Service (POS) contract for vendors. Provider meetings with shelters (and other direct service vendors) are held on an ongoing basis. Various meetings to discuss the needs of DCF involved youth are held with providers. For example,

trade association meetings are held at a routine cadence with the DCF Executive Team and there is a statewide advisory council held with vendors and stakeholders.

The Department can terminate a provider's contract with 60 days notice. The Department can also take adverse licensing action (e.g., revocation of a license, non-renewal, etc.) for licensed programs (e.g., extended day programs, outpatient psychiatric clinics, child caring facilities, child placing agencies). All contractors operate programs with policies and procedures specific to their own agency.

DCF staff facilitate statewide meetings of congregate care program leadership, inclusive of STAR programs. In addition, specific to the Bridge program, DCF staff have attended local community advisory council meetings to discuss and address concerns.

**A description of any contractual protections the Department has against injuries or death.**

The Department has indemnification clauses in all our contracts.

**Any metrics used by the Department to evaluate the effectiveness of the services to help these children.**

For STARs, the Department responds to information on all incidents and events that occur at the facilities. It also has information on the weekly census, referral acceptance rates, and the average overall length of stay.

There is also a Department process called the Service Oversight Advisory Committee (SOAC) that will update performance measures for the STAR contracts in November, 2023. Each youth has a regional office team that works towards accomplishing individualized case planning goals. Throughout this process the site also had visits and feedback from contract support related to the scope of service. This included chart audits, review of investigations, risk management, youth treatment participation and assessments.

**Any safety protocols that the Department requires as a condition of ensuring the safety of the residents.**

When Careline receives a report, screeners assesses the call and determine if the report is accepted or not. When a report is accepted on a licensed program, Careline investigates, and licensing and other staff follow up with the site through a range of responses. This includes phone calls, requests for more information, site visits, monitoring, and corrective action plans. A similar process occurs for significant events and incidents that do not involve Careline. The provider leadership is contacted for information on how personnel matters and training issues were addressed and handled. DCF Regional Office staff (administrative, clinical, social workers) are notified of incidents involving individual youth. There is monthly contact between DCF divisions (Careline and licensing).

The Department also requires that providers notify the Careline if a child is AWOL. "AWOL" differs from "Runaway/Missing" (i.e., AWOL refers to situations when youth are not where they are supposed to be whereas Runaway/Missing means there is no information where the youth is at a point in time). DCF policy specifies that immediate notifications are made when a youth

under age 13 are AWOL from group care or foster homes. For youth over 13, notifications must be made after 12 hours unless certain criteria are met (e.g., youth is in a hospital setting, youth has a medical condition, youth poses a danger to him/her/themselves or others, etc.).

In 2022 and early 2023, meetings with congregate care providers, including STARs, included discussions on run prevention, and best practice responses to AWOL.

**A description of the protocols established by the Department for crisis intervention.**

Providers are required to train their staff in an **emergency services intervention** model (ESI). These models emphasize prevention and de-escalation. When efforts to prevent and de-escalate fail, providers call emergency personnel (e.g., Emergency Mobile Psychiatric Services, Police, EMS, etc.). Youth in STARs may also access the full array of behavioral health supports in the state, including but not limited to, outpatient clinics, extended day programs, emergency mobile psychiatric services, and new urgent care centers.

Regulatory staff check the personnel records to ensure that all staff are trained and re-trained in the provider's selected ESI model.

**The extent of the screening and background checks required by either the Department or Bridge Family Center for the staff.**

The Department requires that all staff working in child caring facilities have criminal background checks and DCF protective service checks completed before working with youth. Contractors are expected to notify the Department if a staff person has been arrested during employment. All staff at child caring facilities are mandated reporters and any offense related to abuse or neglect of a child must be reported to the Careline.

**A description of the process used in collecting and logging incidents.**

Each vendor maintains their own system to track and record incidents occurring at their program. The Department collects significant event incident reports from contractors through an electronic portal located in our Careline; this information is then funneled to DCF Regional teams, the licensing team, and staff supporting the contract for review and any indicated follow-up.

**A timeline describing when DCF was first notified of these serious incidents and any remedial action taken by the Department; and Any action/corrective plans requested by the Department of Bridge Family Center and the outcome of those actions.**

DCF is notified of incidents through Careline reports and through an electronic portal system. When reports come into the Department, there is follow up with the program to explore the provider's response to the incident including their debriefings, reports, analysis, or any human resource actions.

Consistent with the Department's standard of practice, Careline investigated reports and partnered with licensing team members throughout 2021 and 2022 as well. The teams met together monthly.

Part of the immediate follow up to a Careline report on a child caring facility involves assessing the provider's human resource response to an allegation (including immediate removal of staff, putting staff on unpaid leave, etc.). There were three Careline substantiations on staff from 2021 through 2023. In those situations, staff were removed immediately after the report was made. There were also three licensing regulatory action plans in 2021, two in 2022, and one in 2023 prior to the issuance of a comprehensive Corrective Action Plan (CAP).

Issues at this site that resulted in a hold on admissions and a formal action plan culminated in Spring of 2023. Licensing responded with site visits (at times on the next day). Admissions were temporarily held on May 31, 2023, and monitoring began (i.e., unannounced, 2-3 times a week through various shifts). Admissions were temporarily held beginning 5/31/23.

The Bridge attempted to support and provide remedial coaching at the site and took human resource action when warranted. After a period of assessment and review of monitoring, a CAP was written by the licensing team and reviewed with the Bridge leadership. This plan is dated 7/27/23. The hold on new admissions has continued. The contractor also secured a consultant at their own expense. The current Corrective Action Plan was originally in place through 9/27/23 and will extend for an additional 60 days as the vendor has faced hiring challenges.

Unannounced, on-site visits continue once a week. There is currently one resident at the site who has been matched and accepted into another level of service. The contractor is also continuing to work with their consultant on training and other activities. The purpose of the timeframe is to demonstrate the process that resulted in the action plan and is not inclusive of all activities.

The Department has been open and communicative with the contractor throughout this process. For example, the entire DCF Executive Team met with Bridge leadership in response to a community incident in April 2023. In addition, the Bureau of External Affairs also coordinated two meetings with emergency personnel, town officials, and state legislators in response to expressed concerns. These meetings were held in November 2022 and in July 2023.

**Any training or guidance issued by the Department on how to de-escalate potentially volatile situations.**

The Department provides service providers access to our Academy of Workforce Development training curriculum, including those that focus on trauma, development, crisis prevention and intervention. Crisis intervention is also an essential part of ESI models. Over the years the training has also included various interagency conferences including conferences on Six Core Strategies for Reducing Seclusion and Restraint Use.

Training in Domestic Minor Sex Trafficking (DMST) is provided to all STAR programs by DCF staff. In addition, the Bridge received training in the *Love 146 My Life My Choice* model of DMST prevention and intervention. The Bridge has received a year-long *My Life My Choice* fellowship to continue and expand this work.

Residents of STARs and other child caring facilities have full access to the state's array of community behavioral health supports. These supports may be helpful to augment planning for individualized responses.

**Confirmation of whether the Department or the facility requested or suggested that police calls be avoided or minimized.**

The Department never asked the Bridge not to call the police or emergency services for incidents. Service providers attempt to prevent and de-escalate situations before emergency services are called. In the event a youth does become arrested, the follow up is handled through the juvenile justice system.

As evidenced by the sheer number of calls to this facility, the Department works closely with local law enforcement when child maltreatment has been alleged. The acute needs of the youth needing placements render them extremely vulnerable to predatory behavior by adults. The Department and our contractors find these acts completely unacceptable and act swiftly in response.

**Whether health and mental health services have been provided to the youth victims involved in the assaults.**

When serious incidents occur, DCF regional staff are notified and there is follow up with social work staff including clinical staff in the field when needed. The contractor may offer additional clinical support and counseling through their own team resources and/or refer youth to other partners for follow up. At times youth are referred to different levels of service as well. Any additional services recommended (e.g., trauma informed counseling) depends on a clinical assessment of youth. As part of their response to these incidents the Bridge hired a part-time weekend clinician to provide additional support to the youth.

Specific services that were provided to the girls include, but are not limited to:

- Love 146 - a provider specializing in trafficked youth
- DCF Regional Resource Group - clinical DCF staff located in area offices
- Functional Family Therapy Teams
- Natural support that served as mentors (3) - (1 of them is a State Trooper)
- Substance use services
- Tutoring
- After-school activities
- Youth Advocate Program Mentors
- Therapeutic Support Services
- Inpatient hospitalization at Institute of Living and Solnit Psychiatric Residential Treatment Facility
- Behavioral health services provided by Wheeler Clinic
- Intensive Diversion Program at the Juvenile Resource Institute

**The Department's actions towards youths who perpetrated the criminal acts or aggressions and whether they continue to remain in the homes or have been – or will be - transferred to other facilities.**

When criminal acts occur by adults or youth, law enforcement takes action and the process (and any consequences) are administered by the Judicial Branch's Court Support Services Division. The assessment of level of care for youth in DCF care occurs, between DCF regional office staff, Carelon, the contractor, and the youth to secure other placement arrangements and treatment



resources. In May 2023, girls involved in the incident with the state troopers were charged through the law enforcement process. Currently in this program, one youth remains and she has been interviewed and matched to a different level of service.

I am available to discuss any questions or provide clarification on the actions taken by the Department in this matter.

Sincerely,



**VANNESSA L. DORANTES, LMSW**  
COMMISSIONER  
CT DEPT OF CHILDREN & FAMILIES  
505 HUDSON STREET  
HARTFORD, CT 06106

CC: Sen. Henri Martin  
Rep. John Piscopo  
Rep. Lezle Zupkus  
Sarah Eagan, Child Advocate  
Jonathan Dach, Office of the Governor  
Matthew Brokman, Office of the Governor  
Margaret Hann

# DEMONSTRATION OF INCIDENTS/ACTIVITIES AND RESPONSES

2021

2022

Winter	Spring	Summer	Fall	Winter	Spring	Summer	Fall
<div>Incident/Activity<ul style="list-style-type: none"><li>• Report of alleged sexual contact between two youth</li><li>• Allegation of sexual contact between a Bridge employee and a youth</li></ul></div>	<div>Incident/Activity<ul style="list-style-type: none"><li>• Escalating AWOL incidents</li></ul></div>	<div>Incident/Activity<ul style="list-style-type: none"><li>• AWOL incidents continue</li></ul></div>	<div>Incident/Activity<ul style="list-style-type: none"><li>• Alleged physical assault on a youth by a Bridge employee</li><li>• Report of alleged physical assault - a youth on a youth</li></ul></div>	<div>Incident/Activity<ul style="list-style-type: none"><li>• Allegation of sexual contact between a Bridge employee and a youth</li></ul></div>	<div>Incident/Activity<ul style="list-style-type: none"><li>• No significant activity</li></ul></div>	<div>Incident/Activity<ul style="list-style-type: none"><li>• No significant activity</li></ul></div>	<div>Incident/Activity<ul style="list-style-type: none"><li>• Alleged physical assault on a youth by a Bridge employee</li><li>• Report of alleged sexual contact between two youth</li></ul></div>
<div>DCF &amp; Provider Response:<ul style="list-style-type: none"><li>• Careline report made &amp; Immediate HR action by Bridge staff</li><li>• Special Investigations Unit (SIU) investigation on Bridge employee - Substantiated</li><li>• SIU collaborated with law enforcement and an arrest warrant was filed</li><li>• Licensing quarterly visit - Service Development Plan - Written policies &amp; procedures</li><li>• Quarterly group care meeting - DCF 101 and Anti-Racism Training offered</li><li>• SIU monthly meeting</li></ul></div>	<div>DCF &amp; Provider Response:<ul style="list-style-type: none"><li>• AWOL prevention discussed in group care meeting</li><li>• SIU monthly meeting</li></ul></div>	<div>DCF &amp; Provider Response:<ul style="list-style-type: none"><li>• Licensing quarterly visit - Service Development Plan - Sleeping accommodations</li><li>• Quarterly group care meeting - Wilderness School outing offered to adolescents as a positive activity, discussion on Narcan</li><li>• SIU monthly meeting</li></ul></div>	<div>DCF &amp; Provider Response:<ul style="list-style-type: none"><li>• Careline report made &amp; Immediate HR action by Bridge staff</li><li>• SIU investigation on Bridge staff for inappropriate restraint – Substantiated</li><li>• Bridge terminates the employee</li><li>• Bridge staff called 911 for medical evaluations</li><li>• Licensing follow up - did not follow physical restraint procedures - guidance given</li><li>• SIU monthly meeting</li><li>• 1:1 services offered to help provide supervision for particular youth</li></ul></div>	<div>DCF &amp; Provider Response:<ul style="list-style-type: none"><li>• Careline report made &amp; Immediate HR action by Bridge staff</li><li>• SIU investigation - Unsubstantiated</li><li>• Licensing Citation/Regulatory Action - Service Development Plan - lack of staffing</li><li>• Bridge re-trains on staffing &amp; supervision policies</li><li>• Suspension on new admissions</li><li>• Licensing quarterly visit - Service Development Plan – Physical space</li><li>• Community meeting with stakeholders</li><li>• Monthly group care meetings</li><li>• Domestic Minor Sex Trafficking (DMST) training offered</li><li>• SIU monthly meeting</li></ul></div>	<div>DCF &amp; Provider Response:<ul style="list-style-type: none"><li>• Monthly group care provider meetings</li><li>• AWOL prevention discussed in group care meeting</li><li>• SIU monthly meeting</li></ul></div>	<div>DCF &amp; Provider Response:<ul style="list-style-type: none"><li>• Licensing quarterly visit - Service Development Plan -Kitchen, equipment, food-handling.</li><li>• Community meeting with stakeholders</li><li>• Monthly group care provider meetings</li><li>• DMST prevention presentation</li><li>• SIU monthly meeting</li></ul></div>	<div>DCF &amp; Provider Response:<ul style="list-style-type: none"><li>• Careline report made &amp; Immediate HR action by Bridge staff</li><li>• SIU investigation – Substantiation/placed on Central Registry</li><li>• Collaborate with law enforcement and arrest warrant is filed</li><li>• Youth was arrested for sexual assault</li><li>• Bridge terminates employee Licensing Quarterly Visit - Service Development Plan – Physical space</li><li>• Community meeting with stakeholders</li><li>• Monthly group care meetings</li><li>• DMST training offered &amp; provider collaborating with agency serving DMST youth.</li><li>• SIU monthly meeting</li></ul></div>

# DEMONSTRATION OF INCIDENTS/ACTIVITIES AND RESPONSES

January/February 2023	March 2023	April 2023	May 2023	June 2023	July/August 2023	September/October 2023
<div>Incident/Activity</div> <div><ul style="list-style-type: none"><li>•Youth arrests for community theft</li></ul></div>	<div>Incident/Activity</div> <div><ul style="list-style-type: none"><li>•Community incidents</li><li>•Escalating incidents between youth</li></ul></div>	<div>Incident/Activity</div> <div><ul style="list-style-type: none"><li>• Allegation of sexual contact between a Bridge employee and a youth</li></ul></div>	<div>Incident/Activity</div> <div><ul style="list-style-type: none"><li>• Youth become aggressive with state troopers</li></ul></div>	<div>Incident/Activity</div> <div><ul style="list-style-type: none"><li>•Youth stole the Bridge van</li></ul></div>	<div>Incident/Activity</div> <div>No significant activity</div>	<div>Incident/Activity</div> <div><ul style="list-style-type: none"><li>•No youth in program as of 9/26/23</li></ul></div>
<div>DCF &amp; Provider Response:</div> <div><ul style="list-style-type: none"><li>• Next day licensing follow up</li><li>• Bridge response: one youth moved to another program</li><li>• Quarterly group care provider meeting - AWOL best practices shared</li></ul></div>	<div>DCF &amp; Provider Response:</div> <div><ul style="list-style-type: none"><li>• Licensing follow up</li><li>• Site visits</li><li>• Monitoring begins</li><li>• One youth referred out of site</li><li>• AWOL prevention guide sent to providers</li><li>• Quarterly group care meeting: guest speaker from Carelon on 1:1; Implicit Bias, substance use training, DMST training offered, guidance on securing agency vehicle keys.</li></ul></div>	<div>DCF &amp; Provider Response:</div> <div><ul style="list-style-type: none"><li>• Careline report made &amp; Immediate HR action by Bridge staff</li><li>• SIU investigation – Substantiated/placed on Central Registry</li><li>• Law enforcement contacted</li><li>• Bridge terminates employee</li><li>• Licensing follow up</li><li>• DCF offered HART consults for DMST</li></ul></div>	<div>DCF &amp; Provider Response:</div> <div><ul style="list-style-type: none"><li>• New admissions suspended</li><li>• Licensing quarterly visit - Service Development Plan - Instructions in safety procedures. Supervision</li></ul></div>	<div>DCF &amp; Provider Response:</div> <div><ul style="list-style-type: none"><li>• Careline report</li><li>• SIU investigation reopens on employee from April assault - disposition pending</li><li>• Collaborate with law enforcement</li><li>• The Bridge takes HR action, develops remediation plans, and develops new protocols and procedures</li><li>• 2/3 times per week unannounced monitoring</li><li>• Corrective Action Plan (CAP) development begins</li></ul></div>	<div>DCF &amp; Provider Response:</div> <div><ul style="list-style-type: none"><li>• Licensing action and formal corrective action plan begins</li><li>• Quarterly group care meeting: discussions on AWOLS and returns</li><li>• 2nd community meeting with stakeholders and legislators</li><li>• Bi-weekly updates on CAP plan</li><li>• Harwinton site has new program director</li></ul></div>	<div>DCF &amp; Provider Response:</div> <div><ul style="list-style-type: none"><li>• Admission hold continues</li><li>• Monitoring continues</li><li>• Quarterly group care meeting – DMST training offered</li></ul></div>

*Note: Between. 2021 -2023 Trainings given by the provider or offered by DCF also included self - care, restorative justice, positive relationships and boundaries, trauma and anxiety, attachment, DMST, and substance misuse*