Giving Children A Chance For A Change

2007 – 2008 Annual Report

State of Connecticut
The Office of the Child Advocate
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Introduction

The Office of the Child Advocate (OCA) is responsible for monitoring and providing system examination of the care and protection of Connecticut's children. The OCA, by law, has responsibility to oversee all state funded services and state operated programs and services to children. This includes, but is not limited to, health and mental health, education, child protection, juvenile justice, and services for youthful offenders, OCA utilizes its significant authority to evaluate the effectiveness of services to children and identify areas in need of attention and improvement. The OCA makes every effort when identifying any problem to put forth recommendations intended to help improve the systems responsible for meeting the needs of children.

The recommendations are derived from investigatory work, facility review, fatality review, ombudsman activities, and participation in a broad variety of policy committees and task forces, researching trends, and conversations with citizens throughout Connecticut.

The OCA is committed to improving the circumstances of Connecticut's most vulnerable children, primarily focusing on those with significant health and/or developmental special needs, children with unmet mental health needs, children who have experienced repeated exposure to violence, abuse and neglect, and children in the care and custody of state agencies.

We are the voice of children who are often not heard. The OCA is an oversight and investigatory agency. We work as hard a possible to hold public entities and publicly funded programs accountable. We believe that the fundamental question is "what if this were your child?"

The Office of the Child Advocate is extremely fortunate to have a highly professional, highly skilled, and very passionate staff. The accomplishments and activities to be described in the body of this annual report reflect their tireless commitment to bettering the circumstances for so many of Connecticut's children. Budgetary constraints continue to hamper the efficiency, but not the quality or effectiveness of our work. Eleven individuals, some employed only part-time, work together to determine priorities and develop strategies to getting the work done. Of course, to us, it is not enough and much work is left to be done.

System Examination: Paying Attention and Seeking Details

Examining and investigating systems that have vast responsibilities for ensuring the safety and well being of children can be a daunting task, but one that continues as a very high priority for the Office of the Child Advocate, despite limited staff resources. OCA takes very seriously its responsibilities and unique authority and realizes that such review or scrutiny would otherwise not be done. Over the last year, the OCA continued the work of several complex investigations initiated over the past few years and reform efforts that involve multiple state agencies. These include the examination of the delivery of mental health services to children in Connecticut, the care and treatment of children placed out of their own homes and into residential treatment settings by state agencies , conditions of confinement of youth within the Department of Correction (DOC), the quality of transition services for youth with serious and prolonged mental health needs exiting DCF and entering the Department of Mental Health and Addiction Services(DMHAS), and mandated reporting of alleged abuse and neglect by school professionals across the state.

Riverview Hospital

OCA has completed its first year of a two-year intensive monitoring of DCF's Riverview Hospital for Children and Youth, the state's only free standing children's psychiatric hospital. The monitoring commenced upon the order of Governor M. Jodi Rell, following a 2006 collaborative investigation conducted by the OCA, DCF, and the Juan F. Court Monitor's office. The investigation revealed significant and pervasive problems within the facility. A number of critical recommendations were detailed by an intensive program review process and the monitor, who reports to the Child Advocate, has been in place since June of 2007. Quarterly reports are prepared and shared with the DCF Commissioner and facility leadership and made available to the public on the OCA website (www.ct.gov/oca). We are pleased to report that progress has been made in several areas identified in need of improvement, such as leadership, communication, and facility morale. Areas of continued concern and currently under review include the over utilization of restrictive measures, facility quality assurance processes and the involvement of necessary parties in the treatment and discharge planning processes.

Voluntary Services

There are growing numbers of children in CT being identified with significant mental health issues . Timely access to qualified mental health professionals and appropriate home and community-based services is critical for effective treatment to occur and prevent worsened symptoms. Children with poorly assessed and managed mental health issues are at significant risk of school problems, social isolation and disconnection from healthy peers, family problems, and involvement in the juvenile or criminal justice systems. CT has invested tremendous resources over the past several years in developing the state's capacity to provide needed mental health services to children. DCF is the lead state agency in Connecticut for children's mental health. In the past, OCA has reported on problems with access to qualified child and adolescent psychiatrists across the state. This year and next, we are focusing our reviews on DCF's Voluntary Services (VS) imitative and hope to report by the end of this year on the experiences of children and families with accessing VS. Our investigatory efforts related to the care and treatment of children in residential treatment facilities continues as well, however we are confident that the need for out of home placement of children will be dramatically decreased when there is a reliable and competent continuum of services available to children and families at a much earlier time.

Mandated Reporting compliance within CT Public Schools

The OCA, in collaboration with the Office of the Attorney General's Whistleblower Unit, has continued throughout this year to pursue its investigation into the numerous complaints received regarding compliance of public school professionals/administrations with mandated reporting of suspected child abuse and neglect. The investigation has taken longer than anticipated because of the unanticipated scope of the issue as well as significant staffing constraints. Preliminary findings indicate significant systemic reform needs which we intend to share as soon as possible.

Youth in the custody of the Department of Correction (DOC)

OCA continues active participation on the DOC Multi-Agency Working Group on Youth (MAWGY) convened by the DOC commissioner in 2005 following the suicide of a boy at Manson Youth Institution. This group continues to meet on a regular basis to advise the DOC Commissioner regarding policies and practices appropriate for the youthful offender population. Both the DOC administration

and leadership of the contracted health/mental health services provided through University of Connecticut Correctional Managed Health Care (UCMHC) have embraced the efforts of this working group and have to date implemented multiple changes in policy and practice regarding the youth in custody. Examples include expanding the educational hours, adolescent focused health and mental health services, enhanced programming specific to the needs of youth and a commitment to examining the disciplinary actions for their developmental appropriateness.

A MAWGY subgroup, coined " 'she'MAWGY", was formed to review the special circumstances of the girls incarcerated at York Correctional Institution (YCI). Given OCA's ongoing concerns about the lack of gender responsive services and supports available to teens in the state, OCA committed extensive staff resources to the population served by YCI this year. This has included frequent site visits and participation in the now weekly youthful offender team meeting held at the facility. OCA is very encouraged by the reforms at YCI for the adolescent population and is committed to working with DOC on continued improvements. Most important, OCA has examined the pathways of girls into the criminal justice system and is preparing a report describing this work for early FY 2008. It was very clear from our extensive review of the individual girls at YCI that their histories were common for abuse and neglect and that those responsible for their safety and well being did not respond to their needs in timely or effective manner. Failed parenting, failed protection and failed mental health services are the pathway. OCA is in the final stages of preparing a briefing paper on the circumstances of the girls at YCI, which we hope can serve as a catalyst for prevention focused action.

Transitioning Youth

OCA has persistent and serious concerns about the effectiveness of the transitioning planning for youth exiting the DCF child serving systems of child protection and mental health and entering the DMHAS adult serving system. OCA has advocated for improved transition planning and services through legislative initiatives and discussion with DCF. The tragic April 2007 death of Alexandria C. illustrated many problems. During 2007-08 OCA participated in a work group led by the DCF and DMHAS to examine the circumstances of the tragic murder of Alexandra, a young woman who transitioned from the DCF service system to the DMHAS Young Adult program. Four of her peers have been charged in the homicide and all four were young adults who were extensively served by DCF prior to their transition to DMHAS. This work group

produced for the DMHAS/DCF commissioners a report outlining a number of recommendations stemming from a review of a larger group of transitioning youth. The Office of the Child Advocate and many of its advocacy partners intend to continue advocating for policy and practice reforms desperately needed to ensure that young people with mental health needs are given an opportunity for healthy and productive adult lives.

CASA

OCA and the Office of the Attorney General collaborated on an exhaustive review of Connecticut's Court Appointed Special Advocate (CASA) program in response to concerns expressed to both offices. A report will be released early in FY 2008 with a number of recommendations aimed at improving representation of children in the courts.

Lake Grove at Durham

The quality of the care and treatment of children who have been determined to have such extraordinary needs that they must be removed from their homes and communities to have their needs met should command the most vigilant oversight. Lake Grove at Durham, a 116-bed residential treatment setting licensed by DCF to care for children with both intellectual disabilities and significant mental health issues serves as yet another example of failure on the part of the DCF to ensure quality treatment and provide quality oversight to some of our most vulnerable children. Despite the facility's ultimate closure in September 2007, an exhaustive investigation, done in partnership with the OAG, revealed serious systemic and recurrent concerns over a period of several years. This past FY, OCA and the OAG committed to preparing for public review a report which goes beyond a failed facility and speaks to the failed processes of quality oversight. That report will be released in early fall, 2008. Unfortunately, Lake Grove is not alone in its inability to maintain a safe and therapeutic environment for children. OCA is currently in the process of reviewing other programs whose story is strikingly similar. We will make every effort to ensure that these problems are not categorized and dismissed from memory as isolated and disconnected and that the patterns that have clearly emerged through our multiple facility investigations are brought to the attention of those responsible. It has never been the intention of the OCA to, at taxpayers' expense, produce extensive documents with findings and recommendations that are never implemented.

Ombudsman/Citizen Response Activities

The OCA has the responsibility to respond to citizen concerns or complaints regarding the provision of state or state-funded services to children. The OCA provides citizens with information on child-serving systems and programs within Connecticut and an avenue by which citizens may express their concerns for the children who are served by such systems and programs.

OCA tried several new strategies for citizen response during FY08 in an effort to maximize efficiency, assess internal consistency in response to concerns and develop more effective methods of analyzing trends. OCA continues to receive multiple calls daily from citizens with questions regarding where to go or who to call for a wide variety of child and/or family related issues and our highly competent support staff have managed most of those calls. OCA received slightly fewer requests for assistance regarding specific children than it has in past years (465 contacts documented) which we believe is at least in part due to greater community awareness of the existence of the DCF ombudsman office. OCA staff has found that many of these callers can be effectively assisted through "coaching" on navigating public systems and effective advocacy. During this fiscal year, the available five OCA staff rotated ombudsman responsibilities among themselves on a weekly basis and reviewed inquiries relevant to the Office's systemic projects with the entire staff on a weekly basis.

Approximately 9% of inquiries were determined to require further action by OCA; most of these related to adolescents and young adults transitioning from child welfare to adult services, difficulties with accessing needed mental health services and supports through Voluntary Services offered by DCF and DDS, and the availability of services for children with special health care needs. The information gleaned through the OCA ombudsman activities provides the necessary detail and real life experiences of children, their families and those responsible for their care to keep us focused on the real needs of children in our state. During FY08, OCA experimented with alternate means of data collection, as the Office's database remained woefully inadequate in its analysis and reporting functions. We have been thus far unsuccessful in securing needed funding for more optimal data management and are committed to continuing to include this in our budget requests in future years.

Child Fatality Review

"Children are not supposed to die.
The death of a child is a great loss to family, friends and community and often represents unjust suffering and unfulfilled promises. Understanding the circumstance causing a child's death is one way to make sense of the tragedy and may help to prevent other deaths of children. A child's death is a sentinel event and can be a marker in a community of the heath and safety of children. Efforts to understand the entire spectrum of factors that lead to a death may help prevent other deaths, poor health outcomes, injury or disability in other children." [1]

In Connecticut, the child fatality review process is outlined in the statutory authority of the Office of the Child Advocate. The statute designates a state child fatality review panel to review the circumstance of the deaths of children due to unexpected or unexplained causes to facilitate the development of prevention strategies, as well as to address any identified trends, patters of risk, and to improve the coordination of services for children and families in the state. During this annual reporting period (July 1, 2007 to June 30, 2008), 172 Cases were reviewed by the Child Fatality Review Panel.

76 Natural Deaths
55 Accidents
21 Undetermined
14 Homicides
6 Suicides

Accidents
- 32 motor vehicle related fatalities
- 9 drowning
- 4 accidental asphyxia by hanging
- 3 overdose
- 2 fire
- 5 other

Undetermined
- 12 Sudden Unexplained Infant Death (SUID)
- 1 drowning,
- 1 gun shot wound
- 7 undetermined

Homicides
- 7 head blunt trauma
- 3 gun shot wound
- 2 smoke inhalation
- 1 drowning,
- 1 stab wound

Suicides
- all 6 were by hanging

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[1] National Center for Child Death Review, Program Manual for Child Death Review, 2005.

Key OCA/CFRP accomplishments in 2007 / 2008 include the following:

- Reviewed all unexpected or unexplained child fatalities via the Child Fatality Review Panel (CFRP), providing information about health and fatality risks to children, offering an opportunity to examine the effectiveness of state agencies and community programs as child welfare safety nets, and inspiring advocacy for systems improvement and prevention strategies;
- Maintained comprehensive data base of all child deaths;
- Plan for all aspects of the monthly CFRP meetings;
- Monitored all critical injuries of children reported to the Department of Children and Families;
- Consulted with the National Center on Child Death Review;
- Collaborated with the Child Welfare League of America and DCF on multiple fatality investigations of children involved with DCF
- Leadership in the New England Fatality Coordinators Annual Meeting;
- Partnered with other organizations in sponsoring a statewide Anti-Bullying Conference with internationally known speaker;
- Training for the Melanie Rieger Victims of Homicide Conference;
- Training for the Statewide Injury Prevention Planning Group;
- Organized efforts for the Governor's Teen Driving Task Force;
- Served as preceptor to forensic nursing student(s) from Quinnipiac University;
- Reviewed fatality reports from the Department of Developmental Services;
- Responded to all community requests for fatality data;
- Membership: *DCF Youth Suicide Advisory Board, St. Francis Hospital Adolescent Depression and Suicide Prevention Initiative, DPH Interagency Suicide Prevention Network, DMHAS Garret Lee Smith Grant, UCONN School of Social Work Institute for Violence Prevention and Reduction, DPH Statewide Injury Prevention Planning Group.*

Legislative Advocacy

The substance of calls received and investigations conducted determined the OCA's legislative and public policy initiatives for the 2008 Session of the General Assembly. During this year, the OCA focused on several areas of legislative advocacy and policy change including children with special health care needs, children transitioning into adulthood, educational stability for children in foster care and juvenile justice.

Legislation proposed by the Office of the Child Advocate

H.B. 5498, "An Act Concerning a Catastrophic Illness in Children Relief Fund," which would have protected families from financial devastation by created such a fund. Catastrophic relief funds for children are safety nets for families who have excessive expenses related to a child's medical needs. These funds can be accessed when medical expenses not covered by public or private insurance, or some other source, exceed 10% of family's income. The bill did not pass.

H.B. 5495, "An Act Concerning Youth Transitioning from the Department of Children and Families to the Department of Mental Health and Addiction Services which would have required DCF and DMHAS to report annually to the legislature regarding the process for transition from DCF to DMHAS, the number of youth who need mental health services from DCF and/or DMHAS, the anticipated needs of the youth , and the barriers or providing timely and appropriate treatment services This would have held both agencies accountable and helped the legislature design targeted solutions. The bill did not pass.

S.B. 159, "An Act Concerning Foster Placement and Education" which would have allowed foster children to remain in their home schools, as long as it was in the3i3r best interest. Foster children in Connecticut are, sadly, frequently uprooted from their schools when they are shuffled between foster homes or institutions. Frequent school changes are traumatic for these children and disruptions have devastating short and long-terms effects on the education of foster children.

In addition, the OCA supported numerous pieces of legislation proposed by others on a variety of issues, including juvenile justice/families with service

needs; implementing the provisions of the "Raise the Age" law, child protection, children with disabilities, prevention, bullying, mental health, health care and other matters.

Policy Development

The OCA has responsibility to actively participate on many task forces and state committees charged with development of policy that affects the children of our state. This participation enhanced collaborative efforts with other agencies and organizations to make improvements in the systems responsible for the care and protection of children. These include:

- CSHCN Collaborative
- Child Poverty and Prevention Council
- CT Coalition Against Domestic Violence Fatality Review Committee
- Department of Public Health Injury Community Planning Group Committee
- Garrett Lee Memorial Grant, Youth Suicide Initiative
- Greater Hartford Infant Mortality Review Committee
- Interagency Suicide Prevention Network
- St. Francis Hospital, Adolescent Depression and Suicide Prevention Committee
- Shaken Baby Prevention Initiative
- University of Connecticut School of Social Work, Institute for Violence Prevention and Reduction
- Youth Suicide Advisory Board
- Family Support Council
- Governor's Coalition for Youth with Disabilities
- Behavioral Health Partnership Oversight Council
- Governor's Task Force on Justice for Abused Children
- Department of Developmental Disabilities Services Children's Services Committee
- Juvenile Jurisdiction Planning and Oversight Committee: Services Subcommittee
- Department of Correction Multi-Agency Working Group on Youth (MAWGY) and "She"MAWGY
- CT Joint Justice Strategic Planning Committee
- Reaching Home Leadership Council

- Commission to Reduce Racial and Ethnic Disparity in the Criminal Justice System
- Juvenile Justice Alliance
- Children of Incarcerated Parents Workgroup

Priorities for the Upcoming Year

- Complete the review of DCF's Voluntary Services and communicate findings and recommendations.
- Continue OCA special projects and facility/fatality investigations.
- Oversee continued advocacy and reform efforts for children and youth in state care and custody, with particular focus on court-involved children, children in residential care, and children with complex disabilities.
- Advocate for legislation to provide more and enhanced home- and community-based services for children with disabilities and special health care needs.
- Advocate for legislation to provide greater educational stability for children in foster care.

Enhance Citizen Response Capacity:
The OCA will be exploring ways to enhance our citizen response capacity. Priorities for system response include:

- Increasing our capacity for data analysis and reporting.
- Continuing improvement in application of citizen inquiries to OCA's systemic work.
- Communicating with InfoLine and other referring agencies to assist them in effective referrals to OCA and other agencies.
- Partnering with agencies and organizations to increase their visibility and accessibility to the public.
- Expand content on OCA's web page to provide information on frequent citizen concerns and referrals.

Services and Supports for Girls:
The OCA continues to be very concerned about the lack of services and supports available to girls who are involved with DCF, yet end up in record numbers at YCI, the only adult prison for women in Connecticut. Despite an increased awareness and understanding of the impact of trauma on youth and the importance of developing gender-specific services and supports, the majority of services available to girls are neither gender-specific nor trauma-informed.

Although some progress has been made, none of the DCF-supported programs serving girls has met expectations. Many consultants and numerous training programs have not yet had an impact on service and program reform. The OCA continues to be very concerned about the significant increase in the number of girls involved with the criminal justice system. In the coming year, the OCA will continue to advocate for substantive reform in services and programs for girls in Connecticut.

Children with Disabilities:
During the past year, the OCA was the catalyst to expanding and enhancing efforts on behalf of children with complex medical needs and disabilities. The initiative involved the development and implementation of a focused legislative agenda, led by the OCA, the Commission on Children, parents of children with disabilities, the Office of Health Care Access, and other advisory groups. The team developed a broad policy agenda that outlines how Connecticut can better support children with disabilities and complex medical issues. Legislation was introduced to provide catastrophic relief for children and we intend to pursue its passage in the upcoming legislative session.

OCA is concerned that the well-intended transfer of responsibilities for providing voluntary mental health services to children with co-occurring mental retardation from DCF to DDS in 2005 is inadequately resourced to meet the demands. While DDS has been successful in serving many such children within their homes and communities, there remain significant problems with access to psychiatric services, respite, and qualified in-home supports to help families learn how to support their children safely and effectively. In addition, for the group of children whose needs are so extraordinary that they require out-of-home residential treatment services, out-of-state facilities are the only options. This presents tremendous hardships to families and caregivers and affords children with significant vulnerability little protection and oversight by CT authorities with responsibility for their care and protection.

Youth in Transition:
The OCA spearheaded efforts to focus attention on the importance of effective transition planning and implementation to help young people actualize their fullest potential. As a result of the OCA's work, DCF, DMHAS, and DDS will likely be more vigilant in preparing young people to move to small state-funded group homes or independent living settings. DCF has agreed to identify affected youth earlier, do better assessments of individualized needs, and more effectively communicate among agencies, schools, and service providers.

Effective Oversight of Children and Youth in Residential Treatment and other Congregate Settings:

Safety of children in treatment settings is paramount and the State of Connecticut has an obligation to ensure that when a decision is made to remove a child from their home and community because of specialized treatment needs, we have a duty to ensure that their treatment needs are being effectively addressed. There is a national trend for less reliance on residential care with more effective interventions being developed and delivered in the child's home and community. Connecticut's child serving agencies are all demonstrating positive progress in serving children in the community. For those children determined to be in need of out-of-home treatment services (June 30,2008 there were more than 1500), that treatment must be specific to that child's needs and delivered efficiently and effectively. Extensive removal from home and community sets a child up for many difficulties as they progress through adolescence and into adulthood. Historically, too many children have spent up to years in facilities, there under the guise of receiving needed treatment. Quality oversight efforts have only very recently begun to look at the actual treatment being provided in settings across the state. In addition, Connecticut still has more than 300 children who have been sent outside the state for treatment unavailable in CT. Going forward, the OCA will continue its oversight of DCF and other state agencies responsible for the placement and funding of these placements for their effectiveness in ensuring adequate levels of supervision, relevance of programming, and quality of care

Riverview Hospital:

Formal monitoring of Riverview Hospital through the current agreement ordered through the Governor will end in the spring of 2009. While the hospital administration has made progress in some areas, the OCA remains concerned that without significant continued external oversight, the positive changes may not be sustained and the substantive treatment oriented changes will not be achieved. The Child Advocate will continue to meet with the DCF Commissioner and keep the legislature informed over the next several months.

Teen Dating Violence Prevention Initiative:

Through a grant from the Connecticut Health and Educational Facilities Authority (CHEFA), the OCA has been continuing work with the Institute for Community Research to build a statewide group to conduct research on healthy teen relationships. The goal is to build upon the successful framework established over the past two years to prevent domestic violence and abuse

among teens by establishing a statewide network of youth researchers who are focusing on by engaging youth in discussions, identifying socio-economic factors, reviewing existing policies, and creating a variety of potential solutions to the problem.

W.R. v. Dunbar, et al.:
The OCA was an intervening party in a lawsuit brought against the commissioner of DCF on behalf of families seeking home- and community-based care for their children with significant mental and behavioral health care needs. The OCA is participating in the oversight of the settlement reached in July 2007:

- Over 3.5 million dollars to expand and enhance Emergency Mobile Psychiatric Services, to allow maximum mobility and more immediate response times;
- Over 5.3 million dollars to develop and implement Individualized Community-Based Options to keep mentally ill children in the community (via therapeutically supported living, crisis supports, and related services); and
- Hiring a consultant to oversee the implementation of the settlement;

Expansion of Staff:
There is a need to add at least three positions to the Office of the Child Advocate. One position would be responsible for facility oversight and investigation. Another would be charged with conducting research, data analysis, upgrading the data system, and overseeing quality improvement. The third position would be an attorney. Finally, the OCA needs to be allowed to structure the agency and establish staff positions and job classifications that most appropriately meet its needs.

OFFICE OF THE CHILD ADVOCATE STAFF
2007-2008

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