OFFICE OF THE CHILD ADVOCATE
ANNUAL REPORT
JULY 1, 2009 – JUNE 30, 2010

The Office of the Child Advocate (OCA) was established in 1995 after the tragic death of an infant in state care. The child's death made clear that an independent agency with the power to investigate and issue public reports was necessary to ensure the well-being of children and provide transparency to government services otherwise shielded from public view by confidentiality laws and institutionalized practices intended to protect children and families.

The statutory authority of the office is broad. The OCA is mandated to:

- evaluate the delivery of services to children through state agencies or state-funded entities;
- periodically review the procedures of state agencies and recommend revisions;
- review and investigate complaints regarding services provided by state agencies or state-funded entities;
- advocate on behalf of a child and take all possible action necessary to secure the legal, civil, and special rights of children, including legislative advocacy, making policy recommendations, and legal action;
- periodically review facilities and procedures of facilities in which juveniles are placed and make recommendations for changes in policies and procedures; and
- periodically review the needs of children with special health care needs in foster care or permanent care facilities and make recommendations for changes in policies and procedures.

The OCA has harnessed our unique statutory and independent authority to investigate and evaluate state-funded and state operated programs and services for children, identify areas in need of attention and make recommendations to protect the rights of Connecticut's children. The OCA operates as the office of accountability for Connecticut's children.

Since 1995, the OCA has been an effective watchdog of over $4 billion of state funds and state funded entities. OCA has identified ineffective and sometimes harmful state expenditures for facilities, programs and services to Connecticut's children. During the last year, OCA continued to evaluate and uncover where children languish in unnecessarily high levels of very costly care and advocated for the discharge of those children to more appropriate and often, more cost effective programs. In addition, OCA continued to identify costly and duplicative bureaucracy existing in state-run and state funded agencies, institutions, programs and services for children. OCA's accomplishments are achieved by the efforts of a small number of expert, multidisciplinary staff. Their collective expertise encompasses knowledge regarding child health and development, child welfare, juvenile justice, children with special health, mental health and

developmental needs, legal issues pertaining to children and families, education and public policy. The OCA routinely reaches out to others possessing expert knowledge and experience both within CT and across the country to ensure we maximize our ability to meet responsibilities, collaborate effectively, and create critically necessary lasting partnerships.

Summary of Achievements 2009-1010

- Participated in the Children and Recession Task Force, created by the Speaker of the House.
- Completed a joint investigation on how DCF, SDE and the Connecticut school systems respond to allegations of school employees abusing and neglecting children.
- Led prevention efforts on infant safe sleep, bullying and suicide.
- Provided vigorous advocacy for children with disabilities across public service systems and recommendations for systems reform.
- Continued to participate in the oversight of the W.R. lawsuit, resulting in an increase of more than $10 million to build the state's capacity to provide services to mentally ill youth in care, which has since settled, resulting in an increase of more than $10 million to build the state's capacity to provide services to mentally ill youth in care.
- Spearheaded efforts to focus attention on the importance of effective transition planning for young adults leaving DCF care.
- Actively participated in planning and oversight for a smooth and complete transition of the juvenile justice system as it relates to the change in the age at which youth are considered juveniles (January 1, 2010 for 16 year olds).
- Reviewed all unexpected and 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 system improvement and prevention strategies.
- Investigated and monitored unsafe conditions for children in out of home care.
- Spearheaded a project to examine the number and plight of children under the age of 6 in congregate care.
- Continued efforts to expose inefficient and ineffective practices at DCF and other state agencies serving children.
- Prepared an Amicus Brief to be filed early in FY 2011 with the Federal Court to support the continued need for the Juan F. Court Monitor.

Citizen Response Activity

The OCA has statutory responsibility to respond to citizen concerns or complaints regarding the provision of state or state-funded services to children. In the reporting period July 1, 2009 – June 30, 2010, OCA documented **1703** requests for assistance regarding specific children. These requests come from family members, providers, educators, attorneys, legislators, public agency staff and administrators, and from children themselves. Caller confidentiality is assured by statute. Assisting callers to navigate public systems effectively to ensure that their voice is heard and their concern is addressed appropriately continues as a significant priority for the OCA. Providing education, coaching on self-advocacy strategies, providing support to individuals who often are highly distressed by their circumstances, and providing follow up are all critical components of this work. When deemed appropriate and necessary, the OCA becomes directly involved in investigating reported concerns. During this past FY, OCA opened more than **100** individual cases, where an OCA staff member identified significant concern regarding the safety

or unmet needs of a child (or children) and proceeded to take any and all necessary action to ensure child safety and well-being. In addition, OCA had direct contact with more than **350** individual children, many in state run or licensed institutional settings, to assess their needs and assist them through direct advocacy. OCA staff conducted or participated in almost **2000** case reviews during this past year. Case investigation and advocacy included over **1800** documented contacts with public agencies and almost **200** contacts with attorneys representing children and families.

In addition, OCA continues to review every significant event, critical incident, and reported allegations of facility-based abuse and/or neglect of a child reported through the DCF from both the state operated and licensed programs responsible for the care and treatment of children. These reports are useful in highlighting possible troubling systemic trends in need of further evaluation and investigation. During FY 2009-10, OCA staff reviewed approximately **4000** such reports, as well as the resulting DCF risk management and administrative analyses. This review resulted in numerous requests by the OCA for meetings with DCF central administration to discuss troubling data and incidents and urge needed action. Because of OCA's broad authority regarding access to information, including subpoena authority, OCA is often the only entity with access to such comprehensive information. The Child Advocate has used this knowledge and authority to inform and assist other oversight entities including the Governor, the Legislature and the Judicial Branch.

Facility Oversight and System Evaluation:

Riverview Hospital for Children and Youth (Department of Children and Families)

Formal monitoring of the state's children's psychiatric hospital, Riverview Hospital for Children and Youth, was under a two- year agreement ordered by the Governor, which ended in the summer of 2009. The Hospital made a good faith effort to address multiple concerns and has worked intensively to create progress in a number of areas. Despite the cessation of formal monitoring, OCA continues to communicate with facility administration and visit the facility regularly. It appears from these contacts and regular review of performance data provided to OCA by Riverview administration that the hospital continues to operate in an organized manner, has sustained more effective communication processes, and continues improvement in its treatment planning, clinical review and staff development processes. However, the OCA remains concerned about the need for a more vigorous quality improvement process and disparate practices within the hospital. Child specific advocacy efforts have continued with continued great concerns regarding the children and youth with the most complex mental health needs who do not have critically needed social supports to advocate on their behalf. Effective transition planning and implementation persists as a major problem.

During the past year, the OCA continued to focus attention on persistent disturbing practices at Riverview Hospital involving continued excessive use of punitive and restrictive measures such as restraint and seclusion on children and excessive utilization of law enforcement. Quarterly summary reports for the period of formal monitoring 2007-2009 are available on the OCA website (www.ct.gov/oca).

Connecticut Children's Place (CCP)

Connecticut Children's Place (CCP) is a 48 bed, co-ed residential treatment facility operated by the Department of Children and Families. The facility treats DCF involved children between the ages of 12 and 21, with the average age of 15.5years. The average daily census in 2009 was 44.

The Department of Children and Families describes CCP as a diagnostic behavioral health treatment program which provides onsite education and behavioral health services including medical, nursing, psychiatric and clinical social work treatment, a paid work program and a therapeutic recreation program to children who have been removed from care at other treatment facilities, are returning to CT from out of state treatment programs, who are in need of sub-acute treatment service as a discharge plan from psychiatric in pt settings, who are in need of specialized treatment and that treatment is not available in the private sector or who are in crisis and need immediate behavior health treatment in a residential setting.

As a state operated facility, CCP is completely unregulated. DCF is the licensing body for children's residential programs within the state. CCP holds no accreditation. CCP is not subject to any external routine inspections or program reviews and utilization management is currently outside the purview of the CT Behavioral Health Partnership. Data reported through DCF reveals high runaway rates, high arrest rates and excessive utilization of restrictive measures. The OCA has brought these concerns and others to the attention of both facility administration and DCF executive administration. The DCF Commissioner has very recently acknowledged the concerns and has expressed intent to implement corrective actions to address the problems. OCA intends to vigilantly monitor program reforms and the care and treatment of children in residence at the DCF operated CT Children's Place.

New Hope Manor

New Hope Manor (NHM) is a residential treatment facility and group home for 20 adolescent girls with co-occurring mental health and substance abuse issues. The program is licensed and monitored by DCF. In January 2007, OCA requested that DCF conduct a comprehensive program review of NHM due to serious concerns related to the lack of gender and trauma responsive treatment and high rates of runaways and police calls. In response, DCF sent a team to conduct an evaluation of the facility and make recommendations for program improvement. In April 2010, OCA responded to letters received from both concerned professionals and children that detailed serious allegations related to the lack of staff supervision and programming and failure to provide for girls' basic food and hygienic needs. OCA reported the concerns to the DCF child abuse and neglect hotline, visited the facility on several occasions, reviewed case records and interviewed NHM staff and residents. OCA strongly advocated on behalf of individual girls at the program to ensure that their needs were assessed and met as DCF investigated the allegations and made recommendations for program improvement.

Young Children in Congregate Care

As CT continues to decrease its reliance on institutional settings for children in out of home care through improvements in home and community based supports and services, DCF continues to depend excessively on congregate care settings for out of home care for very young children. More than 200 children /year (30-40 on any given day) under the age of six who have been removed from their families are placed in congregate settings across the state. Inherent challenges in institutional care include inconsistent and possibly unreliable caregivers and chaotic environments housing groups of children, many of who have experienced significant traumas.

Despite DCF commitments to minimize lengths of stay for children placed in institutional settings, the youngest children are more likely to experience extended stays. The OCA, in collaboration with a number of other child advocacy groups, seeks to eliminate the use of congregate care settings for children in out of home care under the age of six. OCA has enlisted expert researchers from Yale to help examine available data so as to guide advocacy efforts. We

anticipate completion of a 3-year review of children under 6 in out of home congregate care to be ready within the next several months.

Juvenile Justice and Criminal Justice Oversight

The OCA has continued to commit extensive staff resources to examine the pathways and conditions of confinement of youth in or at-risk for entering the adult justice system as well as the quality of planning and implementation of transitional supports designed to promote their success upon return to their communities.

The Department of Correction (DOC) Manson Youth Institution

OCA continued to commit staff resources to overseeing the conditions of confinement at Manson Youth Institution (MYI) and the pathways for boys in Connecticut into the adult criminal justice system. OCA regularly attends team meetings at MYI, conducts tours of the facility and participates in the newly established MYI Re-Entry community meeting. OCA staff also meets regularly with leadership at the Department of Correction to advocate on behalf of the boys incarcerated at MYI and boys who are discharged from MYI and returning to the community. OCA has also begun to examine the conditions of confinement of youth located in the restrictive housing units.

The Department of Correction (DOC) York Correctional Institution

The OCA has continued to commit staff resources to examine the pathways, conditions of confinement of girls in or at-risk for entering the adult justice system and the quality of services and supports available to allow for successful discharge to home. OCA continues to work closely with the DOC to implement necessary reforms, ensure sustainability, and establish the critical interagency partnerships to effectively serve this extremely vulnerable population.

The DOC has acknowledged the unique needs of incarcerated teens and has been working collaboratively with multiple stakeholders, including the OCA, to provide more effective services, which have the potential for impacting recidivism. The DOC has prioritized clinical supports, more group work, and overall services to enhance the time spent incarcerated in and effort to teach and rehabilitate. Ongoing contact and collaboration with the DOC and other stakeholders has provided bridges to the community and has enhanced knowledge of services for discharge planning.

Children with Special Health Care Needs

The OCA has made diligent efforts on behalf of children with complex medical conditions and developmental disabilities. As a result of their work during the past year, diligent efforts were made to try to ensure better protection for our most vulnerable children and towards creating more supports and services. The OCA's advocacy for children in out-of-state placements also remained vigorous.

Universal Waiver Work Group

In 2010 the OCA joined an active group of advocates, state professionals and providers in a collaborative effort to review options and develop strategies to promote a universal Medicaid Waiver. A universal waiver would provide support for persons requiring long term care who

prefer to live at home rather than an institution and would do so regardless of age, diagnosis or disability. For too long advocates have promoted initiatives to support specific groups of people, exacerbating an already "siloed" or disconnected system of human services. The universal waiver-working group is the first to propose streamlining supportive programs for all persons in need, thus creating more effective and efficient systems.

The OCA contributed to the development of a pamphlet, *Your Home, Your Way: Support Choice in How and Where Connecticut Residents Receive Long Term Care Services and Supports.* The pamphlet will soon be distributed widely around the state for concerned citizens to use in dialogue with candidates for governor and other public offices. The purpose is to educate and promote awareness about the needs of people with disabilities who desire to live in the community and the options to support that desire.

Connecticut Family Support Council

The OCA remains committed to supporting families and the Family Support Council in identifying support needs and advocating for systems change to improve the circumstances of children with disabilities. During this past year, the OCA staff designee was elected to Secretary of the FSC marking the first time an agency member held office. (Traditionally, appointed parent members have held all executive positions.) Given the very nature of the responsibilities parents and family members have when raising children with disabilities or complex medical conditions, it became clear that executive committee members are frequently called away from Council business. The FSC unanimously concluded that an agency representative could provide more consistency as well as in-kind support. A grant that funded administrative support ended in Spring 2010 so in-kind support will be relied upon for FSC operations.

The FSC undertook a self-evaluation process beginning in the spring of 2010 that will culminate at an annual retreat in the fall of 2011. With a combination of new leadership, many new members and impending new executive administration the Council determined it was time to revisit mandate and mission. Through the process, membership roles will be clarified including expectations of agencies like the OCA – as well as what the OCA and others can expect from the FSC in regards to advocating for children with disabilities and complex medical conditions.

Education Investigation: Joint Report of the Child Advocate and the Attorney General

The Office of the Child Advocate (OCA) and the Office of the Attorney General have completed an exhaustive investigation into how the Department of Children and Families (DCF), the State Department of Education (SDE) and the Connecticut local school systems respond to allegations that school employees have abused and/or neglected students. The investigation explored the systems in place to protect children in schools, including the screening processes for certification of administrators, teachers and coaches; screening processes for hiring school employees; mandated reporting laws; the quality of investigations of allegations that school employees ah e abused or neglected children; and the response of local school districts, the DCF and the SDE. The investigation revealed significant gaps both in the statutory and regulatory scheme as well as the policies and practices of local school districts, DCF and SDE. The report, *Protecting Our Children: Improving Protections for Children When Allegations Are Made That School System Personnel Abused and /or Neglected Children* contains important recommendations for administrative practice and policy changes as well as recommendations for legislative changes. The report will be released imminently and made available on the OCA website (www.ct.gov/oca).

Transitioning Youth with Serious and Persistent Mental Health Issues to Adult Services

Transition planning and services for DCF youth with complex mental health histories. transitioning into the adult Department of Mental Health and Addiction Services (DMHAS) system continues to receive priority attention in the OCA. Extraordinary OCA staff time has been dedicated to several youth who essentially have no one to support them during this tumultuous time. Too often these young people have spent many years in DCF care with multiple disruptions in treatment, education, social connections and placements. They are frequently without any healthy adult or peer connections, are grossly undereducated, and are without the necessary life skills to transition to independence.

OCA continues to work with a number of public policy and legal advocates who are committed to advocacy for adults with complex mental health needs served by public agencies and will maintain efforts to strengthen these valuable and necessary partnerships on behalf of this highly vulnerable population. OCA will also continue efforts to educate young adult service providers, both public and private, regarding the experiences of these young people within the child serving systems and seek reforms within both systems that are age and developmentally appropriate, trauma informed, gender responsive and result in sustainable benefits.

Child Fatality Review

The Child Fatality Review Panel (CFRP), created within the same statutory framework as the Office of the Child Advocate in 1995, is mandated to review the circumstances of the death of a child placed in out-of-home care whose death was due to unexpected or unexplained causes to facilitate the development of prevention strategies to address identified trends and patterns of risk and to improve coordination of services for children and families in the state. In addition, the panel has the authority to conduct in-depth investigations and issue reports with recommendations. Those reports are provided to the Governor, the General Assembly, and the Commissioner of any state agency cited in the report, and is available to the general public. During the past fiscal year, the CFRP reviewed 132 child fatalities.

- Seventy-nine were *Natural* deaths, including SIDS, children with complex disabilities,, cancer and other natural causes.
- Twenty-two were *Accidental* deaths, including motor vehicle related fatalities, falls and drowning.
- Fourteen were *Undetermined* deaths, these deaths are typically infant deaths whereby a definitive determination of death could not be made.
- Seven were *Homicide* deaths
- Three were *Suicide* deaths
- Seven cases were children from other states that died in CT. Some of those cases were children who were transported to a CT hospital from a contiguous state; others may have been in CT for a visit or vacation.

Of the cases presented, several required an in-depth review/investigation and more than half required case follow-up. These reviews provide important information about health and fatality risks to children, offer an opportunity to examine the effectiveness of state agencies, and advocate for stem improvement and prevention strategies. As part of this work, OCA has initiated and continued statewide anti-bullying initiatives, child suicide, and teen dating violence prevention initiatives. During this period of time, OCA also reviewed weekly fatality reports of the Department of Developmental Disabilities (DDS). OCA fatality review staff actively participate

with various community groups and committees focused on prevention initiatives as well, such as:

- Youth Suicide Advisory Board
- Child Poverty and Prevention Council
- Interagency Suicide Prevention Network
- CT Statewide Safe Sleep Coalition
- Shaken Baby Prevention Partnership
- Domestic Violence Fatality Review
- Teen Driving Work Group
- Statewide Injury Community Planning Group
- Institute for Violence Prevention and Reduction

Legislative Advocacy and Policy Development:

The OCA continued to be an active participant and convener of numerous task forces and committees that are responsible for the development of policy that impacts the children of Connecticut (attached). Our collaborative involvement with other organizations and agencies reflects our commitment to improving the systems responsible for the care and protection of children.

OCA's legislative advocacy is an important part of our work. Legislative and policy reform initiatives are guided and driven by the information learned through all the other work of the OCA. The Child Advocate and OCA staff members meet regularly with legislators to provide information and respond to their questions and concerns about the provision of state or state funded services to children. In addition, OCA had a shared leadership role in the following successful legislative efforts during the past year:

- Educational Stability: PA10-160 requires that children who are placed in the custody of DCF attend their original school unless this is not in the child's best interest.
- Raise the Age: Defeated proposed legislation that would restrict the jurisdiction of the juvenile court to children under 16 years of age.
- Children in the Recession: PA10-133 implements the recommendations of the Child Poverty and Prevention Task Force to mitigate the long-term effects of economic recession on children, minimize the number of children who enter poverty as a result of recessions, and promote policies and practices that reduce the human costs of economic recessions.

OCA also advocated in support of numerous other legislative proposals which were unsuccessful during this past session including but not limited to: independent monitoring of HUSKY, cross-reporting of child abuse and animal cruelty, promoting Differential Response protocols for DCF reports, facilitating transfer of educational credits from the USD II, providing assistance to homeless youth, establishing a catastrophic medical expenses pool, requiring school suspensions be served in school, improved planning and transparency for transitioning youth from DCF to DMHAS, and returning children from out of state residential treatment facilities.

Given the significant current and future budget deficits, OCA will continue vigorous advocacy to ensure preservation of the safety net of services and supports for CT's children.

Public Education:

OCA staff members are regularly invited to speak at colleges, universities, non-profit organizations, professional associations, youth events, educational forums, conferences and at many more. Formal speaking engagements and participation in public education events totaled over 120 for the year. OCA remains committed to continued public education and welcomes invitations for the upcoming year.

Priorities for the 2010-2011 fiscal year:

- Complete analysis of the numbers and outcomes of children under the age of 6 in congregate care.
- Continue to provide significant oversight of children in out of home care, and in particular the DCF operated mental health facilities-Riverview Hospital and the Connecticut Children's Place.
- Continue to work with the Department of Correction to improve services for children at York and Manson.
- Education and advise policymakers on ways to improve safety and care of vulnerable children.
- Participate in a working group to develop ways to improve the mental health system for children in Connecticut.
- Advocate for implementation of recommendations made in the joint report with the Attorney General on abuse and neglect by school employees.
- Continue vigilant efforts to ensure better transition of young adults from DCF to DMHAS and DDS.
- Continue to vociferously advocate for the availability of more accessible and equitable services for children with disabilities and/or special health care needs.

OFFICE OF THE CHILD ADVOCATE STAFF PARTICIPATION ON BOARDS/COMMISSIONS/COMMITTEES/TASK FORCES

- Youth Suicide Advisory Board
- Child Poverty and Prevention Council
- Interagency Suicide Prevention Network
- Statewide Safe Sleep Coalition
- Shaken Baby Prevention Partnership
- Domestic Violence Fatality Review Board
- Teen Driving Work Group
- Statewide Injury Community Planning Group
- Institute for Violence Prevention and Reduction
- Children of Incarcerated Parents Steering Committee
- DCF Differential Response Steering Committee
- University of Connecticut School of Social Work Field Advisory Committee
- Family Support Council
- Behavioral Health Partnership Oversight Council and BHPOC subcommittee on Quality Access
- DDS Children's Services Committee (multidisciplinary, multi-agency committee which reviews requests for out of home placements for children served within DDS VSP)
- DCF Provider Academy Advisory Board (new Oct 2010)
- DCF/Judicial Executive Implementation Team (oversight of implementation of the DCF/Judicial Joint Strategic Plan for JJ) and DCF/Judicial EIT subcommittee on confidentiality/sharing information across agencies
- Commission on Racial and Ethnic Disparity in the Criminal Justice System
- Governor's Task Force on Justice for Abused Children
- Ct Medicaid Care Management Oversight
- Council National Advisory Board member, Complex Trauma Network Children's Committee
- Keep the Promise Coalition
- DOC Multi-agency Working Group on Youth and Manson Youth Institution/York Correctional Institution facility based multidisciplinary teams