# OFFICE OF THE CHILD ADVOCATE ADVISORY COMMITTEE
# EVALUATION OF THE EFFECTIVENESS OF THE OFFICE OF THE CHILD ADVOCATE

Pursuant to Connecticut General Statute §46a-13q(a), the Office of the Child Advocate Advisory Committee shall provide an annual evaluation of the effectiveness of the Office of the Child Advocate (OCA). We herewith submit our report, covering the rating period July 1, 2009 through 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 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 recommendation for changes in policies and procedures.

Once again, over the course of the last fiscal year Jeanne Milstein and her staff continue to do an outstanding job as advocates for Connecticut's most vulnerable children especially given the tremendous financial constraints imposed by the State's budgetary troubles.

During the last year, the OCA has continued its vigilant oversight of state-run facilities, to wit:

- The OCA continued to focus attention on persistent practices at Riverview Hospital involving excessive use of punitive and restrictive measures such as restraint and seclusion and the excessive utilization of law enforcement.

- The OCA brought concerns regarding Connecticut Children's Place (CCP) to the attention of both facility administration and the Department of Children and Families (DCF) executive administration. Chief among the OCA's concerns regarding CCP as a state operated facility, licensed by DCF is that CCP is completely unregulated, holds no independent accreditation and is not subject to third party inspection or program review. Utilization management is currently outside the purview of the CT Behavioral Health

Partnership. DCF compiled data reveals high runaway rates, high arrest rates and excessive utilization of restrictive measures. The DCF Commissioner recently acknowledged the concerns and expressed her intent to implement corrective actions to address the problems. OCA will monitor the implementation of corrective measures and program reforms as well as the overall care and treatment of children in residence at the DCF operated CCP.

- In April 2010, OCA responded to letters received from concerned professionals and children detailing the lack of basic care, staff supervision and programming at New Hope Manor (NHM), 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. 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.

Additionally, OCA reviewed cases of individual children in congregate care settings and institutions in furtherance of its systemic oversight and monitoring efforts and in some cases as a launch point for direct intervention on behalf of individual children. More than 200 children per year (30-40 on any given day) under the age of six are removed from their families and placed in congregate settings across the state. The OCA, in collaboration with a number of other child advocacy groups, is advocating the elimination of the use of congregate care settings for children under the age of six in out of home care under the age of six OCA engaged researchers from Yale to examine available data as part of OCA's 3-year review of children under six in out of home congregate care. This review should be completed within the next several months

The OCA continues to respond to citizen concerns and to complaints regarding the provision of state or state-funded services to children. These complaints come from family members, providers, educators, attorneys, legislators, public agency staff and administrators, and from children themselves. In this reporting period, OCA documented approximately 1700 requests for assistance regarding specific children. From these complaints, OCA identified over 100 actionable cases involving child safety or other unmet needs. In those circumstances OCA took any and all necessary action to ensure child safety and well-being.

OCA also participated in the Children and Recession Task Force, created by the Speaker of the House and spearheaded efforts to focus attention on the importance of effective transition planning for young adults leaving DCF care. OCA actively participated in planning and oversight of a significant change in 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).

The OCA worked on behalf of children with complex medical conditions and developmental disabilities to ensure better protection, supports and services. The OCA's advocacy included children placed in out-of-state facilities. The OCA also continued its oversight of the W.R.

lawsuit 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.

The OCA committed extensive staff resources to examine the pathways and conditions of confinement of youth at-risk of entering the adult justice system. The OCA also examined the quality of planning and implementation of transitional supports designed to promote a confined youth's return to the community. OCA continues to commit staff resources to oversee the conditions of confinement at Manson Youth Institution and York Correctional Institution and work closely with the Department of Corrections to implement necessary reforms to effectively serve this extremely vulnerable population.

The OCA joined in a collaborative effort with health care advocates, state professionals and service providers 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 regardless of age, diagnosis or disability. 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.

The Child Fatality Review Panel (CFRP), created within the same statutory framework 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. The Panel's findings are utilized to develop prevention strategies that 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.

The Child Advocate and OCA staff meet regularly with legislators to provide information and respond to questions and concerns about the provision of state or state funded services to children. In addition, OCA shared a 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.

All of these accomplishments (and more) were achieved by the efforts of a small number of staff. OCA has highly specialized and expert multidisciplinary staff. The staff includes master's level nurses with expertise in maternal and child health and the care of children with special health care needs; master's level social workers with expertise in child development, child fatality investigation, and treatment of children with disabilities; attorneys experienced with child welfare, child health, and juvenile justice; and experts in facility oversight. Their experience in dealing with major problems-including those that routinely occur in state run or state funded entities-is critical.

The Child Advocate and her staff have played an essential role in Connecticut by overseeing the care and protection of our children. They have provided invaluable oversight and accountability at a time when our children and families need them more than ever. The OCA is the only entity by law that is an independent authority with specialized expertise that can ensure that tax dollars are used effectively and responsibly to protect the rights of Connecticut's children.

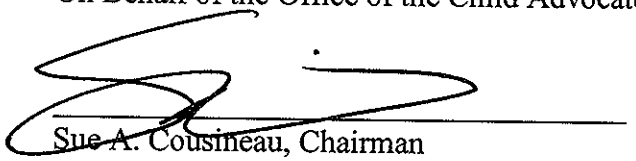
Since 1995, the OCA has been an effective watchdog of over $4 billion of state funds and state funded entities. They have identified ineffective and sometimes harmful state expenditures for facilities, programs and services to Connecticut's children. During the last year, they continued to evaluate and uncover places 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.

The OCA continued during the last year to provide high quality, cost-effective services to the state. They have been vigilant in taking action to hold state government accountable for their state funded services to children.

We, the members of the OCA Advisory Committee, could not be more pleased with the accomplishments of the OCA and the people who staff it, especially Child Advocate Jeanne Milstein. We are proud of their outstanding service, laudable commitment, tenacious, diligent, and dedicated efforts on behalf of our most vulnerable children. Ms. Milstein continued to provide exemplary leadership. We extend our profound thanks and appreciation.

As always, the OCA Advisory Committee looks forward to assisting the Child Advocate and her distinguished staff in improving the quality of life of Connecticut's children.

On Behalf of the Office of the Child Advocate Advisory Committee,



Sue A. Cousineau, Chairman