



Jeanne Milstein
Child Advocate

STATE OF CONNECTICUT

OFFICE OF THE CHILD ADVOCATE
999 ASYLUM AVENUE, HARTFORD, CT 06105

TESTIMONY OF JEANNE MILSTEIN, CHILD ADVOCATE November 13, 2008

Good afternoon, Senator Meyer, Representative McMahon, Senator Harris, Representative Villano, and members of the committees. Thank you for a second opportunity to participate in the joint investigatory hearing related to the functioning of the Department of Children and Families (DCF). I welcome this process and believe it is a critical to better understand the outcomes for Connecticut's children and families whose lives are touched by DCF and to identify new strategies that can improve and sustain their well-being.

At the hearing on October 20th, I shared my belief that DCF is an agency in peril. I described how the work of my office during my eight years as Child Advocate has documented a pattern of deficient leadership, management, and quality assurance. I testified that these deficiencies are echoed in the reports from the Juan F. Court Monitor and the Legislative Program Review and Investigations Committee and other oversight entities. Finally, I expressed my concern that many of the people in leadership positions at DCF during my investigations and the seventeen years under the Juan F. Consent Decree continue to guide the agency in leadership positions today.

To address my concerns, I recommended that Connecticut conduct an analysis of the present leadership at every level of DCF. I asked you to act immediately to assess whether DCF has the right people with the right skills in the right positions to implement -- and not just plan for -- badly needed and immediate fundamental change. I urged you to work with the Governor to appoint a working group similar to that created for the Department of Transportation (DOT): a working group comprised of business leaders and child well-being experts that will assess whether the DCF leadership and workforce has the appropriate mix of talents to address challenges and opportunities; a working group that will be informed by the management and organizational principles used by successful corporations; a working group that will examine the skills and talent demonstrated by proven child welfare reform leaders in places like New Jersey, Tennessee and Allegheny County, Pennsylvania.

Many people have asked me why I would recommend another working group to conduct another study, and why now. Others have argued that DCF needs to be dismantled. I can see no reason to believe that structural change alone can transform ineffective managers into effective leaders that can execute and sustain fundamental change in outcomes for our children. If anything, separately housing the programs and services needed to assess and address the needs of a "whole" child requires an even greater confidence in leadership talent to communicate and collaborate across state agencies. I firmly believe that an analysis of leadership and recommendations for talent enhancement is a necessary first step to getting it

Phone: (860) 566-2106, (800) 994-0939 Fax: (860) 566-2251

oca@ct.gov

An Affirmative Action/Equal Opportunity Employer

right. This is not just another task force or another study. It is a focused look at leadership at all levels to ensure that the agency has the right people with the right skills in the right places to bring about the kind of fundamental change that is needed. This kind of analysis of DCF has never been done and I believe it is the critical next step and the most effective action that we can take to address the agency's long-standing pattern of failure.

Echoing national research on organizational change, the Governor's DOT working group found that the proper sequence of actions was to develop strategy, goals and actions first, get the right leadership in place to execute that strategy, get leaders to align the workforce behind the strategy, put quality and continuous improvement process in place and then decide on the right structure to deliver the strategy. In a few short months, they determined that DOT should undertake a complete a talent assessment of its leadership and workforce. They endorsed Governor Rell's decision to engage in a national search for a new DOT leader, and ultimately chose a Commissioner with significant experience as a manager outside Connecticut, as an opportunity to achieve the fundamental change required. I recommend that DCF undergo a similar time-sensitive analysis to assess existing talent and make recommendations to implement and measure future talent recruitment, matching, development and supervision. Our commitment to ensuring the best possible leadership team for children and families should parallel our commitment to building the state's infrastructure for transportation.

DCF has demonstrated pockets of progress and has developed promising initiatives. The Juan F. Consent Decree in many ways highlights the agency's progress, particularly in the area of safety from abuse and neglect. Last week, Commissioner Hamilton provided me with her draft strategic plan that includes measurable outcomes beyond Juan F. which span across the bureaus of child welfare, mental health, juvenile justice and prevention. The draft strategic plan is a hopeful beginning and I will provide the Commissioner and the Legislature with specific feedback and recommendations related to the draft priority areas and indicators of success in the upcoming weeks. I have also asked my staff to review strategic plans and outcome indicators used by other states and to recommend additional indicators that can measure effective leadership, management, supervision, and preventive interventions.

I want to be optimistic about the Commissioner's endeavor and I am confident in her commitment to improved outcomes. Yet, we know that numerous promising plans from DCF have taken years to reach implementation, only to be scrapped for new plans and others have been poorly implemented or simply placed on a shelf. The children of Connecticut, especially in this extraordinary economy, cannot wait any longer to experience fundamental change in how DCF engages their families and caregivers, plans for their treatment and meets their needs. DCF must have the leadership capacity at all levels to implement a comprehensive agency-wide strategic plan, alongside the monumental and immediate tasks required under the Juan F. stipulation agreement. If we do not know whether DCF has the mix of talent to lead effectively, how can we trust that improved outcomes will be sustained once the Monitors and reviewers are removed?

About one year into the tenure of Commissioner Hamilton and her leadership team, the Juan F. plaintiffs became so concerned about the lack of progress that they triggered the process to place DCF under federal receivership. The plaintiffs cited the continued need for effective management to fix well-known systemic problems. In my view, the stipulation agreement represents a lack of faith that DCF leadership -- from the area offices to central office -- can

independently implement fundamental change. Connecticut's children and families need a DCF with the internal capacity to identify problems and immediately act to address them.

Good leadership has vision. DCF leadership should not require a road map from the federal court to develop and implement a review of the use of congregate care facilities, a case practice model, and targeted reviews of the large number of children lacking appropriate permanency goals and basic medical, dental and mental health screens. Most concerning, even under the guidance of the Juan F. Action Plan and the Juan F. Monitor, DCF remains deficient in the two most fundamental and qualitative outcome measures of meeting the needs of children and families and appropriate treatment planning. Despite the intensive work done over the years under Juan F. and two federal Child and Family Service Reviews (CFSR), the most recent Juan F. Quarterly Report and preliminary 2008 CFSR review tells us that DCF's ability to seek input from providers, engage families and articulate action steps and goals to meet permanency and well-being for children remain significant problem areas.

Good leadership is proactive. During my eight years as Child Advocate, DCF leadership has been highly reactive and change has occurred too often only in response to significant external pressure and monitoring. It took investigations initiated by my office to see action regarding the unsafe conditions for children at Haddam Hills, CJTS, Lake Grove and Stonington Institute. Proactive and ongoing quality assurance should have resulted in DCF intervention and improvement in the care and treatment of children before such investigations became necessary. Good leadership would have developed and implemented a plan for a continuum of community-based services for girls as soon as problems at Long Lane became crystal clear in 1998. Instead, the legislature had to step in to require the agency to do so in 2004. Good leadership would have implemented the recommendations outlined in the 2005 plan for girls and 2006 girls' report before my office issued a report documenting a record number of girls following a pipeline from DCF to the York Correctional Institution. Good leadership would have, through its own quality assurance practices, identified and immediately acted to correct the 18-month upward trend in restraint and seclusion incidents and injuries at Riverview Hospital. Good leadership would have known about and taken action to correct the decade long practice of not entering unsubstantiated allegations of abuse or neglect against DCF employees into DCF's automated database. It should not take the death of a seven-month-old child for this kind of practice to come to light and be corrected.

Good leadership imparts a sense of urgency for necessary reform. After seventeen years of federal monitoring and on the brink of federal receivership, DCF remains in the planning stages of a statewide Differential Response initiative, has only recently released a foster care recruitment and retention plan, and still lacks a statewide continuum of services for girls. After seventeen years under Juan F. and two federal Child and Family Service Reviews, we should expect and demand greater traction than not quite 60% compliance in the most fundamental areas of treatment planning and meeting the needs of children and families. After a decade of independent facility investigations, child fatality reports, and program reviews, we should not see substantially similar and persistent problems of poor care, inadequate quality assurance and oversight, and missed opportunities to intervene, especially not with a nearly one billion-dollar budget.

There are other states that are doing better than Connecticut: in less time, for more children, with proportionately smaller budgets. In those states that demonstrate the most improved and sustained outcomes for children, leadership at every level of the child welfare agency,

Phone: (860) 566-2106, (800) 994-0939 Fax: (860) 566-2251

oca@ct.gov

An Affirmative Action/Equal Opportunity Employer

leadership from the Office of the Governor, and leadership from the courts have acted proactively and with one voice to develop and implement reform.

I also urge us to resist the temptation to "spin" the outcomes submitted by the Juan F. Monitor. The methodology has been negotiated by the parties and approved by the federal court. I believe it is most productive and in the best interests of Connecticut's children to focus our full attention on the work of meeting the outcomes yet to be achieved and sustaining the successes. While recognizing the hard work of its staff, DCF leadership should make clear its expectations that every child must have an attainable permanency goal, that every child who needs medical and mental health services must receive care in a timely fashion and in the least restrictive environment, that the goal for every facility is to cease the practice of restraint and seclusion, or that even one substandard investigation will not be tolerated. This is not about DCF's success; it is about the success of the children and families involved with DCF.

I am not going to share data with you today. You have the data you need in the Juan F. Quarterly Reports. You have the data you need from the Riverview Monitor Quarterly Reports. You have data from the Program Review and Investigations Report. You have the data you need in the most recent reports from my office on Lake Grove, Stonington Institute, and the pathways of girls involved with DCF. You will soon have data on the investigation of the systemic deficiencies uncovered following the death of Michael B.

Instead, I want to complete my testimony today with the stories of four children who were brought to the attention of my office during this past month. These are individual cases, but each case shares a pattern of missed opportunities for prevention and intervention by DCF at an early point in their involvement. Despite the very real risks to the safety, well-being, and permanency to the children, these cases would not necessarily be captured by the Juan F. outcome measures or even by some of the indicators proposed in the Commissioner's draft strategic plan. For example, some of the cases would not count as cases of repeat maltreatment or re-entry because there was no repeat maltreatment within 6 months of case closing, or no re-entry because the child was never placed in out-of-home care.

Let me also be clear that these stories are one part of case review completed by my staff this month. They are not isolated incidents. We have reviewed approximately 50 citizen complaints, 190 significant events and critical incidents (57 of those were arrests of children in DCF care). My office continues to review the cases of every girl incarcerated at York who has past or current contact with DCF. We continue to monitor the cases of young adults with mental health needs under the W.R. Settlement Agreement. During this month, we observed and interviewed children and staff during our site visits to Riverview Hospital and residential treatment programs. These four stories evidence the troubling and substantially similar patterns found in all of our work this month – patterns of DCF failure to lead in the areas of prevention and early intervention, case practice based on a sophisticated understanding of the impact of trauma on children's behaviors and need for services, and child and family engagement. The patterns are substantially similar to what we have found over the years and they are happening now and under today's leadership.

Daniel

Daniel is a fourteen year old who recently overdosed on drugs and alcohol and was brought to the emergency room. He was dirty and not attending school. In the course of treatment, the

Phone: (860) 566-2106, (800) 994-0939 Fax: (860) 566-2251

oca@ct.gov

An Affirmative Action/Equal Opportunity Employer

hospital learned that the Daniel had been hospitalized previously for mental health reasons, diagnosed previously with encopresis, or fecal incontinence, which ended after his father left home, and that Daniel's older brother reported that Daniel's father had sexually abused him. Daniel reported seeing his father daily, but denied being abused or neglected. All four of the mother's children have drug and alcohol problems. As required by law, the hospital reported its concerns to the DCF hotline. DCF did not accept the call noting that "mother's case was closed at the end of July 2008" and that the child was exhibiting delinquency issues at that time. Had my office not been contacted, that would have ended DCF's involvement – no investigation, no action on behalf of the child. Our review found that Daniel's family has been known to DCF for the last 18 years, with 8 prior reports of abuse or neglect, at least 4 of which had been substantiated. In 1992, prior to Daniel's birth, DCF substantiated physical abuse by Daniel's parents of the three children then living in the home. In 1994, one of Daniel's older brothers reported that Daniel's father sexually abused him. It is unclear if this was substantiated. In 1997, Daniel's older brother again reported sexual abuse by Daniel's father. Daniel's father admitted to the allegations and sexual abuse was substantiated. In 2001, Daniel's father, who was still living in the home, attacked an older child, punched Daniel's mother in the head, and threatened to cut everyone's head off. Daniel, then 7 years old, witnessed the entire incident and was reported to have been pleading with his father not to kill him. Eight months later, DCF closed its case. In 2005, the family again came to the attention of DCF when Daniel had an excessive number of absences from middle school. DCF's investigation discovered heavy drinking by Daniel's father, Daniel's diagnosis of encopresis, and that Daniel had missed 26 days of school and was failing with all of his classes. Despite all of this information, DCF closed the case as unsubstantiated. In 2007, educational neglect was reported, after Daniel missed 45 days of school. This time neglect was substantiated after DCF identified a number of concerns including that the mother was suicidal and that the father had threatened mother so often that she no longer took his threats seriously. The father left the home and Daniel's encopresis ended. The family was provided with a number of services including Multi-dimensional Family Therapy. Daniel was minimally cooperative with this service and refused substance abuse assessments. DCF appeared to advocate for residential placement in the delinquency court, but the delinquency charges were dropped. Rather than seeking out-of-home placement through the neglect case, DCF closed the case in July 2008, indicating that mother had been cooperative with services and Daniel was refusing services. Two days after the case closing, DCF received a report that Daniel was found passed out in the town center. DCF did not accept the report for investigation. It was only three months after the case closing that this 14 year old boy was treated in the emergency room for overdosing and DCF again refused to accept the hotline report. Concerned for the child's safety, my office intervened and the report was accepted. Despite everything, it appears that DCF is planning to again close this case and my office is advocating aggressively for DCF to provide this child with services necessary to address a long life of neglect, exposure to violence, and the resulting self-destructive behaviors in which the child now engages.

Josh

Josh turns sixteen today. He entered DCF before age five after significant abuse and neglect. At age seven, he was adopted by a well-intentioned, loving couple that spent the next several years asking for DCF's assistance in dealing with Josh's increasingly challenging and escalating dangerous behaviors at home and in school. The case history documents a series of unsuccessful home and community based services. None of these services focused specifically on Josh's trauma history and attachment issues. The family is now caving under the stress of

Phone: (860) 566-2106, (800) 994-0939 Fax: (860) 566-2251

oca@ct.gov

An Affirmative Action/Equal Opportunity Employer

caring for Josh. The DCF case record documents the family stress observed during recent home visits and the worker's conversation with the family regarding case closure because there is **"nothing more DCF can do."** If the family asks DCF to remove Josh from their home, DCF plans to consider placement at a large residential program that serves delinquent youth without the trauma-based mental health services Josh needs. Josh struggles in school and reports having no friends. Developmentally much younger than his 16 years, he has limited independent living skills.

Ashley

After experiencing eight different placements, fifteen-year-old Ashley is now a sophomore in the public school in the town where her residential treatment program is located. DCF has been Ashley's statutory parent since age eleven. She suffered significant neglect, exposure to domestic violence and suspected ritualistic abuse. After an initial series of foster homes and safe home stays, Ashley was placed in a therapeutic foster home. During this time, Ashley's mother made covert contact with her and Ashley's desire to reconnect with her mother resulted in conflicts with her foster home and DCF. After three years in the foster home, the placement was disrupted and Ashley became threatening to herself and others resulting in a lengthy hospitalization. Ashley was then admitted to a state operated residential treatment program and DCF obtained a restraining order prohibiting any communication with her mother. For the past eight months, Ashley has been doing well. She attends school, holds her own academically, has friends and is effectively engaged in treatment. Her clinicians believe she is ready for a lower level of care. DCF has told Ashley that she must go to a different treatment setting "for a few months or so." As a result, Ashley will need to leave her current school, friends, and sports teams. This will be her third change in schools in two years and may actually require an additional move in schools at the end of this year. Ashley wants to stay at her school, get a permanent family, and in her own words, be a "normal kid." Her permanency goal, stated in June 2008 Administrative Case Review of her treatment plan is Another Planned Permanent Living Arrangement (APPLA), meaning that DCF has determined that she will never have a permanent family.

Vivian

Vivian came to my office seeking due process assistance. She recently received an unfavorable hearing decision and was being discharged from DCF. In June, just after her 21st birthday, DCF terminated Vivian from DCF because they stated she had "failed to comply with the education policy." As a result, Vivian lost her \$449 month stipend to support all of her basic living expenses and faces considerable risk for homelessness. Vivian's involvement with DCF dates back to her second year of life. By the time she reached age nine, she and all her siblings had been removed from home and placed with a relative foster aunt. Four years later, at age 13, the DCF record described Vivian as "an angry child" and provides little reference to the losses and traumas she had experienced since early childhood. By age 15, Vivian had been in numerous foster homes and had landed at a youth shelter. She was regularly attending the Sports and Science Academy in Hartford, was involved in after school activities including cheerleading and she had a mentor. Unfortunately, the stress of living in the shelter led to altercations with other girls. After one incident, Vivian was arrested, placed on probation, and subsequently moved to placement in a group home and a different school. After this point, Vivian never again returned to public school. One year later, at age 16, she made a significant suicide attempt. Two weeks after her attempt, she fought with another girl in her group home

and was sent to York because the fight violated her conditions of probation. Despite obvious significant mental health needs, the DCF narrative instructs the caseworker to continue only “monthly” contact with Vivian. Once released from prison, Vivian experienced a few more residential placements and at age 18 entered the independent living program. Despite making some tremendous strides, balancing the expectations of full-time school, part-time work, and maintaining a household was challenging. Vivian told us that she found the college courses especially challenging since much of her high school educational program was disrupted by placement changes and her courses in the “treatment” programs did not prepare her for the “real world” courses in college. By failing to maintain her student status or full-time vocational program, she lost her ability to continue DCF services. At age 21, with significant mental health needs and few supports, Vivian is on her own.

I urge you to consider what type of leadership and supervision might have made a difference in the lives of these children. Then ask how we can ensure that DCF has the skills and talent to provide this leadership.