

Center for Children's Advocacy

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TESTIMONY OF THE CENTER FOR CHILDREN'S ADVOCACY FOR THE HUMAN SERVICES COMMITTEE & SELECT COMMITTEE ON CHILDREN INVESTIGATIVE FORUM REGARDING THE CONNECTICUT DEPARTMENT OF CHILDREN & FAMILIES

December 5, 2008

This testimony is submitted on behalf of the Center for Children's Advocacy, a non-profit organization based at the University of Connecticut School of Law. The Center provides holistic legal services for poor children in Connecticut's communities through individual representation and systemic advocacy. Through our Child Abuse Project, the Center represents individual children in child abuse and neglect proceedings.

Juan F. was ten years old when we originally brought the lawsuit in 1989 which eventually led to the DCF Consent Decree. I remember well the DCF caseloads of 80, the DCF training office in the basement of the Sigourney St. building, and the wholesale lack of adequate services for kids. Emily was 13, locked in her cell at Bridgeport Detention, urinating on the floor because they wouldn't let her out when I brought the Emily J. class action case that eventually resulted in consent judgments involving the conditions of detention. When we went back to court in that case a few years ago, I will never forget the testimony about the child with mental health problems crawled up in a ball under the detention bed waiting to go to Riverview until Judge Chatigny said "no more". . . Today, Monique, Chastity, Derek, Eddie and Jose are the names and faces of some of the kids that I and the 8 other attorneys at my office represent on a daily basis. While there have been many, many significant improvements in the agency, sadly, many of them cope with the same challenges as Juan and Emily: Eddie has had over 12 placements, Jon desperately needs a therapeutic foster home, Tommie sits at a psychiatric hospital waiting to get to Riverview.

And so I offer this testimony through this lens of looking at this agency systemically from the top and individually, child by child, from the bottom. For over 20 years I have watched this agency weather 7 different Commissioners, centralization, decentralization, and back to centralization again, two Program Review and Investigations Reports, three Court Monitors, a Consent Judgment, 13 Manuals, two sets of outcome measures, numerous court orders, child fatality review reports and repeated legislative hearings.

I lay this history out, not for the purpose of painting a picture of an agency with a sorry history, but to put my remarks in context, and to emphasize that when you ask what can be done with this behemoth agency, there is no quick fix, and there is no one solution.

I have given a lot of thought and reflection as to what I might to suggest to you as you struggle to turn these public hearings into meaningful action. I have tried to keep in the forefront two factors: first, that we must distinguish between administrative recommendations that frankly, the agency can impose without any legislative action, from those which could and should be

legislatively mandated, and secondly, because of the economic crisis, the focus must be on low cost or no cost suggestions.

I offer you, respectfully, suggestions in six different areas, all of which have a similar theme running through them: increasing accountability and improving outcomes for the kids.

I. ELEVATE THE IMPORTANCE OF EDUCATION -MANDATE EDUCATIONAL REVIEWS AND OUTCOMES BY DCF AND JUDICIAL

Much of the present focus of the agency centers around how many visits did the worker do, did she complete the treatment plans, and did she get the child to the doctor. But I would submit that one of the most important outcomes is wholly overlooked by both DCF and the Judicial system, and that is the educational outcomes for youth. Education, for most of these youth, is the ticket out. It is the way to break not only the cycle of poverty, but the cycle of abuse. Do we know how many of DCF youth are part of that 63% who are not graduating from the Hartford public schools? Do we know how many of the DCF youth are attending the three Bridgeport high schools, all of which are on probation? Is Ct. prepared to implement the new Federal Fostering Success legislation, effective as of October 1 this year, which requires state child welfare agencies ensure educational stability, attendance and enrollment for all youth in the agencies' custody? Sadly, the answer to these questions is no.

We offer the following legislative solution:

A. Pass a comprehensive educational stability/reform bill for youth in foster care.

An educational reform bill should build on the educational stability proposals raised in the Children's Committee in 2007 and 2008¹ to provide the following:

- a. allow youth to stay in their home schools
- b. provide educational liaisons in all the schools
- c. ensure immediate enrollment and transfer of records for all youth in foster care who must change schools
- d. provide for more educational advocates; and
- e. add educational consultants to the area office consulting staff
- f. require monitoring of educational outcomes

Educational success is critical to a child's well-being and permanency plan. Educational stability, allowing a child in foster care to remain in their home school, is as much about relationships as it is about improving test scores and graduation rates. Ties to teachers, coaches, guidance counselors and peers may be the ties that bind for the abused and neglected children in DCF care. The emotional, academic and ultimately economic cost of dooming so many youth to educational failure is a burden our state cannot withstand any longer.

Again, the legislature can look to at least a dozen other states that have passed educational stability and even comprehensive educational reform bills for youth in child welfare custody. California and Oregon passed legislation in 2004 and 2005 respectively that are serving as national models for how

¹HB 7172 (2007); SB 159 (2008)

to bring school districts, child welfare agencies and courts together to ensure educational stability and improved academic outcomes for youth in foster care.

II. IMPROVE QUALITY ASSURANCE BY DCF

Presently there are two important internal DCF quality assurance mechanisms and one external imposed by the Court. All three have the potential to substantially improve quality assurance within the Department with closer monitoring and supervision by the legislature.

A. Mandate the reporting of the CCOR results

The CCORs (Ct. Comprehensive Objective Reviews) consist of case reviews of 15-20 cases per office, interviews with staff and families conducted by DCF Central Office Quality Assurance Bureau. In order to have more consistent and closer monitoring of the results of these, I suggest the legislature mandate reporting of the results, recommendations and implementation of the recommendations by DCF.

B. Mandate the reporting of ACR aggregate data; change its process.

The legislature should require aggregate data from the ACR reviews which are held twice yearly on each case by central office DCF quality assurance personnel. The reporting should aggregate information relating to the strengths and deficiencies, and should include responses as to how the department is going to address such deficiencies by office.

Change the Administrative Case Review process by holding Treatment Planning Conferences and court Case status conferences at the same time at the court (See recommendation no. 26 of the most recent Program Review and Investigations Report)

C. Mandate regular service needs reviews and case conferences for "stuck" kids

Presently, the Court Monitor is monitoring and requiring special case conferences for 8 cohorts of children, including those who are overstaying in SAFE or STAR Homes, or psychiatric hospitals, and those who have permanency goals of adoption or APPLA. (Another Planned Permanent Living Arrangement). But this is a one-time review and it is being done by judicial court order. These reviews need to become embedded into the fabric of DCF's quality assurance system and be done on a regular basis.

There are also several other cohorts of youth that we term in our office the "unseen population," -- the out of state youth and the runaway and homeless youth. The legislature should include mandated reviews of these two additional cohorts. There are presently 300 kids out of state. This number has fluctuated, but it has never been reduced in any substantial way. There are presently 75-100 runaway youth, but DCF is not sure this is an accurate number.

- D. Determine measurable outcomes (e.g. successful school completion, child well-being) incorporate them into the contracts of the private providers and incentivize private providers who achieve such outcomes.**

See Recommendation no. 3 in the PRI Report. The private providers, whether they are residential, therapeutic foster care, or behavioral health should be held more accountable to particular outcome measures. Foster care recruitment and retention is a huge problem. Incentives need to be given if there is to be any substantial increase.

- E. Provide a system which fosters the ability for new and out of state providers to bid for contracts.**

The contracting rules have been instituted such that private providers are calling our office and other advocates to get information. There needs to be a system that can still adhere to ethical standards and yet allow for some flexibility in sharing of information.

III. INCREASE JUDICIAL OVERSIGHT

The most recent report by the Legislative Program Review and Investigations Committee specifically noted the ability of the courts to hold DCF accountable for meeting its statutory obligations to children and families. It is clear that until the agency's internal systems of checks and balances are optimally functioning, the court (both federal and state) continues to provide a vital safety net to protect children's most basic right to safety, permanency and well-being.

Currently, despite state law that provides the juvenile court jurisdiction over all child protection cases and grants courts broad authority to direct adults and agencies to take steps to protect children's welfare, a large number of significant decisions regarding a child's life are left to the discretion of DCF without court oversight or legal representation for the child.

- A. Require more frequent periodic reviews in court**

Once a child is committed to DCF custody (early in the life of a child protection case), there is no scheduled judicial review until the permanency hearing—a hearing which is not required until the child has been in care for 12 months.² Exacerbating the problems caused by this lengthy oversight vacuum, is that even on the agency side, once the initial treatment plan is completed (typically around the same time as the child is committed to DCF care), another administrative treatment plan conference is not convened for six months.³ These first six to twelve months after a child comes into DCF care are critical in ensuring that the family's needs are accurately assessed and treated, that children's traumas are addressed in a meaningful and timely way and that effective permanency services are identified and implemented as soon as possible.

By permitting courts to conduct judicial reviews (or at a minimum, to require submission of detailed agency reports to the court and the parties) every three months, the court will be able to assess the services and events that are substantially affecting a child's permanency and wellbeing. These

² Conn. Gen. Stat. § 46b-129

³ Conn. Gen. Stat. § 17a-15

reviews would help the parties to take a more active approach to case planning, potentially reduce the time children wait for services and accelerate permanency outcomes.

Again, other states and counties around the country have statutory examples for Connecticut to draw on with regard to review hearings.⁴ Allegheny County, Pennsylvania—a nationally recognized leader in child welfare agency reform--has significantly improved children's well-being and permanency through several methods, including minimum 3-month court hearings in the community.⁵ Additionally, Oregon employs numerous judicial review and agency reporting requirements to ensure that children in care are receiving appropriate treatment, placement, educational and reunification services.⁶

B. Pass an "open courts" pilot statute modeled after New York "open courts" law.

To the public and even to the legislature, the children and families in the child protection system are usually nameless and faceless; their stories are never heard. Our effort to protect children and their families from stigma and to ensure their privacy unfortunately silences children who are the victims of both abuse and a service system that functions inadequately. Open courts can also hold the system, and all of the people in it, accountable—which is, of course, what these hearings are really all about.

Currently, media coverage is skewed, with the public learning only of extreme cases. What the public never sees are the lengthy delays for trial dates and the physical conditions of the courthouses. They don't hear about the lasting effects of the trauma children experience or the lengthy waiting lists for services. They don't hear about youth living in temporary or inappropriate placements for months on end, or who move from one placement to another because there aren't enough foster homes.

Silence is not helping these families. Previous legislation proposed by CCA and modeled after New York rule would open juvenile court proceedings, while maintaining the Court's ability to exclude members of the public and providing the court authority to prohibit the dissemination of any personally identifiable information disclosed during the proceedings.

Connecticut would not be the first state to open its child protection courts. **Indeed, such proceedings are partially or completely open in over 15 states** (with pilots in several others). Those states are following the lead of Minnesota, which also contracted with the National Center for State Courts (NCSC) to evaluate the project over a three-year period. The NCSC concluded that open courts had benefits including enhanced professional accountability, increased media and public attention to child protection issues, increased participation by the extended family, foster parents and service

⁴ At least one study has demonstrated that reducing the time between court hearings from six months to three months significantly improved outcomes for children by doubling the odds of a child being freed for adoption without reducing the likelihood of family reunification. *See* Testimony of Mark Courtney, Ph.D., in Support of Raised Bill No. 338 before the Select Committee on Children, Dated February 26, 2008.

⁵ Allegheny County, Department of Human Services, December 5, 2007 Connecticut Permanency Briefing, pp. 11-14.

⁶ Or. Stat. §§ 419B.349; 419B.440; 419B.443 (attached)

providers in child protection proceedings.⁷ The report found that open hearings and records did not result in documented direct or indirect harm to any parties involved in child protection proceedings.

IV. INVEST IN THE FRONT END....IMPLEMENT SUCCESSFUL INITIATIVES THAT KEEP FAMILIES TOGETHER WITHOUT EXTENSIVE AND PROLONGED DCF INVOLVEMENT

We pay lip service to initiatives that keep families together. We pay lip service to being concerned about the overrepresentation of children of color in the child welfare system. Yet there are concrete proposals to address this that could be implemented through a reallocation of dollars.

A. Implement Differential Response System "DRS" statewide by a date certain.

DCF has indicated 2 of 3 investigations are initiated due to an allegation of neglect (not abuse) in families that struggle with domestic violence, substance abuse, mental health, low cognition, and/or poverty. A DRS system allows families to access services without needing formal DCF child welfare involvement. How many fits and starts and roll-outs has this program had in the last 8 years?!

B. Enhance family preservation services, particularly in the area of supportive housing.

Amend the state's housing plan to give preference to DCF families who can be reunified but for a lack of housing by:

- (1) Designating such families as a "special class" with the "Allocation Priority Class" in Connecticut's Qualified Allocation Plan under the CHFA.
- (2) Incentivize (e.g. award additional points) applications that develop housing units which give priority to families referred by DCF
- (3) Requiring owners of supportive housing to give priority to families referred by DCF

C. Implement kinship care initiatives

Equalize the kinship care/guardianship subsidies so they are equal to the foster care subsidies. Enhanced supports must also be provided for relative foster care families on a 24/7 basis. Presently, such week-end supports consist of a telephone no. to the hotline, rather than full case management support similar to those families providing therapeutic foster care.

D. Implement a pilot system where the money follows the child, like in the Wraparound Milwaukee model.

DCF's mandate to provide mental health services as part of its integrated mission still has some major flaws. Several years ago there was a lot of hoopla in regard to Kidcare, systems of care, and

⁷ Key Findings from the Evaluation of Open Hearing and Court Records in Juvenile Protection Matters. Volume I (Aug. 2001) (on file with the Minn. Sup. Ct. State Ct. Admin. Office).

community collaboratives. But as the findings summarized in Ct.'s latest 2008 State Plan Community Mental Health Services Block Grant application showed, there is still a need for gender specific services, trauma-informed care, culturally and linguistically appropriate services. Solutions to these issues go beyond any testimony I can give today, but there are several specific legislative solutions.

Right now, wraparound is only available for either the populations that are already in out of home placements, or at risk of residential placements.. I have represented a child, Monique, for the past six years. She's fifteen and been in the child welfare system for 9 years...She's had 8 placements, 3 mentors, 4 therapists. and 5 schools and 7 DCF workers.. Imagine a system where her mentor follows her wherever she goes, her therapist remains the same, and she gets to stay in the same school and her DCF worker knows who she is. I long for the day that I don't go to Manson Youth facility or detention to visit a child who, as a DCF ward of the state, has grown up in foster care and who tells me he has not one person to put on his visiting list.

E. Privatize voluntary services.

This would eliminate the problem where DCF voluntary services workers have a caseload of 49:1 and can't really do effective case management.

V. MANDATE MINIMUM QUALIFICATIONS FOR DCF WORKERS , IMPROVE THE TRAINING AND ELIMINATE LEVELS OF BUREAUCRACY

The first deposition we took in Juan F. in 1989 was of a case worker who had been an airplane mechanic some 5 weeks before and had assumed a caseload of over 45 cases. This lack of workforce qualifications today is not quite as dramatic, but if you polled the families, advocates, and providers regarding one of the biggest frustrations they encounter on a daily basis with this agency, it is the inconsistency—region to region, office to office, worker to worker.

a. Mandate that supervisors have a masters degree in social work or a related field; require workers who are in specialized units to have the requisite educational degrees and training to perform the tasks.

The only requirement to be a DCF social worker is to have a Bachelors Degree in Social Work or a related field. Many DCF workers and more importantly many DCF supervisors do not have a Masters Degree in Social Work or any extensive specialized training that gives them expertise to do more than case management. But the work of social workers has now become much more complex and sophisticated. Those workers who are in sexual abuse units need to specialize and have the requisite degrees and training. Similarly, those workers and managers who are assigned to the mental health units need a different set of credentials. And those workers who are making decisions to remove a child out of a home or sever a parent child relationship forever; don't we need them to have the highest degree of expertise? We expect different training and qualifications of our radiologists than we do of our surgeons. This work is no less demanding.

b. Integrate the training offered by the two state schools of social work at UConn and Southern with that offered by the state agency.

Again, this is a proposal that will substantially improve the level of training, save resources, and has been discussed for years.

c. Eliminate the levels of bureaucracy.

I used to support the levels of bureaucracy until I started doing the individual cases. How frustrating it is to hear the voice mailboxes of the case worker, supervisor, program supervisor and program director. Why do we need so many broken links in our "chains" of command.

VI. INTEGRATE JUVENILE JUSTICE AND EDUCATION BUREAUS INTO OTHER PARTS OF THE AGENCY; REMOVE PREVENTION AND LICENSING;

There is much talk about splitting the agency. I do not support such action. To fracture juvenile justice from mental health from child welfare breaks the same child into three different pieces, but does nothing to address the underlying problems. As long as 50% of the youth in detention have been DCF involved and 60% are found to have behavioral health problems, we are talking about the same child.

Alternatively, I offer three structural suggestions:

A. Integrate Juvenile Justice and Education Bureaus into other parts of the agency

The Juvenile Justice Bureau is only responsible for CJTS, three girls' facilities and parole. But many of DCF adolescents on the child welfare side are involved in the juvenile justice system. The social workers who handle those abused and neglected kids in the child welfare system have little to no experience, training or knowledge about the juvenile justice system. The Juvenile Justice Bureau of DCF should be involved with those kids who are arrested, in detention, or on probation. If we want an integrated agency, this part cannot be exempt.

Similarly, the Education Bureau is only responsible for USD II, the education system within the state facilities such as Riverview, High Meadows, Ct. Children's Place and approximately five educational consultants for 5,000 children in foster care. But education cross cuts all the children in DCF care. As I mentioned before, attention to educational outcomes must be elevated.

The two mandates of the agency which would be better served elsewhere are prevention and licensing.

B. Move prevention out of DCF.

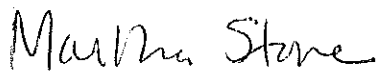
Whether prevention is given to the Children's Trust Fund, the Commission on Children, or some other entity, it needs its own focus. How many of us have sat on Task Force after Task Force only to have the recommendations sit on the shelves. Youth Futures, Child Poverty Council, FWSN Advisory Board... the reports and the blueprints for prevention are there. They need the legislature to impose timetables, and mandate implementation plans. These reports do need closer monitoring by the legislature.

C. Move licensing out of DCF

Similarly, to avoid the perception and the reality that the fox guards the chicken coop, give licensing to the Department of Public Health.

We welcome the opportunity to work with you or any of your staff to show you statutory models around the country that work better and could be implemented with little or no cost in Connecticut.

Respectfully Submitted,



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