



# STATE OF CONNECTICUT

## OFFICE OF THE CHILD ADVOCATE

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Testimony of Jeanne Milstein, Child Advocate

In Support of HB 5416, An Act Concerning the Transition of Care and Treatment of Children and Youth From the Department of Children and Families to the Department of Mental Health and Addiction Services

February 24, 2009

Thank you for the opportunity to testify in support of Raised Bill No. HB 5416, An Act Concerning the Transition of Care and Treatment of Children and Youth From the Department of Children and Families to the Department of Mental Health and Addiction Services.

I believe the bill is necessary because despite the existence of an interagency agreement between the Department of Children and Families (DCF) and the Department of Mental Health and Addiction Services (DMHAS) establishing protocols for transitioning youth from the care of DCF to DMHAS, youth with serious mental health needs continue to fall through the cracks.

Let me first address sections 1 and 2 of Raised Bill No. 5416. These 2 sections would:

1. Set specific timelines by which youth would be referred from DCF to DMHAS, eligibility for DMHAS would be determined, and transition plans would be developed;
2. require a transition planning meeting to discuss the services needed to develop the youth's skills to allow the youth to transition to adulthood and engage in the adult mental health system by the date of the proposed transition and make recommendations for modifications to the youth's treatment plan;
3. require DCF to provide services for the youth recommended in the transition plan; and
4. require both agencies to monitor the implementation of transition plans to ensure that the identified goals are being achieved and assist in the resolution of any problems that occur.

I would request one change to Section 1(a)(1) to require referral two years prior to the expected date of transition rather than one year. This would require referral at the age of 16 in most cases and is the timeframe required by the existing memorandum of agreement between the agencies.

The existing memorandum of agreement between DCF and DMHAS provides a framework for the bureaucratic transfer of a child's case from one agency to the other. It includes, however, few timeframes and is often not followed. For example, while the MOA states that youth who may require transition from DCF to DMHAS should be referred at the age of 16, DMHAS continues to receive referrals for youth who are 17, 18, and sometimes 19 years old. Once youth are referred, it can take as much as 8 months before DMHAS determines whether the youth may receive services and several more

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months before a transition meeting occurs. Even when youth are referred and transition meetings occur, transition plans are often not implemented or poorly implemented. Youth who have been in residential settings for years deteriorate in those settings as they contemplate their uncertain futures. Often, when youth transition into DMHAS care, they do not have the skills to be successful in the types of placements currently offered through DMHAS. Sadly, some of these youth become homeless and/or incarcerated. Tragically, last year, one such youth was murdered by several other youth in a DMHAS program for young adults.

These youth have frequently grown up in DCF care. All have significant mental health needs. Many have lived in residential treatment settings for years. Because of their mental health needs, often resulting from traumatic experiences at very young ages, they have not had an opportunity to experience typical adolescence or to learn basic living skills. They need to be taught how to set an alarm clock, earn money, buy groceries, cook food, pay bills, and use public transit. Most have no permanent adult connection, no relatives, and few friends. They need to be connected with adults upon whom they can rely for support – emotional, moral, and financial. To transition successfully to adulthood, each youth needs a carefully designed transition plan that outlines how and when they will receive skills training, services, and supports tailored to their individual needs. These plans must be made as early as possible; the youth must be engaged; and youth need to know where they are going to live and whom they can depend on when they leave DCF care.

Over the last few years, my office has worked extensively with a growing number of youth in the process of transition. Last year, one young lady had absolutely no idea where she would be living until only a few weeks before her 18<sup>th</sup> birthday. Even when a placement was identified, no one could tell her when she might be able to go there because DCF and the provider had to negotiate a rate. The uncertainty caused her to deteriorate. After 2 ½ years in Riverview Hospital, and after having made great progress over the prior year, the youth resorted to self-injurious behaviors, which she had not engaged in for over 8 months resulting in hospitalization. Only then did DCF finally reach an agreement with the provider and discharge her to an adult setting. This young lady is one of many. This is simply unacceptable and it cannot continue.

Sections 1 and 2 would put in place clear requirements that would ensure timely transition planning. More importantly, sections 1 and 2 would ensure that meaningful transition planning would take place so that youth develop the skills they need to access DMHAS services before they age out of DCF. This is critical because it is this skill development that can make the difference between homelessness and housing, between employment and prison, and sometimes between life and death.

Section 3 would require both agencies to provide an annual report to the Select Committee on Children, Human Services Committee, Appropriations Committee, and the Community Mental Health Strategy Board. The report would describe the process for transition and specific data related to outcomes, barriers, and budget needs. For example, the report would provide data regarding:

- a. The number of youth 14 years of age or older in DCF care who may need services from DMHAS when they leave DCF care, their diagnostic and behavioral issues, their permanency plans and service needs, and the anticipated budget implications;
- b. Average timeframes for referral and transition from DCF to DMHAS;
- c. The number of youth aged 16 and over who may need services from DMHAS who are in residential treatment or psychiatric hospitals and on discharge delay status;
- d. The number of youth aged 16 and over who may need services from DMHAS and who have been adjudicated delinquent, have been arrested as adults, or incarcerated;
- e. The number of youth referred from DCF to DMHAS and denied services and the reasons for denial;
- f. Outcomes for those youth accepted by DMHAS; and
- g. Barriers to timely referral, transition, and receipt of services.

Requiring reporting of such data would not only hold the agencies accountable, it would also require both agencies to do the kind of long term planning that will allow our state to better meet the needs of youth with mental health needs in the coming years.

Section 4 would require both agencies to utilize existing funds to develop an interagency pilot program to provide age-appropriate housing and services to youth and young adults that allows them to transition between the departments without the currently mandated changes to their housing or services. This would provide the youth with stability and continuity. Having a living setting where youth can live prior to aging out of DCF care and remain when they age out, make friends, keep the same mental health provider, and develop basic life skills would have a tremendous impact. Youth could be identified early. Staff at DMHAS would develop relationships with youth prior to their transition to DMHAS. Youth would have an opportunity to transition, in the full sense of the word, into adulthood.

Connecticut cannot continue to allow youth who have been removed from their biological homes to languish in DCF care only to turn 18 with no prospect for a future, no permanent connections, and no hope.

I urge you to support Raised Bill No. 5416, An Act Concerning the Transition of Care and Treatment of Children and Youth From the Department of Children and Families to the Department of Mental Health and Addiction Services.

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I also would like to share my concerns regarding **Raised Bill No. 955 An Act Concerning Authorization of a Treatment Plan for a Child's Outpatient Psychiatric and Counseling Services**. The bill eliminates the requirement, under Department of Children and Families regulations, to obtain authorization or signature for a treatment plan for psychiatric or counseling services from a child when the child's parent or legal

guardian has authorized the treatment on the child's behalf. **I do not support Raised Bill No. 955.**

I believe that this bill silences the voice of the child in the treatment planning process and erroneously presumes that every parent or legal guardian has the capacity to act in the best interest of their child with mental health needs. Best practice requires clinicians and child welfare staff to engage both children and their families and encourages the active participation of children, where clinically appropriate, in their treatment planning and services.

Children should participate in the treatment planning process and sign a plan for needed psychiatric or counseling services as an important part of effective treatment. It can help children understand the critical role they have in implementing a plan successfully. Engaging children in their own treatment planning and services also is a critical step toward helping children understand and address mental health needs so they may advocate for themselves when they transition to young adulthood.

Raised Bill No. 955 seeks to avoid an atmosphere of discord between the guardian and child that may inhibit needed treatment. Yet, it is the responsibility of the treating clinical professionals and the Department of Children and Families staff to work with the child and parent or guardian toward resolving any conflicts as part of the treatment process. I believe that this approach reflects best practice and better outcomes for children. **I urge you to not support Raised Bill No. 955.**