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STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES
PUBLIC HEARING TESTIMONY OF
BRIAN MATTIELLO

SELECT COMMITTEE ON CHILDREN
FEBRUARY 19, 2009

**S.B. No. 877 AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE
PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE
DEPARTMENT OF CHILDREN AND FAMILIES**

The Department of Children and Families is in general agreement with S.B. No. 877 AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE DEPARTMENT OF CHILDREN AND FAMILIES, which incorporates the recommendations from last year's report prepared by the Legislative Program Review and Investigations Committee concerning DCF Monitoring and Evaluation. In fact, we have already initiated implementation of the vast majority of the recommendation contained in report. Attached is a summary status report of department progress on implementing the various recommendations (see ATTACHMENT A). A more complete status report was made available to the Program Review and Investigations Committee last week in response to several questions that they posed.

Section 1 - Subsection (b) deletes the existing biennial 5-year master plan requirement (*PRI Recommendation # 21*) and replaces it in subsection (c) with a new comprehensive strategic planning process (*PRI Recommendation # 1*). The Department **supports this modification** and is in the process of finalizing an integrated agency-wide strategic plan in conjunction with the National Resource Center for Organizational Improvement.

Section 2 - This section would require that the four DCF-operated facilities have DCF facility advisory boards and mandates that all boards respond to their facility's annual report and require that they add recommendations deemed necessary (*PRI Recommendation # 30*). The Department **supports the intent of this recommendation** and is committed to ensuring that each of our facilities has an active advisory board, but we do not believe it is necessary to establish this as an independent statutory mandate. We are already explicitly permitted to establish such panels under statute and are committed to ensuring we have parity across all our facilities in the use of advisory boards.

Section 3 - This section requires that all DCF facilities produce an annual report for their respective advisory groups. The report shall contain at a minimum the following: (1) aggregate profiles of the residents; (2) description and update on major initiatives; (3) key outcome indicators; (4) costs associated with operating the facility; and (5) description of education programs and outcomes (*PRI Recommendation # 22*). The Department **supports this reporting requirement**. We would like to allow each facility to develop its own format in conjunction with their advisory groups. We believe that this could provide an instructive basis for systems improvements.

Section 4 - Repeals the statutory requirement for the CJTS Public Safety Committee (C.G.S. § 17a-27f) (*PRI Recommendation # 36*). The Department **supports this recommendation**.

Section 5 - This section adds a requirement that any state agency cited in a Child Fatality Review Panel report respond to recommendations from the internal special reviews of child fatalities and other critical incidents (*PRI Recommendation # 8*).

The Department **generally supports this recommendation** and currently has a strategy and protocol by which information and recommendations from internal reviews and child fatality reviews are collected and tracked. This data is aggregated on a regular basis and distributed to program and contract owners at senior management meetings. At that time, a decision is made to either: (1) implement the recommendation, (2) acknowledge that a recommendation is appropriate but determined at the time not right for implementation, or (3) implement an alternate course of action that addresses the findings. To build on this, our Bureau of Continuous Quality Improvement is preparing an annual report which provides a more formal compendium for tracking progress on recommendations over time. With regard to the specific language in this section, we would propose that the forty-five day time frame be extended to sixty days and that the response be submitted to the Governor as well as the General Assembly.

Section 6 - Subsections (a) and (b) modify the role of the State Advisory Council (SAC) to include monitoring the agency's progress in achieving its goals, as well as offering assistance and an outside perspective, and make other recommendations regarding the operation of the SAC (*PRI Recommendation # 31*).

The Department has been working to enhance the role of the SAC, and **this recommendation is generally consistent with the direction the Department has been moving**. (see **ATTACHMENT B**) However, elevating the SAC to having a Department oversight function raises potential conflict of interest issues as well as introduces multiple and duplicative oversight authorities. As for administrative supports, the Department can and does provide administrative support to the SAC and its members, including, but not limited to, the posting of agenda and minutes.

Subsection (c) incorporates the Connecticut Behavioral Health Advisory Council into the State Advisory Council, as opposed to remaining a separate entity (*PRI Recommendation # 34*). While the Department supported this recommendation last year, **we believe that we should retain the current structure and role of CBHAC**. CBHAC serves an important advisory role and has formal duties each year in the development of the children's portion of the Mental Health Block Grant.

Section 7 - Repeals the separate statutory provision regarding the Connecticut Behavioral Health Advisory Council (CBHAC) contained in subdivision (3) of § 17a-1. Subsection (c) of section 6 incorporates this group into the DCF State Advisory Council as opposed to keeping this as a separate advisory entity (*PRI Recommendation # 34*). As with our comment regarding the role of CBHAC in section 6, **we do not support this recommendation**.

Sections 8, 9, 10 and 11 - Eliminates the following statutory reports recommended by the committee in *PRI Recommendation # 21*: KidCare Community Collaborative annual self-evaluations (C.G.S. § 17a-22b); Licensed child care facilities annual reports (C.G.S. § 17a-145); DCF annual evaluation reports on Unified District #2 to the education commissioner (C.G.S. § 17a-37(d)); and DCF/DSS 5-year independent longitudinal evaluation of KidCare (C.G.S. § 17a-22c(c)).

The Department **supports the elimination of these obsolete or redundant reporting requirements.**

Section 12 - This section establishes a pilot program to assess the feasibility of conducting one treatment plan conference to be held at the court that combines the Specific Steps identified during the initial case status conference at court and the corresponding DCF treatment plan conference currently held in the area office (*PRI Recommendation # 26*).

While the intent behind this recommendation is well meaning and of interest to the Department, **DCF is opposed to this recommendation.** We believe that its implementation would be problematic and may not be conducive to promoting family engagement and a family-focused treatment planning process. The adversarial nature of many court proceedings would make elements of this recommendation difficult to achieve and not necessarily in the best interests of the children and families we serve. The Department will continue discussions with the Judicial Branch to improve the treatment planning process and to ensure that appropriate components of the Specific Steps are incorporated into the treatment plans and discussed as part of the Administrative Case Review process.

Sections 13 and 14 - These sections make technical statutory changes related to the Department of Mental Health and Addiction Services and the Department of Developmental Services, respectively.

Section 15 - Repeals the following statutory reports recommended by the committee in *PRI Recommendation # 21*: DCF annual report on CJTS (C.G.S. § 17a-6b and C.G.S. § 17a-6c); CBHAC annual local systems of care status report (C.G.S. § 17a-4a(e)); CBHAC biennial recommendations on behavioral health services (C.G.S. § 17a-4a(f)); Quarterly Hospital reports to DCF on psychiatric care (C.G.S. § 17a-21); and CPEC cost-benefit evaluation of juvenile offender programs (C.G.S. § 46b-121m). The provisions of this section are also included in **H.B. No. 6236 AN ACT CONCERNING THE ELIMINATION OF CERTAIN REPORTS AND ADVISORY COMMITTEES RELATED TO THE DEPARTMENT OF CHILDREN AND FAMILIES** which was favorable reported out of the Select Committee on Children on February 10th and **H.B. No. 6373 AN ACT CONCERNING THE REPEAL OF CERTAIN OBSOLETE STATUTES**, which is currently before the Government Administration and Elections Committee. We would also note that this bill does not include two reports that were recommended for repeal by the Program Review and Investigations Committee: DCF monthly report to legislature on children in sub acute care in psychiatric or general hospitals who cannot be discharged (C.G.S. § 17a-91a); and an advisory committee that studies and makes annual reports to DCF on programs to promote adoption of minority and hard-to-place foster children

(C.G.S. §17a-116b). The Department **supports the repeal of these obsolete or redundant reporting requirements.**

Please note that there are also two other similar bills that have been introduced this session which deal with the Program Review and Investigations Committee report. **H.B. No. 6236 AN ACT CONCERNING THE ELIMINATION OF CERTAIN REPORTS AND ADVISORY COMMITTEES RELATED TO THE DEPARTMENT OF CHILDREN AND FAMILIES**, deals with the elimination of various reports and advisory committees as recommended by the Program Review and Investigations Committee. This bill was favorably reported by the Select Committee on Children last week. Also, there is **H.B. No. 6475 AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE DEPARTMENT OF CHILDREN AND FAMILIES**, which was raised by the Program Review and Investigations Committee.

S.B. No. 878 AN ACT CONCERNING THE PREVENTION ROLE OF THE DEPARTMENT OF CHILDREN AND FAMILIES

S.B. No. 879 AN ACT CONCERNING DCF OVERSIGHT AND REORGANIZATION OF THE DEPARTMENT OF CHILDREN AND FAMILIES

H.B. No. 6419 AN ACT CONCERNING TRANSPARENCY AND ACCOUNTABILITY OF THE DEPARTMENT OF CHILDREN AND FAMILIES

The Department of Children and Families **offers the following comments** regarding **S.B. No. 878 AN ACT CONCERNING THE PREVENTION ROLE OF THE DEPARTMENT OF CHILDREN AND FAMILIES**, **S.B. No. 879 AN ACT CONCERNING DCF OVERSIGHT AND REORGANIZATION OF THE DEPARTMENT OF CHILDREN AND FAMILIES**, and **H.B. No. 6419 AN ACT CONCERNING TRANSPARENCY AND ACCOUNTABILITY OF THE DEPARTMENT OF CHILDREN AND FAMILIES**. Each of these bills are likely intended to serve as vehicles to address issues raised during the joint hearings of the Select Committee on Children and the Human Services Committee last fall.

The Department appreciates many of the concerns raised by Committee members and looks forward to working collaboratively to achieve consensus on a number of issues. We have already reached out to the leadership of both committees and welcome the continued dialogue.

The Department already produces numerous reports and data as part of its ongoing management and oversight of its programs and would be happy to discuss and share these reports with the committee members in our ongoing effort to educate the legislature about both the strengths of Connecticut's child welfare system as well as those areas needing improvement.

We recognize that the task force membership in these bills may just serve as a "placeholder," but we believe that if you are to establish a task force or multiple task forces, that they should include individuals with expertise in the subject area and should include both executive and legislative branch appointments.

We also recognize that the task force membership in the bill may just serve as a "placeholder," but we believe that if you are to establish a task force it should include individuals with expertise in the area of prevention and should include both executive and legislative branch appointments.

Regarding prevention services, it is the Department's mission to promote a range of services that enable children and families to thrive independently in their communities and to apply evidence-based or best practice prevention approaches at strategic points in the DCF continuum of care to ensure a smooth, timely and sustained transition for children, youth and families from DCF involvement to a state of independence and well being or to prevent DCF involvement altogether.

DCF seeks to target vulnerable children and families experiencing: isolation; substance abuse; domestic violence; cognitive limitations and other disabilities; teenage pregnancy; single heads of household; incarceration and hospitalization; and poverty. Very young children are particularly vulnerable. Our draft Strategic Plan contains outcomes seeking a fewer number of families requiring DCF services, fewer delinquency petitions, fewer FWSN petitions and reduction in repeat maltreatment.

Currently, the Department is involved in the following prevention activities:

- Suicide Prevention - 912 parents, DCF and community staff trained on youth substance abuse, depression and suicide prevention in 2007-2008 and ~ 200 attended a 2008 statewide conference for schools, DCF, school resource officers and community providers;
- Positive Youth Development - 3 "Strengthening Family 10 -14" Facilitator Trainings conducted since 2007 resulting in 40 people trained;
- Family Strengthening – 2,400 youth and adults served since 2005, resulting in improved communications between youth and parents and improved life skills in the youth;
- Parents with Cognitive Limitations (PWCL) - 1,131 individuals trained in working with Parents with Cognitive Limitations since 2005;
- Shaken Baby Prevention – interagency collaboration resulting in 43 trained facilitators in two promising models (Dr. Karp and Purple Crying);
- In 2007 and 2008, 946 people trained in community workshops, e.g. Homelessness Prevention, Making College a Reality and Engaging Fathers;
- Early Childhood Consultation Partnership (ECCP) community based training - 280 individuals in the first quarter of 2008, 2,804 teachers since 2003 and community networks created among sites served, 8,063 children served within core class rooms since 2003, 89% class rooms demonstrated improvement in at least one dimension on the CLASS instrument and 97% of at risk youth were not suspended;
- DCF Head Start Partnership – Since 2006, 8 Area Offices linked with their local Head Start offices resulting in more DCF young children receiving a high quality preschool experience, more offices engaging in joint treatment planning and more potential foster parents identified, from July – October 2008, 108 children referred to Head Start and 67 enrolled;
- 4,000 letters and brochures on suicide prevention mailed to all schools, superintendents, chiefs of police, youth service bureaus and DCF Area Offices;

- 2007 *Have a Safe Summer* campaign and CT Parenting website launched in 2008 with a multi-media campaign resulting in 1,100 unique individual website visits every week;
- Prevention list serve disseminates information daily to 2,000 individuals;
- Shaken Baby Prevention Pilot – DCF, DMHAS, DPH and DOC populations (a minimum of 200 parents) scheduled to engage in training in awareness and baby soothing techniques and evaluation;
- Parents In Partnership – early childhood programs rebid in 2008 resulted in two new programs each to serve 45 – 65 families;

DCF's prevention programming is allocated as follows:

- Juvenile Criminal Diversion- 5%
- Positive Youth Development / Family Strengthening – 13%
- Early Childhood Intervention – 79% (97% Programs and Services)
- Training/Capacity Building – 2%
- Public Awareness/media – 1%

Service Type	Amount
Juvenile Criminal Diversion	\$359,618
YDI/Family Strengthening	\$924,315
Early Childhood	\$5,564,450
Suicide Prevention	\$75,795
Training	\$60,000
Media/Public Awareness	\$40,000
Other	\$54,000
Total Prevention Dollars	\$7,078,178

H.B. No. 6420 AN ACT CONCERNING A LEADERSHIP AUDIT OF THE DEPARTMENT OF CHILDREN AND FAMILIES

The Department of Children and Families has **some concerns** regarding **H.B. No. 6420 AN ACT CONCERNING A LEADERSHIP AUDIT OF THE DEPARTMENT OF CHILDREN AND FAMILIES**.

Over the past three decades, there have been at least 11 studies conducted by either the Legislative Program Review and Investigations Committee (LPRIC) or management consultants regarding the Department of Children and Families. As you consider a leadership audit, attached is a brief summary of these studies. (see ATTACHMENT C)

As the Committee is aware, the Department is already working with the National Resource Center for Organizational Improvement in the development of an integrated, agency-wide strategic plan that sets clear outcomes and indicators to measure our progress. This has included

a review of our current organizational structure and identification of changes to that structure and realignment of existing resources that will better position the Department to meet those strategic planning goals. We need to make sure that any study that may be undertaken is well scoped, that it accounts for past studies, and that if costly, must be weighed against other priorities given our fiscal climate.

H.B. No. 5915 AN ACT CONCERNING "STUCK KIDS".
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The Department of Children and Families **offers the following comments** regarding **H.B. No. 5915 AN ACT CONCERNING "STUCK KIDS."** This bill requires DCF to review and monitor the placement of every out-of-state, runaway and homeless child and youth in the custody, care or supervision of the Department of Children and Families.

It is important to note that out-of-state placements only occur when in-state options are exhausted and a child requires a specialized level of care not available in Connecticut. Our staff conduct regular visitations with the child and make arrangements for visits from family members. It's also important to recognize that anytime a child in our care runs away, it's a concern not only to staff who work with child, but also to the Department as a whole, and every effort is made through various means to locate the child as quickly as possible.

The Department already tracks all out-of-state placements and maintains a daily log of all runaway youth in DCF care. We also have the some capability of breaking this information down in various demographic categories, however, depending on the specificity desired, there may be a fiscal impact associated with modifying the databases needed to track some of the information referenced in this bill.

ATTACHMENT A

Status of Major Areas of Recommendation from PRI Study:

Recommendation	Current Status
Use provider feedback re. procurement and program enhancement	On 7/16/08 the Contracts Director was assigned to take the lead to complete agency policy including standard notification and degree of involvement. Procurement schedule approved by OPM for Executive Team review. Notice and an opportunity for input into new program deaths
All DCF facilities to produce annual report for their advisory groups	<ul style="list-style-type: none"> ▪ CJTS report will be produced in January, 2009. ▪ CCP, High Meadows and Riverview are establishing advisory groups, and their annual reports will be ready in January 2010.
Area Advisory Councils (AAC) to be invited to attend office Quality Improvement Team (QIT) meetings	This was not a viable recommendation given the variability of the AACs and the QIT process across area offices. Many have incorporated QIT into their management team structure. Of the 3 offices that invited their AACs to attend QIT meetings, none attended.
Strengthen State Advisory Council (SAC) with statute change for strategic plan oversight and provide SAC with administrative support and funding	<ul style="list-style-type: none"> ▪ The Director of the Policy and Planning Division continues to work with SAC. ▪ Consumer SAC members have been told that they can be established as vendors and reimbursed for travel. ▪ The Director of the Policy and Planning Division has provided information about the strategic planning process and explored options available regarding posting minutes. ▪ Statute change did not pass.
Establish electronic mechanism for SAC and AAC members to communicate	The Department will begin posting minutes without interactive component. SAC to take lead on the process.
Establish outcomes for each contract, collect data, compare provider performance, and take corrective action as necessary.	<ul style="list-style-type: none"> ▪ The establishment of outcomes for all contracts and the time frame for accomplishment will be a part of the agency's strategic plan. ▪ The Department has worked closely with provider trade associations to develop core outcomes for all residential providers. ▪ Two meetings were held with Contracts and Fiscal representatives. Decision: to use performance indicators identified in the Logic Models as measures of performance.
Consider reallocation of Contracts Division staff	Agreed and decided it was not a viable option.
Require external evaluation of programs in excess of \$20M	The Department will develop a protocol for determining the necessity of external evaluation that does not contain cost as a sole determiner.
Expand the role of the Service Enhancement Evaluation Committee (SEEC)	SEEC has been bi-furcated and other senior management meetings have been re-structured.
Establish repository for research and evaluation studies of the Department and its practices	Completed
Establish policy for responding to Special Review Unit (SRU) reports	Existing protocol is sufficient. The Bureau of Continuous Quality Improvement will do an annual statutes report of the results of the recommendations. Policy development underway.

ATTACHMENT B

STEPS WE HAVE TAKEN WITH SAC IN 2008

- a. SAC members have been involved in a number of agency planning and assessment activities over the past year. Members participate in the preparation for the recent Child and Family Services Review (CFSR) by serving on committees that helped assess DCF's performance on the federal safety, permanency and well-being outcomes. The SAC has also provided feedback on drafts of the DCF strategic plan.
- b. Although the SAC is only required to meet quarterly by statute, the members have been meeting monthly for the past several years. There were 9 SAC meetings held during 2008, including a summer planning meeting in lieu of regular meetings in July and August. One meeting was cancelled due to inclement weather. Commissioner Susan Hamilton attends the majority of the SAC meetings, as does Fernando Muñiz, who provides staff support to the SAC as needed. Other DCF managers are invited to attend on an as-needed basis depending on the topics being discussed.
- c. SAC meetings are generally held at the CAFAP office in Rocky Hill. One meeting was held in Gayle's Ferry to facilitate participation from the Area Advisory Councils in the eastern part of the state. SAC minutes are posted to the DCF website.
- d. The SAC does not have a designated budget or line item in the DCF budget, but support is provided on an as-needed basis for special projects. Additionally, DCF provides an administrative assistant to take meeting minutes and coordinate meetings and a Program Director to serve as the DCF liaison for scheduling presentations and providing the SAC with data they request.
- e. Parents who are members of the SAC are eligible for mileage reimbursement to attend the monthly SAC meetings.
- f. The Department communicates with the advisory groups through e-mail. DCF has not implemented a blog or other electronic feedback mechanism for the advisory groups.
- h. The Department facilitates the sharing of information between the SAC and CBHAC through sharing minutes and recommendations with each of the groups. A joint meeting of the two groups was scheduled by the SAC in December 2008, but was cancelled by the SAC chairs.

ATTACHMENT C

Year	Title/Author	Key Points
1977	<p><i>A Critical Review of Mandates and Resources in the Connecticut Department of Children and Youth Services by the Review Team of the DCYS Advisory Council</i></p>	<p>Agency problems related to:</p> <ul style="list-style-type: none"> • striking gap between department mandates and resources provided • transfer of authority incomplete; agency lacks full control over some key management functions; no mechanism for resolving interagency conflicts • lack of commitment on part of executive and legislature to improve agency performance <p>Management issues:</p> <ul style="list-style-type: none"> • crisis management operation; no evidence of commitment to long range planning or improved service delivery • functions not integrated; services remain three largely separate tracks • basic management documents nonexistent; management authority ambiguous and overlapping • staff turnover high, morale low; relationships with providers poor • information systems inadequate; lack information needed for informed decision making; cannot assess worker, contractor performance or client progress <p>To address management issues recommend:</p> <ul style="list-style-type: none"> • detailed management plan endorsed by governor, shared with legislature • clear table of organization, comprehensive budget with new categories related to policy, and automated information system capable of monitoring performance • advisory groups be given data to assess agency effectiveness, progress in implementing plan
1978	<p><i>Study of Juvenile Justice in Connecticut by the Program Review and Investigations Committee</i></p>	<p>The committee found:</p> <ul style="list-style-type: none"> • virtually no analysis is done by DCYS to indicate what treatment methods work with what kinds of delinquents • DCYS ability to oversee Youth Service Bureaus is questionable • A major problem of the Long Lane School is that of runaways and the Long Lane treatment manual contains no goal statement on the role or importance of maintaining a secure facility • Private agencies play a crucial role in addressing Connecticut's juvenile delinquency problem and are essential to the development of a continuum of needed services • DCYS reimbursement of private providers of juvenile delinquency services is inadequate and inefficient • Juvenile needs assessments are lacking • DCYS Office of Evaluation, Research, and Planning has not demonstrated its capacity to effectively evaluate programs • There are few additional standards, beyond licensing, for private providers <p>To address these issues, the committee recommended:</p> <ul style="list-style-type: none"> • More analysis of the effectiveness of various programs designed to treat juvenile offenders should be undertaken by the department • The Law Enforcement Assistance Administration should provide technical assistance to DCYS to help the agency develop evaluation procedures that could be integrated into the department's system for managing funds • DCYS detention staff job classifications and salaries should be upgraded • Information about juveniles must be maintained and tracked in a more effective manner • DOC should be utilized by the department to provide technical assistance to

		<p>Long Lane on security and custody matters</p> <ul style="list-style-type: none"> • Long Lane's primary role should be limited to the treatment of a small population requiring secure custody • DCYS should articulate, as part of its master plan, clear policy on the use of private resources, including the development of programs equipped to handle difficult cases • DCYS should provide more reasonable cost related payments for private delinquency treatment services • DCYS should exercise aggressive leadership to stimulate the development of family-centered programs in the private sector • DCYS should require private programs to provide transitional aftercare services following release from residential treatment and reimbursement rates should be adjusted to reflect this additional requirement • A written plan should be developed by the DCYS Office of Evaluation, Research, and Planning which establishes priorities and specifically shows how and when major tasks will be accomplished • DCYS must update licensing standards, hire more qualified workers, and improve workers' training • DCYS must improve its communications with DSS, DMH, DMR, and the Juvenile Courts
1978	<p><i>DCYS: A Program Review by the Program Review and Investigations Committee</i></p>	<p>The committee found:</p> <ul style="list-style-type: none"> • DCYS managers are unable to effectively manage the operations of the department or to fully comply with statutory mandates • Management information systems are ineffective • Projections of caseloads and staffing requirements are insufficient • There are deficiencies in the child abuse and neglect reporting system • The timeliness of abuse and neglect investigations is not monitored • One in five cases has no written treatment plan and only 68% of those with treatment plans have had a current review • 50-70% of the children in DCYS care are not receiving routine medical examinations or other routine medical services • Many children are in foster care for more than two years without a permanent placement plan • The inadequacy of board and care funds for both foster and other private placements has been caused, in part, by the department's poor forecasting and budget preparation • DCYS has weak oversight, at best, of troubled youths between the ages of 16 and 18 who cannot be forced to stay in a foster home or a group home • DCYS has not fulfilled its prevention mandate <p>To address these findings, the committee recommended:</p> <ul style="list-style-type: none"> • DCYS draft a five-year rolling master plan together with a comprehensive budget • Fines be imposed for mandated reporters who intentionally fail to report suspected child abuse or neglect • DCYS implement a manual tracking system to provide more thorough information to supervisors • All DCYS foster care commitments must be limited to two years. 90 days before expiration of the commitment, DCYS should be required to file a petition with the Superior Court to either: (1) terminate parental rights, (2) revoke the commitment, or (3) extend the commitment for an additional two years based on a finding that continued commitment would be in the best interests of the child • DCYS must expedite the recruitment process for foster parents. The

		<p>Department must recognize that foster parents make a vital contribution to the treatment of DCYS children</p> <ul style="list-style-type: none"> • DCYS must not only improve its forecasting and budget preparation, but also place children in foster homes and other appropriate settings within the limits of physical, rather than fiscal resources, even if such a policy results in the need for a deficiency appropriation • DCYS must improve its supervision of difficult youth between the ages of 16 and 18
1987	<i>Study of Psychiatric Hospital Services for Children and Adolescents by the Program Review and Investigations Committee</i>	<p>The committee found:</p> <ul style="list-style-type: none"> • DCYS has not met its statutory mandate to complete a comprehensive child's mental health plan • DCYS has not assessed the demand for existing services to determine if supply of state beds was appropriately allocated among age groups, treatment needs, and regions • There is a high demand for hospital services but DCYS hospitals frequently operate under capacity • There is a lack of information on psychiatric hospital services available to children. No state or private agency maintains a centralized directory • Incomplete or sporadic compliance by hospitals with statutory client information reporting requirements is typical • The DCYS database does not provide accurate information on children treated for psychiatric problems in emergency rooms <p>To address these issues, the committee recommended:</p> <ul style="list-style-type: none"> • DCYS must meet its statutory mandate and complete a comprehensive child's mental health plan • DCYS must reassess the role of psychiatric hospitals in terms of bed space and regional services • DCYS should utilize psychiatric hospitals to their fullest if demand for psychiatric services is high • DCYS should develop and maintain a statewide telephone clearinghouse on public and private inpatient bed openings • DCYS should establish an emergency psychiatric services program to provide crisis intervention and triage in each region • DCYS should develop a plan to more thoroughly collect psychiatric emergency room information
1989	<i>Study of Juvenile Justice in Connecticut by the Program Review and Investigations Committee</i>	<p>The committee found:</p> <ul style="list-style-type: none"> • The contents of DCYS treatment plans for committed juveniles are lacking • There is an imbalance in the staff-to-client ratio between aftercare and Long Lane staff • There is an increase in the number of escapees from Long Lane and many escapees are serious juvenile offenders • Little new money, high utilization rates, rigid criteria, and lengthy acceptance processes all create a lack of private residential facilities for juvenile delinquents in the state <p>To address these issues, the committee recommended:</p> <ul style="list-style-type: none"> • DCYS include specific information in treatment plans and case files • Long Lane allocate a number of its correctional staff to aftercare services • DCYS either make Long Lane a secure facility with a fence or build a medium security unit attached to the existing structure • DCYS monitor treatment and care of committed children and should take care

		that the automatic review policy does not further constrict limited resources
1991	<i>Study of DCYS Child Protective Services by the Program Review and Investigations Committee</i>	<p>The committee found:</p> <ul style="list-style-type: none"> • The reorganization of DCYS has focused on protective services programs and case management • There is a need for an independent review of DCYS handling of cases to provide oversight. There are no random audits to ensure that practice follows policy • There are broad variations between regions in case management and an absence of uniform standards in the Department • DCYS does not follow up cases to ensure that treatment and service plans have been implemented. Reviews are only done every 6 months • Staff training is not a top priority and training is inadequate • There are a number of deficiencies in case management • DCYS is deficient in administering and funding community-based programs • DCYS social workers are an untapped resource in the evaluation of community-based programs <p>To address these issues, the committee recommended:</p> <ul style="list-style-type: none"> • The DCYS management team must evaluate measurements of program effectiveness • Program evaluations and monitoring of client outcomes should be placed in one division • DCYS create a comprehensive system for managing cases, evaluating client outcomes, and reducing administrative paperwork for social workers • DCYS should develop an independent case audit unit to monitor regional compliance with policy and procedure • DCYS should develop a Staff Development and Training Division • DCYS should reduce the caseloads of workers, particularly new workers • All protective service social workers should, within first 10 years of employment, obtain MSW • DCYS should install an on-line computer system with 24-hour access and develop outcome measures for evaluating the effectiveness of client interventions • DCYS should design a grant processing system that funds proportionate to success in treating clients and allows for the reduction of funds against ineffective programs. The success of programs should be measured against specific criteria. Data on program outcome measures should be collected and analyzed • As part of the program evaluation process, social workers and supervisors should be surveyed and asked to gauge program effectiveness • DCYS should develop and maintain a computerized database of all available community service programs
1995	<i>Study of DCF Foster Care by the Program Review and Investigations Committee staff</i>	<p>The committee found:</p> <ul style="list-style-type: none"> • DCF does not sufficiently focus on the placement of children which consumes over half of its resources and is the primary focus of its work • The DCF practice of matching and placing children does not conform to policy. The lack of information about children prohibits appropriate matching to foster homes and hinders foster parents' abilities to care for children • The certification of family relatives for foster care is a questionable practice with no centralized oversight • DCF practice is confusing for staff and providers. There is a repetitive effort to maintain two separate investigation units. Also, there is no scale of authority

		<p>for DCF to enforce its investigation recommendations</p> <ul style="list-style-type: none"> • DCF foster parents typically have a poor working relationship with the Department <p>As a result of these findings, the committee recommended:</p> <ul style="list-style-type: none"> • DCF should be reorganized to create divisions responsible for coordinating, licensing, managing, and quality assurance of all placement resources, including those specific to foster care • DCF implement a child-placing portfolio containing all relevant and necessary information and documents to adequately provide foster care to a child. A copy should be provided to foster parents • Division of Quality Assurance should have the same responsibilities for relative certification as it does for foster care licensing • There be investigations of abuse and neglect allegations against foster homes conducted by regional staff, and completed within 14 days of referral. There should also be an investigation resolution process.
1995	<p><i>Report on DCF Organization and Staffing by KPMG</i></p>	<p>KPMG found:</p> <ul style="list-style-type: none"> • There are numerous small divisions and units in DCF's organizational structure which hinder department integration and horizontal communication • The current organization structure ineffectively divides and groups some functions • Some functions currently performed in the central office can be performed more appropriately in the field or on a contracted-out basis • Central Office and staffing have grown substantially • There are a high number of managers/supervisors in central office relative to staff yet the span of control of these managers/supervisors is low • Additional layers of management exist in the functional layers than is necessary • The commissioner's span of control is too great, yet it excludes important areas of the agency such as health and mental health • Too much of the department's functional responsibility is concentrated under the deputy commissioner for programs (DCP). Combining programmatic and administration functions under the deputy commissioner for administration (DCA) may not be optimal • Planning and program development functions are lacking at a high level within DCF's organizational structure <p>To address these issues, KPMG recommended:</p> <ul style="list-style-type: none"> • DCF bring together all aspects of research, clinical planning, strategic business planning, program development, and policy development. Closely integrating these with DCF's implementation unit will strengthen DCF's implementation of the consent decree • The number of senior employees reporting directly to the commissioner should be reduced from 9 to 7 and the commissioner should hire an executive assistant. A chief of staff and a public information officer should report directly to the commissioner • DCF should eliminate both deputy commissioner positions and replace them with five equivalent-level senior managers overseeing: child welfare services; health; mental health and education services; administration and finance; program development and planning; and juvenile justice • The chief of staff, public information officer, and executive assistant positions should be created. The chief of staff should coordinate external relationships and interaction with the commissioner, as well as internal agency initiatives and responses to events. He/she would also supervise DCF's case investigation unit.

		<p>The agency ombudsman and legislative liaison should report to the chief of staff rather directly to the commissioner as under the current structure. The public information officer should manage external communications. He/she should continue to report directly to the commissioner. The executive assistant to the commissioner should handle administrative tasks such as responding to correspondence and scheduling</p>
1998	<i>Study of the DCF Bureau of Juvenile Justice by Loughran and Associates</i>	<p>The consultants found:</p> <ul style="list-style-type: none"> • Very little of the Juvenile Justice Reorganization Plan (mandated by PA 95-225) has been implemented, such as the reconfiguration of the Long Lane School and the development of a full continuum of community programs and parole services • Most of DCF's budget, administrative structure, and support systems are dedicated to its child welfare operations • Parole services, the community case management arm of the Juvenile Justice Bureau, suffers from its disconnection from the rest of DCF <p>To address these issues, the consultants recommended:</p> <ul style="list-style-type: none"> • The department must better integrate the Juvenile Justice Bureau • The Juvenile Justice Bureau's regional offices should be co-located with those of the Bureau of Child Welfare Services. They should be large enough and have enough computers, phones, and fax and copy machines to accommodate the number of parole officers and support staff assigned to a particular office • Administrative practices must be changed to allow for better integration of the juvenile justice function into the department • The Juvenile Justice Bureau's administration should be transferred to DCF's central office, and the bureau's director should report to the juvenile justice bureau chief rather than to the assistant superintendent of Long Lane
1999	<i>Study of the Department of Children and Families by the Program Review and Investigations Committee staff</i>	<p>The committee found:</p> <ul style="list-style-type: none"> • Goals of a consolidated children's agency -- leadership and advocacy for children's issues and integrated service delivery -- have not been fulfilled. • No overarching policy guides state government efforts to promote well-being of children and their families. • No formal structure exists to examine the "big picture" or coordinate services and resources of the many state agencies responsible for children. • Major barriers to integrated services are categorical funding, lack of a coordinating mechanism, and "turf wars" among programs and agencies; most effective incentive for interagency coordination is financial. • Noncategorical, flexible funding is more important to integration than organizational structure. • Children and families are best served by integrated, individualized care delivered through community-based systems. • Coordinating resources and services to achieve an integrated care system must be the priority of a single entity without responsibilities for providing direct services. • All three branches of government, not just DCF, have responsibility for prevention; coordinating prevention efforts needs to be one entity's focus. • Leadership and management for child protective services, children's behavioral health, and juvenile justice must be strengthened; each mandate must be an agency's priority to ensure it receives sufficient attention and resources. • Despite continuous efforts to "fix" DCF, it is plagued by systemic management deficiencies. • DCF's child protective services mandate dominates agency policy and resources; it must be a priority due to dramatic increases in the number and

		<p>severity of child abuse and neglect cases as well as a federal court consent decree.</p> <ul style="list-style-type: none"> • Children's behavioral health and juvenile justice mandates have been seriously neglected by DCF and the legislature and only receive attention in response to a crisis. • Separate state agencies can focus on each mandate to ensure leadership and parity; service delivery can be integrated through a statewide coordinating structure and "pooled" resources. <p>As a result of these findings, the committee recommended:</p> <ul style="list-style-type: none"> • the creation of a secretary for children responsible for coordinating state efforts to implement the state's policy on children and families. • realigning the responsibilities of DCF as follows: children's mental health and substance abuse shall be transferred to the Department of Mental Health and Addiction Services; juvenile justice shall be transferred to the Connecticut Juvenile Authority (CJA) -- a new statutorily created state agency; and protective services for abused, neglected, or abandoned children shall remain within DCF. • that DCF develop an assessment standard and tool to determine which calls require a full investigation response by its staff and which can be referred to a state-contracted community partnership for assessment and services. The differential response process shall be fully implemented by the fourth year of the phase-in of community partnerships.
2007	<p><i>Study of DCF Monitoring and Evaluation by the Program Review and Investigations Committee staff</i></p>	<p>The committee found:</p> <ul style="list-style-type: none"> • little attention has been given to examining DCF as a whole or assessing how well the agency is achieving its broad goals of safety, permanency, and well-being for all children and families. • while the department is responsible for carrying out four major mandates, monitoring and evaluation is focused primarily on the child protective services mandate, due largely to the ongoing impact of the federal <i>Juan F.</i> lawsuit consent decree and requirements of federal agencies. • there is greater emphasis on tracking how services for children and families are delivered rather than on assessing their end results. While high quality service delivery is important, the crucial indicator of effectiveness is whether programs are making a difference and achieving stated goals. In general, more attention to outcome information is needed throughout the DCF accountability system. • pockets of strength within the system, such as the <i>Juan F.</i> exit plan process and related DCF area office quality improvement processes, the department's licensing procedures, the agency's recently revised special review process, and the activities of on-site facility monitors. • Some major weaknesses were revealed as well. In particular, the agency's contracting process provides little accountability, consequences for poor performance are rare, and working relationships with private providers need improvement. The committee also found ineffective use of some important sources of feedback on services and programs, such as child fatality reviews, OCA investigations, and even the department's own program review reports and contracted evaluations. In part, these deficiencies are due to both fragmentation of quality improvement efforts within the agency and the fact that results data are not regularly integrated and analyzed. Both problems are related to the department's information systems, which are themselves fragmented and in some cases inadequate. Another challenge is a lack of department staff with the analytic skills and research experience needed to use results data and information. Further, there is no centralized place -- like an agencywide strategic

		<p>plan – where all DCF goals and information about service delivery and outcomes are brought together.</p> <ul style="list-style-type: none">• Duplication of external monitoring efforts also was revealed by the program review committee's examination of statutorily required DCF plans and reports. The committee determined several mandates could be eliminated without a loss of accountability, as certain documents have become obsolete or been replaced by newer sources of similar information. In addition, reducing the number and clarifying the purpose of reporting mandates could improve the quality of information on department results available to the legislature and the public. <p>As a result of these findings, the committee recommended:</p> <ul style="list-style-type: none">• making agency goals explicit;• integrating quality improvement activities and incorporating best practices throughout the agency;• improving the quality and quantity of available data; and• promoting the use of results information to better meet the needs of children and families.
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