



**STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES**

**Public Hearing Testimony of
Commissioner Susan I. Hamilton, M.S.W., J.D.**

**Human Services Committee
February 23, 2010**



**S.B. No. 31 - AN ACT IMPLEMENTING THE BUDGET RECOMMENDATIONS OF
THE GOVERNOR CONCERNING THE EDUCATIONAL PLACEMENT OF
CHILDREN IN THE CARE AND CUSTODY OF THE DEPARTMENT OF CHILDREN
AND FAMILIES**

**H.B. No. 5066 - AN ACT CONCERNING EDUCATIONAL STABILITY FOR
CHILDREN IN THE CARE AND CUSTODY OF THE DEPARTMENT OF CHILDREN
AND FAMILIES**

The Department of Children and Families strongly **supports** S.B. NO. 31 - AN ACT IMPLEMENTING THE BUDGET RECOMMENDATIONS OF THE GOVERNOR CONCERNING THE EDUCATIONAL PLACEMENT OF CHILDREN IN THE CARE AND CUSTODY OF THE DEPARTMENT OF CHILDREN AND FAMILIES. H.B. NO. 5066 - AN ACT CONCERNING EDUCATIONAL STABILITY FOR CHILDREN IN THE CARE AND CUSTODY OF THE DEPARTMENT OF CHILDREN AND FAMILIES contains similar language to the Governor's bill.

Both bills enact the provisions of Public Law 110-351, the federal Fostering Connections to Success and Increasing Adoptions Act of 2008. A key component of this act requires, as a condition of continued receipt of federal IV-E funds, that states take steps to insure the educational stability of foster children by permitting each child, if it's in his or her best interest, to remain in the schools of origin even if the foster or relative placement is in a different town. There are additional requirements as well for children whose best interests require that they move to new schools, including immediate enrollment and immediate transfer of school records. Connecticut is required to implement the federal law by July 1, 2010.

We believe strongly that providing a child with a stable educational environment is an important consideration when removing a child from his or her home and into foster or relative care. By far the biggest challenge will be funding the transportation component. Transporting children back to their home school will present some logistical challenges but the Department is preparing to solicit proposals to accomplish this in the most cost-effective manner.

Failure to enact this legislation will jeopardize the state's ability to seek federal Title IV-E reimbursement for children in out-of-home care. Connecticut receives over \$100 million in Title IV-E funds annually. The Governor's recommended budget adjustment includes funding of \$2.8 million in FY 11 to begin implementation of this new federal mandate. The annualized cost in future years could potentially exceed \$10 million. While this legislation will make Connecticut

eligible for partial federal reimbursement, it is estimated that it will be approximately 25 cents on the dollar.

Finally, DCF supports the language change in subsection (c) to add a reference to section 10-253 of the General Statutes that is suggested in Commissioner McQuillan's testimony. Also, the Judicial Branch has suggested a technical modification to clarify further that the parents' and child's rights to appeal a decision made pursuant to this bill is first to the agency, not to the Superior Court, utilizing the Uniform Administrative Procedures Act. This clarification is necessary to ensure that the appeal is handled as expeditiously as possible. The Department has already committed to an expedited hearing, which the Superior Court cannot guarantee due to docket constraints. We therefore support this suggestion.

H.B. No. 5067 - 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.

The Department of Children and Families **offers the following comments regarding** H.B. No. 5067 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.

This bill would require the Department of Children and Families (DCF) and the Department of Mental Health and Addiction Services (DMHAS) to submit annual reports to the Community Mental Health Strategy Board and certain committees of cognizance of the General Assembly on the transition process for young adults from DCF to DMHAS.

Both DCF and DMHAS have worked on similar legislation with the Office of the Child Advocate over the past two sessions, seeking a reporting mechanism that can be accomplished within existing resources. Two years ago we had worked collaboratively on legislation that would have minimized, but not eliminated, the fiscal impact of this type of requirement. **We are concerned that H.B. No. 5067**, as written, is similar to the language from 2009 Substitute House Bill No. 5416 (File 918) that the Office of Fiscal Analysis determined to have a **significant cost**.

The OFA fiscal note on that bill read:

"The Departments of Children and Families (DCF) and Mental Health and Addiction Services (DMHAS) would incur costs to comply with reporting mandates contained within this bill.

The DCF would require an additional 2.5 positions (1.5 Clinical Social Workers, 1 Clinical Services Manager) at an FY 10 cost of \$176,207 (annualized cost of \$190,891) to compile, analyze and report specified data concerning children and youth who may require DMHAS's services at age eighteen. Additional fringe benefit costs would be incurred (\$44,809 FY 10; \$48,543 FY 11).

DMHAS would require a Research Analyst at an FY 10 cost of \$51,718 (annualized salary of \$56,028) to compile, analyze and report specified data on transitional youth (with additional fringe benefit costs of \$13,152 in FY 10 and \$14,248 in FY 11).

In order for the DCF and the DMHAS to track, analyze and produce the required data they would each need the above mentioned positions. Due to the bill's provision that the departments meet the reporting requirements within existing budgetary resources, they will either: 1) shift resources from other existing agency priorities; 2) run a deficiency; 3) not be able to fully meet the reporting requirements; or 4) delay implementation until resources are made available."

DMHAS has developed an array of Young Adult Services to provide specialized, age and developmentally appropriate supports for young people -- many of whom are transitioning out of the DCF system of care and diagnosed with a major mental illness. Age-specific programs have been developed at both state-operated and private non-profit local mental health authorities throughout Connecticut to assist young people to transition successfully into adulthood. Young adults who are referred to these specialized services must meet DMHAS' target population eligibility criteria.

Individuals with a history of involvement with DCF may be referred to Young Adult Services as early as age 16 by DCF, or they may be referred by family members, local mental health authorities, schools or other providers. In general, services do not begin prior to age 18, and, in some cases, they may not begin until age 21. For youngsters referred by DCF, DCF area office workers send a complete referral packet to the DCF Central Office Transition Coordinator who in turn forwards the referral packet to the Clinical Director of DMHAS Young Adult Services to review. If a youngster is also a client of DDS, the DDS Regional Director must decide whether the individual will be referred to DMHAS' Young Adult Services.

Highlights of the program include:

- 1,333 referrals given to DMHAS in fiscal years 2005-2008 (an average of 333 compared to 97 for the two preceding fiscal years)
- Standardized screening process utilized statewide to determine the need for DMHAS referrals
- Centralized process to track and monitor referral submission and completeness
- Local DMHAS/Area Office joint meetings for the purposes of coordination, transition planning and problem resolution
- ACCESS database with the potential for improved monitoring of referral, eligibility, transition and funding of youth going to DMHAS
- Bi-weekly administrative meetings between DCF and DMHAS Commissioner Office staff and the Office of Policy and Management
- Specialized group home for young adults transitioning to DMHAS with co-occurring psychiatric, neuropsychological and/or neurological deficits being developed
- Protocol in place with DMHAS for review of referrals with co-occurring psychiatric and traumatic/acquired brain injury

Attached to this testimony is a more detailed summary of these transition activities.

S.B. No. 140 - AN ACT CONCERNING YOUTH TRANSITIONING BETWEEN THE DEPARTMENT OF CHILDREN AND FAMILIES AND THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

The Department of Children and Families **expresses concern** regarding S.B. No. 140 - AN ACT CONCERNING YOUTH TRANSITIONING BETWEEN THE DEPARTMENT OF CHILDREN AND FAMILIES AND THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES.

This bill would require DCF to provide all necessary and appropriate services to a youth who is transitioning between the custody of the Department of Children and Families and the custody of the Department of Mental Health and Addiction Services until the Commissioners of Children and Families and Mental Health and Addiction Services agree that all elements of the youth's transition plan have been successfully completed. Unfortunately, as written, the bill would inappropriately expand DCF's statutory authority to adults with no limitation until DMHAS is ready to assume responsibility regardless of whether the young adult is engaged with DCF or not and regardless of what is in the individual's best interests.

Frequently, youth who turn 18 may not be in agreement with and/or may not be cooperating with the DCF treatment plan while they are in the process of transitioning to DMHAS. We support the goal of ensuring that young adults have timely access to the services they need but are concerned that this legislation could hamper the transition process.

H.B. No. 5144 - AN ACT CONCERNING THE OPERATION OF RIVERVIEW HOSPITAL AND CONNECTICUT CHILDREN'S PLACE

The Department of Children and Families is **opposed** to H.B. No. 5144 - AN ACT CONCERNING THE OPERATION OF RIVERVIEW HOSPITAL AND CONNECTICUT CHILDREN'S PLACE.

This bill would require the Department of Children and Families and the Department of Mental Health and Addiction Services to report to the Community Mental Health Strategy Board and several committees of cognizance of the General Assembly on or before January 1, 2011, regarding the feasibility of transferring responsibility for operating Riverview Hospital for Children and Youth and Connecticut Children's Place from the Department of Children and Families to the Department of Mental Health and Addiction Services.

While we can appreciate that one of the stated goals of this evaluation would be "to permit the Department of Children and Families to increase its focus on child protection and welfare," we believe that the framework of a consolidated children's services agency best serves the children, youth and families in Connecticut. We believe that we are in a unique position to seek pertinent clinical and social information about the children and also recommend appropriate care in the community thanks to the collaboration in place between the behavioral health and child

protective functions of the agency, thus preventing multiple referrals to Riverview or other hospitals. This could also impact the coordination of services which children get through DCF, including, but not limited to, area office involvement and crises mobilization services. Separating these functions and coordination could result in increased use of hospitalizations and fragmented care.

In addition, we would point out several other important considerations:

- While providing care at Riverview and Connecticut Children's Place, families are an essential part of treatment. This focus comes from years of training and experience in treating children, which is not necessarily available in the adult mental health system.
- School involvement is also an integral part of a child's life and treatment, which is not generally an integral part of DHMAS' purview. DCF operates its own school district, Unified School District II, which provides educational services at Riverview, Connecticut Children's Place and the Connecticut Juvenile Training School.
- The teams at Riverview and Connecticut Children's Place include Child Psychiatrists, Psychologists, Social Workers, Pediatrician, Nursing, Rehabilitation Staff, Occupational Therapist, and Dentist. This team concept is unique to Riverview and Connecticut Children's Place, and might be compromised if these facilities were to be operated by the adult mental health system.
- Child Psychiatrists, Psychologists, Social Workers, Pediatrician, Nursing, Rehabilitation Staff, Occupational Therapist, Dentist at Riverview and CCP have special education, training and experience which can't be replicated at DHMAS. For example, Child Psychiatrists receive two years of additional training after adult training before they can treat children and adolescents. Child Psychiatry has a developmental perspective, looking at growth and development starting from pregnancy versus the adult mental health systems that starts taking care of patients at age 18. Developmental disorders, including autism, learning disabilities and cognitive limitations, require special training and experience for diagnosis and treatment which DCF is uniquely positioned to provide.

We believe having these facilities under the jurisdiction of DCF is an essential part of a consolidated children's services agency, and for the effective treatment focused on the needs of children and youth.

By way of background Riverview Hospital for Children and Youth is the only state administered psychiatric hospital for Connecticut's children who are under the age of 18. The hospital provides comprehensive care to children and adolescents with severe mental illness and related behavioral and emotional problems who cannot be safely assessed or treated in a less restrictive setting.

Connecticut Children's Place is a diagnostic behavior health treatment facility that currently treats 48 boys and girls ages 12-21, who are in the care and/or custody of the Department of Children and Families. CCP provides a complete educational program, behavioral health services including medical, psychiatric, and clinical social work treatment, a paid work program and a therapeutic recreation program. The facility serves as a safety net to youth of Connecticut who have been removed from care at other treatment facilities, returning to Connecticut from out-of-state care, who are in need of sub-acute treatment service as a discharge plan from psychiatric in-patient settings, who need specialized treatment and that treatment is not available in the private

sector, or who are in crisis and need immediate behavioral health treatment in a residential setting.

H.B. No. 5143 - AN ACT CONCERNING INVESTIGATIONS BY THE DEPARTMENT OF CHILDREN AND FAMILIES

The Department of Children and Families offers the following comments regarding H.B. No. 5143 - AN ACT CONCERNING INVESTIGATIONS BY THE DEPARTMENT OF CHILDREN AND FAMILIES.

We appreciate and respect the need for the Department to ensure that parents, when involved in a child protective investigation, understand the process and their legal rights. Our major concern with this legislation as written are the provisions contained in subsection (b) which would make information obtained by the department in the absence of the notice required by this legislation inadmissible in any administrative or judicial proceeding.

This legislation has been characterized as a "Mini Miranda" warning for parents in child protective investigations; however, it should be noted that DCF investigations are not criminal proceedings, and a "reading of rights" is neither appropriate nor required. Also, even in criminal cases, the alleged perpetrator doesn't get Mirandized until the end of the investigation when an arrest is imminent. It would be inappropriate for a child protection investigation to require more stringent statutory restrictions than the Constitution provides to criminal suspects, particularly given that the focus of the investigation is on the safety and well-being of the child.

However, because we do believe it's important that parents know their rights, DCF does, and has for many years, voluntarily provided a written "*A Parents Right to Know*" brochure at the start of every investigation. This brochure provides the information similar to that required by this bill and the following is the Questions and Answer section from the brochure. We have met with the proponent of this legislation and would welcome any suggested modifications to this publication to add more clarity to this information.

Q & A for Parents about Protective Services

Why is a DCF Social Worker contacting me?

A social worker is contacting you because the Department received a report that your child may have been abused or neglected, or may be at risk of being abused. State law (Connecticut General Statutes Sec. 17a-101) requires DCF to investigate all reports of suspected child abuse or neglect. The social worker will want to talk to you about the report and your child's well-being.

Who reported my child as abused or neglected?

Anyone - a friend, neighbor, family member, or stranger - can make a report of suspected abuse or neglect. Any reporter may remain anonymous. However, the reporter's identity may be disclosed under certain limited circumstances. Some professionals are required by law to report suspected abuse or neglect and are called "mandated reporters." Mandated reporters include teachers, physicians, nurses, social workers, police officers, mental health counselors, clergy, daycare workers, and other professionals.

Why would a report be made?

Children are reported for a variety of reasons. Mandated reporters, for example, must contact the Department if they suspect a child: • has been neglected, which means the child has been abandoned, is being denied proper care and attention, or is being permitted to live under circumstances which harm his or her well-being; • has non-accidental physical injuries; • has physical injuries that are inconsistent with an explanation of the injuries; • has a condition resulting from maltreatment, such as malnutrition, sexual abuse, sexual exploitation, deprivation of necessities like food, clothing, shelter, and emotional maltreatment or cruel punishment; and • is placed at imminent risk of serious harm.

Children have a right to be safe from these conditions.

What happens when DCF receives a report regarding my child?

Each accepted report of suspected abuse or neglect is assigned to a social worker who is responsible for conducting an investigation. It is the social worker's responsibility to investigate the report and determine if ongoing DCF involvement is required.

Who will the social worker talk to?

First and foremost, the social worker will talk to you, your child(ren), and other family members. It is important to hear from you so the Department can offer help, if needed, to your family. The social worker will contact physicians, teachers, daycare staff, baby-sitters, neighbors, relatives, or other people who have first-hand knowledge of you and your child(ren). You may also suggest others who you feel have information concerning your child. In certain situations, the worker may contact people without the parent's consent. The police must be contacted if the report indicates sexual abuse or serious physical abuse or neglect.

Does the social worker have to talk to my child?

Yes. The social worker must see and talk with your child, and will need to see and talk with other children in the home. In certain circumstances, the social worker may talk with your child before contacting you. He or she may talk with your child at school or at daycare.

What if I don't want to talk to the social worker?

DCF encourages parents to cooperate with an investigation. This provides parents with the opportunity to tell their story. You can choose not to speak with the social worker, but the Department is still required by law to investigate the report. If DCF believes your child is in immediate danger of serious harm, we will contact the police and, if necessary, file a petition with the court to see your child.

Will my children be taken away from me?

The great majority of children served by DCF remain at home with their parents. DCF's goal is to keep families together whenever possible. When support services are needed, your social worker will help arrange them. There are times when it is determined that the risk to a child's safety requires out-of-home placement. DCF may authorize a child's removal if there is probable cause to believe that the child is at imminent risk of physical harm and that immediate removal is necessary to ensure the child's safety. An emergency administrative removal is called a 96-hour hold. The parent should receive in writing the reason for the Department's actions and the legal basis for the removal. Within 96 hours after such removal, the Department must seek an Order of Temporary Custody (OTC) from the Court if it is necessary to maintain the child in out-of-home placement. If that is the case, you will be entitled to a Court hearing within 10 days and have the right to an attorney. If you cannot afford an attorney, the court will appoint one for you. Your child(ren) will be represented by an attorney as well. When a child must be placed in out-of-home care, DCF's goal is his or her safe return as soon as the family situation is determined to be stable and safe.

What happens after an investigation?

If DCF finds that your child has not been abused or neglected, the report is "unsubstantiated." This means that there is insufficient evidence to prove that your child was, in fact, abused or neglected. Many "unsubstantiated" cases are immediately closed. However, DCF may determine that there are risk factors present that warrant keeping the case open to provide services to you and your family. If DCF finds that your child has been abused or neglected, the report is "substantiated," and your case will most likely remain open with DCF for services. Your social worker will then work with you to develop what's called a case plan. The social worker will discuss the services you can receive and how DCF will work with you to

improve your family's situation. If a child has been seriously abused or neglected, or sexually abused, DCF is required to refer the case to the police. At times, DCF's involvement begins after a call from a police department to help investigate a situation involving children.

Can I disagree with the Department's finding?

Yes. If at any time you disagree with a finding of substantiated abuse or neglect, you may:

- Request in writing a review of the finding addressed to the area director. If you disagree with the results of the review, you can request an administrative hearing.
- You are not required by law to talk to the social worker during the investigation. But if you choose not to say anything, the hearing officer may not be able to consider your side of the story at the administrative hearing.
- You can also send a written statement with the facts you feel are important and ask that your statement be added to your file.

What kind of help can DCF give my family?

The Department of Children and Families provides and funds a wide range of community-based services. Your social worker will explain these and other services available in your community. They may include:

- Information and Referral
- Individual and Family Therapy
- Intensive Family Preservation Services
- Parent Education and Support Centers
- Family Support Centers
- Parent Aide
- Parenting Classes
- Parent Support Groups
- Sexual Abuse Treatment
- Substance Abuse Services
- Children's Mental Health Services
- Voluntary Services For Children With Mental Health Needs

If you do not agree with the case plan or the services provided to your family, you can:

- Participate in case planning conferences. These reviews are held within 45 days of your case being opened for services or your child(ren) going into placement.
- Participate in administrative case reviews of the case plan. These reviews are held every six months. Your social worker will notify you when an administrative case review is scheduled, or, you may request one at any time.
- Request a case plan hearing to contest the Department's plan and/or provision of services. A hearing officer will hear both sides and issue a written decision on the appropriateness of the case plan in meeting the needs of the child(ren). You may choose to be represented by an attorney at your own expense. A case plan hearing may be requested by writing to the Commissioner of Children and Families at 505 Hudson Street, Hartford, CT 06106. Your written request must state the specific issues with which you disagree.
- If you are not satisfied after all administrative remedies are provided by the Department, you may have the right to bring an appeal to the Superior Court.

What other rights do I have as a parent?

- You have the right to be treated with respect and dignity.
- You have the right to have an interpreter present to assist you to understand all of the proceedings of your case.
- You have the right to request all of the documents related to your case translated into your primary language.
- You have the right to request and receive thorough and understandable answers to any questions you may have about the Department's involvement with your family.
- You have the right to have any person of your choosing (such as friend, relative, or clergy person) present during meetings with DCF social workers, unless a court restraining or protective order forbids the involvement of that person.

- You have the right to request and receive information contained in the Department's records about the investigation and findings concerning you and your child(ren). Access to the identity of the person(s) who reported suspected abuse or neglect may be restricted.
- You have the right to a written notification of and reasons for any action regarding the placement of your child(ren), if removal is determined to be necessary.
- You have the right to privacy. Records regarding you and your family will not be publicly released by the Department without your permission unless authorized by law. However, information may be disclosed to other agencies for investigation, treatment, or other purposes as permitted by law.
- You have the right to have an attorney with you at any time. If DCF files a court petition for temporary custody of your child, you should consult an attorney. If you are unable to pay for an attorney, you may ask the court to appoint one for you. A separate attorney will be appointed to represent your child(ren) in the proceedings.
- You have the right **not** to work or talk with us.
- You have the right to have information about your case expunged under certain circumstances.
- You have the right to contact the DCF Ombudsman's Office. In the best interest of children, the purpose of this office is to resolve disputes between clients, foster and adoptive parents, providers, citizens, and the Department. The Ombudsman can be reached from 8:00 A.M. to 5:00 P.M. Monday thru Friday at (860) 550-6301.

H.B. No. 5146 - AN ACT CONCERNING VISITATION OF CHILDREN COMMITTED TO THE DEPARTMENT OF CHILDREN AND FAMILIES

The Department of Children and Families **offers the following comments** to H.B. No. 5146 - AN ACT CONCERNING VISITATION OF CHILDREN COMMITTED TO THE DEPARTMENT OF CHILDREN AND FAMILIES.

Judges already have the authority pursuant to Section 46b-121 of the Connecticut General Statutes to issue orders that are in the best interests of the child, and they often issue visitation orders envisioned by this bill.

**DCF TRANSITIONING YOUTH-
INTERSECTING CHILD AND ADULT SYSTEMS OF CARE
February 2010**

I. BACKGROUND

Transitioning from adolescence to adulthood is perhaps the most challenging stage of human development. For nearly 500,000 children and youth who are currently in foster care in the United States, that transition can be even more complicated. Within this foster care population, 30-35% are adolescents, and approximately 30,000 of them will emancipate from care each year.

Evidence also suggests that a significant portion of these young adults will require services from an adult-serving system. Research has found that approximately 14-20% of all children and youth meet criteria for a psychiatric disorder. Because of the severe abuse, neglect and trauma experienced by youth in the care of the Department of Children and Families (DCF), the proportion of youth with psychiatric disorders served by DCF is even higher. In fact, nationally, children and youth involved in the child welfare and juvenile justice systems have been found to be four to six times more likely than young people in the general population to experience behavioral health problems that impede their educational, psychological, and interpersonal functioning.

DCF carries important responsibilities to help meet the needs of these youth and their families, and to work in connection with the adult service system and assure timely, effective and appropriate transitions from one service system to the other when appropriate. It begins with DCF's support and care for children and youth through age 18, including those who need protection, those who require mental health or substance abuse services, and those who come to our attention through the juvenile justice system. DCF also may continue to provide services to young people through age 21 if the individuals remain voluntarily in services and are enrolled in an educational or vocational program.

It is important to note that children and youth enter the DCF system in one of two ways: through a court order following documentation of maltreatment or through the Voluntary Services Program in which parents who are not abusive or neglectful seek services for their children for serious emotional disturbances, mental illnesses, and substance dependency. DCF provides services and treatment across many modalities and in a range of settings to children and young people and their families.

In most cases our services are provided to children and youth with intact families, or we are able to achieve permanency in some form over the course of our interventions. Inevitably, however, there will be a universe of adolescents and young adults who will age out of our system and require on-going services through either the Department of Developmental Services (DDS) or the Department of Mental Health and Addiction Services (DMHAS).

This report offers a description of the policies and procedures that guide DCF's work in transitioning youth to DMHAS. It also provides a current status of activities aimed at improving this area of the work, related outcomes and evaluations, and highlights of key next steps for service development and system coordination.

II. COMPONENT PARTS

There are three component parts to transitioning: 1) Screening; 2) Referral, and; 3) Transition Planning and Preparation. Below is an outline of how DCF manages and performs these components of our transition activities as they relate to DMHAS transfers.

1. GENERAL SCREENING PROCESS

In order to assess who should be referred to DMHAS, DCF conducts a formal screening process at age 15 or older if youth enters later to determine the service needs subsequent to aging out of DCF. Using standardized criteria, DCF Area Office clinical staff determine if a referral is needed, and if so, the Area Office Social Worker completes the referral paperwork. On a monthly basis, each Area Office receives an e-mail along with a list generated from DCF's database which triggers a review and screening process. DCF Central Office staff then utilizes the returned lists to prepare monthly monitoring reports which notify the Area Offices of referrals due and past due dates.

2. DMHAS SPECIFIC REFERRALS

DMHAS and DCF have entered into a Memorandum of Agreement (MOA) to facilitate the coordination of services for clients who are within the care of DCF (committed or voluntary) and who are eligible for services through DMHAS. The MOA establishes the general framework for the transitioning of each eligible client from DCF to DMHAS. In addition, specific protocols and practices have been developed over time in order to bring further governance to this work. These are outlined below:

Prioritization Criteria

- 1) All youth on the list (provided by Central Office Division of Behavioral Health), need to be reviewed in conjunction with a licensed mental health professional in the ARG. It should be based on looking at a combination of the following:
 - a. current and past diagnoses of a major mental illness (see below),
 - b. current and past mental health treatment including inpatient, outpatient, medication, residential, emergency crisis, partial hospital, extended day, etc.,
 - c. any significant trauma history (physical, sexual, emotional) and the impact on behavior and functioning,
 - d. current and future (anticipated) functioning level and related treatment and support needs, and
 - e. having any current DCF status (can be committed, voluntary, FWSN, dual committed, parole/probation, protective supervision, in jail, etc.).

2) Once a determination is made that a DMHAS referral is appropriate based on the above, referrals should be prioritized and sent to DCF CO, according to the following criteria:

a. First priority group - **for immediate referral** - is any youth (aged 16 +) who has a diagnosis of:

- Schizophrenia
- Psychotic Disorder NOS
- Schizoaffective Disorder
- Bipolar Disorder
- Major Depression
- Post Traumatic Stress Disorder
- Obsessive Compulsive Disorder
- Significant/serious Personality Disorders
- Pervasive Developmental Disorder in addition to one of the above diagnoses and without a co-occurring mental retardation

Note: This group should include anyone with a psychosexual history (sexually offending or sexually reactive behavior) who has one or more of these diagnoses.

b. Second priority group for referrals are youth who do not have any of the above diagnoses, but may have any combination of the following:

- Diagnosis of Reactive Attachment Disorder, Anxiety Disorders, Depressive or Mood Disorder NOS (as opposed to a Major Depressive Disorder), serious personality disorders.
- Diagnosis of Conduct Disorder or Oppositional Defiant Disorder (or other not noted here) with a history of trauma, multiple and/or lengthy psychiatric hospitalizations, use of medications, residential treatment and/or disrupted placements, functional deficits, and/or significant behavioral dyscontrol.
- Pervasive Developmental Disorder or other Autism Spectrum Disorder (e.g. Aspergers) with high risk/dangerous behaviors (that put themselves or the community at risk) and a significant need for supportive services at the point of DCF age-out and without a co-occurring diagnosis of mental retardation.

Formal Referrals

For all referrals going from DCF to DMHAS, there is a standard referral form and format. Referrals are given to DMHAS on a monthly basis only after they have been determined by DCF Central Office staff to be complete. While the formal screening is done at age 15 and above (depending on when the youth has entered the DCF system) referrals are not given to DMHAS until age 16.

Referral Patterns

Currently referrals are at a rate of 30 per month and a February 2010 point-in-time view of referral patterns reveals the following:

Current capacity in DMHAS YAS Programs	866
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DCF Youth Currently Referred to DMHAS	# of Referrals
DMHAS Accepted and Transition is in Process	291
Referrals at DMHAS--DMHAS requested further Information	78
Referrals pending DMHAS Eligibility--Not yet Reviewed	337
Grand Total	706

From FY 2004 to FY 2007, the number of referrals from DCF to DMHAS has more than doubled, from 150 to about 300 clients a year. In FY 2008 DCF referred 383 youth to DMHAS and 426 in FY 2009. The peak year for referrals was in 2005 when DCF referred over 579 youth. The increase was directly related to DCF initiating its statewide screening and referral process and improved collaboration between DCF and DMHAS.

In estimating the demand going forward, based on experience under the new referral and screening process, DCF anticipates that the referral level will average 340 per year. DCF and DMHAS have historically planned for a 3-6 month transition; however due to the increased volume of referrals to DMHAS since FY 2005 and in light of DMHAS' limited program capacity, the length of time required post referral to effectuate individual transitions to DMHAS may currently take more than 6 months.

**FISCAL
YEAR**

NUMBER OF REFERRALS

1998	51
1999	79
2000	156
2001	146
2002	114
2003	133
2004	175
2005	573
2006	311
2007	200
2008	383
2009	426

3. TRANSITION PLANNING AND PREPARATION

This component part of the process is designed to establish an essential framework for case decision-making, for the establishment of goals, tasks and priorities, and to outline what interventions and services will best facilitate successful outcomes for a particular youth. Timelines for the development of an initial treatment plan and for its subsequent updates is governed by established DCF policy. Specifically, for all youth 14 years of age or older who are placed in out-of-home care, including those receiving Voluntary Services, must have a yearly case conference through their 18th birthday. Among the many purposes of the case conference,

plans are set for service provision, achieving permanency, and to assure successful transition to adult services.

To assure accountability in the treatment planning process, in addition to worker supervision, an Administrative Case Review is conducted by a third party case reviewer at minimum every six months (more frequent when case circumstances dictate) to provide an orderly and structured review of the case and progress toward case goals. Among the areas for review the Administrative Case Review examines appropriateness of placement and effectiveness of permanency and transition planning.

4. DMHAS SPECIFIC PLANNING AND PREPARATION

When planning a transition to DMHAS, DCF uses existing treatment planning documents that are entered into DCF's LINK data system. DMHAS uses a form called the Transition Action Plan. Within DCF, responsibility for tracking individual transition plans rests within the Area Office. The DCF Area Office Social Worker and the Social Work Supervisor work directly with DMHAS to effectuate individual transitions. Each Area Office also has an identified liaison to DMHAS; this liaison may also be involved in transition activities as needed.

Over the past 2 years, DCF Central Office has worked with our Area Offices to develop local interagency meeting to provide a forum for DCF and DMHAS staff to discuss referral, eligibility and transition issues. This has been implemented in 11 of our Area Offices to date; an additional Area Office/DMHAS meeting is beginning in March 2010.

If the adolescent planning team for a specific youth believes that a youth is in need of a referral to DMHAS, the Area Office adolescent Social Worker follows the defined referral mechanism referenced herein to ensure that a timely referral to DMHAS or DDS is completed. For younger adolescents, the team would assess where each youth is in relation to the need for referral and the referral would be made at the appropriate juncture.

In order to develop transition plans and to determine the long-term needs of youth with serious mental illnesses, DCF obtains input from a variety of sources, including: clinical evaluations and recommendations from outpatient and other community-based providers, inpatient and residential providers, psychosocial assessments, case conferences, individual and adolescent treatment planning conferences, Administrative Case Reviews and recommendations from DMHAS following formal acceptance into their services.

Once an individual is accepted to DMHAS, transitions can occur anywhere between the ages of 18 and 21. DMHAS cannot start actual services prior to age 18, but can begin transition activities earlier. The agreement between the agencies has been that DMHAS gets the referrals no earlier than age 16, which would make that the earliest point that a transition could technically begin.

The process envisioned for transition is as follows:

1. Once DMHAS has determined that a client is eligible for services, DMHAS Young Adult Services (YAS) staff in DMHAS Central Office (CO) will contact the DCF worker to discuss transition-planning activities. DMHAS immediately involves the Local Mental Health Authority (LMHA) from the area where the youth wants to reside in transition

planning. CMHAS and/or LMHA staff meet with the youth (and family if appropriate) individually to explain DMHAS YAS, discuss client interests and plans.

2. Prior to the anticipated date of entry into DMHAS YAS, the designated staff person will schedule a transition planning meeting to include the YAS program that will be working with the youth, as well as the youth and other involved parties (family, advocates, providers, school system, etc.). These are called Transition Action Plan (TAP) meetings.
3. If there are complicated transition or clinical issues, it is likely that a meeting or case conference would have been held prior to the TAP meeting in order to look at those particular issues and determine if there are resource issues, additional evaluations needed or other barriers to the transition which need to be resolved prior to actually beginning transition activities.
4. From the TAP meeting, a written Transition Action Plan is developed, which outlines:
 - a. The DMHAS YAS program liaison
 - b. Treatment and/or other services to be provided by DCF until the client's transition date
 - c. Identification of the DMHAS level of care, community support and other services to be provided to the client following transfer
 - d. An opportunity for the client to visit the program prior to finalizing the service plan
 - e. Discussion of issues such as need for conservator, need for inpatient care and how that will be coordinated and impact the transition timing, etc.
 - f. Specification of clinical, personal and financial information needed by DMHAS and/or the youth prior to transition, i.e. original birth certificate, photo id., etc.
 - g. Identification of issues with regard to transfer of entitlements with an agreed upon division of labor between DCF and DMHAS regarding related tasks.
 - h. Identification of the Local Education Authority (LEA) which will be responsible for education when the youth transfers and designation of DMHAS and or DCF staff who will interact with the school district to ensure that appropriate educational planning occurs
 - i. Establishment of transfer time frames
 - j. Determination if DCF is going to stay involved or end involvement, depending on the youth's educational status at transition.
 - k. A plan for transition visits so the youth can become familiar with the program and vice versa
 - l. If specialized or additional services are needed (e.g. mentor).
 - m. Determine what follow-up meetings and/or communication will be needed to assure smooth transition
5. Transition visits would happen as outlined in the TAP and both DMHAS and DCF share responsibility for assuring this happens -- particularly when there is transportation or geographic barriers.

6. The time frame for the actual move should be determined by the individual youth needs and whether they will be better served by a long or short transition – this is highly variable by individual.
7. Part of the transition prior to and after the move of the client should also include staff sharing and teaching around how to work best with the individual; those sending staff that have good relationships and know the youth well can provide training to the receiving staff about what they have found really works to engage the client, help them through a crisis, manage difficult behaviors, etc.
8. Once the youth has moved DCF could either continue involvement - as defined under the MOA or DCF would close the case at that point.

III. DISCUSSION

The above descriptions and data provide a general framework and experience with transitioning from DCF to DMHAS. To provide greater insight as to the overall performance of transitioning, below are discussion points and descriptions of recent steps taken to improve this work and ultimately the outcomes for the young adults involved.

Referral and Screening

Many changes and improvements have been made to the referral and screening process over the last 3 years. It is evident that these changes have made a significant improvement in the identification and readiness of cases in need of transition.

Some of the changes were inspired by an explicit outcome measure under the *Juan F.* Exit Plan: Outcome Measure #21: "Discharge of Mentally Ill or Retarded Children". This measure states that DCF shall submit a written discharge plan to DMHAS or DDS for all committed or dually committed children (except probate, interstate or voluntary cases) who are mentally ill or retarded and require adult services, within 180 days prior to the anticipated discharge date. This measure requires that 100% of all referrals be made.

Significant improvements have been made in this measure since 2007 showing consistently higher outcomes. For 2009, there were only 1 referral not made in both the first and second quarter (97%) and all referrals were made in the 3rd Quarter (100%).

Transition Planning and Preparation

As a result of the gains in the referral and screening, it follows that changes were necessary to the transition planning and preparation process in order to accommodate increased demand for services. Many changes have taken place and many lessons have been learned. One key lesson is that transition planning must be initiated as early as possible as it requires considerable communication and collaboration between agencies, the youth, his/her family or support network, and other providers.

The actual timing of transitions are influenced by many variables, including the type and availability of services, whether access to those services are best met at DCF or DMHAS, the

youth's educational status, and the resources available to the individual to support community living. Taking this into account, historically transitions to DMHAS took 3-6 months. Given the increased volume in referrals to DMHAS since FY 2005, and in light of DMHAS limited program capacity, the length of time required post referral to effectuate individual transition to DMHAS is currently taking up to 9 months.

As a result of this delay, DCF has begun to utilize its therapeutic group homes in certain cases as a transitional opportunity for some youth prior to going to DMHAS. This has been helpful to the degree that DMHAS lacks program capacity at that level of care and a great many youth are not clinically ready to move into DMHAS supported apartment programs.

With the huge volume of referrals and limited program capacity, many eligibility determinations are not being made until the youth is 17 ½, which means that most transitions are not happening until after the age of 18. During this delay, some youth make alternative plans, decide they are no longer interested in services, or they leave programs and return home to family situations that are ill equipped to meet their needs. In other cases, youth wait for the "right" level of care and remain at Cedarcrest Hospital or residential programs.

Efforts underway to respond to these issues include: local meetings between DMHAS and DCF Area Office staff to improve collaboration; improvements in IT and data management to better track youth and their transition status; implementation of senior management meetings to help support the local work and deal with issues around resource, policy and systems issues, as well as update and revise the MOA as necessary. In addition, both agencies are developing program capacity and have collaborated on a Life Skills initiative. DMHAS is expanding young adult service sites to new areas of the state.

In addition, DCF is improving internal accountability to measure quality of practice and guide improvements and learning in this area of the work. Recent changes in the Administrative Case Review (ACR) process and our treatment planning policy and practice in part aim at evaluating, guiding and improving our transition work.

The experiences of transitioning youth over the last few years has highlighted the importance of the mechanics of transitioning (i.e. the Component Parts). Success is in fact dependent on how well systems communicate, align resources and processes, and collaborate around problem solving. But, in the absence of expanding program capacity - service array, quality and availability - growth and development in serving transitioning young adults will be limited as will improvements to the outcomes associated with this population.

It is evident for transitions to DMHAS additional services and levels of care are needed, most acutely for those youth between the ages of 17 and 21 with serious mental illnesses and those youth with histories of significant trauma who require continued treatment as young adults. In FY 10 DCF has transferred approximately \$3.5 Million to DMHAS to continue to fund approximately 60 youth who had already transitioned to DMHAS but had remained in DCF care. This eliminated the need for quarterly transfers between the agencies. In addition, DMHAS was allocated additional resources in order to enhance its existing YAS programs through budgetary increases which will assist in responding to the ongoing and significant demand for YAS.