STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES

Public Hearing Testimony

Committee on Children
February 5, 2015

Proposed S.B. No. 302 AN ACT CONCERNING THE IDENTIFICATION OF CONNECTICUT'S CHILD PLACEMENT NEEDS

The Department of Children and Families **offers the following comments regarding** Proposed S.B. No. 302, An Act Concerning the Identification of Connecticut's Child Placement Needs. This bill proposes to help identify the services and programs needed in Connecticut in order to meet the treatment needs of Connecticut's children and avoid out-of-state placements.

Observers are correct that Connecticut is undergoing a major change in how we serve children with mental health and substance abuse treatment needs. In the not-so-distant past, children who needed such behavioral health services were almost always forced to leave their families, homes, schools and communities, Connecticut now has significantly enhanced and expanded its capacity to get these kids help without leaving everything they know and love behind them.

The numbers are dramatic: there are 829 fewer children in the care of the Department of Children and Families (DCF) who are living in a group setting to receive treatment than when this administration took office in January 2011. That represents a decline of 56 percent and has allowed the state to reduce spending on group care by $70 million per year. These savings have been offset by $49 million in additional spending for services at home and in the community. (*See Attachment A - DCF Actual Spending and Caseloads, SFY 11 – SFY 15*) In addition to the reinvestments on the community side, we have also started the Family and Community Ties program to keep youth with complex needs in family based settings. This is a foster care model that includes access to clinical supports. We've also expanded resources to find and engage family members—our resources in Wendy's Wonderful Kids was expanded last year and some of our Central office staff were trained in family search/engagement. In-home and community based services are far more efficient because the more restrictive levels of care are the most expensive. Therefore dollar for dollar, more children can be served in the community than in a group setting.

As important as being responsible with public funds, however, is that the children are far better served at home and in the community. National research and clinical experts have long held that treatment in institutional or even small group settings is only appropriate when used for those *individuals who absolutely need a restrictive setting and then only for the shortest time possible*. In other words, early intervention and treatment in the home and community are far more preferable for the vast majority of children. Ask any parent, a child should get the help he or she needs while living at home.

Beyond the compelling common sense of keeping kids at home, Connecticut data shows that the children discharged from group care have done very well. Not only are the kids just as safe and just as likely to avoid re-entry into the foster care system, but 30 to 40 percent returned home with services as needed. The majority of youth who remained in care did not experience a placement change within six months of exit from their congregate care settings.

Some observers point to the usage of hospital emergency departments as evidence that the reform is not working. That argument does not hold up to the facts. The overwhelming majority (93 percent) of the emergency department visits are NOT related to behavioral health needs, and, of those that are, less than one in four are children served by the Department. Emergency department usage has no relationship to the fact that the Department has fewer children placed in group settings. While DCF did not cause or contribute to the increase in emergency department use, we are contributing to the solution by expanding staffing and hours of Emergency Mobile Psychiatric Services, which has proven effective in diverting children from crisis-driven hospital visits by responding to the crisis and connecting families to community services.

While we have seen a lot of progress, I also know there is a lot more work to do. Last October, we submitted a plan to the Legislature to further reform the children's behavioral health system as mandated by Public Act 13-178. Much of that plan calls for integrating behavioral health services into school and pediatric settings because the more we can make help accessible to families, the more likely they are to participate in services. The Department looks forward to working with lawmakers, sister state agencies and stakeholders to move that plan forward so that we can better serve children and families.

Below is recent data regarding this topic that Committee members may find beneficial:

How many youth are out-of-state with age and gender breakdown. What are the programs?
11 youth are in out-of-state placements as of 2/2/2015
Compare to: 1/1/2011 – 362
1/1/2012 – 217
1/1/2013 – 75
1/1/2014 – 34
<u>Youth in out-of-state placements has decreased 96.7% since 2011</u>

Gender/Age
7 Males
2-15 yo, 1-16 yo, 2-17 yo, 1-18 yo, 1-20 yo
4 Females
1- 12 yo, 1-16 yo, 1-17 yo, 1-19 yo
Ages range from 12 – 20
12: 1 female
13: 0
14: 0
15: 2 males
16: 1 male and 1 female

17: 2 males and 1 female
18: 1 male
19: 1 female
20: 1 male

Note: The 12 year old is placed near her mother

Out-of-State Programs

JRI, Berkshire Meadow, Housatonic, MA (2 youth)
JRI, Meadowridge/Walden School, Concord, MA
Becket House, East Haverhill Academy, Pike, NH
Spurwink Services, Casco, ME
Spurwink Services, Cornville, ME
Evergreen Center, Milford, MA
Hillcrest Educational Centers, Highpoint, Lenox, MA
Hillcrest Educational Centers, Hillcrest Center, Lenox, MA
Cumberland Hospital, New Kent, VA
Laurel Ridge TX Center, San Antonio, TX

What are needs of each youth currently placed out-of-state?

With the exception of one (1) youth who is receiving substance abuse treatment in the state where she resides with her adoptive family, the other youth all present with a complex mix of significant mental health, behavioral and medical issues. These include:

- Seven (7) of the youth are either on the Autism Spectrum or have cognitive delays.
- Four (4) have significant medical issues (in addition to other mental health and behavioral issues)
- Three (3) present with problem sexual behaviors (as well as other mental health and behavioral issues)
- Four (4) of the youth are described as highly impulsive
- Three (3) of the youth are described as highly aggressive
- Two (2) are non-verbal
- Other mental health diagnoses include: Schizoaffective, bi-polar, borderline personality

Average length of stay of youth OOS

Current average length of stay is 1,143 days
The range is 31 days to 1,971 days
Compare to: 2012: 640.1
2013: 888.8

Source: Value Options and LINK

Average length of stay of youth in-state at Residential Treatment Centers from 2012 to 2014

2012: 253.7
2013: 227.0
2014: 346.5

The increase in length of stay can likely be attributed to the fact that youth with more complex needs have been returned to in-state facilities from OOS. All providers are actively working to reduce lengths of stay. The Department has given congregate care providers specialized training in family engagement. The goal is to help in-state residential treatment providers increase their work with families and discharge youth directly home with wrap around supports. Value Options has also been assisting our in state congregate care providers in disposition planning at the point of a youth's residential treatment intake.

Source: Value Options and PSDCRS

Since 2011 how many Connecticut programs have opened to serve youth previously going Out-of-State?

Five - Adelbrook (Coed, youth on the autistic spectrum with psychiatric involvement); Boys and Girls Village (Males, problem sexual behavior); Klingberg Family Centers Webster House (Coed, medically complex/mental health needs); CHR Woodbridge House (Females, behavioral and psychiatric complexities who present with highly aggressive behaviors); and JRI Susan Wayne Center for Excellence (Coed, intellectual and developmental disabilities).
The Department is actively engaged with in-state residential treatment providers to help serve several of the 11 youth out of state with the hope that additional youth may be served in Connecticut.

What's legal status (voluntary, committed, JJ, dual)?

Four (4) not committed (three (3) are services post-majority – youth are over 18 - and one (1) is a subsidized adoption for whom we are paying for a short-term substance abuse program in the same state in which she resides - TX)
Five (5) committed
Two (2) statutory parent

Entry Rates: There were 1,833 (rate 2.3/1k in child population) children who entered DCF care during CY14 who met the federal Adoption and Foster Care Analysis and Reporting System (AFCARS) definitions.

Kinship Care: Of the 1,833 entries, 748 (40.8%) were initially placed into a Kinship Foster home.

Congregate Care: There were a total of 5,100 children who spent any amount of time in DCF care during CY14 who met the AFCARS definitions. Of those, 904 (17.7%) spent any amount of time in a Congregate Care setting , which includes Safe Homes, Shelters, Group Homes, Residential Treatment Centers, DCF Facilities or Hospitals (for medical and/or psychiatric reasons). The number of days spent in a Congregate Care setting, however, accounted for only 13.3% of all the days that these 5,100 children spent in DCF care during CY14.

The Department's Office for Research and Evaluation (ORE) has conducted a number of qualitative studies regarding children who exited from congregate care since 2011. Below is data from a mix methodology study completed in January 2014. Because this study included a qualitative review, a sample (N=116) was utilized rather than the total exit population. ORE is

currently conducting a fourth review of congregate care exits which will provide an updated quantitative analysis for the total population of kids who exited from 2011 – 2014.

In January 2014, the Department published the second of two formal studies regarding the outcomes of children and youth who have exited from Congregate Care settings since the current DCF administration initiated significant policy changes in Calendar Year (CY) 2011. These policy changes were designed to reduce the agency's reliance on such settings. The Office for Research and Evaluation (ORE) used a mixed-method evaluation strategy (i.e., quantitative and qualitative approaches) to monitor and report on outcomes for this population, and the sub-populations requested by the Juan F. plaintiffs.

The initial report provided results for a sample of 60 children with exits between 4/1/11 and 6/30/11, and the 2014 report provided results for a sample of 56 children with exits between 1/1/12 and 3/31/12, and compares them to the previous sample of 60 children exiting during CY '11. Both samples were divided into three sub-groups, as requested by the Juan F. plaintiffs. That report includes these three sub-groups which are as follows:

- 15 children age 12 years and younger at the time of their exit from a congregate care setting
- 26 children who exited an out-of-state congregate care setting
- 15 children who exited a temporary (Safe Home or Shelter) congregate care setting

The below provides data about where the children who exited from congregate went:

Quantitative Trends for Congregate Care Exits 1/1/09 - 12/31/12:

- Fewer children exiting congregate care remained at the same level of care (25% in CY '09 to 19% in CY '12); those that stepped-up to a higher level of care remained constant (12% in CY '09 and CY '12)
- Increasingly, a greater proportion of children exiting (64% in CY '09 to 68% in CY '12) either step-down or discharge entirely from DCF care.
- Most children discharging entirely from DCF care were reunified, with a small group (i.e., 25 or 17.5% over the four-year study period) discharged to guardians or transferred to the care of other agencies.

Quantitative Trends for Specific Sub-Groups of Congregate Care Exits 1/1/09 - 12/31/12:

- Out-of-State: Almost two-thirds of children who exit out-of-state congregate care move to another out-of-state or in-state placement. During CY '12, 75% moved to another placement in CT. Those returning in-state increasingly step-down to a lower level of care (74% in CY '12). Whereas, most remaining out-of-state move from one residential program to another.
- Ages 0 - 12: Exits for young children from congregate care are to family based settings (i.e., foster care of all types and permanent homes) accounting for 74% of the exit destinations for youngsters under age seven over the past four years. The exits to foster care settings have been stable but legal discharges to permanent settings have decreased

steadily over the past four years. Concurrently, the proportions of exits to other congregate care settings over the same period have increased.

- Temporary Settings: The largest group exiting temporary settings move to foster care (i.e., family based settings), though in lesser proportions each year since 1/1/09. The next largest group moved to other non-temporary congregate care, most often group homes or residential. The third and smallest group exiting these settings to legal discharge to reunify home.

As mentioned previously, DCF's ORE is presently conducting another study to examine qualitative and quantitative data pertaining to children who exited from congregate care settings that closed during CY 2014.

Proposed S.B. No. 303 AN ACT CONCERNING CHILDREN EXPOSED TO FAMILY VIOLENCE

The Department of Children and Families **offers the following comments regarding** Proposed S.B. No. 303, An Act Concerning Children Exposed to Family Violence. This bill would create a task force to ensure that state policy and practice offers effective, evidence-based models for strong intervention and prevention remedies for children and youth exposed to family violence.

Data has demonstrated that child abuse is 15 times more likely to occur in families beset with Intimate Partner Violence. The Center for Disease Control reports that studies from countries around the world -- including the United States -- have established the relationship between Intimate Partner Violence and child abuse. The Department is continuing to enhance the service array to address Intimate Partner Violence grounded in best practice and inclusive of a strong evaluation component. Again, see our written testimony for more detailed information.

In 2012, to strengthen the response to families impacted by IPV, the Department assigned a Behavioral Health Clinical Manager to oversee intimate partner programming within the agency to reduce the impact of IPV on families and to promote and enhance effective intervention initiatives. In Connecticut, there are approximately 20,000 family violence incidents annually resulting in at least one arrest. Seventy three percent (73%) were intimate partner violence incidents. (*Connecticut Coalition against Domestic Violence, 2014 Fatality Review report*) The DCF internal data on families also shows that violence is occurring within homes in Connecticut, as indicated with the following 2013 DCF data. In Calendar year 2013, the Department received 23,340 reports. Of those reports, there were allegations of intimate partner violence in 5,779 reports. In regards to Intimate Partner Violence reports, sixty-five percent (65%) were served through the investigation track, and thirty-five percent (35%) through the Family Assessment Response (FAR), DCF's Differential Response track. There were 2836 of the 2013 reports that had co-occurring IPV and substance use, consistent with studies that indicate a very strong intersection between IPV and substance use. Studies of IPV frequently indicate high rates of alcohol and other drug use by offenders during abuse. Not only do offenders tend to abuse drugs and alcohol, but IPV also increased the probability that victims will use alcohol and drugs to cope with abuse. Consistently over the last 13 years, the number and percent of accepted reports that include allegations of intimate partner violence from calendar year 2000 through calendar year

2013 remain consistent at approximately 21%. This reflects only the reports that are received with allegations and does not reflect the additional instances of domestic violence discovered through assessment. In 2013, approximately 11% of substantiations were of emotional neglect which included impact on the child due to exposure to domestic violence.

In 2013, a Request for Information (RFI) was issued by the Department to assist in the redesign of the Intimate Partner Violence Service array to be offered through the Department. Seventeen (17) responses were received from stakeholders, including community providers and advocates. The responses were reviewed and included the following recommended practices, which are critical to moving the intimate partner violence work forward in Connecticut:

- Increase service coordination and cooperation among all stakeholders, including clients, associations, courts, DCF, providers, spiritual and faith based communities and other stakeholders;
- Enhance the ability to address the lower and mid-level safety and risk cases, which frequently do not have court involvement to motivate service compliance;
- Develop a consistent service array statewide;
- Increase cultural awareness; impact of culture on intimate partner violence presentation and intervention methodology;
- Increase length of services to four months - exceptions may be made for an additional 2 month length of service based on case specific needs;
- Strengthen relationships between DCF staff and intimate partner violence providers;
- Use the Greenbook Initiative and national best practice standards to further inform the development of intimate partner violence services.

During 2014, in an effort to build a much broader continuum of services to meet the diverse needs of the community, the department provided training and support for CT's 18 domestic violence shelters to offer Moms Empowerment and Kids Club, an evidence-based intervention for mothers who have left a domestic violence relationship and their children. The Connecticut Coalition against Domestic Violence (CCADV) has contracted with the Department to offer Moms Empowerment and the Kids Club to their shelter residents. Additionally in 2014, Safe Dates an evidence based program that targets attitudes and behaviors associated with teen dating abuse and violence was also offered to staff at DCF, CCADV and a number of community based service providers.

DCF is currently seeking proposals to deliver a supportive service array of assessment, interventions and linkages to services to address families impacted by intimate partner violence. The deadline for this RFP is in early March. The goal of this new service is to establish a comprehensive response to intimate partner violence that offers meaningful and sustainable help to families that is safe, respectful, culturally relevant and responsive to the unique strengths and concerns of the family. Each contractor will be responsible for the delivery of key clinical services as well as assertive linkages to existing community based services.

DCF has also begun creating a new training, consultation, service delivery and evaluation model based on the most current research and practice serving families impacted by Intimate Partner

Violence (IPV). New Domestic Violence specialists are working in every region to provide internal expertise.

In-home and clinic-based services for families where intimate partner violence (IPV) has been identified. Core services include a comprehensive assessment that addresses past history of violence, patterns of coercive control, coping and protective strengths and strategies; parenting and the parent child relationship; the impact of the IPV; the risk for recurrence of violence; services and treatment needs. Additionally, safety planning for survivor and child, trauma focused work with children, interventions focused on repairing and healing relationships, and batterer interventions. In SFY2014, 369 families and 791 children received services.

Proposed S.B. No. 306 AN ACT ESTABLISHING AN INDEPENDENT DEPARTMENT OF CHILDREN AND FAMILIES OMBUDSMAN

The Department of Children and Families **offers the following comments regarding** Proposed S.B. No. 306, An Act Establishing an Independent Department of Children and Families Ombudsman. This bill would establish an independent Department of Children and Families ombudsman to give children in the care and custody of the department an avenue to have any complaints or grievances heard, reviewed and addressed.

We believe that this **legislation is unnecessary** and the creation of a new office would result in costs that are not anticipated to be included in the Governor's budget, so this proposal cannot be supported by the Department. DCF already has an Office of the Ombudsman located within the Commissioner's Office. Its role is to receive and assess inquiries and complaints relating to Department services in an effort to bring about a resolution for the best interests of children as well as to ensure the rights of individuals involved with the Department are upheld and maintained.

Connecticut also has an Office of the Child Advocate that monitors and evaluates public and private agencies that are charged with the protection of children. Connecticut is one eleven states to operate such an independent and autonomous office.[1]

The DCF Office of the Ombudsman responds to inquiries and complaints received from, but not limited to; youth, adult clients, foster and adoptive parents, members of the public, community providers, legislators and the Governor's Office. The Office is also charged with responding to particular issues and correspondence on behalf of the Commissioner of the Department of Children and Families that require an independent assessment. This includes reviewing and

---

[1] National Conference of State Legislatures website, Kate Bartell Nowak, "*Children's Ombudsman Offices | Office of the Child Advocate*," September 3, 2014, **http://www.ncsl.org/research/human-services/childrens-ombudsman-offices.aspx**

responding to grievances filed by the residents at the Connecticut Juvenile Training School and Pueblo Girls Unit.

For the calendar year 2014, the Ombudsman staff handled total of 2,999 inquiries of which 1,612 were Informational Calls, 1,198 were calls made with inquiries about DCF related activities, and 189 were grievances filed by the youth at the Connecticut Juvenile Training School and Pueblo Unit.

The most common types of inquiries received are from a clients concerned about the manner in which their case is being managed, from the services being offered to the length of time their case is open and from grandparents requesting information about Departmental policies and procedures leading to them being a support to their grandchildren.

The grievances filed by the youth at CJTS and Pueblo range from concerns about staff conduct, conditions within the facility and disputing discipline placed upon them for new offenses.

The Director of the Office of the Ombudsman directly handles the grievances filed by the youth at CJTS and Pueblo. He meets with the youth, determines the extent of their concern and then reviews the facility's response to the inquiry. Furthermore, follow-up is provided to the youth about the outcome of their grievance and the next steps.

Below is a summary of the grievances filed for the Connecticut Juvenile Training School and the Pueblo Unit for girls:

<u>Connecticut Juvenile Training School</u>

Grievances:

- 172 grievances filed
- 14.5% or 25 were found to have "Merit" or "Partial Merit"
- 75% or 129 were found to have "No Merit"
- 3% resulted in a referral to the Careline or Human Resources
- 8% are pending further information

Distinct Residents:

- 84 distinct residents filed grievances
- 7 residents accounted for 35% or 61 of the grievances as they each filed 5 or more grievances with two residents filing 14 and 15 grievances respectively

Distinct Staff:

68 distinct staff were the subject of grievances being filed

43 grievances were on the general conditions of the facility and did not name a particular staff member

6 staff members had 5 or more grievances filed against them with two staff having 10 grievances filed against them and another staff member had 9 grievances filed against them

<u>Pueblo Unit</u>

Grievances:

- 17 grievances filed
- 18% or 3 were found to have “Merit” or “Partial Merit”
- 82% or 14 were found to have “No Merit”

Distinct Residents:

- 7 distinct residents filed grievances
- 1 resident filed 9 grievances and another resident filed 4 grievances

Distinct Staff:

- 3 distinct staff were the subject of grievances being filed
- 7 grievances were on the general conditions of the facility and did not name a particular staff member
- 1 staff member had 4 grievances filed against them

Proposed S.B. No. 307 AN ACT IMPLEMENTING A QUALITY ASSURANCE PROGRAM FOR DEPARTMENT OF CHILDREN AND FAMILIES PROGRAMS AND FACILITIES

The Department of Children and Families **offers the following comments regarding** Proposed S.B. No. 307, An Act Implementing a Quality Assurance Program for Department of Children and Families Programs and Facilities.

While the Department supports enhanced quality assurance programming at the Connecticut Juvenile Training School (CJTS), we believe that this **bill is unnecessary.** This bill would require DCF to implement the "Performance-based Standards Program" (PbS) quality assurance program offered by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) of the Office of Justice Programs in the U.S. Department of Justice. The OJJDP PbS program is a program for juvenile justice agencies, facilities and residential care providers to identify, monitor and improve conditions and rehabilitation services provided to youths using national standards and outcome measures.

CJTS did utilize PbS several years ago; however, we ended the contract in 2008 when we pursued accreditation as a Juvenile Correctional Facility by the American Correctional Association (ACA). ACA accreditation is recommended by section 17a-27e of the General Statutes. Because there is no "like" facility in New England for data comparative purposes and in light of PbS's cost of approximately $10,000, we decided to forego the contract and utilize those resources for ACA accreditation. Many of the practices of PbS remain incorporated into CJTS operations. CJTS first received national American Correctional Association (ACA) accreditation in 2009, and it was reaccredited in 2012. It is significant that the ACA accreditation is a review by external independent experts while the PbS system relies on self-reporting.

We recognize that we have a unique and relatively small role in the Connecticut juvenile justice system and that we have a responsibility to administer it in the best way possible. To that end, we recently have brought in an outside, independent expert in meeting the therapeutic needs of youths to conduct a top-to-bottom evaluation of both CJTS and the Pueblo girls secure unit. Dr. Robert Kinscherff, a clinical and forensic psychologist and an attorney, is a senior associate at the

National Center for Mental Health and Juvenile Justice. The center's goal is to improve policies and programs for youth with mental health disorders who are involved with the juvenile justice system. He has written specifically about mental health treatment in juvenile justice programs, and he will bring enormous experience and expertise to our efforts to make CJTS and Pueblo model programs of therapeutic treatment and rehabilitation.

While the programs are secure, we do not view them or operate them as correctional in nature or function. Education and clinical treatment are cornerstones of the programs' ability to successfully return youths back to their communities. Accordingly, we view restraints and seclusions as incidents to be avoided and to be used only when absolutely necessary to ensure safety. Without question, they are not therapeutic interventions and, while they are sometimes necessary for safety reasons when working with youths with very complex needs, we also know that they are the most common cause of injury for our staff. For these reasons, we conducted a two-day training for staff in December to support them in reducing the use of restraints. Staff are now engaged in the process of implementing the training into their daily work at both programs. We expect this training along with Dr. Kinscherff's work will help address any concerns surrounding over reliance on restraints and seclusion.

Let me address directly one area of disagreement recently, and that involves the CJTS Advisory Board. As you know, the Commissioner has the legal authority under CGS 17a-6(b) to appoint advisory boards for DCF institutions or facilities. In December, the CJTS advisory board was reconstituted so that its membership has a more diverse set of professional backgrounds and experiences. Only two members of the previous board were not re-appointed. These changes will in no way detract from the ongoing efforts to improve services at CJTS or reform how it conducts its work. Many of the issues that the former advisory board leadership brought up are being addressed. No one on the previous advisory board was punished, and of course, no individual has a right to serve on any advisory board. We are confident that the new board will be more effective in providing feedback and constructive guidance to the facility and myself. The members are: Karl Alston, Court Support Services Division, Judicial Branch; Abigail Anderson, Director, Connecticut Juvenile Justice Alliance; Joseph Bruckmann, Public Defender Bridgeport; William Carbone, Director of Experiential Education, University of New Haven; Francis Carino, Supervising Attorney, Office of the State's Attorney; Felice Duffy, Assistant United States Attorney; James Glasser, Wiggin & Dana; Samuel Gray, CEO, Boys and Girls Club; Dr. Steven Kant, CEO, Boys and Girls Village; Christine Rapillo, Supervising Attorney, Office of the Public Defender; Eugene Riccio, Gulash & Riccio; William Rosenbeck, Superintendent, CT Juvenile Training School; Ann Smith, Executive Director, AFCAMP; and Christine Whidden, Director of Security, Department of Corrections. Ex-Officio members are: Joette Katz, Commissioner, DCF; and Tony DePina, JJSW, DCF.

Proposed S.B. No. 310 AN ACT STRENGTHENING CHILD FATALITY REVIEW PROCEDURES

The Department of Children and Families **offers the following comments regarding** Proposed S.B. No. 310, An Act Strengthening Child Fatality Review Procedures. This bill proposes to provide for an independent review of fatalities involving children with Department of Children and

Families involvement, promote a more transparent review process and ensure a public discussion of findings and recommendations.

Below is information that we provided to the Committee on October 2, 2014:

Child Maltreatment Fatalities Data

1. **Definition:**

   DCF has defined a child maltreatment fatality as one for which at least one allegation of abuse or neglect related to the death has been substantiated [by DCF] against a caregiver.

2. **Data:**

   - The CT maltreatment fatality rates have consistently been below the national rates and the 2.20 national average.
   - The NCANDs report notes that while the national estimate and rate is lower in 2012 than for 2008, both the number and rate have been increasing since 2010.
   - Many states have attributed increases in their rate due to improvements in reporting of such incidents.
   - The Annie E. Casey Foundation's 2014 Data Book, CT is ranked 7th in the nation on overall child well-being. This ranking is based on combined data across four domains: Economic Well-Being, Education, Health and Family and Community.
   - Connecticut was also one of three states with the lowest rates of child and youth deaths overall, 17 per 100,000, in 2010.

The following table shows numbers of child maltreatment fatalities from two separate data sources for CT: the DCF Critical Incidents Database, and the data DCF submits to the federal government's National Child Abuse and Neglect Data System (NCANDS) report. The NCANDS data comes from CPS Investigation data that tends to be limited to information available within a short window following the incident. The data from the Critical Incidents database is considered more authoritative because our Risk Management team conducts additional follow-up to ensure the most accurate reporting as additional facts and information are revealed over time.

	Child Deaths Due to Maltreatment				
Calendar Year of Incident	DCF CT Number	DCF CT Rate*	NCANDS CT Number	NCANDS CT Rate*	NCANDS US Rate*
2005	**1**	0.11	9	1.08	1.94
2006	**3**	0.36	3	0.36	2.00
2007	**4**	0.49	4	0.49	2.28
2008	**10**	1.20	8	0.98	2.28
2009	**6**	0.73	4	0.50	2.30
2010	**5**	0.61	4	0.50	2.08
2011	**9**	1.10	8	1.00	2.11

2012	**10**	1.20	6	0.76	2.20
2013	**16**	2.00	*N/A*	*N/A*	*N/A*
2014	**8**		*N/A*	*N/A*	*N/A*

** All rates are shown as the number of child fatalities per 100,000 children in the relevant population (CT or US)*

The following table shows all child fatalities reported to DCF since 2005, broken out by the type of DCF involvement. It is important to note that not all child maltreatment fatalities involve children who were receiving services from DCF either in the past, or at the time of their death.

Calendar Year of Incident	Child Deaths Due to Maltreatment			DCF Involved But Death Not Due to Maltreatment	Not DCF Involved and Not Maltreatment	Total Child Deaths Reported to DCF Risk Management
	DCF Involved		No DCF Involvement			
	Open DCF Case	Prior DCF Case				
2005	0	0	1	11	7	19
2006	1	1	1	13	9	25
2007	2	2	0	15	5	24
2008	2	5	4	12	14	37
2009	1	2	4	12	12	31
2010	0	3	2	12	17	34
2011	4	4	2	14	17	41
2012	1	5	4	11	15	36
2013	5	5	6	12	12	40
2014	4	4	0**	14	7	29
2005	0.0%	0.0%	5.3%	57.9%	36.8%	100.0%
2006	4.0%	4.0%	4.0%	52.0%	36.0%	100.0%
2007	8.3%	8.3%	0.0%	62.5%	20.8%	100.0%
2008	5.4%	13.5%	10.8%	32.4%	37.8%	100.0%
2009	3.2%	6.5%	12.9%	38.7%	38.7%	100.0%
2010	0.0%	8.8%	5.9%	35.3%	50.0%	100.0%
2011	9.8%	9.8%	4.9%	34.1%	41.5%	100.0%
2012	2.8%	13.9%	11.1%	30.6%	41.7%	100.0%
2013	12.5%	12.5%	15.0%	30.0%	30.0%	100.0%
2014	13.8%	13.8%	0.0%	48.3%	24.1%	100.0%

**NOTE: As of 10/1/14, there are three (3) additional fatalities that occurred during CY14 for which the investigation of maltreatment remain pending. Two of them were on an open DCF case, one that had no previous DCF involvement.*

***NOTE: As of 6/19/14, the one case previously reported (as of 6/9/14) that was due to maltreatment but had no prior DCF involvement had to be reclassified to having had prior involvement. The initial search of LINK by the Careline for parties involved in the case did not return any results, so a new case was created. However, the new case was merged on 6/12/14 with the family's prior case as part of the closing of the investigation.*

Best Practices

The below table shows some initiatives/activities that are being used in other states and in CT to help prevent child maltreatment fatalities.

National	Connecticut
Specialized screening tools for cases that present with risk factors found in child fatality cases. Ex. Florida's Rapid Safety Feedback	• DCF will be participating in a research roundtable with the Casey Forum and the Federal Commission to Eliminate Child Deaths. • DCF met with the Eckerd Foundation, a family service organization, who has worked with the state of Florida in response to child fatalities, and looking to bring RSF to CT. • Policy 34-2-6 "Critical Questions to Answer" • DCF working with Hospitals and Medical Community to improve reporting • CT developed proactive strategies that promote the consistent screening and early detection of child abuse. These guidelines provide medical personnel with a protocol to follow when a child presents in any clinical setting with a traumatic injury that may have been caused by abuse or neglect

National	Connecticut
States are doing Safe Sleep Campaigns	• DCF Policy 44-12-8, Safe Sleep Environments: brochures for families, discussions with families. • Public health campaign is being designed and developed to increase caregiver knowledge and raise public awareness of topics relevant to preventing child abuse and maltreatment. • DCF secured technical assistance from Casey Family Programs and Prevent Child Abuse America to develop targeted messaging to raise public awareness and caregiver knowledge around recurring issues that present in case fatalities, such as unsafe sleep, abusive head trauma, and attention to caregiver choices. • The campaign is to include targeted messages to Dads
States have Safe Haven Laws and CPS policies	• Policy 33-7-15 "Save Haven for Newborns"
Some states not only review the fatalities but near fatalities as well	• CT Child Fatality Special Review Board: Child Fatality Reviews • DCF Special Review - Partnership with Area Offices to conduct Child Fatality Reviews • ORE finalizing 0-3 fatality review report and developing ongoing fatality case review process. • Implementation of Fatality Data Collection and Review protocol
Some states have laws/statutes/protocols to address children born drug exposed or have heavier criminal consequences when children are exposed to drugs/drug activity.	• Policy 34-12-2 "High Risk Newborns"*Policy 34-12-3 "Disabled Infants with Life Threatening Conditions" • Drug Endangered Children Memorandum of Understanding: DCF works collaboratively with law enforcement and other state agencies that serve children and families to improve outcomes for children residing in drug affected environments. • Family-Based Recovery (FBR) provides in-home attachment-based parent-child therapy and contingency management substance abuse treatment. The mission of FBR is to ensure that substance affected children develop optimally in drug-free, safe and stable homes with their parent(s). FBR treats mothers and fathers who are actively using substances or who have recent history of substance abuse that are also parenting a child under the age of 8.

CT DCF and other state agencies also provide services to families with young children who are the most vulnerable (ages birth to three) to child maltreatment fatalities. These services include:

- 24/7 Dads
- Baby Elmo Project

- Birth to Three System
- Child First Program
- Early Childhood Consultation Partnership (ECCP)
- Family Based Recovery (FBR)
- Maternal Infant Outreach Program (MIOP)
- Nurturing Families Network (NFN)
- Zero to Three Visitation (ZTT)

Proposed S.B. No. 311 AN ACT CONCERNING NOTIFICATION TO BOARDS OF EDUCATION OF THE PLACEMENT OF CERTAIN CHILDREN IN THE SCHOOL DISTRICT

The Department of Children and Families offers the following comments regarding Proposed S.B. No. 311, An Act Concerning Notification to Boards of Education of the Placement of Certain Children in the School District. This bill would require the Department of Children and Families and the State Board of Education to notify school districts when a child who is in DCF custody has been placed in such school district.

We believe that this **bill is unnecessary** because current DCF policy (*see Attachment B*), requires the child's assigned DCF Social Worker to provide oral notification to a local education agency (LEA) within one business day of a placement and to provide written notification within two business days.

Proposed S.B. No. 312 AN ACT CONCERNING THE PROTECTION OF PARTICULARLY VULNERABLE CHILDREN

The Department of Children and Families **offers the following comments regarding** Proposed S.B. No. 312, An Act Concerning the Protection of Particularly Vulnerable Children. This bill proposes to require policies and procedures to reduce fatalities in children ages birth to three.

A "case-control" study, just completed by DCF's Office of Research and Evaluation, found that Sudden Infant Death Syndrome (SIDs) was the most common cause of death (28.2%), followed by medical complications (12.1%), unsafe sleep (11.2%) and physical injury (8.1%). Consistent with previous Department reviews, unsafe sleep was found to be related to the deaths in 33.9 percent of the deaths. The study analyzed 124 fatalities between January 1, 2005 and May 31, 2014 of children ages zero to three in families with some agency involvement. This analysis is prompting changes that will pinpoint families with the highest risks and increase oversight and services for these families.

The study, which compared the cases in which a child died to a control group, found the following statistically significant factors:

- Age of the child – The older the child is, the less likely the child will die. Among the 124 children who died, 65 percent were less than six months of age;

- High Risk Newborns – Children who were high-risk newborns due to medical conditions were more likely to die;
- Assessment of parent needs – Fatalities were less likely when the Department conducted comprehensive assessment of the parents' needs;
- Caseworker visits with parents – Fatalities were less likely when there were sufficient frequency of social worker visits with parents;
- Mental health and substance abuse – Parents with these types of treatment needs were more likely to be involved in a child death; and
- Child protective services (CPS) reports – Families with more CPS reports were more likely to suffer a fatality.

Similar strategies for increasing oversight of the most-at-risk families has been effective in Florida and other jurisdictions.

National research shows it is hard to predict when a fatality will occur. However, our own research in Connecticut and the experience elsewhere show this is a promising approach to preventing heart-breaking tragedies. We have a responsibility to do everything possible to save these innocent little children.

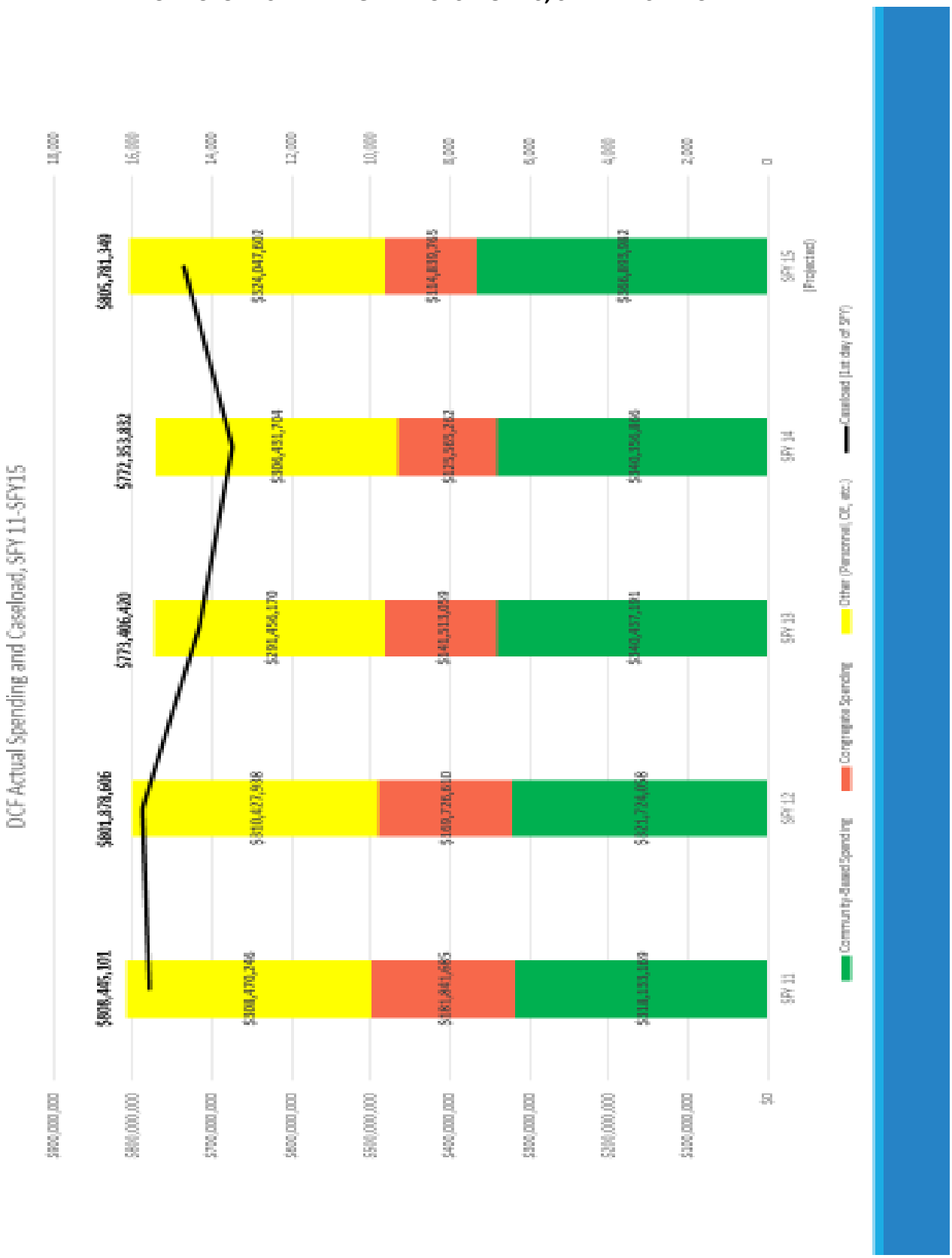
This effort will come at no expense to the State of Connecticut as the Eckerd Foundation, a well-known private provider of social services in some regions of the country, has identified philanthropic sources to fund the first year of the program. Casey Family Programs, a national organization with expertise in child welfare, will fund the second year. The Department is entering an agreement with Eckerd, which has pioneered this "Rapid Safety Feedback" (RSF) approach to reduce child fatalities. RSF uses both qualitative reviews and predictive analytics to better identify CPS-involved families who might be at greater risk for a child fatality. This approach will further support DCF staff to prioritize interventions and supports for the most vulnerable families they serve. Families with the highest risk factors will receive more social worker visits with the parents, more comprehensive assessment of parental needs, and more services to meet those needs.

This latest effort to understand and respond to child fatalities in Connecticut comes as the Department continues to address the largest single factor related to child deaths – unsafe sleep conditions for infants. Last year, the Department instituted a new policy to require social workers to talk with parents of children under the age of one about the importance of ensuring a safe sleep environment, to inspect the family's sleep arrangements, and to offer free "pack 'n plays" to families who need a safe place for the child to sleep. Two hundred "pack 'n plays" have been distributed, and the Department just purchased a new supply to replenish its stock. The Department also has worked with hospitals and enhanced training of its staff and other professional staff to improve the recognition and identification of child abuse. Finally, the Department continues to work with national organizations, including Prevent Child Abuse America and Casey, as well as state partners, including the Office of the Child Advocate and other state agencies, to develop a public awareness campaign to educate families on preventing fatalities. The messages will focus on unsafe sleep conditions, abusive head trauma and shaken

baby syndrome, boyfriends and other unrelated caretakers, and targeted messaging to caretakers on how to prevent sudden violent outbursts.

ATTACHMENT A – SB 302

DCF ACTUAL SPENDING AND CASELOADS, SFY 11 – SFY 15



DCF POLICY 45-4 – Notification to Local Education Agency

EDUCATION

Notification to Local Education Agency 45-4

Policy

In order to ensure that children in the care of DCF receive a free and appropriate public education, the Department of Children and Families shall maintain communication with the local education agencies (LEAs) legally responsible for providing those services and with the LEAs actually educating the children placed by DCF.

Legal reference: 42 USC §671(a)(30).

DCF Staff Responsibilities

The DCF Social Worker or Juvenile Justice Social Worker who is responsible for a child's placement shall provide formal notification via the DCF-603, "Notification to the Local Education Agency," to the LEA legally responsible for the child's education; the LEA responsible for educating children in the town where the child resides; and the surrogate parent office, if a surrogate parent is appointed or needs to be appointed, whenever one or more of the following circumstances occur:

- the child is initially placed;
- there is a change in the child's placement, including reunification;
- there is a change in the residence of the child's parent(s) or guardian(s) from whom the child was originally removed, unless parental rights have been terminated;
- a parent has died, unless parental rights have been terminated;
- there is a change in the child's legal status, including a transfer to another agency; or
- parental rights are terminated.

Notification

Copies of the DCF-603 shall be sent to:

- the Surrogate Parent Program, if a surrogate parent is assigned or needs to be assigned;
- the LEA of the town in which the child will be or has been placed;
- the LEA of the town where the child had previously been placed;
- the LEA of the town where the parent(s) or guardian(s) reside if parental rights have not been terminated; and
- the child's placement.

Timelines

DCF shall notify the child's responsible LEA of an out-of-home placement within the following timelines:

- oral notification within one business day of the placement; and
- written notification within two business days of the placement.

Legal reference: Conn. Gen. Stat. §10-76d(e)(2).

Note: Whenever there is a question regarding the notification to an LEA of a DCF placement, the Social Worker or Juvenile Justice Social Worker shall contact the USD 2 Education Consultant for assistance.

FORM DCF 603 – DCF Notification to the Local Education Agency

DCF-603
08/2014 (rev.)

Department of Children and Families
DCF Notification to the Local Education Agency

To: **Office of the Superintendent** (School district with financial responsibility, *i.e.*, where parent lives)	Date Sent

Please be advised that:		
	Child's Name	Date of Birth

has been placed
Date of Placement:

by the Department of Children and Families in a: (check one box below)		**Name and Address of Placement:**
☐ Foster Home	☐ Parent/Guardian Home	
☐ Group Home	☐ Shelter	
☐ Residential Facility		
☐ Other (specify)		
		Telephone:

☐ **The child requires special education and related services or has been referred to determine special education eligibility.**

☐ To the best of DCF's knowledge, **Nexus exists** with	**Other Parent**
Nexus School District:	
Basis for Nexus (include name and address of the individual listed below who lives in town listed on line above)	☐ Mother:
☐ Mother:	☐ Father:
☐ Father:	☐ Guardian:
☐ Guardian:	☐ Address:
Address:	
	Telephone:
Telephone:	

☐ **No Nexus Exists**
Basis for No-Nexus (check applicable box for each parent)

Mother	Father	
☐	☐	Has No Connecticut Residence
☐	☐	Parental Rights Have Been Terminated
☐	☐	Deceased
☐	☐	Identity Unknown
☐	☐	Resides in a Connecticut Correctional or Treatment Facility
☐	☐	Whereabouts are Unknown

Note: Based upon information available to DCF this Nexus/No-Nexus status has existed since (date):

Legal Status:	☐ The Commissioner of the Department of Children and Families has custody of the child but not guardianship.		
	☐ The Commissioner of the Department of Children and Families is the legal guardian of the child.		
	☐ The Commissioner of the Department of Children and Families is the statutory parent of the child.		
	☐ DCF guardianship ended on:		
Records:	☐ The child previously attended school in:	District	
C.G.S. §17a-16a School Placement Decision:	☐ It is in the best interests of the child to remain in the school of origin.		
	☐ It is in the best interests of the child to attend the receiving school.		
	☐ The child will remain in the school of origin until a best interests determination is made.		
	☐ School placement decision is not applicable.		

DCF SOCIAL WORKER/JUVENILE JUSTICE SOCIAL WORKER	TELEPHONE NUMBER	DATE (m/d/year)
DCF AREA OFFICE/FACILITY	ADDRESS	

Copies sent to:	☐ Surrogate Parent Program – e-mail: surrogate.office@ct.gov – Fax: (860) 713-7052	
	☐ School district where child is attending school	
	☐ School district that child left	
	☐ Placement (*where child resides*)	
	☐ Child's Attorney and GAL (name(s)	
	☐ Other (name)	