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Testimony of Sarah Eagan, Child Advocate, State of Connecticut
In Support of Raised Bills 302,303, 306,307,310, 312.

February 5, 2014

Senator Bartolomeo, Representative Urban, distinguished members of the Children's Committee:

The Office of the Child Advocate appreciates the opportunity to offer this testimony today in support of Senate Bills 302, 303, 306, 307, 310, and 312.

The mandate of the Office of the Child Advocate (OCA) includes evaluating the delivery of state funded services to children and advocating for policies and practices that promote children's well-being and safety.

SENATE BILL 302: AN ACT CONCERNING THE IDENTIFICATION OF CONNECTICUT'S CHILD PLACEMENT NEEDS

OCA supports Senate Bill 302 which will help systematically identify the needs of children who cannot or are not being served close to their home communities.

DCF has worked hard towards a laudable goal of reducing the number of children who are placed in out-of-state residential treatment facilities, recognizing that children most often benefit from services and support that can be provided in their own homes and communities. Children who are placed out-of-state often have a harder time making and maintaining important connections with family members and other supportive adults, and it can be significantly harder to engage families in treatment modalities when children are being served out-of-state.

Senate Bill 302 will assist the state in assessing the unmet needs of children that lead to continued out-of-state placement. This assessment will then support systematic and strategic development of Connecticut's mental health continuum for children.

SENATE BILL 303 An ACT CONCERNING CHILDREN EXPOSED TO FAMILY VIOLENCE

OCA strongly supports the creation of a task-force to evaluate the existing policies and procedures used by state agencies to address the needs and improve outcomes for children exposed to domestic violence.

The youngest people impacted by domestic violence are children. One third of all family violence incidents in CT are committed in the presence of a child. Each year DCF reports that it is serving thousands of families and children experiencing violence in their homes or relationships.

Children who witness domestic violence are typically younger than five years old. Exposure to such violence—threatening, scary and chaotic--traumatizes children and increases their likelihood for developmental challenges, learning deficits, and struggles with shame, guilt, anxiety and depression.

Tragically, in Connecticut last year there were at least 6 children who were present during domestic violence homicides.

In June of 2014 and in the wake of these terrible incidents, the Office of the Child Advocate and the Connecticut Coalition Against Domestic Violence co-sponsored a public roundtable to discuss efforts to improve outcomes for children who witness or are impacted by domestic violence. This roundtable led to a formal working group which included the participation of multiple stakeholders and which was designed to craft specific and achievable goals for moving the state's response to these children forward. The group discussed the pressing need to address the needs of children impacted by domestic violence through provision of accessible, timely and trauma-informed supports. The recommendations generated by the working group were recently finalized and include proposals to improve service delivery for children, and dissemination of best practices throughout the state.

A key recommendation from the working group was a proposal to create a statewide model policy to support the efforts of state agencies and community professionals who work with children exposed to domestic violence.

Senate Bill 306 will provide an infrastructure for continued collaborative reform between state agencies and community partners, jointly engaged in an effort to serve our most vulnerable children.

SENATE BILL 306 AN ACT ESTABLISHING AN INDEPENDENT OMBUDSMAN

OCA supports the concept behind this bill which calls for use of an independent ombudsman to assist with addressing concerns of youth in state care. An ombudsman can be a voice for children and youth confined in juvenile justice facilities. An ombudsmen can monitor conditions of confinement for youth, investigate complaints, report findings and make recommendations for change.

DCF has an internal ombudsman system which responds to many calls and concerns from family members and child welfare stakeholders. Concurrent use of an independent ombudsman who can address the needs of youth in care, particularly those in facilities, should also be considered.

According to an issue brief on the Department of Justice—Office of Juvenile Justice and Delinquency Prevention--website:

> **"The independence of the [facility] ombudsman is especially important in the juvenile corrections context where the interests of the juvenile corrections agency often conflict with the interests of the detained or confined youth."[1]**

The article—entitled "Beyond the Walls, Improving Conditions of Confinement for Youth in Custody," and created under the direction of the Juvenile Justice Center of the American Bar Association, concludes by stating that

> "[w]idespread use of juvenile justice ombudsman programs would allow monitoring of institutions to ensure that conditions are safe, lawful, and humane; that rehabilitative services are being delivered; and that the rights and needs of juveniles are protected."

An ombudsman must also have the staffing, support and authority to investigate complaints, access youth and information, and provide public information regarding findings and recommendations to improve outcomes for youth.

In CT, the Judicial Branch: Court Support Services Division (CSSD) utilizes an independent ombudsman for its detention facilities. The Ombudsman is an independent contractor selected through the Request for Proposal process. The Ombudsman has unfettered access to all juveniles in detention as well as the contracted community residential programs. He accepts and investigates all grievances and complaints. The Ombudsman is on site in the facilities and programs several times per month. He also meets with juveniles monthly to complete juvenile satisfaction surveys.

It is important to note that the use of an independent ombudsman was <u>unanimously recommended</u> to DCF by the Connecticut Juvenile Training School Advisory Board in 2014.

The CJTS Advisory Board included representation from CSSD, The Office of the Chief Public Defender, the Office of the Chief State's Attorney, the Juvenile Justice Alliance, a community advocacy organization for parents of children with disabilities and special education needs, a community mental health provider and other community stakeholders.

SB 307 AN ACT IMPLEMENTING A QUALITY ASSURANCE PROGRAM FOR DEPARTMENT OF CHILDREN AND FAMILIES PROGRAMS AND FACILITIES.

OCA strongly supports this bill that would strengthen quality assurance and transparency for state-run and state contracted juvenile justice facilities—thereby enabling a greater opportunity to address

[1] http://www.ojjdp.gov/pubs/walls/sect-02.html

urgent and significant concerns about conditions of confinement for some juveniles and facilitating well-informed, collaborative juvenile justice response.

Currently, not all of the state's juvenile justice facilities are able to monitor and report on conditions of confinement utilizing a reliable and evidence-based quality assurance framework. Performance Based Standards, referenced in the bill and currently utilized by the CT Judicial Branch Court Support Services Division (CSSD)—was promulgated by the Department of Justice in 1995 as a tool to improve conditions of confinement in juvenile justice facilities.

Performance Based Standards *provides a uniform data collection and reporting tool that shows the impact of the services on youths, staff, and families, using national standards and outcome measures.*

According to a 2013 report on transparency and data collection in juvenile justice facilities, authored by the Lowenstein Center for the Public Interest—*Data Collection and Transparency in Juvenile Justice Systems—"198 [juvenile justice] facilities across 28 states participate in PbS. Of these, 133 are correction facilities, 48 are detention facilities, and 17 are assessment centers."*[2] According to the same report, the vast majority of states utilize either Performance Based Standards or Juvenile Detention Alternatives Initiative (JDAI-a project of the Annie E. Casey Foundation) standards for juvenile justice facilities.[3] Very few states appear to utilize only the ACA standards. Three states utilize nothing.

PBS facilitates rigorous data collection, review and comparison to national field averages.

CSSD for example, through the use of PBS, has overseen improvements in the conditions of its detention facilities. The placement of children in seclusion now measures lower than national PBS field averages. Reliance on the PBS evidence-based framework has also facilitated recent policy changes at CSSD to further reduce reliance on room confinement.[4]

Pressing Need for Improvement: OCA Reviews Conditions of Confinement

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[2] Weiss, C., et al., The Loweinstein Center for the Public Interest, *Data Collection and Transparency in Juvenile Justice Systems*, (2013), pg. 4. Report found on the web at: http://www.lowensteinprobono.com/files/Uploads/Documents/Data%20collection%20and%20transparency%20memo.pdf

[3] JDAI is typically used for pre-disposition juvenile justice facilities, but are a very useful guide for understanding evaluation of conditions and the impact of facility conditions on juvenile's well-being and safety.

[4] The American Correctional Association standards, currently used by DCF, by comparison, permit the removal from general population of juveniles who threaten the secure and orderly management of the facility. Currently, there are several national programs that assist facilities in collecting and evaluating data on conditions of confinement.

OCA has spent the last 7 months investigating various aspects of conditions of confinement for Juvenile Justice-committed youth in DCF custody. This review arose, in part, out of numerous citizen concerns that were brought to the attention of OCA regarding conditions for children at Connecticut Juvenile Training School and Pueblo. OCA's subsequent investigative activities included review of primary source material regarding conditions of confinement, including record reviews, video tapes, interviews with staff and youth, and observation of facility operations.

Beginning in July, 2014, OCA conveyed concerns to DCF regarding over-reliance on restrictive sanctions such as restraint, seclusion and out-of-program time to manage children and youth who often enter facilities with a history of trauma and other mental health disorders. A reliance on restrictive measures is particularly concerning in any child-serving program given the prevalence of mental health disorders in confined children and the advisement from experts that seclusion and restraint can be particularly damaging for children and adolescents.

Additionally, a study commissioned by the Department of Justice in 2009 reported a strong correlation between youth who commit suicide in facilities and time spent in isolation/room confinement.[5] OCA's preliminary review of suicidal behavior at state-run juvenile justice facilities for committed youth reveals multiple reported incidents of suicidal behavior in the last six to eight months with a significant number of such youth on seclusion status at the time of the suicidal behavior.

OCA's review raises urgent concern that youth with significant mental health needs are subject to restrictive measures—including seclusion-- for days at a time.

OCA's review has also raised significant concern that the facilities' system for data collection, analysis, de-briefing and response still remains incoherent, unreliable and opaque.

A consistent and reliable framework for identifying, analyzing and responding to conditions of confinement is essential to inform and improve policy and practice in juvenile justice facilities.

All state facilities must have the ability to report reliable information regarding the use of restrictive or forceful measures (including restraint, isolation and out of program time) and the frequency of suicidal behavior. Additionally and equally important, facilities must be ready to report treatment and educational gains for youth in confinement, mental health and special education needs of youth, and outcomes for youth served and discharged to the community.

DCF has recently reconstituted its CJTS Advisory Board and OCA understands that the Board will focus its attention on data-driven analysis of facilities' performance and outcome measures. DCF has also recently retained a clinical expert to consult on programs at both CJTS and Pueblo. These are both positive steps to improve conditions and outcomes for confined youth.

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[5] Department of Justice-Office of Juvenile Justice and Delinquency Prevention, *Juvenile Suicide in Confinement, A National Survey* (2009), found on the web: https://www.google.com/#q=OJJDP+suicide+in+juvenile+justice+facilities

OCA has concluded that these facilities urgently need rigorous attention to operations, including training, supervision, data collection and analysis, and trauma-informed policies and practices appropriate for use with juveniles.

It should also be noted that adoption and implementation of Performance Based Standards was unanimously recommended to DCF by the Connecticut Juvenile Training School Advisory Board in 2014.

SENATE BILLS 310 AND 312: CHILD FATALITY PREVENTION, TRANSPARENCY AND ACCOUNTABILITY OF CHILD-SERVING SYSTEMS.

SB 310 and 312 both address, in different ways, improving outcomes for high risk infants and toddlers who are served by the state child welfare agency.

In CT and across the country, approximately 80 percent of children that die from abuse or neglect are under the age of 4. These children are the most vulnerable, the most helpless, the most dependent on a competent caregiver and the most invisible in the community. Research cited around the country confirms that at least 1/3 of children who die from abuse or neglect lived in families previously known to a child welfare agency. [6]

New DCF initiatives to reduce child fatalities

In 2014, DCF announced new initiatives to reduce child maltreatment deaths, including a "safe sleep" practice guide, a new protocol to support the hotline in early detection of child abuse, and a recently announced initiative to enhance assessment and support for high need families with young children.

While DCF's new initiatives are positive and promising, the state must also have an expert-driven, comprehensive strategic plan for DCF's response to abused and neglected infants and toddlers. This plan must, in recognition of the profound vulnerability of infants in high risk homes, specifically address protocols for case staffing, training, supervision, visitation standards, case contacts, risk assessment, hotline procedures, expert consultation, progress monitoring and quality assurance.

The OCA strongly supports the proposed legislation, as well as expanded capacity for systemic review of child deaths, as vital steps in the prevention of critical incidents and fatalities of young children.

OCA Reviews Infant Toddler Deaths—Report, July 31, 2014

On July 31, 2014, the Office of the Child Advocate released a report analyzing the unexplained and unexpected deaths of infants and toddlers in Connecticut in 2013. OCA looked at the manner of all children's deaths, but the report closely examined cases where children died during or subsequent to child welfare agency involvement with the family.

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[6] Putnam-Hornstein, 2001, Peddle & Wang, 2001

Any preventable child death requires a rigorous examination of how we mobilize and provide services, including child protective services, when the state comes into contact with a child who is, or who is at high-risk of, being abused or neglected.

Key Findings from OCA's Child Fatality Report Regarding Children in DCF-involved Families

- OCA reviewed 82 infant-toddler deaths that came to the attention of OCA and the Office of the Chief Medical Examiner. More than half of these deaths were ultimately deemed to be of natural causes, many due to prematurity.

Of the 38 children who died from ***non-natural*** causes in 2013:

- 9 of these children had open cases with DCF at the time of their death;
- 4 more children lived in families whose cases closed within the previous six months;
- 5 other children had cases that closed within the previous year.

Children may die from abuse or neglect without ever coming into contact with DCF, and DCF's involvement with a family is not always a pivotal factor contributing to a child's death. However, all child deaths should be rigorously reviewed to better understand risk factors contributing to these tragedies, and to better fashion a strategic and support public health response.

Manner of death for children included Sudden Unexplained Infant Death, Accident and Homicide

- Of the open DCF cases where a child died from Sudden Unexplained Infant Death (n=7), all of the children lived in families that were previously reported to DCF, and 5 of the children were prenatally exposed to drugs. Risks go up for SUID when a caregiver is drinking, smoking, using drugs or has untreated mental health needs.

- DCF response to at-risk infants showed gaps in risk assessment, treatment planning, case follow up, and quality assurance.

- No cases showed application of DCF's High Risk Newborn policy, even where infants were prenatally drug exposed.

- **The key issue in some of the cases reviewed was that the intensity of the interventions, focused on treatment and safety, were not always consistent with the degree of risk in the home. It was unclear how the quality of improvement in parental capacity, judgment and decision- making were being assessed.**

2014 Infant-Toddler Deaths, Preliminary Data

- In 2014, there were again 82 infant-toddler deaths that came to the attention of the Office of the Child Advocate and the Chief Medical Examiner, the exact same number as 2013.
- Of the deaths deemed to be ***not*** from natural causes, there were 15 Undetermined (often associated with unsafe sleep environment), 7 homicides, and 6 accidents.
- 10 children's deaths are still Pending Further Studies by the Office of the Chief Medical Examiner.
- 11 children had open DCF cases at the time of their death—6 of these children's deaths have been substantiated by DCF as related to abuse or neglect.
- 3 other children died within 6 months of DCF case closure—2 of these children's deaths have been substantiated by DCF as related to abuse or neglect.
- Some children's deaths from 2014 are still under investigation for possible abuse or neglect as a contributing factor.

OCA strongly supports maintaining infants and toddlers in their homes whenever possible and OCA does not support the removal of all high risk infants into foster care. However, OCA strongly recommends the need for a strategic, expert-driven, carefully tailored protocol that is designed to permit family preservation in a way that does not undermine child safety.

Senate Bill 310 and 312 will accomplish the following:

1. Develop a DCF-child welfare practice model specific to children birth to three—including ***an effective high risk infant policy***—with appropriate case-loads, visitation standards, case review, clinical supervision and consultation, and informed by early childhood and clinical expertise.
2. Support evaluation and public reporting regarding the value and effectiveness of state-funded child welfare services for abused, neglected and at-risk infants and toddlers, with attention to outcomes.

Multidisciplinary Child Death Review Informs Prevention and Public Health Response

The State's Child Fatality Review Panel, co-chaired and staffed by the OCA, includes participation from pediatricians, law enforcement, mental health professionals, child welfare and public health agencies and other critical stakeholders, to review the factors contributing to preventable deaths of children and offer recommendations for improved system response.

Supporting the capacity of this body and the OCA to meaningfully review child deaths and regularly report findings and recommendations to the public and lawmakers will help create an informed opportunity for investment in strategies for infant-toddler (and older children's) well-being and survival. OCA and CFRP are currently reviewing child maltreatment deaths as well as teenagers who committed suicide in the last year—all for the purpose of creating informed public presentations.

According to the Center for Child Death Review, the state's CFRP process adheres to best national practices and is the most accurate way to assess the total number of child deaths due to maltreatment or other preventable causes. OCA's and CFRP's child death reviews over the years have

contributed substantially to a greater understanding of how often and why children die and steps the state can take to reduce the likelihood of such tragedies.

Unreliable Data on Children Who Die From Maltreatment

Many states, including CT, currently under-report maltreatment fatalities. A 2011 Government Accountability Office report states that because of challenges in child death investigation, over-reliance on child welfare agency reporting and a lack of uniformity regarding determinations of abuse and neglect, state data submissions regarding maltreatment fatalities are "only a proportion of all child fatalities caused by abuse or neglect."[7]

Thank you for the opportunity to submit this testimony.

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[7] The GAO reports that a peer-reviewed study of fatal child maltreatment in three states found that state child welfare records undercount child fatalities from maltreatment by from 55 percent to 76 percent.