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Senate Minority Leader Len Fasano
Testimony re: Child Protection Reforms
Children's Committee Public Hearing
February 16, 2016

Thank you for the opportunity to testify before you today. I am here to testify on S.B 73 AN ACT CONCERNING CHILDREN'S SAFETY, S.B. 74 AN ACT CONCERNING THE WELL-BEING OF CHILDREN, S.B. 75 AN ACT CONCERNING DETAINED YOUTH, H.B. 5136 AN ACT CONCERNING THE HEALTH OF CHILDREN, and H.B. 5138 AN ACT CONCERNING THE DEPARTMENT OF CHILDREN AND FAMILIES. I would also like to thank the committee for raising the following concepts: AN ACT CONCERNING ACCESS TO RECORDS OF DEPARTMENT OF CHILDREN AND FAMILIES; AN ACT CONCERNING THE IDENTIFICATION OF CONNECTICUT'S CHILD PLACEMENT NEEDS; AN ACT CONCERNING THE CLOSURE OF THE CONNECTICUT JUVENILE TRAINING SCHOOL AND THE PUEBLO UNIT FOR GIRLS.

While I applaud the provisions of S.B. 75 which require DCF to limit the use of restraints to children 20 and older and to adopt performance based standards for the operation of CJTS, these bills do not go nearly far enough in adopting the kind of systemic reform needed to improve child safety and DCF operations. The remainder of the bills call for DCF to "study" the quality and efficacy of its programs and ways to increase child safety in the state. With all due respect, the time for "study" has long passed. Decisive action and leadership is what is needed to restore public confidence in DCF and improve safety and outcomes for the children in its care.

Despite promising to improve the lives of Connecticut's children and families and get Connecticut out from under court mandated oversight, recent Court Monitor and Office of Child Advocate (OCA) reports reveal an agency that is in a downward spiral. DCF is failing to meet the needs of over half the children in its care, more than at any point since Commissioner Katz took office. Disturbingly, we have seen an unprecedented number of child homicides involving children who should have been protected by DCF. The agency has ignored multiple known risk factors and has prioritized administrative expediency and keeping children in the home above actual child safety. And we've seen a state facility where child abuse in the form of dangerous physical restraints and seclusion is tolerated.

The heart wrenching case of 2 year old Londyn Sach highlights many of these concerns and starkly demonstrates how promoting lower DCF caseloads above child safety is resulting in the deaths of Connecticut children. According to the Office of Child Advocate report, Londyn died in her home due to a drug overdose. Her death was found to be a homicide. Despite an extensive history of alleged abuse and neglect spanning at least seven years and two states and after receiving multiple reports in 2013 and 2014, DCF nevertheless declared the family "low risk" and assigned them to the Family Assessment

Response (FAR) program. This decision was, according to the Child Advocate, "not appropriate" in light if the documented chronic pattern of child welfare complaints and proved to be fatal for young Londyn.

Even worse, just weeks before her death, DCF refused to accept a report from police to the DCF hotline regarding possible abuse of Londyn and her brother and, astonishingly, closed its case on Londyn leaving her unsupervised and vulnerable in an abusive and unstable home.

The OCA's report found systemic problems with the DCF FAR program including inconsistent and inadequate risk assessment protocols, lack of quality assurance and control, inadequate communication between community providers and DCF to ensure family compliance and success with treatment programs, premature case closures, and lack of independent oversight and accountability. The OCA reports that almost half of all abuse and neglect cases are now diverted through the FAR program. One third of these cases end up coming back to DCF with subsequent reports of abuse and neglect. According to the OCA, the majority of these families were not "low risk" and should not have been sent through FAR, but should have been accepted as higher risk cases requiring DCF oversight and responsibility. That is too many children being put at risk by a failing system.

Unfortunately, this pattern of failure has been repeating itself at DCF for several years. Calls from advocates, parents and others, including myself, for reform have gone unheeded. So, I regretfully find myself before you once again, calling for reform.

I don't blame the case workers who work hard every day to protect the kids they care for. I blame management for allowing the system to weaken more and more each year, for rejecting proposals to strengthen child protection and increase accountability, and for charging full speed ahead with policies that advocates have questioned. It is time for the General Assembly to take action to protect Connecticut's most vulnerable children and families. We can do so by pursuing the following policy reforms. As members of the Children's Committee know, I have asked the chairs to raise all of these proposals as bills this year due to the limitations on the introduction of proposed bills by individual legislators in short session years.

1) Improve the Differential Response (FAR) Program

We must increase the objectivity and accountability of risk assessment by the Family Assessment Response Program (FAR). FAR is a tool used by the DCF to determine if a case will be referred to the agency for appropriate action and monitoring or if the case will be referred to supports provided by the community. This proposal would ***strengthen*** the FAR by requiring DCF to:

- utilize objective evidence based criteria for assessing risk and assigning children and families to the DRP
- increase training for their Hotline and risk assessment workers ,
- implement a tracking system to monitor progress and outcomes for children and families referred to FAR
- require a DCF supervisor to sign off before determining that a child or family has successfully met the goals of the DRP and no longer requires FAR services
- accept all calls to the DCF hotline by law enforcement as high risk
- look at out-of-state child abuse history prior to assessing risk as well as to
- Establish a FAR Advisory Board to oversee, monitor, evaluate and report on the implementation of the FAR

2) Close the Connecticut Juvenile Training School and Pueblo Unit Effective Jan. 1, 2017

- It costs the state $52.9 million to operate CJTS.
- This equates to an annual cost of $545,671 per resident in FY 2015.
- These children are not getting the therapeutic treatment they need in that institution.
- Various non-profit and advocacy organizations feel that these children can be better served in the community.
- The population of CJTS would be grouped based on type of offense and would be either placed in a secure residential facility, residential group home, or at home with intensive community supports.

While the Governor has promised to close CJTS by July 2018, there is no legislative mandate that he do so. There is also no reason to wait that long. There are community placements available to accept the children where they will get better care and treatment at a much lower cost. Every day that children at CJTS are locked in confinement or subject to restraints is a day wasted and an opportunity to improve conditions and outcomes for our children missed.

3) Transfer Juvenile Justice Functions Currently Operated under the Department of Children and Families to the Judicial Department's Court Support Services Division.

Require that ***all juvenile justice functions that are currently the responsibility of the Department of Children and Families be transferred to the Judicial Department's Court Support Services Division.*** The CSSD is a well-respected department that is utilizes performance based standards and appears better equipped to administer this function.

4) Establish an Independent Department of Children & Families Ombudsman.

Transfer current positions to the Office of Child Advocate which will create a ***new independent ombudsman to review youth grievances under the care of the Department of Children and Families.*** The ombudsman would receive complaints and grievances from children who are under the care of DCF. Numerous child advocates have called for an independent ombudsman recognizing that requiring children to report grievances to a DCF employee has a chilling effect on such reports and poses an inherent conflict of interest. The Judicial Department successfully utilizes an outside ombudsman which has resulted in more issues being raised and resolved. An independent ombudsman would also increase public accountability and confidence in DCF's programs.

5) Implement a Quality Assurance Program for Department of Children and Families Programs and Facilities

DCF and any DCF-contracted juvenile justice committee should incorporate the use of Performance Based Standards (PBS) which is a quality assurance program launched by the Department of Justice in 1995 to improve conditions of juvenile confinement. PBS is an evidence-based program that is already used by the Judicial Department at the juvenile detention facilities. While the system will allow for extensive outcomes, in particular this system will allow for the compilation of all incident reports which will allow the CJTS Advisory Board, the Office of Child Advocate (OCA), the independent ombudsmen, legislators and other interested parties to easily see and understand data trends. In addition, require that

data compiled must be shared at least quarterly with the CJTS Advisory Board. PBS should not be used solely for CJTS as proposed but system wide to ensure that all children in DCF operated or contracted facilities are receiving the best evidence based care.

6) Conduct an Independent Review of the Department of Children and Families.

Similar to the review recently conducted for the Massachusetts Department of Children and Families, this proposed bill seeks to ***require the Department of Children and Families to undertake an independent review of their operations, programs and policies by an independent consultant like the Child Welfare League of America.***

7) Ensure Child Placement Decisions Reflect the Best Interests of a Child.

Restore the court's authority to order a child under its jurisdiction (i.e. found to be delinquent) to be placed in an out of state facility if such placement is in the best interests of the child and there is no comparable in state program or facility. The Court previously had this authority but the Department lobbied to take it away and give the Commissioner sole placement authority. As a result, there is no independent oversight to ensure that placement decisions reflect the best interest of the child.

8) Increase Transparency within the Department of Children & Families

Increase public access to DCF records including videos and internal review reports. General statutes should be amended to limit freedom of information exemptions for DCF to only personally identifying information. The bill further proposes that internal reviews, reports, assessments, and other records related to the department's handling of child protection matters and facility operations be deemed a public record as well as any video depicting operations within any DCF facility so long as the identity of the children can be sufficiently obscured.

Thank you for your time and attention.

Sincerely,

Len Fasano
Senate Minority Leader