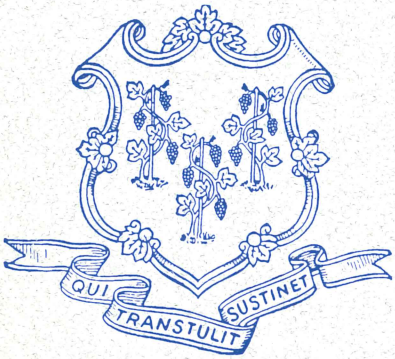
DEPARTMENT OF CHILDREN AND FAMILIES

Connecticut

General Assembly



LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

December 1999

CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

The program review committee is composed of 12 members. The president pro tempore of the senate, the senate minority leader, the speaker of the house, and the house minority leader each appoint three members.

1999-2000 Committee Members

Senate	***House***
John W. Fonfara	Julia B. Wasserman
Co-chairman	*Co-Chairman*
Eileen M. Daily	Kevin M. Delgobbo
Anthony Guglielmo	Paul R. Doyle
Gary D. LeBeau	Robert Heagney
William H. Nickerson	Michael J. Jarjura
Win Smith, Jr.	Robert A. Landino

Committee Staff
Michael L. Nauer, Director
George W. McKee, Chief Analyst
Catherine M. Conlin, Chief Analyst
Carrie E. Vibert, Chief Attorney
Maryellen Duffy, Principal Analyst
Jill E. Jensen, Principal Analyst
Anne E. McAloon, Principal Analyst
Brian R. Beisel, Principal Analyst
Michelle Castillo, Principal Analyst
Renee La Mark Muir, Principal Analyst
Scott M. Simoneau, Associate Analyst
Bonnine T. Klare, Executive Secretary

Staff for this Project

Jill Jensen
Renee La Mark Muir

STATE CAPITOL ROOM 506 HARTFORD, CT 06106 (860) 240-0300

LEGISLATIVE PROGRAM REVIEW
& INVESTIGATIONS COMMITTEE

Department of Children and Families

DECEMBER 1999

Table of Contents

Department of Children and Families

KEY POINTS
EXECUTIVE SUMMARY i

INTRODUCTION 1

I. OVERVIEW OF CHILDREN'S SERVICES 5
History 5
Goals of Children's Service Systems 7
Organizational Models 9

II. DCF MANDATES AND CONSENT DECREE 13
Protective Services 13
Juvenile Justice 14
Mental Health 14
Substance Abuse 15
Prevention 15
DCF Mission Statements 15
DCF Consent Decree 17
Legal Actions in Other States 21

III. DCF RESOURCES AND ORGANIZATION 23
DCF Resources 23
DCF Budget 24
Children's Budget 28
DCF Organization 31

IV. DCF MANAGEMENT AND PLANNING 37
Planning 37
Information Systems 40
Quality Assurance 40

V. DCF ACTIVITIES 43
Client Populations 43
Protective Services 44
Juvenile Justice 48
Mental Health and Substance Abuse 52
Prevention 58

VI. CHILDREN'S SERVICES OUTSIDE OF DCF 61
State Agencies with a Role in Children's Services 61

Table of Contents

Private Providers of Children's Services 64
Advocacy 67

VII. FINDINGS AND RECOMMENDATIONS 69
Overview of Findings 69
Children and Families Policy 70
Coordinating Structure 71
Related Children's Agencies 81
Organization of Children's Services 82
Child Protective Services 84
Children's Behavioral Health 88
Juvenile Justice 91
Transition Plan 96
Sunset Review 97

APPENDICES
A. *Historical Development of DCF Mandates*
B. *Summary of Federal Mandates*
C. *Summary of DCF Management Studies*
D. *History of DCF Mission Statements*
E. *Agency Response*

SOURCES CONSULTED

DEPARTMENT OF CHILDREN AND FAMILIES

- Goals of a consolidated children's agency -- leadership and advocacy for children's issues and integrated service delivery -- have not been fulfilled.
- No overarching policy guides state government efforts to promote well-being of children and their families.
- No formal structure exists to examine the "big picture" or coordinate services and resources of the many state agencies responsible for children.
- Major barriers to integrated services are categorical funding, lack of a coordinating mechanism, and "turf wars" among programs and agencies; most effective incentive for interagency coordination is financial.
- Noncategorical, “flexible” funding is more important to integration than organizational structure.
- Children and families are best served by integrated, individualized care delivered through community-based systems.
- Coordinating resources and services to achieve an integrated care system must be the priority of a single entity without responsibilities for providing direct services.
- All three branches of government, not just DCF, have responsibility for prevention; coordinating prevention efforts needs to be one entity's focus.
- Leadership and management for child protective services, children's behavioral health, and juvenile justice must be strengthened; each mandate must be an agency's priority to ensure it receives sufficient attention and resources.
- Despite continuous efforts to "fix" DCF, it is plagued by systemic management deficiencies.
- DCF's child protective services mandate dominates agency policy and resources; it must be a priority due to dramatic increases in the number and severity of child abuse and neglect cases as well as a federal court consent decree.
- Children's behavioral health and juvenile justice mandates have been seriously neglected by DCF and the legislature and only receive attention in response to a crisis.
- Separate state agencies can focus on each mandate to ensure leadership and parity; service delivery can be integrated through a statewide coordinating structure and "pooled" resources.

Executive Summary

Department of Children and Families

In March 1999, the Legislative Program Review and Investigations Committee voted to study the Department of Children and Families (DCF) to determine the appropriate roles, responsibilities, and structure for carrying out the state's policies on children and families. The department is statutorily mandated to provide child protection services, juvenile justice, mental health, substance abuse, and preventive services. However, DCF does not directly provide the bulk of services to its clients and their families, rather it purchases and funds services from over 200 community-based, private providers.

Connecticut consolidated responsibility for child protection, children's behavioral health, and juvenile delinquency programs in a single state agency in 1974. The overall goal of consolidation was improved leadership for children's issues and the development of a comprehensive network of integrated public and private services to promote the sound growth and development of all children. However, almost since its inception, there have been concerns over the ability of the state's children's agency to carry out its broad mandates and to achieve the goal of its enabling legislation. DCF services are currently organized around client populations and developed and delivered under three separate and distinct processes (i.e., protective services, juvenile justice, and voluntary mental health).

Overall, the program review committee finds the department is plagued by several long-standing management deficiencies. These issues, which have been repeatedly identified in past management studies of the agency, include: an unstable organizational structure; weak accountability; amorphous roles, particularly among central office managers, that do not reflect current organizational structure; overly broad spans of control for administrators; insufficient staffing in key service areas; misallocation of resources; a lack of long range planning; and a poorly designed automated information system. In addition, the committee finds DCF planning regarding its services mandates is neither comprehensive nor integrated, and there is no DCF staff dedicated to analyzing trends, examining models, reviewing research, and compiling and coordinating data generated by the agency.

The program review committee further finds children's services in Connecticut are not consolidated in a single agency, but are carried out by at least a dozen state agencies and the judicial branch. DCF is the clear lead agency in only two areas -- programs to prevent child abuse and neglect and programs to serve children with mental health or substance abuse problems -- and its services are focused on one segment of Connecticut's children -- those in crisis. Separate state agencies will always exist for some children's functions and many adult services that impact children, but there is no formal mechanism currently in place to ensure coordination or collaboration among state agencies serving similar client populations.

The program review committee finds DCF is dominated by protective services issues. Child safety is the driving force for the agency's mission, budget, organization, planning, and management. This focus is due to the emergency and potentially life-threatening nature of child abuse and neglect as well as the impact of the *Juan F.* consent decree. As a result, other DCF mandates, like juvenile

justice and behavioral health, tend to only receive attention when a crisis arises or a lawsuit or legislative initiative is threatened. The department's lack of a long-term plan and the absence of any significant analysis of the client and service data generated by DCF contributed to the emergency nature of the current management.

As a result of its focus on protective services, the committee further finds DCF's management is reactive and crisis-driven. The department does not carry out long range planning or adequately address preventive services. Despite repeated efforts over many years to strengthen planning, research, quality assurance, and accountability, the department has been unable to sustain improvements in these management areas.

Finally, the committee finds service systems for abused, neglected, mentally-ill, substance abusing, and delinquent children and their families are not integrated as was the original intent of the 1974 consolidation plan. The department's organization remains functionally divided, its planning processes and information systems are fragmented. Conceptually, it makes sense to consolidate mandates within a single agency to achieve integration of services. Yet, there is no overriding reason for grouping protective services, mental health, and juvenile justice and not incorporating other key children's services. In practical terms, no single agency can sufficiently balance the importance of every mandate for children and prioritize integration of services.

In its review of an integrated service model for children, the program review committee finds it is generally agreed services are best provided in a comprehensive, coordinated, family-focused, and community-based manner. However, during the study, it also became clear there is no single ideal structure for delivering services to children and their families. Nearly all states, regardless of the organizational model they have adopted, are struggling with integrating services for children and establishing an effective and efficient service delivery system. The key to successfully integrating services appears to be "flexible", noncategorical funding.

The program review and investigations committee formally accepted recommendations resulting from its 10-month study on November 30, 1999. The 30 recommendations are aimed at establishing a structure and system that will promote the well-being of Connecticut's children and their families now and in the future in two primary ways: creating a community-based integrated service delivery network that is based on children's individual needs and family strengths instead of funding categories and target populations; and restructuring children's services so attention and resources can be focused on achieving desired outcomes in one area without shortchanging responsibilities in another.

RECOMMENDATIONS

1. **The General Assembly shall establish in statute the following language: "It is the policy of the state of Connecticut to promote the well-being of children and families through the development of integrated, comprehensive, child-centered, family-focused, and community-based services that are accessible, cost-effective, of good quality, and delivered in the least restrictive environment possible."**

2. **Create a secretary for children responsible for coordinating state efforts to implement the state's policy on children and families.**

   The Office of the Secretary for Children shall be an independent executive branch agency and the secretary shall be authorized to employ staff and purchase equipment, hire consultants, and convene advisory groups of public officials and private citizens as needed. The main duties of the secretary for children shall include:

   - **preparing a biennial Connecticut children's budget that identifies all federal and state resources dedicated to children's services and making recommendations concerning the allocation of those resources;**
   - **developing and implementing a mechanism for pooling resources from multiple state agencies to fund a community-based system of care that will deliver integrated services to children and their families based on individual needs;**
   - **preparing a biennial statewide plan for promoting the well-being of children and families through preventive services;**
   - **establishing benchmarks to measure the well-being of children in Connecticut and reporting annually to the governor and legislature on their status; and**
   - **establishing and maintaining arrangements with local universities to conduct research and evaluations related to children's service needs and the outcomes of state policies and programs for children and families.**

3. **Each state agency with responsibility for serving children and families shall be required to submit to the children's secretary each year: (1) an assessment of the needs of its client population under the age of 18 and their families, overall and by region; and (2) a status report of each region in terms of children's well-being benchmarks relevant to the policies and programs it administers.**

4. **Each child-serving agency shall be required to forward its proposed biennial budget related to services for persons under 18 and their families to the secretary for children who will use the information to prepare the biennial children's budget. In the budget submission to the secretary, each agency shall identify all resources it allocates to preventive services for children and families. Each agency shall also identify the amount of resources it proposes to pool with funds from other children's agencies to support an integrated, community-based care system as well as estimates of the client population to be served and the types and amount of services required to be provided by the system.**

5. **The secretary for children shall convene the heads of all state departments serving children at least two times per year, once to provide advice and assistance in planning and implementing preventive services for children and families and once to help evaluate the state's overall progress in promoting the well-being of children and families and prepare the secretary's annual children's status report to the governor and General Assembly. The secretary may convene the department heads or their designees to meet for other purposes and at other times as needed.**

6. **The secretary shall be appointed to a five-year term by the governor subject to the approval of the General Assembly. The secretary shall have the following qualifications: an advanced degree in management and administration and at least 10 years experience in a high-level management position requiring skills such as strategic planning, financial analysis, negotiations, and public relations.**

7. **To carry out the duties of the Office of the Secretary for Children, the children's secretary shall have specific authority to propose funding levels for an integrated, community-based service delivery system for children and families.**

8. **The Office of the Secretary for Children shall be responsible for funding and overseeing family advocates for children's services.**

9. **The secretary shall develop and provide training about community partnerships to all state agencies, making sure to include both management, line staff, and private provider organizations. The secretary shall also conduct public information programs to educate communities and the general public about the partnership model.**

10. **A schedule shall be developed by the secretary for children to phase in implementation of the recommendations concerning the responsibilities of the secretary and the community partnerships over a five-year period.**

    In the first year following passage of the enabling legislation, the secretary for children, with the advice and assistance of representatives from each child-serving agency and the Office of Policy and Management, shall establish the children's budget process, the service needs assessment process, the process for contracting with community partnerships and shall prepare a plan for phasing in community partnerships statewide over a five-year period.

11. **The secretary shall establish, and the state agencies shall be required to use, standards and guidelines for conducting needs assessment for community-based services.**

12. **The children's secretary, in consultation with officials from the state entities that serve children and with input from the public, shall develop measures to serve as benchmarks of the well-being of Connecticut's children and families.**

13. **The secretary for children shall establish formal relationships with one or more local institutions of higher education to carry out research and evaluation projects related to the well-being of children and families in Connecticut.**

14. **The subsequent terms for the secretary for children shall be four years coterminous with the appointing governor.**

15. **The Office of the Child Advocate, the Commission on Children, and the Children's Trust Fund shall be transferred to the Office of the Secretary for Children for administrative purposes only in accordance with C.G.S. §4-38f.**

16. **The secretary for children shall replace the commissioners of children and families, mental retardation, public health, education, social services, and correction as the sole ex officio member of the Commission on Children and the commissioners of children and families, public health, social services, and education on the Children's Trust Fund Council.**

17. **The responsibilities of the Department of Children and Families shall be realigned as follows:**

    - **children's mental health and substance abuse shall be transferred to the Department of Mental Health and Addiction Services (DMHAS);**

    - **juvenile justice shall be transferred to the Connecticut Juvenile Authority (CJA) -- a new statutorily created state agency; and**

    - **protective services for abused, neglected, or abandoned children shall remain within DCF.**

18. **DCF shall develop an assessment standard and tool to determine which calls require a full investigation response by its staff and which can be referred to a state-contracted community partnership for children for assessment and services. The differential response process shall be fully implemented by the fourth year of the phase-in of community partnerships.**

19. **A Division of Children's Behavioral Health shall be established within the Department of Mental Health and Addiction Services. The division shall have primary responsibility for state mental health and substance abuse services for persons under the age of 18. It shall: develop policy; plan, evaluate, and assure the quality of behavioral health services for children; and oversee the establishment and maintenance of a comprehensive continuum of mental health and substance abuse services responsive to the individualized needs of children.**

20. The children's behavioral health division shall be headed by a deputy commissioner who is a clinically competent professional experienced in the administration of children's mental health and substance abuse services. The deputy commissioner shall have responsibility for all children's mental health and substance abuse programs, services, and facilities.

21. All existing statutory requirements relating to children's mental health and substance abuse shall be transferred from DCF to DMHAS. Responsibility for the policies, procedures, administration, and operation of the state's existing children's mental health facilities, Riverview Hospital and the High Meadows residential treatment facility, shall be transferred to the Department of Mental Health and Addiction Services. DMHAS shall be authorized to establish any other facility or program required to carry out its children's behavioral health mission.

The children's behavioral health division shall have the following specific powers and responsibilities:

- **establish policy and long-range strategic plans for children's behavioral health;**
- **develop standards and protocols for a continuum of children's mental health and substance abuse facilities, programs, and services that are responsive to the individual needs of children and their families;**
- **conduct evaluation, research, and quality assurance of behavioral health programs and services for children;**
- **establish procedures for the transition of clients from the children's system of behavioral health services to the adult system, when necessary;**
- **provide clinical and technical assistance related to children's mental health and substance abuse issues to other state agencies including the Department of Children and Families and the Connecticut Juvenile Authority;**
- **coordinate efforts with the secretary for children and the Department of Social Services (DSS) to ensure the provision of medically necessary behavioral health services required by children who are mentally ill or emotionally disturbed and who are covered by the Medicaid program;**

- **assist and coordinate with the secretary for children, including submitting: (1) an annual assessment of the statewide and regional behavioral health needs of children, including those who are abused, neglected, abandoned, or delinquent; (2) a status report on the benchmarks relevant to children's behavioral health; and (3) an estimate of its client population to be served by the community partnerships for children;**

- **submit a proposed biennial budget related to services for children under 18 and their families, separate from the department's adult services budget, to the legislature and the children's secretary and fully participate in the process to pool funds with other state children's agencies to support an integrated, community-based care system and prevention services; and**

- **coordinate efforts with the judicial branch and any other state agency as necessary to effectively and efficiently provide behavioral health services to children.**

22. The composition of the Board of Mental Health and Addiction Services shall be amended to include representation from individuals with experience and interest in children's behavioral health as follows: four of the 10 board members who must be experienced in substance abuse and in mental health shall have expertise in children's services in those areas including one who must be a child psychiatrist and one who must be a child psychologist. Five new members, who shall be individuals interested in children's behavioral health but not service providers and shall represent each region in the state, shall be added to the board.

23. The commissioner of mental health and addiction services shall be required to establish regional children's behavioral health advisory councils comprised of up to 20 individuals, with the majority being persons who earn less than 50 percent of their salaries from providing services to children and families. The regional councils shall advise the commissioner and deputy commissioner for children's behavioral health on the mental health and substance abuse needs of and services for persons under the age of 18 within their respective regions. Each council shall elect its own chair who shall not be a service provider and will serve as the regional representative to the state mental health and addiction services board.

24. Create the Connecticut Juvenile Authority, which shall be responsible for ensuring public safety and intervening in delinquent behavior by providing individualized supervision, care, and treatment to juveniles under 16 who require pre-trial detention or who are committed as delinquent by the court.

25. The Connecticut Juvenile Authority shall be headed by a commissioner who is experienced and qualified as a juvenile justice administrator. The commissioner shall be appointed by the governor. The commissioner shall be assisted by two deputy commissioners, one of whom is experienced and qualified in the administration and operation of secure juvenile facilities and the other in the development and implementation of programs and services to treat delinquent youth.

26. Responsibility for the policies, procedures, administration, and operation of the state's existing juvenile justice detention facilities, pre-trial detention centers, Connecticut Juvenile Training School, Long Lane School, and the Wilderness Program, shall be transferred from DCF to the Connecticut Juvenile Authority. CJA shall be authorized to establish any other facility or program required to carry out its juvenile justice mission.

All existing statutory requirements relating to juvenile justice shall be transferred from DCF to CJA. The CJA shall also have the following specific powers and responsibilities:

- **implement the mandates of C.G.S. 46b-121h (reorganization law);**
- **organize its facilities, programs, and services in accordance with geographical boundaries defined by the state's five human service regions;**
- **conduct intake and assessment of all youth in its custody and facilities and provide that information, when necessary, to the judicial branch and other state agencies serving the delinquent population;**
- **establish intake guidelines and protocols for pre-trial detention centers, including eligibility requirements and supervision conditions for pre-trial release supervision;**
- **develop policies and procedures for a minimum time served requirement based on a standardized risk assessment and individualized treatment plan for all committed delinquents to determine when and under what conditions the youth may be released from confinement to a residential program or the community;**
- **establish a community supervision program that includes an offender revocation unit and other specialized supervision units for specific populations (e.g., sex offender or sexually reactive youth, violent or repeat offenders, dually diagnosed offenders, etc.);**

- **assist and cooperate with the secretary for children, including submitting: (1) an annual assessment of the statewide and regional needs of the delinquent population; (2) a status report on the benchmarks relevant to juvenile justice; and (3) an estimate of its client population to be served by the community partnerships for children;**

- **submit a proposed biennial budget related to services for delinquent youth under 16 and their families to the children's secretary and fully participate in the process to pool funds with other state children's agencies to support integrated, community-based care systems and prevention services; and**

- **coordinate efforts with the judicial branch and any other state agency necessary to effectively and efficiently provide juvenile justice services.**

27. The law authorizing the judicial branch to order a specific confinement location for committed delinquents shall be repealed.

28. A team of individuals from outside state government shall be established to develop and oversee implementation of a transition to realign the Department of Children and Families and create the Division of Children's Behavioral Health within the Department of Mental Health and Addication Services and the Connecticut Juvenile Authority.

The team shall be comprised of five public members appointed by the governor. A transition plan shall be developed by the team with the advice and assistance of the commissioners of children and families, mental health and addiction services, the chief court administrator, the secretary of policy and management, and the heads of the new juvenile authority, the children's behavioral health division, and the children's secretary, once they are appointed. The court monitor should also be invited to participate in the planning related to services for children covered under the *Juan F.* consent decree. The team shall be authorized to hire its own staff and consultants to assist in carrying out its duties.

29. The plan for transition shall be completed and submitted to the General Assembly for approval within one year after the reorganizing legislation goes into effect.

30. The Office of the Secretary for Children, the Department of Children and Families, the Division of Children's Behavioral Health within the Department of Mental Health and Addiction Services, and the Connecticut Juvenile Authority shall be scheduled to terminate effective July 1, 2006, unless reauthorized by the General Assembly. During the year prior to the automatic termination, the Legislative Program Review and

Executive Summary

Investigations Committee shall conduct a sunset review and report its findings and recommendations regarding the continuation, modification, or termination of each entity for consideration by the General Assembly during the regular legislative session in 2006.

Executive Summary

Chapter One

Overview of Children's Services

Prior to the 20th century in Connecticut and other states, children's services were provided by local and county governments or private charitable organizations. State government had little funding or administrative responsibility for the education, care, or support of Connecticut's children and youth. In Connecticut, towns had primary responsibility for supporting their dependent residents -- those who were poor or "mentally defective," as well as orphans and neglected children.[1] Delinquent children, too, were handled by local authorities, usually municipal police departments, and housed in town jails.

During the 1800s, county boards of management were responsible for finding "temporary homes" -- the precursor of today's foster homes -- for dependent and neglected children. The first statewide agency with a role in child welfare was the State Board of Charities, established in 1884. It was responsible for a wide variety of public welfare services, including almshouses, an institute for the blind, the state reformatory (prison), homes for the aged, infant boarding places, insane asylums, orphan asylums, and institutions for girls and paupers. Its initial role in child welfare was limited to recommending to the county boards suitable family homes to serve as temporary residences. Also in the mid-1800s, the first state juvenile institution, a reform school for delinquent boys administered by a board of trustees, was established. During this same time period, the first state mental hospital, similarly supervised by a trustee board, was founded to care for insane persons of any age. Later, the state also established institutions -- residential training schools -- for mentally retarded persons and a state reformatory school for girls.

Over time, primary responsibility for child welfare, mental health and juvenile justice shifted from local to state government. State social service mandates broadened and the number of programs and facilities to carry them out increased. Also, with greater awareness of how children’s treatment needs and service requirements differ from adults, separate children’s facilities and units were created and age-appropriate programs were developed.

The state welfare department, which replaced the charities board in 1921, eventually became responsible for supervising wards of the state, operating the aid to dependent children program, and reviewing the family situation of cases presented in juvenile court. By the 1960s, its child welfare division was also investigating and responding to reports of child abuse and neglect. Offices of

[1] In the 19th century, dependent and neglected children were statutorily defined as "waifs, strays, and children of prisoners, drunks, or paupers and those committed to hospitals, the almshouse, workhouse, and all deserted, neglected, cruelly treated, or dependent children or children living in a disorderly house or a house of ill-fame or assignation".

mental health and mental retardation created within the state public health department in the 1920s became independent departments responsible for overseeing state-supported services and facilities for those client populations in the 1950s and 1960s. A statewide juvenile court system was created in 1941, and in 1969, a state agency, the Department of Children and Youth Services, was established to provide care and custody of adjudicated juvenile delinquents.

In the 1970s, Connecticut became the first state to consolidate juvenile justice programs, child protective services, and children's mental health functions in a single executive agency focused solely on children and their families. Legislation enacted in 1974 significantly expanded the mandate of DCYS to include: (1) psychiatric and related services for children transferred from the Department of Mental Health; and (2) protective services functions for dependent, neglected, and uncared-for children formerly assigned to the state welfare department.

The 1974 act also established a commission to study the consolidation of children's services that was charged with preparing an action plan for the transfer of mental health services. In its plan submitted to the General Assembly in 1975, the commission outlined recommended goals, a structure, and programs for the new department, noting the end result is an agency with major responsibility for a large number of seriously disadvantaged children (delinquent, dependent, neglected, uncared-for, mentally ill, and emotionally disturbed) and the potential for treating each one according to his or her needs, whatever they may be.

Since the 1974 consolidation, no major changes have been made in scope of the department's mandate although a few specific programs have been transferred in and out of the agency. The department maintained its independent status through a number of government reorganization efforts over the last 20 years and only underwent a name change, to the Department of Children and Families, in 1993.

At the same time, there have been significant policy shifts, prompted by both state and federal initiatives, that have had an impact on how DCF carries out its mandates. For example, there has been a renewed emphasis on protecting children since 1995, in response to the deaths of and serious injury to several children involved with the department. New federal laws stressing permanency require state child welfare systems to shorten the length of time children spend in out-of-home care without a long-term goal and reduce the amount of time birth parents are given to meet the objectives of a treatment plan in order to regain custody of their children. The more punitive approach for serious juvenile offenses called for by the state's 1995 Juvenile Justice Reorganization Act has focused attention on the effectiveness of court commitment to the state's only secure facility for adjudicated delinquents, Long Lane School. The impact of managed care on access to mental health services has led to questions about the availability of appropriate treatment for emotionally disturbed and mentally ill children.

However, the factor that has most influenced the Department of Children and Families over the past 10 years is the 1991 *Juan F. v O'Neill* federal consent decree. The consent decree, described in detail in Chapter II, has mandated the department and legislature to focus resources and activities on child protective services, especially the foster care system. As analysis presented in Chapters III and IV shows, the consent decree has been the driving force behind the

most recent improvements in DCF operations and the increase in appropriations for child protective services and related staffing. However, by prioritizing protective services over other mandates, the consent decree has contributed to a decrease in attention and resources that might otherwise have been focused on juvenile justice, mental health, and prevention mandates. In effect, the consent decree has promoted separateness rather than integration of DCF's primary mandates.

It is important to note the legislative and organizational changes that have occurred in child protection, juvenile justice, and mental health services are the result of many factors. Federal mandates, court decisions, medical advances, advocacy groups, and public opinion all have had an impact on the development of the current system. As Figure I-1 illustrates, changes in one mandate area are often paralleled in the others. A brief legislative history of each service area highlighting these various factors is presented in Appendix A**.** The major federal mandates that have an impact on children's services in Connecticut are summarized in Appendix B.

Goals of Children's Services Systems

A frequently stated goal for children's services is a "seamless system of delivery," with a single point of entry, a continuum of care, and funding that follows the child. Comprehensive, integrated service systems are viewed as critically important for children. Children tend to have multiple needs that change as they grow and develop.

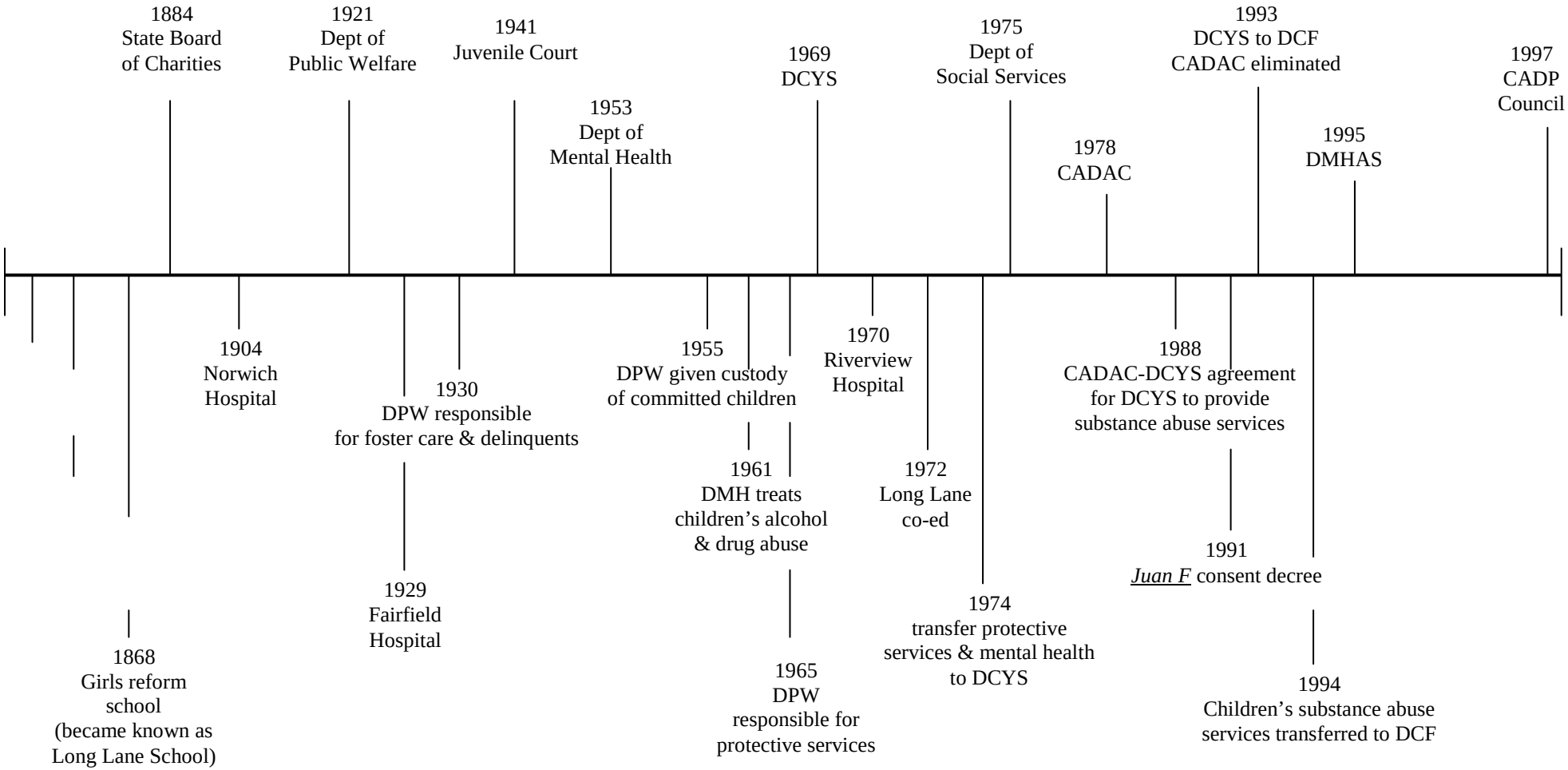
From the early 1900s through the present time, a number of studies, reports, and surveys have been conducted in Connecticut examining the needs of neglected, dependent, and delinquent children, mental health issues related to children, and ways to improve services to children. The earlier reports called for greater attention to children's services and a stronger state role in providing them. All contained one or more of the following recurring themes:

- coordination, communication, and joint planning needed;
- study/research/understanding of children's problems needed;
- treatment of the whole child and/or family required;
- mental health services lacking for children;
- specialized services, separate from adults, needed;
- critical services lacking, existing services too fragmented, and gaps and overlaps in service delivery; and
- early discovery/identification/intervention critical and prevention is a must.

Findings from many of these studies were used in 1975 as evidence of the need to establish a consolidated children's agency in Connecticut with a commissioner whose priority and commitment is to the needs of children. Supporters of the consolidated children's agency expected the new department would:

Figure I-1. Timeline of Legislative Changes in Children's Services

Development of State Agencies



Development of Policies and Facilities

- be important enough to have parity with other human services agencies;

- increase the state's commitment to prevention of emotional, developmental, behavioral, and social problems of children; and

- increase the quality and effectiveness of children's services.

The overall goal for the new consolidated agency was to provide leadership and support in developing a comprehensive statewide network of public and private programs and services. The network would be designed to: promote the sound growth and development of all children; prevent dependency, neglect, delinquency, and mental illness and emotional disorder in children; identify children at risk; and restore children to useful functioning. In addition, it was intended the new department, together with citizens advisory councils and private voluntary organizations, would provide broad advocacy for children and help safeguard their basic rights.

Organizational Models

State structures for providing child protection, children's mental health, and juvenile justice services vary considerably. However, there are three main organizational models: (1) multiple agencies; (2) multiple divisions within an umbrella agency; and (3) a consolidated children's services agency. To date, there is no consensus on an ideal structure for child welfare services or for human services generally.

Other state structures. The current administrative structures for children's services for all 50 states are summarized below in Table I-1. As the table shows, the vast majority of states (38) have adopted a multiple agency approach with two or more autonomous, cabinet-level agencies having separate chief administrators, budgets, and policy development processes, each responsible for protective services, juvenile justice, and children's mental health.

Seven states (Alaska, Arkansas, Iowa, New Hampshire, North Carolina, Pennsylvania, and Utah) fall under the umbrella agency model, maintaining two or more separate divisions within a single cabinet-level agency. The divisions in these states are organized around specific populations or functions and typically share a single chief administrator, budget, and policy development procedure. Only five states -- Connecticut, Delaware, New Mexico, Rhode Island, and, most recently, Tennessee -- have created a single, autonomous, cabinet-level agency responsible for administering child protective services, mental health services for children, and juvenile justice services.

The most common combination of services in multiple agency states is protective services and juvenile justice. Twenty-two states administer protective services and juvenile justice within a division under an umbrella agency. Thirteen states administer protective services and mental health services for children via one agency or a single division within an umbrella agency. Six states administer juvenile justice and mental health services for children by way of a single agency or particular division within an umbrella agency.

Table I-1. Current State Administrative Structures for Child and Families Services (Child Protection, Juvenile Justice, and Children's Mental Health)			
Model	***Multiple Agencies***	***Multiple Divisions in Single (Umbrella) Agency***	***Consolidated Agency***
Description	Two or more Autonomous Cabinet-level agencies Separate chief administrators, budgets, policy development	Two or more separate divisions within single cabinet-level agency Divisions organized around population or function Same chief administrator, overall budget and policy development	Single, autonomous cabinet-level agency
States	38 states 3 agencies -- 17 2 agencies -- 21	7 states (AK, AR, IA, NH, NC, PA, UT)	5 states (CT, RI, DE, NM, TN) Texas considering
Sources of Data: Ct. Office of Legislative Research, National Conference of State Legislatures, The Council of State Governments, and LPR&IC staff telephone survey of children's services agencies in other states.			

Coordination mechanisms. Results of a telephone survey of other states conducted by program review committee staff showed at least nine states have an executive branch human services cabinet or a similar body responsible for coordinating services for children on a statewide basis. However, the presence of such a coordinating body seems unrelated to a state's administrative structure for child welfare services. Other modes of coordinating and integrating services for children common among the states surveyed included: preparation of a children's budget, which identifies all resources expended by a state to benefit those under 18; formal statewide children's needs assessments; memoranda of understanding or agreement among state agencies responsible for serving children; and interagency coordinating committees. These various mechanisms occur irrespective of whether a state has a consolidated or multiple agency approach for providing services to children and youth.

Concerns and trends. Regardless of their type of organization, state children's agencies are experiencing similar challenges in the delivery of services. For example, a number of states interviewed reported substance abuse treatment programs and prevention efforts are generally lacking. A number also reported having difficulties coordinating services for children with multiple needs or for those who are dually committed (e.g., delinquent and under agency care because of abuse or neglect). Another problem noted by most states surveyed is that children's service systems are not well coordinated with adult service systems, particularly in the area of mental health. A widely noted observation crossing state boundaries is that many youth in critical need of mental health services "age-out" of the custody of their children's agency, but do not transition to the adult system. Left without treatment, they often engage in criminal activity and end up in the adult correctional system.

A growing trend among the states surveyed is the development of innovative community-based approaches to treating abused, neglected, delinquent, and mentally ill children. Indiana, for example, began to develop "pilot communities" in 1998 that are working to identify and overcome regulatory, fiscal, and policy barriers to the integration of services for children and youth. Missouri created the "Interdepartmental Initiative for Children", a consortium of the Departments of Elementary and Secondary Education, Mental Health, and Social Services, designed to be a more responsive and localized approach to treating children with severe behavioral health needs. Oregon's Commission on Children and Families has identified core statewide goals and given local citizens' commissions responsibility for developing and implementing their own plans to achieve better outcomes for children and families through strong community supports and prevention efforts. Georgia, through its children and families policy council, also has established benchmarks intended to improve results for children and families, and is promoting local community partnerships as a way to develop comprehensive, integrated services with a bias toward prevention. Finally, in Florida, legislation to privatize foster care and certain related child welfare functions, including child protection investigation responsibilities, is under consideration by the state senate as a way to strengthen community involvement in child and family services.

Objectives. Consolidated and multiple agency models have both strengths and weaknesses. For example, while consolidation can reduce duplication and improve communication and coordination, the resulting agency can become too large to be managed effectively. In addition, service components within a consolidated agency must compete for attention and resources in what becomes an internal battle out of the view and support of the service's constituency. With multiple agencies, expertise, specialization, and accountability can be promoted, but "turf wars" are often a by-product.

Historically, consolidation has been pursued as a way to reduce fragmentation of services, streamline programs, and contain administrative costs. However, it must be remembered restructuring alone may not overcome turf issues, policy conflicts, lack of leadership, inadequate funding, poor management, and other factors that impede effective service delivery.

While the perfect structure for administering and delivering children's services has not been identified, experts agree it would have the following traits:

- family-focused services;
- prevention-oriented;
- comprehensive continuum of services;
- "flexible" funding;
- well-trained staff with manageable caseloads;
- community-based services responsive to local needs;
- accountability; and

- communication and collaboration encouraged and facilitated [2].

[2] *Putting the Pieces Together: Survey of State Systems for Children in Crisis*, Susan Robison, National Conference of State Legislatures, 1990.

Chapter Two

DCF Mandates and Consent Decree

The Department of Children and Families' broad statutory mandate is to: "…plan, create, develop, operate, arrange for, administer and evaluate a comprehensive and integrated state-wide program of services, including preventive services, for children and youth whose behavior does not conform to the law or to acceptable community standards, or who are mentally ill, emotionally disturbed, substance abusers, delinquent, abused, neglected, or uncared-for …." By law, its clients include all children and youth who are or may be committed to it by any court and all who are voluntarily admitted for services of any kind.

DCF has specific mandates concerning child protection, juvenile justice, mental health, substance abuse, and prevention for children up to age 18 and, in some cases, up to age 21. It must also provide health and education services to children in its care and custody. Some mandates are very general and simply give the agency overall responsibility for a service area, such as prevention of abuse, neglect, delinquency, mental illness, and substance abuse among children. In other areas, especially child protection, objectives, procedures, and programs are set out in detail in statute. An overview of DCF's policy mandates for child protective services, juvenile justice, mental health, substance abuse, and prevention follows.

Protective Services

The state's child protection policy is to "protect children whose health and welfare may be adversely affected through injury and neglect, strengthen the family and make the home safe for children by improving the parent's abilities to provide child care, and provide temporary or permanent homes offering a safe and nurturing environment for children who must be removed from their birth homes".

Specifically, DCF is required to provide general supervision over the welfare of children who require the care and protection of the state because they are abused, neglected, or uncared-for. Guided by this policy, DCF must: develop comprehensive prevention programs for problems facing children and provide "flexible, innovative, and effective placement programs" for children committed to the department; provide appropriate services to families; develop and implement aftercare and follow-up services for children receiving DCF services; and provide outreach and assistance for persons caring for committed children.

Juvenile Justice

The state's juvenile justice policy, established in the 1995 Juvenile Justice Reorganization Act, is "to provide individualized supervision, care, accountability, and treatment to juveniles who violate the law to ensure public safety and to promote delinquency prevention". The statutory goals of the system are to:

- hold juveniles accountable for their criminal behavior;
- provide secure and therapeutic confinement for those juveniles who are a threat to public safety;
- protect the community and juveniles;
- provide community-based programs and services;
- retain and support juveniles within their homes if possible;
- provide probation treatment based on individual case management plans;
- include the juvenile's family in the case management plan;
- provide supervision and service coordination, and monitor case management to prevent reoffending;
- provide follow-up and nonresidential post-release services to juveniles and their families; and
- develop and implement community-based programs to prevent delinquency and to minimize the extent and duration of a juvenile's involvement in the juvenile justice system.

Primary responsibility for carrying out the state's juvenile justice policies rests with the judicial branch rather than DCF. Family court and court support services units provide intake and assessment of all juveniles charged with a crime and supervise adjudicated delinquents. DCF's role in juvenile justice is narrowly defined and limited to providing secure care of committed (convicted) delinquents. By law, the department administers Long Lane School, the state's only secure juvenile institution, and operates parole supervision programs.

Mental Health

The state's mental health policy with respect to children is not as clearly spelled out as the policies relating to child protection and juvenile justice. The Department of Children and Families, however, clearly is responsible for mental health services to persons up to age 18 under its broad agency mandate to plan, provide, fund, coordinate, and evaluate services to meet the needs of certain children and youth including those who are mentally ill or emotionally disturbed.

DCF is required by law to maintain certain mental health facilities: Riverview Hospital; High Meadows Residential Treatment Center; and The Connecticut Children's Place (CCP). At present, Riverview and High Meadows are facilities solely for the intensive care and treatment of mentally ill and emotionally disturbed children and youth. Mental health-related services are just part of CCP's role, which includes a number of protective services responsibilities.

DCF is also statutorily required to develop and maintain a program of outpatient clinics for children, youth, and their families as well as day treatment centers and extended day treatment programs. Recent legislation (P.A. 97-272) also mandated creation of local "systems of care," which are community-based programs for coordinating mental health services for children up to age 18 who need services from two or more public agencies and have been or are at risk of being placed out-of-home primarily to receive mental health treatment.

Substance Abuse

The state's substance abuse policy is defined by current laws that make it illegal for persons of any age to possess, sell, distribute, manufacture, or transport illegal drugs. The use of a controlled drug is not expressly prohibited. Policies regarding substance abuse treatment and prevention, especially for children, are not set out in state statute. Instead, DCF is required under its broad agency mandate, to plan, provide, and fund services for children and youth who are substance abusers. There are no specific statutory provisions requiring the agency to operate, license, or fund specific substance abuse treatment facilities or programs.

In 1997, the Connecticut Alcohol and Drug Policy Council (CADPC) was statutorily created (P.A. 97-248) to establish public policy to address the issue of substance abuse through prevention, education, treatment, and criminal sanctions and to develop an interagency plan to coordinate the activities and resources of all relevant state agencies and the judicial branch in implementing the state’s substance abuse policy. The council consists of members from the treatment, medical, education, prevention and intervention, and criminal justice fields and is staffed by the Department of Mental Health and Addiction Services and the Office of Policy and Management (OPM).

Prevention

The state's policy concerning preventive services for children and youth is not defined in statute. However, the Department of Children and Families is responsible by law for a comprehensive and integrated program of services for children and youth that includes preventive services. The department is required to cooperate with other child-serving agencies and organizations in providing or arranging preventive programs for children and their families that address, but are not limited to, teenage pregnancy and youth suicide. Several statutes require DCF to carry out specific prevention programs such as Healthy Families Connecticut, which is aimed at reducing abuse and neglect of infants by identifying and working with high-risk parents.

DCF Mission Statements

The mission statement of a state agency typically operationalizes its statutory mandate. It sets a direction for agency policy and procedures, and often defines it goals, objectives and client population. The mission of the Department of Children and Families, according to its current budget and other public documents, is to "ensure the safety of children, achieve permanency for

children in a safe environment, strengthen families, and help young people reach their fullest potential."

During 1999, DCF developed a strategic plan that included a revised mission statement. The latest mission includes references to services for mentally ill and substance abusing children as well as juvenile delinquents. However, the strategies outlined in the strategic plan focus primarily on child protective services and further advance the traditional approach of categorizing clients, resources, and services within each service mandate.

The department's mission statements, which are outlined in Appendix D, have changed significantly since the initial statement was developed nearly 30 years ago. Originally, the agency's mission focused on juvenile delinquents. Over time, the mission broadened as DCF's role and responsibilities grew to include a wider range of children and youth. In recent years, revisions to DCF's mission statement have focused on the emphasis given to protecting abused and neglect children. Changes in mission statements since the agency was established are analyzed below.

Progression of mission statements. The original mission of the department was to administer two statewide juvenile correctional facilities and to provide delinquency prevention services. When the department's mandate expanded in the mid-1970s its mission statement changed to become: "*to provide leadership and support to the development of a comprehensive statewide network of governmental and non-governmental programs and services promoting the sound growth and development of all children in Connecticut.*"

In the early 1980s, the mission statement was fine-tuned to clarify the types of children the department was directing its attention toward (e.g., "abused, neglected, mentally ill, emotionally disturbed, or delinquent"). In 1987, the agency's mission statement was revised to read: "*to preserve and strengthen families so they may care for their children while simultaneously ensuring that children are safe and have opportunities for healthy development.*" The mission focused, for the first time, on preserving and strengthening families so children could remain safely at home or be returned to a safe family environment if an out-of-home placement had been made. The next year, the department issued its first ***public*** mission statement; which stressed coordination and integration with "others" to provide services to ensure safe and healthy conditions under which children could develop as healthy and productive persons.

In 1991, the department rewrote its mission and returned to its practice of specifying its client population. The statement now read: "*children are in need of protective, mental health, juvenile justice, and substance abuse services as well as permanent, stable settings, free from harm, where they are able to achieve their potential.*". In 1996, the department's mission was again revised. This time references to specifically mandated client populations were dropped. The mission was narrowed to the following: "*to protect children, strengthen families, and help young people reach their fullest potential*."

Yet another new mission statement was issued by DCF in 1999. It places emphasis on the safety of the child and clearly de-emphasizes preserving the family. Even more significant

with respect to the program review committee's study is the absence of any direct mention of the department's juvenile justice, mental health, substance abuse, and prevention mandates.

The pattern of mission statement changes during the 1990s raises questions about DCF's long-range focus. In the early 1990s, DCF's mission statement identified the department's client group as "all children." Mission statements from the mid-1990s more clearly specified the department's client group as children "in need of protection, mental health, juvenile justice, and substance abuse services." By 1996, DCF narrowed its stated mission to "protect children and strengthen families," and eliminated references to specific types of children in need.

The importance of DCF's mission statement in guiding its activities should not be underestimated. For example, it is central to the specific child protection mission statement included in the agency's official policy manuals, which guide both policy development and direct case work practices and procedures. According to the manual, the DCF child protection mission is based on the following three principals, two of which come directly from the overall agency mission statement:

- the child is the client;
- the primary focus is safety; and
- the secondary focus is permanent placement of the child, which includes reunification with the birth family or relatives if appropriate.

It should be noted, similar mission statements for juvenile justice, mental health, substance abuse, or preventive services have not been developed for the agency policy manuals. In fact, these mandate areas are only addressed by the current manuals within the context of child protection policies and practices.

DCF Consent Decree

In addition to its state statutory requirements, DCF is obligated to comply with the provisions of a federal court consent decree resulting from a class action lawsuit concerning its child protective service mandate. Background on the consent decree and overview of its current status are provided below. Information on consent decrees in other states is also presented.

Background. In 1989, a federal lawsuit, *Juan F. v. O'Neill*, was filed on behalf of nine minors against the Department of Children and Families. The suit alleged the department did not adequately protect the children it was required to care for in violation of the federal constitution and two federal statutes. Forgoing lengthy litigation, the parties agreed to mediate a settlement.

The federal court signed the mediation order in July 1990. The order appointed a three-member mediation panel: one person was selected by the plaintiffs, one by the defendants (DCF), and one by the settlement judge (the Honorable Robert Zampano). The mediation panel was granted full and complete authority to formulate procedures and to take any and all action to resolve each issue or matter detailed by the lawsuit. The panel had until December 31, 1990, to prepare a consent decree.

The parties signed the consent decree on January 7, 1991. It covered all areas of policy, management, procedures, and operations of the department's child protective services. The services included: investigations of child abuse and neglect; foster care and other out-of-home placements; care for children placed in the care of DCF; adoptive services; and mental health services both for children involved in protective services cases and children receiving such services on a voluntary (noncommitted) basis.

The decree also covered qualifications, training, responsibilities, workload, and supervision of DCF's protective services staff, as well as internal systems operations such as case reviews, quality assurance, data management, and administration. The consent decree did not cover juvenile justice, substance abuse, or prevention services unless they were included as part of a protective services case.

Court monitor. Initially, the consent decree established the original mediation panel as the monitoring panel with authority to determine the specific methodology and pace for implementing the decree. The monitoring panel developed and approved policies, standards, procedures, programs, operating manuals, and staff levels needed for compliance. It also established the funding levels needed to accomplish implementation of the decree. The panel was empowered to decide all matters related to interpreting the decree, and its unanimous decision was final. The decree stipulated that the state pay for all consent decree mandates.

The panel prepared the manuals required by the consent decree, which were approved by the court on September 1, 1992. On October 26, 1992, the panel was dismantled and the court appointed a full-time monitor to oversee implementation of all consent decree provisions.

The court monitor is responsible solely to the court, specifically the trial judge (now the Honorable Alan Nevis), but the monitor also works closely with the department and plaintiffs to ensure timely and effective compliance with the provisions of the consent decree. The office of the court monitor is funded by the state. Currently, the monitor's office has two full-time professional staff and one child welfare consultant under contract.

The consent decree's monitoring order established the role and responsibility of the court monitor, and the procedure for tracking compliance, requesting modifications, and negotiating between the parties. The monitoring order requires the court monitor to focus on patterns of compliance or noncompliance, and not on individual cases. The court monitor is not responsible for the administration of any DCF programs or activities. The monitor's specific responsibilities are to:

- monitor implementation of and compliance with the consent decree;
- perform duties specified in the consent decree;
- establish a reporting structure to assess the progress in implementing the consent decree;
- meet with either party alone or jointly;
- review requests for modification of the consent decree by either party, attempt to resolve the request informally, or make a recommendation to the court regarding the request; and

- submit semi-annual compliance reports to the court.

The monitor has access to all DCF files, reports, and case records as well as the authority to make site visits and interview agency staff and clients.

DCF monitoring team. During the mid-1990s, the department assigned a team of employees to oversee implementation of the consent decree. The team consisted of a central office coordinator, who reported directly to the commissioner, and a regional coordinator in each of the five regional offices. Currently, one full-time manager within the strategic planning division performs this function. Two other planning unit staff assist with consent decree implementation duties.

Dispute resolution and modifications. The consent decree and monitoring order established a procedure for the parties to attempt to resolve disputes without the intervention of the court. Under the procedure, the court monitor is used to mediate disputes between the parties regarding compliance or progress. If the issue cannot be resolved, then the parties may go to court and the monitor will present recommendations to the judge.

A dispute over noncompliance can be raised by either the court monitor or the plaintiffs. If noncompliance is alleged, the monitor confers with DCF and, if there is significant noncompliance, the plaintiffs in an attempt to resolve the issue. The monitoring order provides five days to reach a resolution. If there is no resolution, the court monitor must notify the plaintiffs within 15 days and then submit the issue, with recommendations, to the court for resolution. The court monitor and staff may be called as witnesses at the hearing by the trial judge or either party.

DCF may request modifications of any provision of the consent decree when it has shown after a good faith effort that it cannot comply or when compliance would: (1) be unsuccessful in carrying out a specific mandate; (2) create an unnecessary detrimental effect on the services or operation of the department; or (3) no longer be the most cost-effective means of achieving the mandate.

To request a modification, DCF must provide written notice specifying the area of noncompliance and proposed change to the court monitor and plaintiff. The monitor then attempts to informally resolve the issue with the department and plaintiff. If an agreement is reached, it is incorporated into the consent decree upon court approval. If no agreement is reached, the court will decide whether to approve the modification.

Since the signing of the consent decree in 1992, there have been three instances in which issues regarding DCF compliance were filed with the court. The first, in June 1993, addressed the department's failure to comply with the staffing requirements set out in the consent decree. The court ordered the state to fund the hiring of additional social workers. The state appealed the order to a federal appeals court, but the lower court ruling was upheld in1994. The United States Supreme Court later denied the state's request for a review of the decision.

A second issue, presented to the court in June 1996, addressed the department's failure to prepare and implement a resource development plan for the delivery of services to children. The court ordered the department to develop the plan. The state filed a notice of appeal to the federal appeals court but it was never pursued. In December 1996, the plaintiffs filed a motion related to DCF's failure to complete the resource development plan in a timely manner, and after two court hearings, the parties reached an agreement regarding the plan's completion.

The third instance of court activity, filed in February 1999, focused on DCF's failure to comply with the consent decree requirements regarding the foster care system. Hearings and were held throughout 1999. A resolution was eventually reached between all parties and the department’s compliance with the specific requirements is being monitored.

Compliance monitoring. Implementation manuals were developed to operationalize requirements of the consent decree by identifying specific tasks, staffing levels, funding, and compliance schedules. These manuals focused on the process to implement the consent decree requirements, and not on outcomes. Rigidly drafted, the manuals quickly became unworkable. DCF subsequently drafted its own manuals, which are now used by the court monitor to track compliance.

Initially, the court monitor was tracking over 1,000 requirements. During the past three years, compliance monitoring has focused more on broader areas of concern and overall goals of the system, such as permanency for children in out-of-home placement and reduction of caseloads.

Although the monitoring order requires the court monitor to issue a report on the department's compliance status every six months, the monitor ceased producing these reports about two years ago. According to the court monitor it became too difficult and time-consuming to prepare written reports, and the court is satisfied with informal updates.

The consent decree does not contain an exit plan or termination agreement. Nor does the consent decree define a process to stop monitoring a requirement once full compliance has been achieved. The court monitor, however, intends to draft an exit plan that will measure outcomes based on the broad mandates contained in the consent decree. The exit plan will also outline how an area can be removed from the monitoring process once full compliance is achieved and a method to vacate or suspend the consent decree or dismiss it without prejudice.

Areas monitored. While the consent decree addresses hundreds of specific issues, current monitoring is focused on broad goals and mandates. These include:

- caseload reduction;
- foster care, particularly recruitment, licensing, training, and retention of foster homes, restructuring of the DCF division and units responsible for foster care, determination of resources, matching children with appropriate foster homes, and reducing multiple placements per child;
- the agency's Safe Home initiative;
- automated case management system and resource directory;

- needs assessment and outcome-based contracting;
- Child Abuse and Neglect Hotline (or Careline);
- training; and
- quality assurance, especially the treatment planning and case review process.

Because there is no written compliance report available, program review committee staff met with the court monitor to discuss the department's compliance status in the areas listed above. Overall, the monitor is satisfied with DCF's recent efforts to meet the consent decree mandates and improve its performance. The monitor believes the department, under the current administration, is making a "good faith" effort to comply; however, DCF is not in full compliance.

Specifically, the court monitor is satisfied with the department's progress to date in the following areas: the Safe Homes program for children between the ages of 3 and 12 who are being placed for the first time in foster care; the agency's automated case management system; the Child Abuse and Neglect Hotline; the training academy; and the treatment planning and case review processes. However, at present, the department is not in full compliance with the foster care provisions or requirements related to needs assessment and outcome-based contracting. Although progress has been made by DCF in its method for calculating caseloads, this issue remains an obstacle to achieving full compliance.

Legal Actions in Other States

As part of its analysis, the program review and investigations committee conducted a telephone survey of agencies responsible for children's services in other states. Information was obtained from 40 states. One issue discussed with other states was whether they have federal court consent decrees or other legal actions in effect that cover aspects of their child protection services, children's mental health, or juvenile justice systems.

Of the 40 states contacted, 21 are operating under a consent decree or judicial order affecting either their child protective services, mental health services, or juvenile justice system. As shown in Table II-1, the consent decrees focus overwhelming on protective services (16 of the 21 states). Interestingly, 12 of the 16 states have consent decrees that target the foster care system. Of the remaining five states, four have juvenile justice consent decrees, generally focusing on the conditions at reformatory facilities and institutions, and one state has a children's mental health consent decree.

Three states -- Illinois, New York, and Pennsylvania -- have multiple protective service consent decrees. In these states, child welfare systems are county-adminstered and thus have specific consent decrees. One other state, Kentucky, has consent decrees in two different child welfare areas -- protective services and juvenile justice.

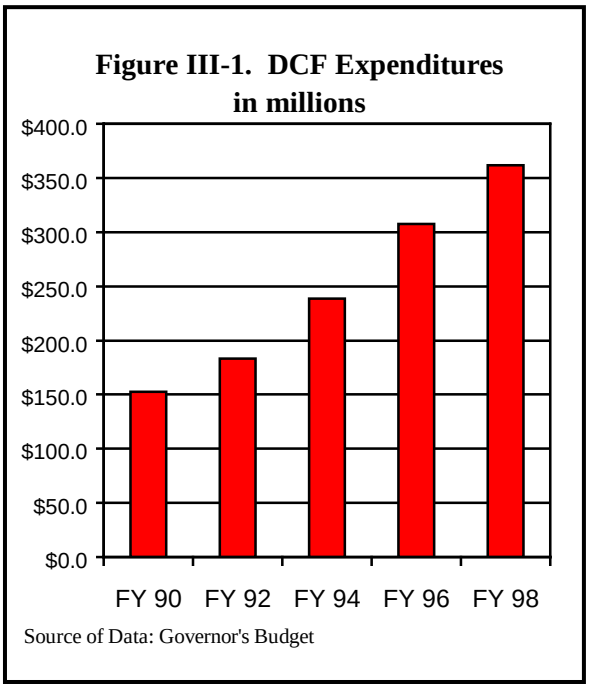
All of the consent decrees, with the exception of Rhode Island’s, were ordered by federal courts during the 1990s. Most (16 of 21) occurred prior to 1995. Rhode Island's consent decree was ordered more than 20 years ago (in 1975) and focuses on that state's social worker training academy.

Table II-1. States with Federal Child Welfare Consent Decrees		
Protective Services	Juvenile Justice	Mental Health
Alabama	Georgia	Maine
Arkansas	Hawaii	
Connecticut	Kentucky*	
Delaware	South Carolina	
Illinois*		
Kentucky*		
Maryland		
Michigan		
Missouri		
New Jersey		
New Mexico		
New York*		
Ohio		
Pennsylvania*		
Rhode Island		
West Virginia		
*States with multiple consent decrees.		

In recent years, only one state -- Delaware -- has successfully complied with a consent decree allowing the court to vacate the order (terminate the consent decree). The program review committee found only two states -- Idaho and Oregon -- of the 40 states contacted had avoided consent decrees. While no suits were filed against these states, children's advocacy groups had threatened action to correct inadequacies in the child welfare systems. However, the states' responses, prior to legal action, were deemed sufficient enough so that no suits were filed. In addition, Louisiana, New York, and Virginia are currently litigating suits alleging inadequacies in the protective services system and juvenile justice and mental health facilities.

From a state's perspective, an important aspect of a consent decree is a mechanism, such as an exit plan, for determining full compliance, which would vacate the decree. As noted above, Connecticut's *Juan F.* consent decree has no formal exit plan. The program review committee found only six states (Alabama, Arkansas, Delaware, Hawaii, Missouri, and New Jersey) that have an exit plan or termination agreement as part of their consent decrees. As previously stated, only Delaware has successfully terminated its consent decree. It should be noted that the lack of an exit plan or termination agreement does not prohibit the states from attaining full compliance or the court from vacating an order.

DCF Resources and Organization



DCF's total expenditures (state, federal, and private) are shown in Figure III-1, at two year intervals. The time period begins with FY 90, the last year prior to the consent decree, and ends with FY 98, the last year for which complete expenditure data are available. As illustrated by the graphic, spending by DCF more than doubled during the eight-year period. This high growth rate has been continued by the FY 00 appropriation, which increases the DCF's budget by nearly 26 percent over FY 98 spending.

The rapid increase in spending by DCF is about two and a half times the rate of increase in overall state spending during the same time period. Figure III-2. compares the biannual increases in DCF's expenditures with the state as a whole. The chart shows DCF's spending increases ranged from 18 to 30 percent and exceeded overall state spending increases in each of the years compared.

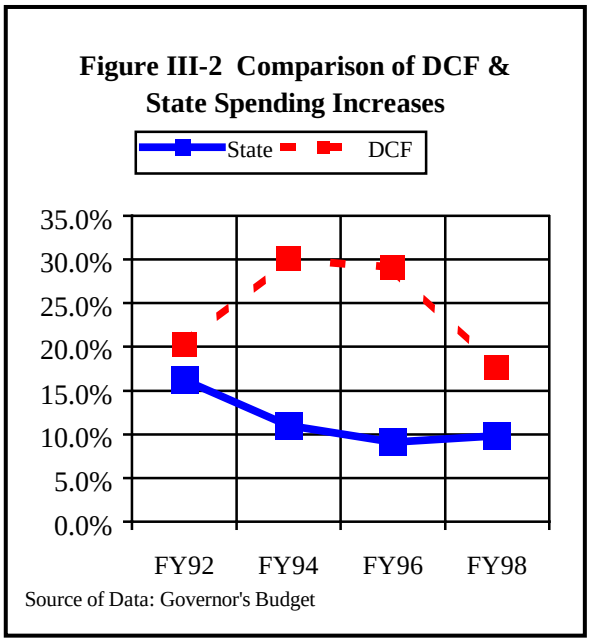
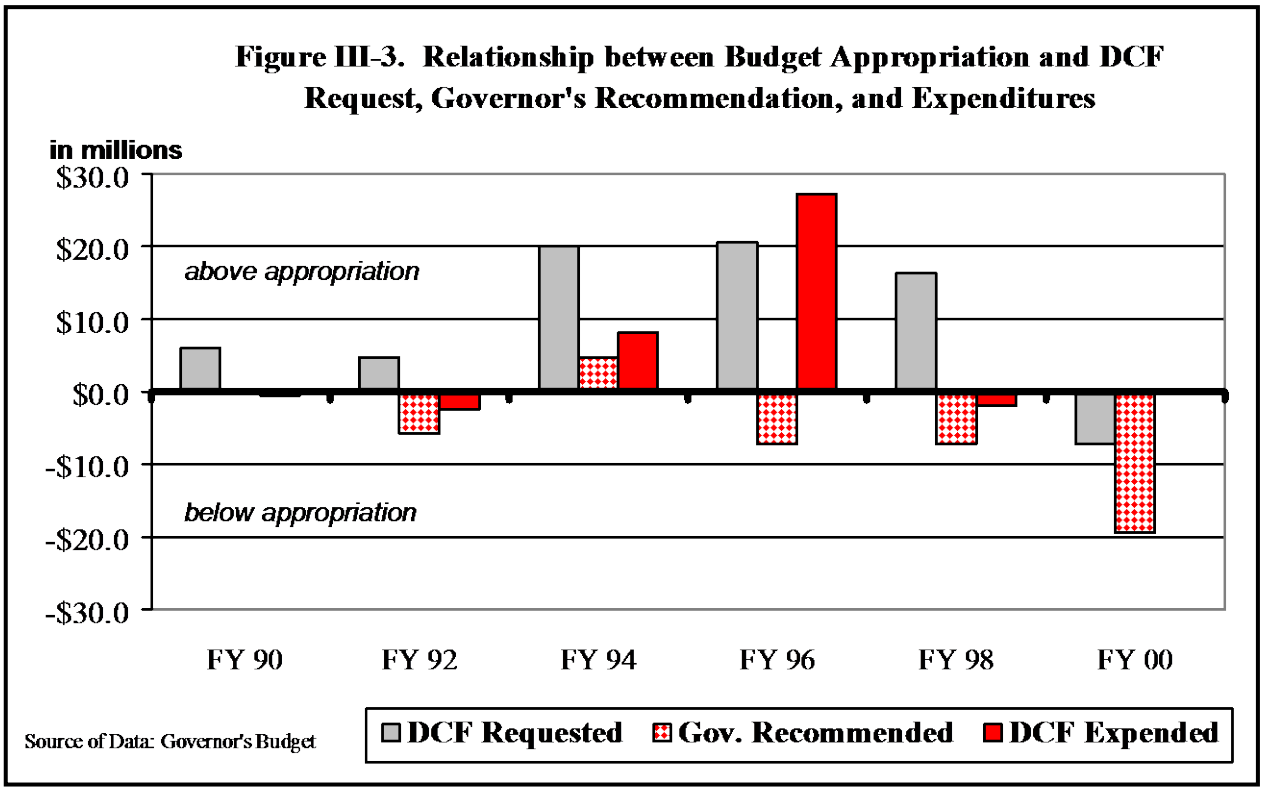


Figure III-3 graphs the relationship among the funds appropriated through the state's budget process (designated by the heavy horizontal line labeled as $0) and the funds requested by DCF, recommended by the governor, and expended by the department at two-year intervals between FY 90 through FY 00. The figure shows that in all but one of the years graphed (FY 00), DCF's budget requests exceeded the amount appropriated by the

legislature. Conversely, in only one of the years was the governor's recommendation greater than the amount appropriated.



Budget Organization and Expenditure Patterns

As currently organized**,** DCF's budget requests seek funding to support management services and four levels of client services. According to the department, the four levels represent a continuum of care for children that include: (*I) youth and community development*; (II) *support services;* (III) *supplemental services; and (IV) substitute* services. Despite significant changes in the department's mission statement between 1990 and 1998, which were outlined in the previous section, no substantive revisions in DCF's description of the four service levels occurred until the Fiscal Year 2000 budget submission.

A description of each budget level is contained in the box below. Changes in the descriptions introduced in the FY 00 budget document are shown by marking additions with bold-capitalized type and deletions with a strike-through line. An examination of the modifications show they correlate with the shift in DCF's mission -- discussed in Chapter II -- from family preservation to protecting the safety of the child. This is most clearly demonstrated by the changes highlighted in Level II and to a lesser degree by the changes in Level III.

Unfortunately for analytical purposes, DCF's budget levels do not directly correspond to the department's statutory mandates. In some instances, the mandates can be related to a single budget level, while in other cases a mandate may be addressed through programs financed under two or three of the levels. For example, the programs supporting DCF's prevention

responsibilities are found under Level I, *youth and community development*. On the other hand, financial support for programs dealing with DCF's protective services mandate can be found under Levels II, III, and IV. As a result, caution must be used interpreting the data below, which deal with changes in expenditures by budget level over time.

Changes in DCF's Budget Levels Descriptions from FY 94 to FY 00 Budget Requests

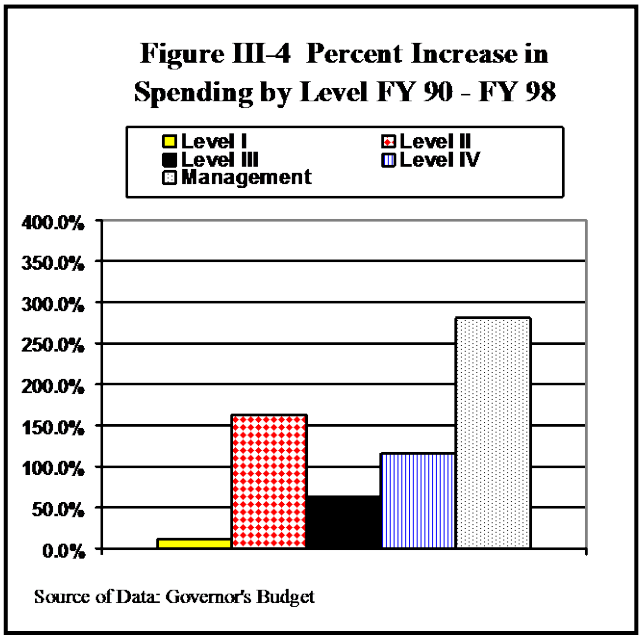
Level I of the continuum is *Youth and Community Development Services* which promote the healthy functioning of children and youth who are **POTENTIALLY** at risk of abuse, neglect, mental illness, alcohol and other drug use, or delinquency by encouraging the healthy involvement of children and youth in their families, at their schools, among their peers, and in their community **[**~~This level of care serves the largest number of children, youth and their families for the lowest unit cost and is the least intensive and least restrictive form of intervention.~~**]**

Level II of the continuum is *Support Services* which protects children from abuse or injury, **[**~~prevents children's removal from their families and homes, enables to children and their families to manage their problems~~**] PROVIDES IN-HOME SERVICES TO CHILDREN AND THEIR FAMILIES AND ATTEMPTS TO REUNIFY CHILDREN** (from substitute out-of-home care) with their families. This level of care serves children, youth, and their families in their own homes and communities.

Level III of the continuum is *Supplementary Services* which **HELPS** restore the functioning of children and youth and **[**~~develops the ability of parents to cope with family life so that children and youth can remain safely at home~~**] ENABLES YOUTH TO REMAIN IN THE COMMUNITY**. Supplementary care, provided through Extended Day Treatment programs, often compensates for parental limitations or the child's serious impairment. **[**~~This level of care serves a small number of children, youth, and their families in order to maintain children in their own homes.~~**]**

Level IV of the continuum is *Substitute Services* (out-of-home placement) including residential treatment and foster family care which protect children and/or the public and restore the child so he/she may return home or to a permanent placement which is most family-like and least restrictive. Substitute services treat children and youth who require the most intensive level of care and protect children who have been seriously abused and must be removed from their homes. The most intensive substitute services are provided by DCF-operated institutions. **GENERALLY,** less intensive substitute services are offered by private/non-profit temporary shelters, group homes, residential facilities, and substance abuse treatment facilities. The least intensive and least restrictive Substitute Services are offered by foster families. Care and treatment at this level, in general, is the most costly, most intensive and most restrictive of the four levels of care.

Figure III-4 depicts the changes in DCF's total spending by level between FY 90 and FY 98, the last year for which complete expenditure data were available. The figure shows the biggest increase was in management services (281 percent) and the smallest gain was in Level I, which as noted above is mainly composed of the department's prevention services (10 percent).



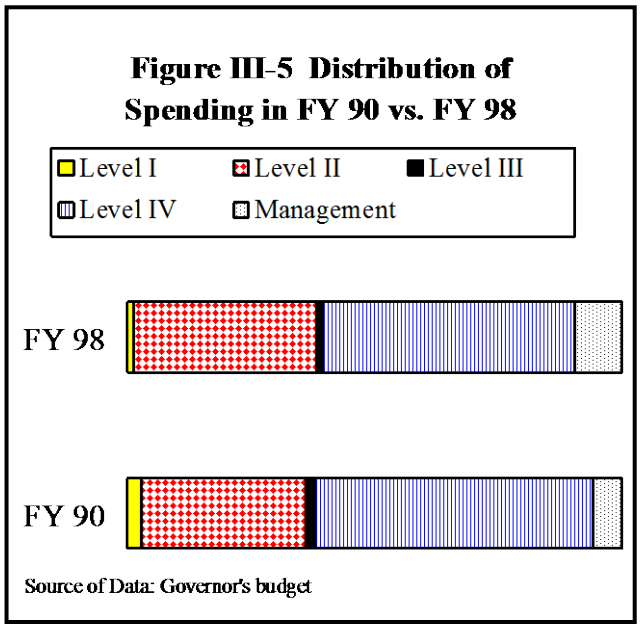
The large increase in expenditures under management services can be attributed to a number of factors. Chief among these is the near consensus view that DCF's management infrastructure (e.g. organization, staff, technology, training, etc.) was woefully inadequate in the 1980s and early 1990s and additional resources were needed. Other factors contributing to this rise include a change in the state budget process resulting in an agency's workers' compensation costs being included in the agency's budget, the inclusion of the cost of operating DCF's training academy mandated by the consent decree, and DCF's tendency to use the management services category to temporarily house the costs of the new programs.

Within the level of care continuum, the biggest increase during the FY 90 - FY 98 period occurred in Level II, support services (163 percent). The programs driving the increase in spending under Level II were *children's protective services* (up 242 percent from roughly $24.1 million to $82.3 million), *adoption services* (up 204 percent from roughly $6.7 million to $20.4 million), and the *community protective services program* (up 99 percent from roughly $4.8 million to $9.5 million). All three of the programs are associated with DCF's protective services mandate. Conversely, the program under Level II exhibiting the least amount of growth was *community child psychiatric services* (up 26 percent from roughly $8.5 million to $10.8)), which is associated with the department's mental health mandate.

The third budget category to more than double its expenditures between FY 90 and FY 98 was Level IV. Programs under this level include foster care, private facilities, and DCF facilities. Foster care, the Level IV program directly related to DCF's child protection mandate, sustained the largest increase in expenditures of the three programs, 344 percent (from roughly $15.2 million to $67.4 million). Spending on DCF facilities -- its juvenile justice and mental health institutions -- showed the least growth, 36 percent (from roughly $33.8 million to $46.2million).

In general, spending programs associated with the department's child protection mandate grew at a much higher rate than spending on programs linked to DCF's other mandates. This is a strong indicator regardless of the driving force, the stated shift within DCF from family preservation to child safety was more than words on paper.

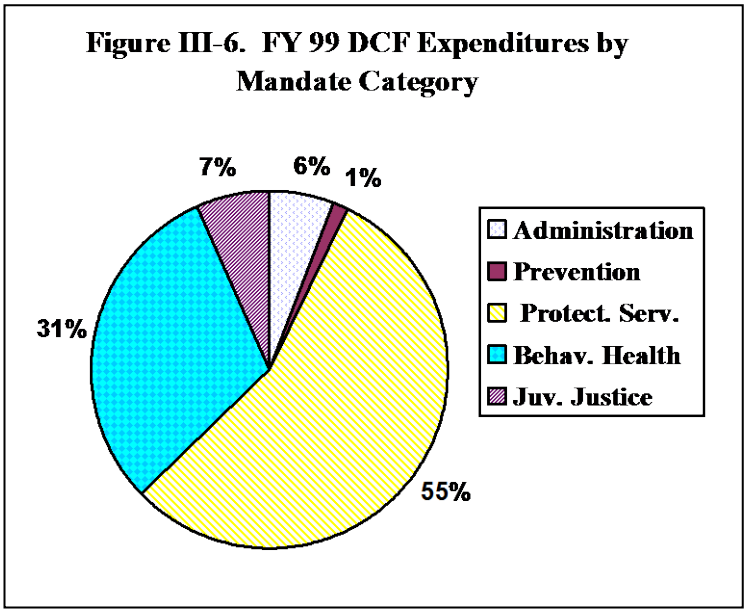
The effect on resource allocation of the different growth rates associated with the shift in DCF's philosophy can be seen in Figure III-5. The figure compares the distribution of spending among DCF's five major budget categories prior to the consent decree (FY 90) with the spending distribution for the most recent year for which final expenditure data were available (FY 98).



The figure shows the proportion of DCF's spending on Level II programs rose from 33 percent in FY 90 to 37 percent in FY 98. Similarly, management services share of DCF's expenditures increased from 6 percent in FY 90 to 10 percent in FY 98. The proportion of DCF's expenditures accounted for by the other three categories all declined between FY 90 and FY 98. The decrease was 2 percent in Level II, 0.5 percent in Level III, and 5 percent in Level IV.

Interestingly, despite having the biggest decrease relative to the other categories, Level IV remained the largest budget category at 51 percent of total DCF spending in FY 98. Level IV illustrates what is taking place throughout the DCF budget. Spending on programs not directly associated with the child protective services mandate, such as DCF facilities for the juvenile justice and mental health populations, grew slowly (36 percent), while spending on programs related to the protective services mandate, such as foster care, grew rapidly (344 percent).

FY 99 expenditures by mandate. At the request of the legislative program review committee, the department's fiscal staff prepared a special analysis of DCF expenditures during the just completed fiscal year by mandate area. The results of this analysis are presented in Figure III-6, which illustrates the proportion of the agency's budget spent on protective services, juvenile justice, mental health and substance abuse (behavioral health), prevention, and administration. The administration category includes functions that support all mandate areas (e.g., commissioner's office, public information, information systems, fiscal, quality management, personnel including workers' compensation, planning, etc.).



As the figure shows, the protective services mandate accounted for over half (55 percent) of all department expenditures in FY 99 while behavioral health made up nearly one-third of the agency budget (31 percent). The juvenile justice mandate accounted for a slightly larger portion of the budget than general administrative costs -- 7 and 6 percent, respectively -- and funding of primary prevention activities related to child abuse and neglect, juvenile

delinquency, and mental illness and substance abuse among those under age 18 constituted just 1 percent of total agency expenditure in the last fiscal year.

Behavioral health expenditures include monies spent for mental health and substance abuse services provided to DCF clients involved in abuse and neglect and juvenile delinquency cases as well as children who are not committed to the agency. In FY 99, about $91 million (76 percent) of the nearly $122 million the department spent on behavioral health was for care and treatment of clients being served under its child protection and juvenile justice mandates. Agency expenditures on mental health and substance abuse services for children and youth not committed to the agency, which include the costs of department's voluntary services program and funding for community-based programs for persons under 18 (e.g., child guidance clinics, day treatment, etc.) totaled around $29.7 million in FY 99, or 8 percent of the whole agency budget.

The allocation of department funding among mandate categories has not changed significantly over the past five years as Table III-1 indicates. The portion of the agency budget spent on protective services increased slightly, from 52 to 56 percent, between FY 95 and FY 99 but all other categories either declined slightly or remained the same. Expenditures for the prevention mandate show a dramatic percentage increase during this period but the growth in dollars was only about $3 million. In contrast, resources devoted to protective services rose by approximately $89 million, which accounted for nearly two-thirds of the total dollar increase in the agency budget since FY 95.

Table III-1. DCF Expenditures by Mandate Category: FY 95 and FY 99

	FY 95 Expenditures	*Percent of Total*	*FY 99 Expenditures*	*Pct. of Total*	*Pct Increase*
Administration	$19,085,758	8%	$23,199,420	6%	22%
Prevention	$2,202,882	1%	$5,304,461	1%	141%
Protective Services	$130,901,873	52%	$220,010,839	56%	68%
Behavioral Health	$81,433,273	32%	$121,057,872	31%	49%
Juvenile Justice	$19,488,472	8%	$25,840,219	7%	33%
Total	$253,112,258	100%	$ 395,412,811	100%	56%

Source of Data: Department of Children and Families

Children's Budget

In February 1999, the General Assembly's Office of Fiscal Analysis (OFA) produced for the first time what is called a "children's budget." Due to the nature of the state's budgeting and accounting systems a number of caveats had to be attached to the document. Nevertheless, the budget is a good source of data, when used for its intended purpose, for describing in broad terms the allocation of resources to address children's needs in Connecticut.

Overall, the Children's Budget identified 13 agencies with programs aimed specifically at persons 18 years old and younger. Table III-2 lists the agencies, amount of money expended on

children's programs in FY 96, FY 97, and FY 98, and share of the total expenditures by each agency.

The table shows spending on children's services is increasing, although as a share of total state spending it has remained constant at about 26 percent. The relatively minor year-to-year variation among agencies in terms of the percent of total funds expended indicates no single agency is acting as a driving force.

In terms of total spending on children, DCF ranks a distant third to the Department of Social Services and the State Department of Education (SDE). The three agencies account for approximately 97 percent of the total expenditures for children, with DCF's share being about 12 percent.

Table III-2. Child-Related Expenditures by Agency

Agency	***FY 96***	***FY 97***	***FY 98***	***FY 96***	***FY 97***	***FY 98***
	In $millions			***Percent of total***		
State Department of Education	$1,462.4	$1,471.4	$1,521.2	55.5%	54.4%	53.0%
Department of Social Services	$813.4	$824.7	$916.9	30.9%	30.5%	32.0%
DCF	$295.3	$329.7	$343.8	11.2%	12.2%	12.0%
Judicial Department	$19.2	$26.5	$31.8	.7%	.1%	1.1%
Department of Mental Retardation	$10.1	$21.0	$23.0	.4%	.8%	.8%
Department of Public Health	$15.0	$15.6	$16.9	.6%	.6%	.6%
Bd. of Ed. & Services for the Blind	$11.4	$8.8	$7.1	.4%	.3%	.3%
Office of Policy & Management	$5.7	$3.5	$4.1	.2%	.1%	.1%
Attorney General.	$1.7	$2.3	$2.8	.1%	.1%	.1%
Department of Labor	$.7	$.8	$.8	<.1%	<.1%	<.1%
Commission on Children	$.3	$.3	$.3	<.1%	<.1%	<.1%
Office of the Child Advocate		$.1	$.1		<.1%	<.1%
Department of Public Works	$.1	$.1	$.1	<.1%	<.1%	<.1%
Total	$2,635.3	$2,283.4	$2,869.0			

Source of Data: Office of Fiscal Analysis Children's Budget

Also included in the Children's Budget is a breakdown of spending by program type. A brief description of the programs identified in the budget document follows:

Advocacy: programs that promote and protect children's interests;

Behavioral Health: programs that provide mental health or substance abuse services;

Child Care: programs that provide child care subsidies to individuals, grants to facilities, and regulation of child care facilities;

Child Welfare: programs aimed at preventing abuse and neglect and providing services to those who have been abused or neglected;

Education: programs that assist children to learn directly or indirectly through support for planning and administration;

Family support: DSS support programs aimed at children;

Health: programs that provide to children direct medical services, prevention, and screening;

Juvenile Justice: programs that support planning and treatment for juveniles adjudicated delinquent;

Mental Retardation/Early Intervention: programs that support developmentally disabled children; and

Youth Services: programs that provide support for youth service bureaus, youth camps, and summer youth employment.

Table III-3 lists the programs identified in the Children's Budget, the amount of money spent on each program in FY 98, the allocation of the money among the programs, the amount spent by DCF on each program, percent of total program spending accounted for by DCF, and the internal allocation of DCF's spending among the programs.

Using share of spending as the criterion, DCF is the lead agency for child welfare and children's behavioral health programs and shares the lead role with the judicial t in the juvenile justice area. In terms of its internal allocation, the Children's Budget indicates DCF spends about three-quarters of its money on child welfare programs (i.e., programs aimed at preventing abuse and neglect and providing services to those who have been abused or neglected). DCF spends an estimated 15 percent of its money on behavioral health programs (i.e., mental health and substance abuse prevention and treatment) and around 10 percent of its funds in the juvenile justice area.

Table III-3. Child Related Expenditures by Program

Program	*FY 98 Spending in millions*	*Share of spending on children*	*DCF's FY98 Spending in millions*	*DCF's share of program*	*Distribution of DCF's spending*
Advocacy	$3.2	.1%	$0	0%	0%
Behavioral Health	$51.2	1.8%	$50.3	98.4%	15%
Child Care	$133.5	4.7%	$0	0%	0%
Child Welfare	$259.0	9.0%	$259.0	100.0%	75%
Education	$1,516.0	52.8%	$2.8	.2%	1%
Family support	$190.3	6.6%	$0	0%	0%
Health	$618.0	21.5%	$0	0%	0%
Juvenile Justice	$63.3	2.2%	$31.7	50.0%	10%
Mental Retardation	$23.0	.8%	$0	0%	0%
Youth Services	$11.6	.4%	$0	0%	0%

Source of Data: Children's Budget

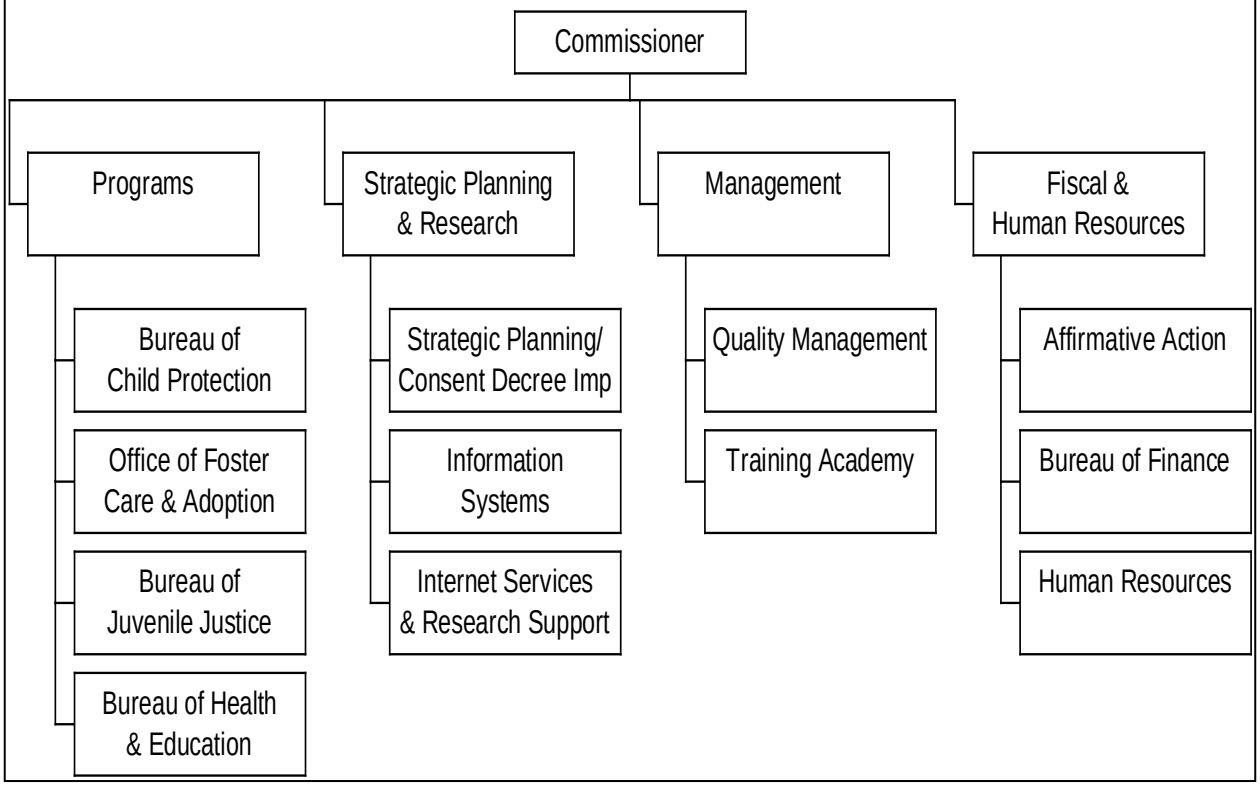
An examination of the three-year spending trends reported in the Children's Budget (FY 96 - FY 98) reveals DCF's expenditures in the child welfare area were up 23.2 percent. The department's spending on behavioral health programs was up 3.1 percent and juvenile justice expenditures were down 6.3 percent. This resource allocation pattern is another indicator of where DCF is placing its priorities.

Department Organization

The Department of Children and Families' organization is evolving under the current commissioner, who was appointed in February of 1997. The latest agency organization chart is shown in Figure III-7. It shows the agency consists of four divisions: Programs; Strategic Planning and Research; Management; and Fiscal and Human Services. The programs and management divisions are headed by deputy commissioners, while fiscal and human services is overseen by an assistant commissioner. The strategic planning division is scheduled to be headed by a director, although the position is currently vacant.

Programs Division. The Bureaus of Child Protection, Juvenile Justice, and Health and Educational Services are located in the programs division along with the Office of Foster Care and Adoption Services. The child protection bureau oversees the department's five regional offices and nine sub-offices.

Figure III-7. DCF Organization (Draft)



The DCF regions were created in 1987 to decentralize administrative and programmatic responsibilities and to increase local involvement in the administration and evaluation of community programs. Figure III-8 is a map showing the boundaries of the regions and locations of the regional offices. The regional offices have primarily responsibility for all field operations related to child protective services including: investigating allegations of abuse or neglect; case management or treatment of open cases involving intact families or families with children in out-of-home placement; and foster family assessment and licensing. The department is in the process of regionalizing its budget and contracting processes to give the regional managers more authority and responsibility for allocating resources to best meet the needs of the clients in each region.

The juvenile justice bureau has primary responsibility for dealing with children adjudicated as delinquents and placed in the custody of DCF. The bureau oversees Long Lane School and the "parole" services program for juveniles, which is administered on a day-to-day basis by the facility's superintendent and staff.

The health and education services bureau is responsible for ensuring children living in any DCF facility or other out-of-home placement receive proper medical care, including behavioral health services, and educational programming. It oversees two DCF mental health facilities, Riverview Hospital and High Meadows, which are run by facility superintendents. Educational services for DCF clients in agency facilities are provided through its Unified School District #2, a DCF entity authorized by the State Board of Education and headed by a superintendent of schools. The school superintendent also administers the Wilderness School, an Outward Bound-type program run by the agency primarily for delinquent adolescents.

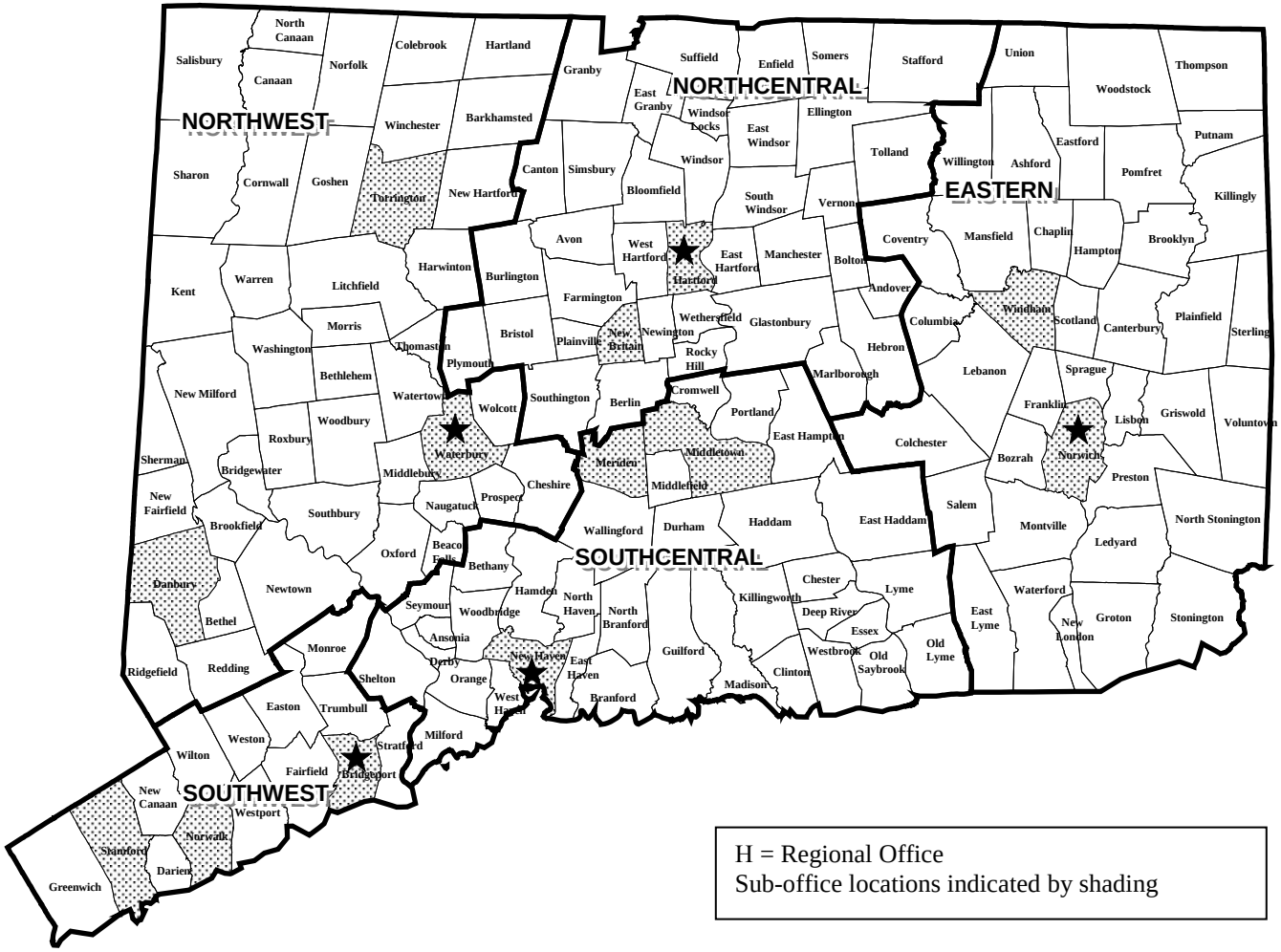
The Office of Foster Care and Adoption Services supports regional activities to recruit, license, and train foster and adoptive families and the state-wide efforts to retain foster parents. The department's adoption specialists, who develop adoption plans and provide case management for adoption cases, are assigned to this office.

Division of Strategic Planning and Research. This division is responsible for agency-wide planning, monitoring implementation of the consent decree, and providing research services. The department's information systems unit, which is responsible for all computer-related services, including administration of the agency's automated case management system, is also located in this division.

Management Division. The Bureau of Quality Management, which is responsible for the agency's internal and external quality assurance functions, and the DCF training academy, is included within the management division at present. The department's quality management activities are described in the Chapter IV. The training academy, which was established to meet consent decree requirements, provides pre-service and in-service training for all DCF employees.

Division of Fiscal and Human Services. The division, through its finance bureau, is responsible for all fiscal operations of the agency including budget preparation and resource

Figure III-8. DCF Regional and Sub-regional Offices



allocation, accounting, and contracting. All personnel functions are also handled by staff within this division.

Organizational issues. The current draft nature of the department's organization is reflective of its structural history. A review of DCF's organization over time shows at least 21 reorganizations between 1970 and 1999. The restructurings were brought about by variety of factors including the need to incorporate new mandates, address the consent decree, and respond to six commissioner changes as well as legislative shifts in philosophy and resources. Except for a brief period in the early 1980s, the department has reorganized itself every year.

The unstable nature of the department's organizational structure has contributed to several long-standing management issues. The issues, which have been repeatedly identified in past management studies of the agency (see Appendix C), include: overlapping responsibilities; weak accountability; amorphous roles; and overly broad spans of control for managers.

Management concerns are clearly evident within the agency's Bureau of Child Protection. The bureau, which is responsible for the bulk of the agency's resources and activities including all protective services field operations, is not a stand-alone functional division. Rather, the bureau is one of four within the programs division, each of which must compete for the attention of one deputy commissioner. The ability of a manager located at this level of the organization to ensure consistency among regional office operations and compliance with agency protective services policy has been questioned by outside reviewers and the agency's own top managers.

Several additional issues with respect to key management roles and relationships are raised by the agency's current configuration. These include the following observations:

- there is no clearly identifiable unit or staff responsible for preventive services, a primary mandate of the department;
- responsibility for the department's mental health and substance abuse mandates rests with two directors within the health and education bureau;
- the mental health director does not have any clear authority regarding DCF's residential facilities even though each provides mental health treatment and services, has no management control over the voluntary services program which serves seriously emotionally disturbed children and their families who are not involved protective services case, and has no direct role in overseeing the agency's new pilot program to develop the continuum of care model for providing community-based mental health and other services to children;
- for the previous 18-month period, the health and education division had been administered by an acting director, who was also the superintendent of Riverview Hospital. In November 1999, the acting director was made permanent, but now the superintendent position for Riverview Hospital is vacant; and
- to date, the department has not filled the director position for its Strategic Planning and Research Division.

Management issues are also raised by the central office staffing levels for key mandates. The agency's mental health division is currently comprised of two individuals, although three additional positions, two professional and one administrative support, were recently authorized to carry out the state mental health mandate for all children and youth in the state. The central office substance abuse staff, responsible for the state's alcohol and drug treatment and prevention mandate for those under age 18, consists of four individuals. DCF's Bureau of Juvenile Justice is staffed by four central office positions -- a director and three assistants. There are four central office and 14 regional office manager positions with direct responsibility for various aspects of child protection services.

Chapter Four

DCF Management and Planning

DCF, like child welfare agencies across the country, faces widely recognized management challenges. A recent U.S. Government Accounting Office (GAO) report on state and local child protection agencies found they are plagued by systemic weaknesses that undermine effective management.[1] These weaknesses include difficulties in:

- maintaining a skilled workforce;
- consistently following key policies and procedures designed to protect children;
- developing useful case data and recordkeeping systems such as automated case management; and
- establishing good working relationships with the courts.

The management weaknesses outlined in the GAO report clearly have been issues for Connecticut's consolidated children's agency. These and other management problems led to the 1989 law suit and resulting consent decree. Lack of planning, inadequate information systems, weak accountability, and ambiguous management structures are repeatedly cited as deficiencies in reports produced by outside consultants and the program review committee over the past 20 years. (Findings and recommendations from prior reports on DCF are summarized in Appendix C) Information on the current status of several key management functions is highlighted below.

Planning

A primary management duty of the Department of Children and Families, by statute, is to plan and evaluate a comprehensive and integrated statewide program of services for children and youth. The agency is required by state and federal law to produce a number of planning documents, including a five-year master plan to be submitted to the General Assembly biennially. The state mandated master plan must incorporate a comprehensive mental health plan for children and adolescents, a comprehensive plan developed in conjunction with the Department of Mental Health and Addiction Services for substance abusers, and a written plan for the prevention of child abuse and neglect.

[1] *Child Protective Services: Complex Challenges Require New Strategies*, U. S. Government Accounting Office, July 1997.

Current planning documents. DCF has not produced the statutorily required master plan since 1986. Mental health and child welfare plans are prepared each year as part of state grant applications for federal funding in these areas. In addition, the department, as a member of the Connecticut Alcohol and Drug Policy Council (CADPC), participated in developing the first statewide interagency substance abuse plan, which was submitted to the governor and General Assembly in January 1999. Other than the recent report on the site selection for a new Long Lane School, no planning document has been prepared by DCF concerning juvenile justice matters.

A variety of special plans have been prepared in recent years, both in response to consent decree requirements and agency initiatives. For example, a plan for DCF facilities was issued in February 1999, a draft statewide training plan for 1998-1999 was prepared by the DCF training academy, and a draft plan for quality assurance was developed in March 1999 by the agency's quality management office. In compliance with consent decree provisions, the department just completed its Program Assessment and Resource Allocation (PARA) Plan for 1999. The PARA plan documents how resources will be allocated among various service categories based on the agency's annual assessment of services used by children and families during the previous year.

Strategic plan. None of the documents currently produced by DCF fulfill the purpose of the agency master plan, which by law should contain:

- the department's long range goals and current level of attainment;
- a detailed description of the types and amounts of services provided;
- a detailed forecast of the service needs of current and projected target populations;
- detailed cost projections of alternative means for meeting projected needs;
- funding priorities for each of the five years included in the plan and specific plans indicating how the funds are to be used; and
- an overall assessment of adequacy of children's services.

At the direction of the commissioner, the department's planning division recently produced a strategic planning document for the agency that set specific goals and identifies actions required to implement them for major functional areas (e.g., administration and finances, child welfare bureau, human resources, education services, juvenile justice, mental health division, etc.) and institutions. According to agency mangement, the strategic action plan is intended to serve as the rolling master plan called for by state statute. However, it does not include any systematic needs assessments by target population, comprehensive cost projections for needed services, or an evaluation of the status of current services provided to children and families.

Planning and research functions. Statewide planning is the responsibility of the small strategic planning division, comprised of seven professionals and two support staff, in the central office. Central office planning staff actually spends about half its time working on annual federal grant applications and related state plans and the rest on consent decree implementation issues and strategic planning. A new function the staff intends to undertake in the upcoming year is

resource development -- finding new public and private funding sources to support agency activities.

Planner positions are also assigned to the regional offices. In general, the regional planners spend most of their time on contract administration and provider relations, not assessing client needs and developing programs. Through their contract management functions, however, needs for new or expanded services can be identified and forwarded to the central office for consideration.

At present, no staff in DCF are devoted to analyzing trends, reviewing research, and compiling and coordinating the vast amount of data generated throughout the agency. However, the current PARA plan proposes formation of a planning and research unit. The only part of the agency regularly conducting research now is the new quality assurance unit that oversees analysis of data collected through the performance-based contract and administrative case review processes.

Advisory groups. Two statutory entities central to department planning efforts are the State Advisory Council (SAC) and the agency's five Regional Advisory Councils (RACs). The State Advisory Council consists by law of 15 gubernatorial appointees including a child psychiatrist, an attorney, three persons between ages 15 and 22, child care professionals, five child care professionals and representatives of young persons, parents, and others interested in the delivery of services to children and youth. The SAC is responsible for recommending service improvements to the commissioner, annually reviewing and advising on the agency's proposed budget, issuing reports it deems necessary, and interpreting the department's policies, duties, and programs to the community. In recent years, the council has been primarily reactive; it has provided comments on agency budgets and plans but has not produced any independent reports or policy initiatives.

The council's role and influence has varied with each agency commissioner. At present, the DCF commissioner usually attends the council's monthly meetings and has asked the council's assistance in developing the latest strategic plan. In addition, a mental health subcommittee of council has been designated to serve as the state's citizen advisory council for children's mental health planning as required by federal law.

The statutes require the DCF commissioner to create regional advisory councils of not more than 21 persons to provide advise on the development and delivery of services in each DCF region and to facilitate coordination of services for children, youth, and their families in the region. The majority of members of each RAC must earn less than 50 percent of their salaries from providing services to children and families with the balance made up of representatives of private human service providers in the region. Each DCF regional office assigns a worker to staff its RAC. The relationship of the regional councils to the department has varied over time and among regional advisory councils, ranging from critic to partner. Under the current administration, the RACs have participated in the development of the agency's routine planning documents as well as the PARA plan.

Another important advisory group with a special purpose is the critical response team established under P.A. 99-26, the legislation mandating a new juvenile training school to replace Long Lane. The nine-member team, which is comprised of representatives of state agencies, the governor's office, a private residential treatment facility, and the judicial branch, is responsible for making recommendations on the operation of the new training school and on DCF's oversight of delinquent children in its custody. The team submitted its recommendations, which primarily focused on the internal operations of the Connecticut Juvenile Training School (CJTS), to the governor and General Assembly on January 1, 2000.

Information Systems

A major management deficiency continually cited in studies of DCF is the lack of an effective automated information system. At present, the department's main computer support for its daily operations is known as LINK. The multi-million dollar system, which became operational in 1996, was funded in part with federal grant dollars made available to all states to help create single statewide computerized child welfare information systems.

Ultimately, LINK is intended to be the agency's case management system capable of tracking the history and current status of all DCF clients, producing reports for planning and policy purposes, and carrying out certain fiscal functions. Now it is used primarily for processing payments for out-of-home placements for children in protective services case and reporting caseload and staffing data to the court monitor.

A major limitation of LINK at this time is the fact that data related to clients of DCF facilities, which include Long Lane School and the mental health institutions, are not incorporated in the system. Also, the system only includes case information back to 1996; prior data on cases must be retrieved from the agency's former computerized systems and from paper files. Agency officials also caution against using information produced through LINK without checking other sources since data entry problems and programming issues have resulted in inaccurate or unreliable reports.

Quality Assurance

A strong quality assurance mechanism within the Department of Children and Families is required by the consent decree and by federal law and regulation. Quality assurance has involved different functions and organizational locations over the past 10 years but currently is carried out by the department's Bureau of Quality Management, which was established in early 1998. In addition to an administrative case review process, the units in the bureau's continuous quality improvement division are responsible for: licensing the facilities subject to DCF regulation (e.g., clinics, shelters, residential treatment facilities, etc.); investigating complaints concerning licensed facilities and other providers of children's services; conducting special, internal reviews of critical incidents (i.e., child fatalities and serious injuries); and analyzing information on the performance of outside service providers.

The foundation of DCF's quality assurance function is the administrative case review (ACR) process. Implementation of the current process, developed in consultation with the court

monitor, began in one regional office in February 1998 and is expected to be fully in place in all regions by the end of 1999. Under the process, an independent review of nearly every open protective services or voluntary services case involving out-of-home placement is conducted every six months "to ensure the right services are provided at the right time in the best way for children in the custody or supervision of the Department of Children and Families."[2]

The ACR process is integrated into the department's overall treatment planning process. In addition to providing regular assessment of the status of each active treatment case, administrative case review is being used by the department to:

- systematically collect data on all cases reviewed;
- prepare quarterly caseload profiles for regional and central planners that can help identify service trends and needs; and
- identify corrective actions for improving case practices.

[2] The consent decree ACR process does not apply to juvenile justice cases unless the child is dually committed to DCF. In compliance with federal requirements, however, similar administrative case reviews of children at Long Lane or on parole and in an out-of-home placement are conducted by a Long Lane staff person.

Chapter Five

DCF Activities

The major activities DCF undertakes to carry out its mandates for protective services, juvenile justice, mental health and substance abuse, and prevention are outlined in this chapter. Agency programs and facilities as well as the key steps the department follows in providing services to clients in each mandate area are described. An overview of the DCF client population is also provided.

Client Population

DCF receives clients from a variety of sources including the courts, schools, police, hospitals, private service providers, neighbors, and parents. There is no single point-of-entry into the department nor is there a single intake or case management process for all cases. In fact, protective services, juvenile justice, and voluntary mental health services case processes are distinct and rarely integrated within DCF. Each service area has a separate case management system and staff as well as its own facilities, contractors, and programs.

The majority of DCF clients are involved in protective services cases; a portion receive mental health and substance abuse services and a small number are "dually committed." These are children committed to DCF care by the court as a result of an abuse or neglect case and as a delinquent in a juvenile justice matter. Typically, the juvenile justice commitment takes precedent in terms of services and case management until the end of the 18-month or 4-year commitment period and, if the protective services case is still active, the case is then managed by the regional treatment office. Protective services may continue to be provided to the juvenile's family as part of the ongoing abuse or neglect case. Juvenile justice and protective services staff, however, do not routinely coordinate services or consult on treatment planning.

Data lacking. Program review staff had planned to include an analysis of the cross-over among major DCF client groups -- protective services, juvenile justice, and mental health -- in terms of services provided, and had requested data necessary to conduct the analysis from DCF in April 1999. The department was unable to provide the information as requested or an alternative method for accurately identifying the proportion of its clients who are single- versus multi-service cases.

Ultimately, the department responded in an August 1999 letter that its automated information system: (1) was not capable of generating data on the cross-over between child protection and juvenile justice; and (2) could not provide information for any client population receiving mental health services

unless those services were provided in a residential placement paid for by DCF. Therefore, the following descriptions of major DCF activities contains no quantitative analysis to support the department's position that the children it serves under each mandate are very similar and often move from one service area to another.

Protective Services

Protective services is a specialized DCF responsibility extended to families in behalf of children who are abused, neglected, uncared-for, or abandoned. It is involuntary in that the parents or guardian of the child generally do not ask for department services and DCF cannot allow the child to continue in the unsafe situation. Protective services continue until the agency determines the child is receiving proper care in the birth home, has been permanently placed in another home environment, or has aged-out of the child welfare system at 18 or, under certain circumstances, 21 years old.

Reports. Figure V-1 outlines the protective services case process. It begins with a report of alleged abuse, neglect, abandonment, or endangerment of a child made to the DCF Child Abuse and Neglect Hotline. Reports are evaluated by hotline staff for severity and classified as low, moderate, or high risk. The classification level determines the appropriate response time for beginning an investigation. The response time for investigation ranges from two hours for a report involving a death or serious injury or the risk of death or serious injury to 24 or 72 hours for other, non-life threatening situations.

Table V-1 shows the total number of calls processed by DCF's hotline, not all of which were reports of abuse or neglect. The number of calls investigated has increased over the three-year period, rising by 3.4 percent in FY 98 and 3.7 percent in FY 99. At the same time the percentage of calls investigated by DCF decreased slightly.

Table V-1 Reports to DCF Hotline and Investigations: FY 97 – FY 99.

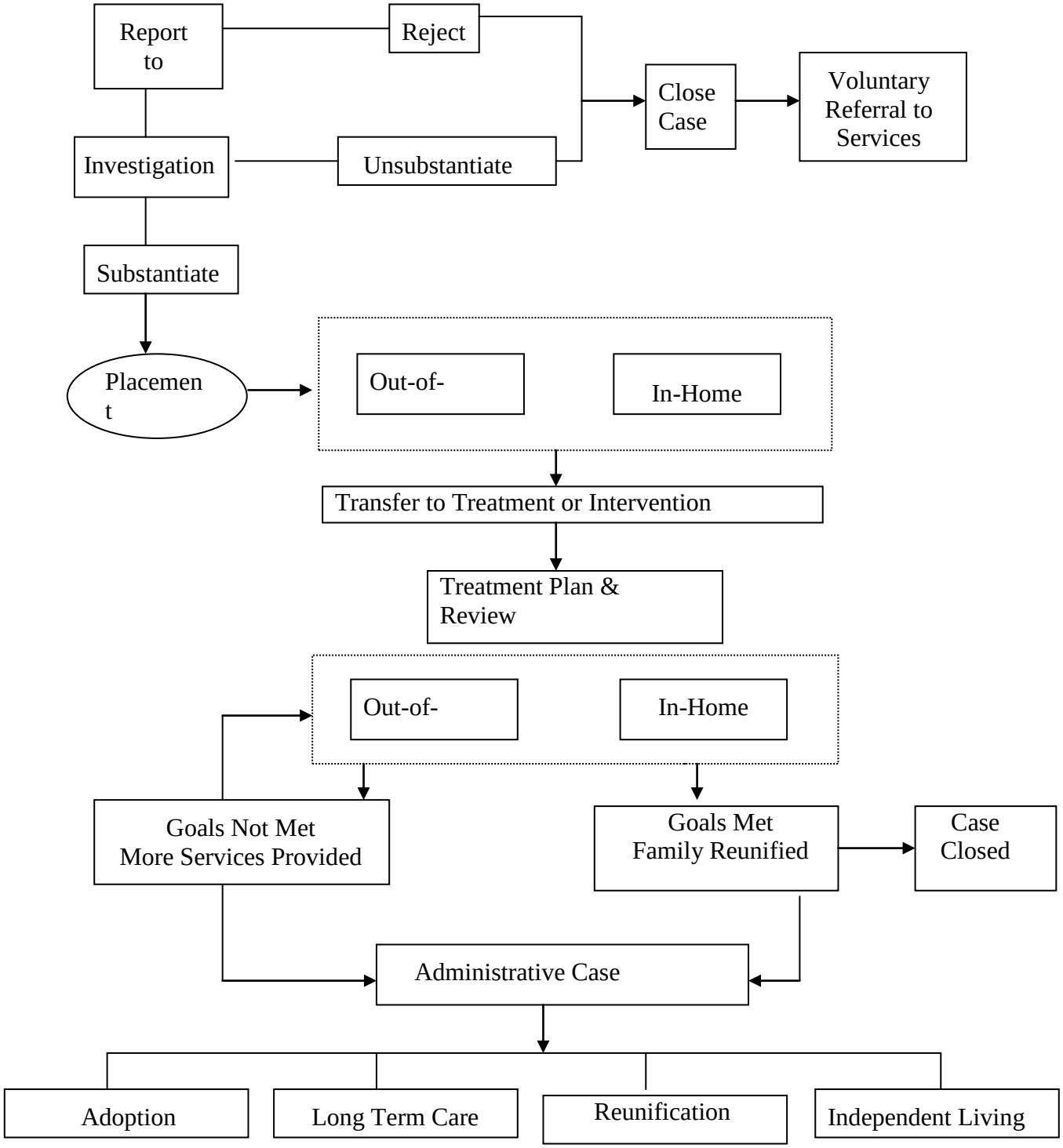
Activity	FY 97	FY 98	FY 99
Total Reports	34,316	38,682	42,164
Total Investigated	28,786	29,769	30,938

Source of Data: DCF

Investigations are conducted by regional office investigators or by hotline investigators during after-business hours. All investigations must be completed within 45 days -- including the mandated 30-day investigation period plus an additional 15-day extension period if needed. The investigation has two objectives: (1) ensure the child's safety; and (2) begin the process of service delivery to the family.

Treatment. Substantiated reports are referred within the regional office to a treatment unit for case management and service referral. Treatment is aimed at assessing and addressing

Figure V-1. Protective Services Case Process



the child's and parents' needs in order to preserve the family unit and protect the child. The treatment relationship between DCF and the family, which is often long-term and can be multi-generational, frequently addresses various related problems that contribute to or exacerbate abusive or neglectful behavior, such as poverty, homelessness, physical or mental illness, alcohol and substance abuse, criminal activity, and a lack of educational or employment opportunities.

A written treatment plan for every child under DCF supervision is required to be developed and reviewed every six months. A treatment plan is a working agreement between DCF, the child, family, and any treatment service provider (e.g., foster family or residential facility). A treatment plan states the diagnosis of the child's and/or family's problems and the services to be provided; based on assessment information, observable and measurable treatment goals are also defined. DCF treatment plans provide a "dual track" -- one that outlines the primary case management and service delivery aiming for reunification of the family and a contingency plan, or secondary track, for permanent placement (e.g., adoption or independent living) should reunification efforts fail.

Out-of-home placement of a child can occur at any point in a protective services case. For example, a child in imminent danger of serious physical or sexual abuse can be removed from his or her home within hours of a report to DCF or a child can be placed at the conclusion of the 45-day investigation or any point during DCF's involvement with the family. Children may also be placed more than once. Some children are placed in several different foster homes, some rotate between foster care and residential care or hospitals, and others return home to their birth families only to be replaced in foster care when the reunification efforts fail. Multiple placements occur for a variety of reasons including inappropriateness of the placement, lack of resources, clinical error, or problems of the child.

Removal. The four primary ways in which children are removed from their homes are: a 96-hour hold; an Order of Temporary Custody (OTC) by the court; court commitment to DCF; or voluntary placement. A 96-hour hold, used by the department when serious conditions pose imminent danger to a child, can be granted by a regional administrator, DCF commissioner, or medical personnel in a hospital setting. The hold is issued without the parents' permission or prior knowledge, and is not reviewed by the court. To continue custody of a child beyond the 96 hours, DCF must be granted an order of temporary custody by the court.

An order of temporary custody is granted by the court when a child is in need of court protection. DCF becomes the child's guardian for an initial 10-day period, during which a show cause hearing is held. The court may continue DCF's custody of the child for 30 days or return the child to his or her family. In either case, a full hearing is scheduled by the court within 30 days to determine whether or not the allegations can be substantiated warranting the child's commitment to DCF care.

The third way a child can be removed from home is through a commitment proceeding. A child is committed when a court finds the child, while not in any imminent danger, is still in need of protection. DCF may be granted care and custody of a child for a period not to exceed 12 months. The department can petition for a revocation which is a return of a committed child to

the home, an extension of the commitment for another 12-month period, or termination of parental rights.

The fourth method of removal is voluntary placement. Parents may request their child be removed from the home for a period of up to 90 days, usually for short-term problems within the family, such as children who run away, have psychiatric, emotional, or medical problems, or exhibit unusual or uncontrollable behavior. The parents retain all rights to and responsibilities for the child and, at their request, the child must be returned immediately to the home.

Placements. During 1999, the department contracted with 14 private providers to operate Safe Homes, a new type of residential placement for children between the ages of three and 12 who are removed from home for the first time. Safe Home programs include a 45-day intake and assessment process, which serves as a pre-placement period and allows the department to evaluate a child's needs and determine the most appropriate longer-term placement. It should be noted, DCF was unable to complete its Safe Homes project – several homes were not opened as planned – and subsequently the state funding for this project lapsed during 1999.

The department also requires all placements in a residential facility or program, for any reason, be approved by a central office child placement team (CPT). The CPT is responsible for managing placement resources and assuring the appropriateness of a placement. The team is comprised of DCF staff and, on the request of the family court, a probation officer.

During FY 99, DCF reported serving 42,041 children in 16,635 families involved in protective services cases, in FY 98, it served 38,283 children in 14,706 families and, in FY 97, 38,771 children in 15,111 families. Because a protective services case often results in long-term involvement between DCF and its clients some children and families are counted in all three years, and many DCF-involved families consist of more than one child.

As shown in Table V-2, DCF has made more than 6,000 protective services placements in foster care, relative care, and various types of residential programs each year since FY 97. It is important to note this is a count of placements made and not individual children placed. A

Table V-2. Number of Out-of-Home Placements by DCF

Placement	FY 97	FY 98	FY 99
Foster Care	4,313	4,161	4,163
Relative Care	929	1,203	1,425
Residential Program	948	1,131	1,090
Other*	183	117	138
TOTAL	6,373	6,612	6,816

*Other placements include independent and adolescent living programs.
Source of Data: DCF

child may be placed more than once, with each placement counted separately. The most common type of placement is a foster family home followed by placement with a relative and

then residential programs. Residential program placements increased (4 percent) in FY 98, but slightly decreased (3 percent) in FY 99. The total number of placements have increased at an annual rate of 3.8 percent and 3.1 percent over the past two fiscal years.

The department conducts administrative case reviews every six months on all abuse and neglect cases. The process is designed to review compliance with required case management practice as well as the treatment services identified as needed by the client, those used, and those needed but not provided and why.

Juvenile Justice

The Department of Children and Families has a limited, but important, role in the juvenile justice process. It is responsible for the supervision and treatment of delinquent youth committed by the court. To accomplish its juvenile justice mandate, DCF operates Long Lane School, a secure care facility, funds residential treatment and custody programs, and provides community supervision of "paroled" delinquents. DCF considers any delinquent not housed at Long Lane School to be "paroled", however, this program bears little resemblance to the adult parole system.

Adjudication. The bulk of the juvenile justice system is administered by the judicial branch, specifically family court and juvenile court support services. The judicial branch is responsible for adjudicating youths under 16 who are charged with delinquency or a serious juvenile offense (SJO).[1] The court also handles youths under 16 who come before it as a member of a family with service needs (FWSN)[2]. The adjudicatory phase -- judicial and nonjudicial -- involves an extensive pre-trial intake and assessment of the youth and, in most cases, probation supervision. The judicial branch also operates the state's three pre-trial juvenile detention facilities, which are the only secure custody state facilities, besides Long Lane School, for youths under 16. [3]

Commitment to DCF. DCF has no role in the juvenile justice adjudicatory process. The agency first becomes involved in a delinquency case when its central office child placement team receives a placement application for either Long Lane or a private residential facility from the court.

[1] A delinquent child is one who has violated any federal or state law, municipal or local ordinance, or a Superior Court order, such as a FWSN order or condition. A child is adjudged a serious juvenile offender when convicted of any one of several specific offenses set out in statute. These crimes include the most serious and violent crimes which if committed by an adult would be serious felonies. The serious juvenile offender law categorizes the offender differently from other juveniles and transfers the case from juvenile to adult criminal court.

[2] FWSN cases involves children who are runaways, truant from school, beyond the control of their parents, or engaged in immoral or indecent conduct. FWSN cases are generally handled in a nonjudicial manner by the court. However, the judicial branch and DCF have entered into agreements to establish a process for DCF to provide more intensive intervention when court services are deemed insufficient and a process for transferring FWSNs needing residential treatment from judicial probation to DCF.

[3] A 1996 consent decree (*Emily J.*) covers almost all operational aspects of juvenile detention centers. Currently, the judicial branch is not in full compliance with the consent decree.

Currently, there are two conflicting state laws that establish the delinquency commitment authority of both the juvenile court and DCF. Since the 1970s, the court has had the authority to commit a convicted delinquent to the Department of Children and Families -- for up to 18 months and a serious juvenile offender for up to four years. The department is statutorily empowered to then determine the most appropriate placement and the length of the commitment period to be spent in such a placement. The department is responsible for custody of the youth for the total 18-month or four-year period, no matter how short the stay in a secure placement. Over the past 10 years, the court has lost confidence in the department's ability to provide secure confinement of convicted delinquents for a sufficient period of time. This lead to the court's current practice of ordering DCF to provide specific commitment arrangements in either Long Lane or a residential program. In effect, the court overrides the department's decision-making authority with respect to delinquency confinement arrangements.

In 1999, the legislature recognized this practice in state law (P.A. 99-26). The new law permits the court to specify a placement facility in its commitment order to DCF. However, the prior law was not repealed.

As previously discussed, DCF implemented a central child placement team to manage its placement resources. The department requires all placements, even court-ordered delinquency commitments, to be approved by the placement team. DCF and the court maintain a working relationship through the appointment of a judicial branch juvenile probation officer to the CPT.

During the past few years, the court has also begun to order juveniles placed in DCF's Riverview Hospital for psychiatric evaluations as part of the pre-dispositional assessment process. Riverview does not have a special assessment unit and the juveniles under court-ordered evaluation are placed on the general population wards. Carrying out the court-ordered evaluations put a serious strain on DCF resources because Riverview is routinely at capacity, must be able to respond to emergency cases, and has a continual waiting list of children in need of hospitalization because they pose a threat to themselves or others.

In an effort to be responsive to the courts and to manage its limited hospital resources, DCF entered into a memorandum of agreement with the judicial branch to reserve 20 inpatient beds at Riverview for court-ordered mental health evaluations of youth pending before the court as FWSNs or delinquents. The children may remain at Riverview while awaiting placement in a residential facility if the judge does not want to place the child back in juvenile detention; however, the court can not use more than its 20-bed limit. As part of the agreement, the judicial branch has provided one part-time staff person to assist DCF with the intake and discharge processes for the youths it orders to Riverview.

Long Lane School. Convicted delinquents between the ages of 11 and 15 are committed by the court to DCF. The department can place the delinquent in a residential treatment or custody facility, in the community under supervision, or in its own juvenile justice facility, Long Lane School. The 240-bed school provides the most intensive level of residential care and supervision for adjudicated boys and girls. It has four residential cottages, one for girls and three for boys.

All new admissions to Long Lane are assigned to an intake unit and have a treatment plan developed. The school operates a secure 20-bed intake unit for boys that is separate from the general population cottages. The boys are housed in this unit while participating in mental health, health, educational, and social history screening. The school does not have a separate intake unit for girls but does maintain a secure mental health unit for them. The girls are placed directly in the general population cottage or, if necessary, in the mental health unit for intake and assessment. The intake and assessment process generally takes 30 days, for girls it runs a bit longer because it is not separated from the daily activities of the school. While in this initial phase, the youth still regularly attends educational classes at the facility.

After intake, the youth are placed in a general population cottage or may be "paroled" to an in- or out-of-state residential treatment program or their community. Long Lane has no specialized units, except for the girls' mental health unit. The general treatment program offered to all youth at Long Lane consists of a year-round five-hour academic day, clinical treatment for the youth and, if possible, his or her family, recreational activities, and some substance abuse education.

Currently, the average length of stay at Long Lane is five months, after which delinquents are "paroled," again, either to a less restrictive residential program, or to their community. Regardless of the post-Long Lane option used, delinquents are under DCF supervision for the remainder of their commitment period.

Parole. The department does not have a minimum time served requirement before a delinquent can be "paroled" nor does it have release criteria or standards. DCF uses a case management team, consisting of a the direct care staff, case manager, and clinical, educational and medical staff, to determine a youth's “parole” eligibility and develop a parole treatment plan. In addition, administrative and recreational staff as well as the youth's family may participate in the review. “Paroled” delinquents sign an agreement that sets out the conditions of release.

The department contracts with several private residential treatment programs in Connecticut and other states to provide services to "paroled" delinquents. Some of these programs are designed to treat special populations, such as sexual offenders or sexually reactive youth, substance abusers, or children with severe behavioral problems like fire-setting. The length of stay varies from six months to two years.

If the "paroled" delinquent is not placed in a residential treatment program, he or she is returned to their community. Under this circumstance, treatment services are provided on an out-patient basis with supervision by a DCF parole officer. The youth is generally required to attend school or a training program and abide by certain conditions to control behavior, such as a curfew, restrictions on contact with certain people or groups, and attendance at counseling or recreational programs. DCF contracts with community-based outreach and tracking programs to provide daily supervision and contact with the youths.

A youth who violates a condition of “parole” or fails to adapt at a residential facility often has his or her “parole” revoked and is returned to Long Lane School. The youth may spend a

period of time at Long Lane before being “paroled” again or may be directly place to a more restrictive or appropriate residential program.

Release. Once the commitment period is completed, the youth is released from the custody of DCF. The department can continue to provide residential treatment services only if the youth voluntarily agrees to extend commitment. This is usually done if the youth is in a residential treatment program and requires an additional period of commitment to complete the treatment. DCF, the child, and his or her parents must sign a service agreement that specifies the continued length of commitment. The department can extend commitment of a child who *does not* agree only if it can show cause the child has an overwhelming need for treatment or the youth's release from commitment will pose a threat to public safety. In this case, only the court can extend the commitment period. DCF also may retain responsibility for the care or custody if a youth was a dually committed delinquent and remains part of an active protective services case. The protective services case manager regains responsibility for such a child as part of the family case once the delinquency commitment ends.

Statistics. Table V-3 shows the total number of delinquency and serious juvenile offender cases adjudicated by the family court and the number of those committed to DCF. As shown, only 12 percent of all adjudicated delinquents and SJOs are committed to DCF; most (88 percent) are sentenced to a period of probation which is administered by the judicial branch. The percentage of youths committed by the court to DCF has decreased over the past four fiscal years from 17 percent in FY 96 to 12 percent in FY 99, however, the total number of youths adjudicated has increased.

The number of court commitments to DCF has remained fairly consistent except for an increase in FY 96 -- the year after the 1995 Juvenile Justice Reorganization Act was passed. Also shown is a breakdown of where the committed delinquents were placed. Less than one-half of the committed delinquents are placed at Long Lane School. The percentage of committed youth directly placed in a residential treatment program has been steadily increasing, rising from 55 percent in FY 95 to 73 percent in FY 99.

Table V-3. Delinquency Commitments From Court to DCF

Commitments:	FY95	FY96	FY97	FY98	FY99
Total Cases Adjudicated by Court		4,641	5,189	5,941	5,760
Total Committed to DCF	679	783	661	678	684
Long Lane Admissions	306	293	246	228	186
Direct Placement Admissions	373	490	415	450	498

Source of Data: DCF and judicial branch

Table V-4 contains information on the total number of delinquents placed on “parole”. The department, however, could not provide data on how many youths are "paroled" to the community or to residential programs. The available data show slight year-to-year changes in the number of youth on “parole”.

Table V-4. Total Number of Delinquents Placed on Parole			
	Boys	Girls	Total
FY 96	1,106	201	1,307
FY 97	1,084	219	1,303
FY 98	1,076	286	1,362
FY 99	1,043	317	1,360
Source of Data: DCF			

Mental Health and Substance Abuse

The Department of Children and Families, directly and through contractors, provides a variety of mental health and substance abuse services to children and their families. Children and youth in the custody of department, as either a protective services or a juvenile justice case, may receive these services as part of their required care and overall treatment plan. Children who are not part of a protective services or juvenile justice case can receive behavioral health from the department if they are admitted to DCF's voluntary services program. Services are also provided to children committed for psychiatric reasons to the agency's mental hospital by court order or a physician. It is important to note, while DCF is responsible for overseeing a comprehensive and coordinated system of services for emotionally disturbed and mentally ill persons under 18, mental health services are not an entitlement program for children in Connecticut.

The department relies, for the most part, on private providers to supply the behavioral health services its clients require. Among the types of treatment it purchases are: substance abuse prevention and treatment; emergency psychiatric services; outpatient treatment from clinics, day treatment, and extended day treatment programs; and inpatient treatment in private psychiatric hospitals, residential treatment programs, therapeutic group homes and specialized foster homes. In FY 99, about 72 percent of the more than $121 million DCF spent on behavioral health was for residential treatment and inpatient hospital services; the remainder was expended for community-based treatment services.

In many cases, contractors funded in part or in whole by the agency provide mental health and substance abuse services to children and families who have no active involvement with DCF. Table V-6 provides some basic information about the status of clients served by community-based facilities and programs that receive department funding. As the table shows, the about two-thirds of the clients served by two types of providers, emergency mobile psychiatric services and child guidance clinics, were not involved in DCF cases in FY 98. In contrast, at least half of the clients served by DCF's day treatment and substance abuse treatment contractors were active department cases.

The Department of Children and Families also operates three facilities that provide mental health treatment to children and adolescents. Two DCF facilities -- Riverview Hospital and High Meadows Residential Treatment Program -- primarily serve children involved in protective services cases, although their beds are available for use by other children and youth who meet their admission criteria. The third, the Connecticut Children's Place, a diagnosis,

evaluation, and brief treatment facility, only serves abused and neglected children committed to DCF who are especially difficult to place.

Table V-6. Status of Clients Served by Selected DCF Contractors: FY 98

	Total No. Cases Starting Service	% DCF Clients	% No DCF Involvement
Emergency Mobile Psychiatric Services	3,209	32%	68%
Child Guidance Clinics	10,280	33%	66%
Day/Extended Day Treatment Programs	468	65%	34%
Substance Abuse Treatment Programs	874	52%	47%

Source of Data: DCF

Basic budget, staffing, and client data for each DCF treatment facility are presented in Table V-6. As the table indicates, these facilities are expensive operations that provide intensive residential care and treatment to a relatively small numbers of clients.

Table V-6. DCF Treatment Facilities: Resource and Activity Data

	FY 99 Budget (No. Staff)*	Client Statistics*	FY 95	FY 96	FY 97	FY 98	FY 99
Riverview	$18.2 million (263)	Avg. No.	72	75	77	90	91
		Avg. LOS	112	92	104	132	n/a
High Meadows	$7.3 million (104)	Avg. No.	n/a	19	50	64	102
		Avg. LOS	n/a	208	532	342	243
Connecticut Children's Place	$6.2 million (127)	Avg. No.	174	183	208	128	127
		Avg. LOS	111	101	163	189	161

* Notes:
Budget = operating budget for FY 99; Staff = Number of filled full-time equivalent positions FY 99
Avg. No. = Average number clients in treatment per month
Avg. LOS = Average length of stay in days
Source of Data: DCF

As noted earlier, overview information on what behavioral health services are provided by DCF and who receives them is not available through the agency's automated case management system. Examination of FY 99 expenditure data, however, shows the majority of mental health and substance abuse services the department provides directly or purchases from outside contractors are used by clients involved in protective services and juvenile justice cases. About $91 million (76 percent) of the agency's total behavioral health budget last fiscal year, was spent for DCF committed children, another almost $11.5 million was related to the department's voluntary mental health services program (described in more detail below), and the remaining approximately $18 million was expended for services used by children without any DCF involvement.

Services for DCF Committed Children. As discussed in the previous descriptions of the department's protective services and juvenile justice activities, the assessment and treatment planning processes for children committed to the agency includes to some extent an evaluation of the child's mental health and substance abuse needs. If needs are identified, the social worker assigned to the case is responsible for including services to address them in the child's treatment plan. Inpatient or other residential mental health treatment, like any out-of-home placement, is subject to review and approval of the department's central office child placement team, discussed earlier in the protective services overview.

Access to behavioral health services has become an increasing problem for clients covered by Medicaid managed care contracts, which includes the majority of the children in DCF care. The department recently assigned health care advocate positions to each regional office to assist social workers in resolving managed care issues that interfere with a child's treatment plan.

Since most regional office social workers responsible for case management do not have special training in mental health and substance abuse issues, they rely on the experts in their office's regional resource group for advice when determining what services to provide for children and families with problems in these areas. At Long Lane, as noted earlier, clinical staff are available to assist in evaluating behavioral health needs and developing appropriate treatment plans for adjudicated delinquents.

The department's responsibility for children in its custody, in most cases, ends when they turn age 18. Those who still require behavioral health services move to the jurisdiction of DMHAS or possibly the Department of Mental Retardation (DMR), depending on their diagnosis and needs. All three departments, in conjunction with the Office of Policy and Management have been working on ways to improve the transition process for DCF clients who "age-out" of the children's system but have still have significant treatment needs. Several memoranda of understanding, as discussed in Chapter VI, have been developed to address each agency's roles and responsibilities regarding some specific client populations with special needs.

Due to the limitations of its automated case management system, the department was unable to provide a compilation of the amount and types of mental health and substance abuse services provided to children the children in its care and custody at present or over time. The special budget analysis prepared by DCF fiscal staff for the program review committee, discussed in Chapter III, did provide some information on behavioral health services used by DCF clients. According to that analysis, 98 percent of the nearly $29 million expended on behavioral health services for juvenile justice clients in FY 99 was for in-patient hospitalization and residential treatment. Eighty-seven percent of the approximately $62 million spent on mental health and substance abuse services for clients involved in protective services cases was for residential treatment and in-patient hospitalization.

Voluntary Services. Since the agency was first created in 1969, the DCF commissioner, in his or her discretion, has been permitted to admit children and youths to the department for services on a voluntary or noncommitted basis. Over the years, the noncommitted program has

developed a focus on children and youth with serious emotional disturbances, mental illness and/or substance dependency, whose cases do not involve abuse or neglect issues. Statutory provisions, added in 1997, clarified that commitment to the department is not a condition for receiving services, established a probate court process for reviewing voluntary admissions and a mechanism for appealing the commissioner's decision to deny a voluntary admission. The main steps in the process according to current law are shown in Figure V-2.

Under current law and department policy, to be eligible for voluntary services a child or youth must meet the following criteria:

- has a serious emotional or behavioral disorder;
- has an emotional disturbance and/or is substance dependent;
- treatment needs cannot be met through existing services available to the parent/guardian;
- the disorder or disturbance can be treated within a reasonable time and within available department resources; and
- not reached age 18 at time of referral.

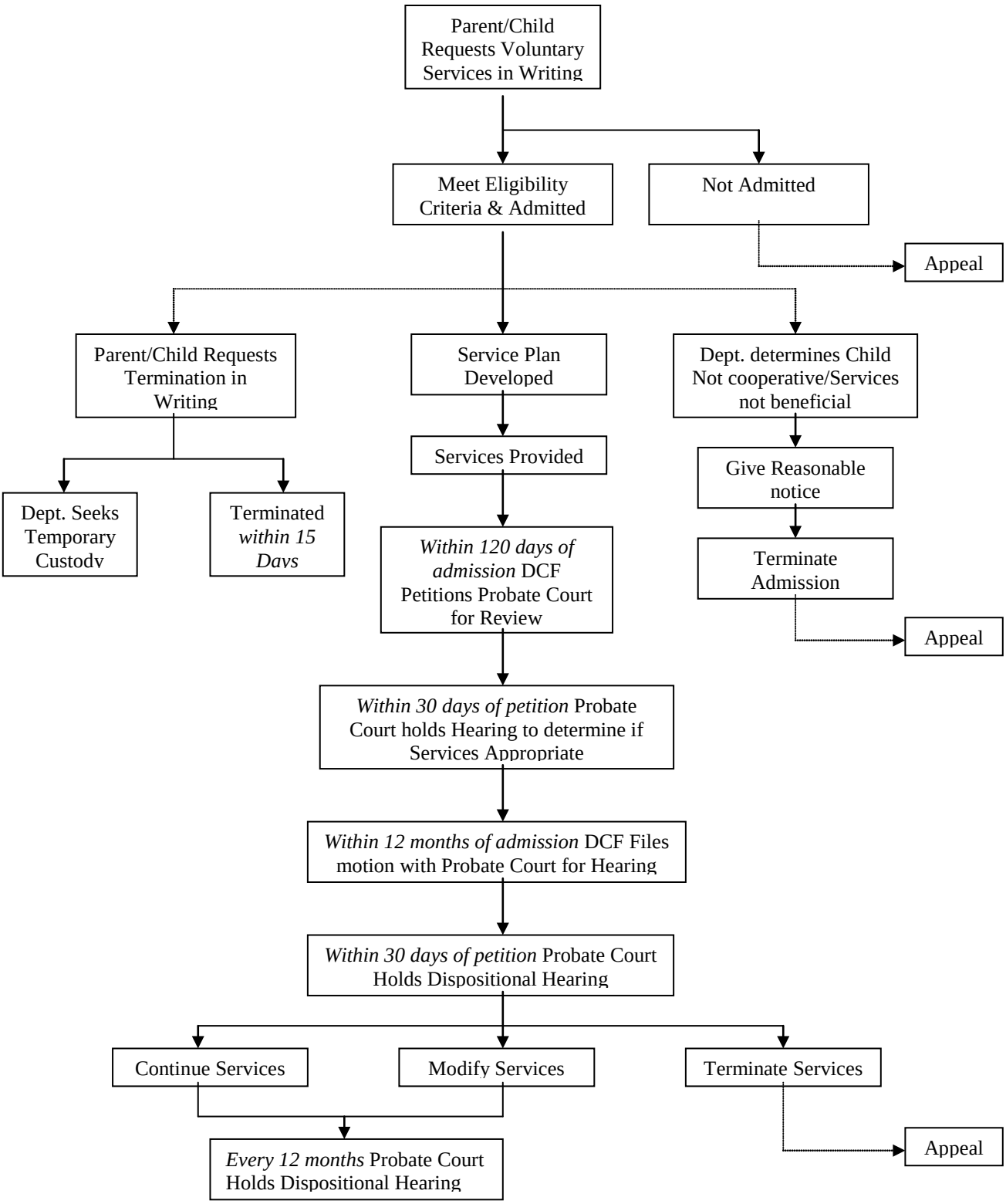
In addition, a person under DCF care and supervision who is over 18 but under 21 may be permitted to stay voluntarily admitted if in the commissioner's discretion the person would benefit from further department care and support. A child or youth will be found *ineligible* if the family is under investigations for abuse or neglect or is part of an active DCF protective services case or if the child or youth:

- has a primary diagnosis of mental retardation;
- has been arrested under the adult criminal system; or
- requires placement because of special education needs.

By statute, any of the services DCF offers, administers, contracts for, or otherwise has available can be provided to a child or youth voluntarily admitted to the department if they would be of benefit in the commissioner's opinion. According to the agency, an array of services, which may vary among regions, is available under the voluntary admission program and can include intensive family preservation, after-care services, mentor services, in-home therapist, intensive behavior management training, respite care, extended day treatment, and out-of-home treatment. According to department policy, eligibility for out-of-home placement under the voluntary admission program is limited to the following circumstances:

- in-home services and intensive outpatient care attempts, which are documented, have been unable to remediate the child or youth's impairment;
- the parent-child relationship will be maintained during and after implementation of the service plan; and
- it is expected the child or youth will return to the family when the service plan is completed.

Figure V-2. Steps in the Voluntary Services Process



At present, each regional offices organizes its voluntary services staff differently; in some offices, social workers only handle voluntary services cases while in others, voluntary services are just part of a worker's protective services caseload. Voluntary services cases generally are managed like protective services cases in that a treatment plan is developed and monitored through a case review process. No single central office unit oversees the program although the head of the administrative law unit of the quality management bureau, in developing regulations for the program and handling appeals regarding denial of services, has become the primary contact for voluntary services issues. In addition, the agency requires anyone wanting to apply for voluntary services to call the DCF abuse and neglect hotline for forms and information.

Proposed regulations for the program, which have taken nearly two years to develop, were finally published and subject to a public hearing in September 1999. They are currently being revised to incorporate comments received through the hearing. While the regulations have been pending, each region has developed its own application forms and procedures. As a result, there have been inconsistencies in who is admitted and what services are provided under the voluntary services program. Each region also maintains its own statistics on requests, admissions, denials, and other program activity. The central office periodically compiles statewide data on the program but does not collect information on trends in demand for voluntary services. The latest statewide statistics on voluntary services are from March 1999 and are shown in Table V-8.

Table V-8. DCF Voluntary Services Cases: March 1999

Regional Office	Total No. Accepted	No. Out-of-Home Services	No. In-Home Services
East	31	11	20
South Central	61	26	35
South West	21	11	10
North West	61	27	34
North Central	129	48	81
Total	303	123	180

Source of Data: DCF

Systems of care. In addition to traditional types of mental health services, the department is also involved in a pilot project to establish local systems of care to serve children with severe emotional disturbances. This effort began in the 1980s in response to the federal Child and Adolescent Services System Program (CASSP) initiative. A system of care is defined by the federal government as:

> a comprehensive spectrum of mental health and other support services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with serious emotional disturbances and their families. The creation of such system of care involves a multi-agency, public/private approach to delivering services, an array of service options, and flexibility to meet the full range of needs of children and their families.

Under the system of care concept, state and local agencies including schools, community service providers, families, advocacy groups, and other organizations, from one or more contiguous towns or cities, collaborate to deliver an array of services to meet children's emotional, behavioral and educational needs. Participants usually formalize the collaborative arrangement through memoranda of understanding and one entity takes on the chief administrative and fiduciary role for the system. Currently, there are 19 active systems of care in various stages of development throughout Connecticut. The number of participating cities and towns per system ranges from one to 21.

State legislation enacted in 1997 established in statute the process for developing and implementing individual system of care plans for children who are mentally ill or emotionally disturbed and are at risk of, or already are in, an out-of-home placement primarily for mental health treatment. DCF is required, *within available appropriations*, to develop and implement such plans for at-placement-risk children and youth. Under the act, the department also is required to prepare annual reports on the status of local systems of care and allowed, again within available appropriations, to establish case review committees and system coordinators in each of its regional offices to assist in developing, implementing, and monitoring care plans.

To date, the department's role in systems of care has been relatively minor. Even the enabling legislation was initiated outside the agency by child advocacy groups and parents. Over the years, DCF has distributed federal grant funding available to Connecticut for CASSP development and provided some in-kind support to communities implementing local systems of care. Federal funds have and continue to be used to pay for family advocates, who assist parents of severely emotionally disturbed children obtain services, and system of care case managers.

At the time of the committee review, there were eight full-time family advocates and 16.5 case manager positions, which the department recognized as insufficient to meet the current workload for the existing systems of care. In addition, while DCF had designated system coordinators in each regional office three of the five positions spend as much as 60 percent of their time on other duties.

Prevention

Preventive services, while not defined in statute, have been interpreted by the Department of Children and Families to incorporate efforts to address all areas within its purview – child abuse and neglect, delinquency and juvenile crime, and substance abuse and mental illness among those under age 18. However, the agency’s actual role in funding and operating primary prevention programs for children and families, which are generally viewed as activities aimed at preventing the occurrence of problems for populations at risk, is relatively small.

According to a prevention budget document prepared by the Office of Fiscal Analysis for the period FY 97 through FY 99, DCF is just one of at least 20 state agencies and the judicial branch that are involved in more than 100 prevention programs that directly or indirectly impact the well-being of children and families. Spending on all child and family prevention programs identified in the OFA report totaled about $240 million in FY 99, while DCF expended just over $5 million on prevention services that year.

Programs funded and operated by the department include the state's Healthy Families initiative, a small grant program for community-based prevention programs that provide parent education, family support and similar services, and some substance abuse prevention efforts. (Most of the state's substance abuse prevention efforts for children as well as adults are carried out through the Connecticut Alcohol and Drug Policy Council, of which the DCF commissioner is a member.) The department was also responsible for administering grants for youth service bureaus, community-based agencies involved in prevention programs for delinquency and other purposes, until 1995 when legislation transferred the program to the education department.

The department also administered the Children' Trust Fund from 1983, when it was created as a mechanism to supplement state resources for funding child abuse and neglect prevention programs, to 1997. The DCF commissioner is now one of 16 members of the independent trust fund council whose main duties include: (1) soliciting and accepting federal funds, grants, and gifts for the fund; and (2) making grants from the fund to eligible programs. The council also is required to adopt regulations for administering the fund and setting eligibility requirements for programs seeking funding. Since the council was established, the fund's annual budget has increased to over $3 million, while it never reached $1 million when administered by the department.

In terms of budget expenditures, the activities of the Children's Trust Fund make up the bulk of DCF's primary prevention efforts. In FY 99, the trust fund budget accounted for nearly two-thirds (62 percent) of the agency's total expenditures (approximately $5.3 million) on its prevention mandate.

Chapter Six

Children's Services Outside of DCF

In Connecticut, government services for children and youth, which include public education, cash and housing assistance, health care, prevention and diversion programs, services for those with disabilities, advocacy, juvenile justice; and community-based corrections, are not consolidated within one agency. Rather, services for those under age 18 are provided by more than a dozen state agencies, the judicial branch, and over 200 public and private facilities and programs, both in- and out-of-state.

This section provides an overview of the services provided to persons under 18 by entities other than DCF. Each one's role in serving children, which may not be its *primary* mandate, is highlighted below. Many agencies and providers do not have a formal or direct relationship with DCF, despite its broad role as the state's children's agency. Current working relationships and mechanisms for coordinating children's services among agencies and providers are also described below.

State Agencies with a Role in Children's Services

The state agencies with a role in providing children's services were categorized by the program review committee according to the type of service provided. Services were broadly classified as: social/welfare; mental health; health; education; juvenile justice; substance abuse; prevention; and advocacy. Table VI-1 shows the state agencies other than the Department of Children and Families that have a role in providing services to persons under 18.

Table VI-1. State Agencies (Other than DCF) Providing Children's Services

Social/Welfare	Department of Social Services* Department of Mental Retardation	Board of Education and Services for the Blind*
Mental Health	Department of Mental Health and Addiction Services*	
Health	Department of Social Services Department of Public Health	
Education	State Department of Education State Board of Education	Department of Mental Retardation Board of Education and Services for the Blind
Juvenile Justice	Judicial Branch Department of Corrections	Board of Parole Division of Criminal Justice
Substance Abuse	Department of Mental Health and Addiction Services	
Prevention	Children's Trust Fund	
Advocacy	Office of Child Advocate Office of Protection and Advocacy	Commission on Children Commission on Deaf and Hearing Impaired
*Denotes an agency with responsibility for more than one type of service category.		

As the table indicates, some agencies, like the Departments of Social Services and Mental Retardation, provide more than one type of children's service. Each state agency's responsibilities for children's services are briefly described below.

- *State Department of Education and State Board of Education* are responsible for the general supervision and control of the state's public educational interests including preschool, elementary and secondary education, special education, and vocational education. Public school education is the primary service provided by the state to all children. The SDE also supports Youth Service Bureaus that provide community-based prevention, intervention, treatment, and follow-up services for children and youth.

- *Board of Education and Services for the Blind* (BESB) is responsible for providing a comprehensive, community-based continuum of individualized educational, rehabilitation, and social services to legally blind and visually impaired children.

- *Department of Social Services* is responsible for a number of programs that directly or indirectly provide goods and services to low-income families, youth, and children. The programs include: Temporary Family Assistance (formerly AFDC); Food Stamps; Medicaid; and General Assistance program. DSS is also the state's lead agency for child support enforcement activity.

- *Department of Public Health* (DPH) is the state's lead agency for public health policy and advocacy. DPH operates or funds a number of programs that serve children and youth, including maternal and infant care projects, adolescent pregnancy prevention programs, supplemental nutrition programs, and school-based primary health care services. The department also licenses a variety of health and behavioral health (mental health and substance abuse) facilities that serve children, and it also regulates child day care facilities.

- *Department of Mental Retardation* is responsible for planning, developing, and administering complete, comprehensive, and integrated state-wide services for persons with mental retardation, diagnosed as having Prader-Willis syndrome, or who are autistic. DMR administers the Birth-to-Three program, a system of early intervention services for all infants and toddlers under age three with any types of disability or significant developmental delay.

- *Office of the Child Advocate* is responsible for: the evaluation and review of the delivery of children's services by state agencies and state-funded organizations; investigation of complaints regarding the actions of any state or local agency or state-funded organization providing children's services; and reviews juvenile delinquency facilities. Furthermore, the advocate can recommend changes in children's policies, conduct public education programs, propose legislative changes, or take formal legal action. The child advocate is also a member of the state's child fatality review board.

- *Judicial Branch* is responsible for the state's court system. The Superior Court's Family Division hears all criminal and civil matters involving children under 16 and all other matters involving a youth between the ages of 16 and 18 are heard by the (adult) criminal or civil divisions of the court. The criminal section adjudicates delinquency and Family With

Service Needs cases and the civil section disposes of cases involving dependent, neglected, and uncared for children, termination of parental rights, and emancipation of minors. The judicial branch also operates court support services that include juvenile intake, assessment, and referral services and probation supervision services that are provided to juvenile delinquents and FWSNs. In addition, the judicial branch administers the state's three juvenile (pre-trial) detention facilities for children up to the age of 16.

- *Division of Criminal Justice* is responsible for all state criminal prosecutorial functions including juvenile delinquency matters.

- *Department of Correction* (DOC) is responsible for providing fair, safe, humane, and secure care of individuals placed in its custody, and intervening to reduce the likelihood of recidivism and criminality of those sentenced to its jurisdiction. The department incarcerates all adjudicated offenders, including male and female youth who are at least 16 years old and 14- and 15-year-old juveniles who have been adjudicated in the adult criminal court.

- *Board of Parole* (BOP), in accordance with the state's sentencing statutes, is responsible for determining when adjudicated inmates, including those between 16 and 18, serving sentences greater than two years should be granted parole and under what supervision conditions. As a result of the 1995 Juvenile Justice Reorganization Act, which authorized the transfer to adult court of juveniles charged with specific crimes, the parole board will soon be considering the release of parole-eligible juveniles who are between the ages of 14 and 16. The board will also be required to provide community-based parole supervision to these youth.

- *Department of Mental Health and Addiction Services* is responsible for administering client-based mental health treatment and substance abuse services to persons who are at least 18. The department's prevention programs serve all children and adults. DMHAS and DCF began a three-year pilot program, in 1998, for youth leaving DCF care who have pervasive developmental disorders or predatory sexual disorders. To be eligible for the DMHAS services the youth must be between 18 and 21 and enrolled in school or training program. The program is intended to ease the transition to the adult system and provide comprehensive and individualized services.

- *Commission on Children*, a legislative agency, is responsible for studying the status of children and recommending improvements to programs, policies, or legislation aimed at improving the development of children and strengthening of families.

- *Children's Trust Fund* was established by the General Assembly in 1983 to receive public and private monies to be used to support families in raising healthy and capable children. Its primary focus in on prevention of abuse and neglect. It is directed by a council comprised of the commissioners of the departments of children and families, public health, social services, and education and representatives of the business community, child abuse prevention field, parents, and a pediatrician.

- *Commission on the Deaf and Hearing Impaired* is responsible for advocating for deaf and hard of hearing individuals, including children. It oversees and provides interpreter services and provides personal and family counseling services.

- *Office of Protection and Advocacy* is responsible for advocating for all citizen's with disabilities. It provides information and referral services, investigates allegations of abuse or neglect of disable persons, provides public education and training, and pursues legal and administrative remedies for disability-related discrimination.

Interagency coordination. Over the years, several organizations have been created to coordinate the activities of human service agencies, including their responsibilities related to children. Most notable were the Council of Human Services, established in the 1970s, and later the governor's Human Services Cabinet. The council was comprised of commissioners of all the state human service agencies and was mandated to coordinate planning, policy, and resource utilization among them. It was in effect from 1973 to 1977. A human service cabinet with a mandate similar to that of the council was informally established during the administration of Governor Weicker.

More recently, a common mechanism for achieving interagency collaboration is a written document signed by the parties involved called a memorandum of agreement (MOA) or memorandum of understanding (MOU). The Department of Children and Families has entered into written agreements with other state agencies and with the judicial branch to either transfer a responsibility or clarify roles in providing a service. Table VI-2 provides a brief description of 14 MOUs/MOAs currently in effect between DCF and other state agencies.

As shown, eight of the memoranda clarify the responsibilities of the agencies. For example, the department has entered into four agreements with DSS to define roles and procedures related to: processing children eligible for Title IV-E and for the Connecticut Access medical program; conducting background checks on unlicensed persons legally providing child care; and depositing and spending funds from the federal social services block grant. Another agreement outlines DCF's responsibility for the educational costs for children it places in residential facilities. The remaining agreements shift responsibility for a particular service or target population from DCF to another agency or clarify procedural issues between the agencies.

Private Providers of Children's Services

The Department of Children and Families relies on a network of private, typically nonprofit, community-based service providers for much of the treatment and care its clients require. About half the agency's total expenditures each year between FY 91 and FY 99 have paid for contracted services that range from prevention and diversion to foster care and residential treatment. The main types of direct services purchased by the agency are shown in Table VI-3. They are grouped according to the service categories DCF uses, which are based on a child's placement (i.e., in- or out-of-home).

Table VI-2. Written Agreements Between DCF & Other State Agencies	
Department	Description of Agreement:
Education	To develop & implement a plan to prevent, identify, and treat child abuse & neglect, and to train education professionals in detection & reporting. (1986) To continue the inclusion of students, who are not enrolled in a public school district that is financially responsible for the child's education ("no nexus"), within DCF Unified School District #2 whenever the child is placed by DCF in a residential facility & DCF will assume responsibility for educational costs. (1993)
Social Services	To establish procedures for effective & timely processing of medical eligibility for Title IV-E children and state-funded children. To improve medical services to children in DCF care through DSS Connecticut Access program by coordinating, integrating, and defining responsibilities of DCF & DSS. (1997) To clarify DSS will deposit federal social services block grant funds & DCF will provide designated services to target populations as per grant plan. (1998) To cooperatively implement a process for screening unlicensed persons legally providing child care in their home or in a child's home to determine a record of substantiated abuse or neglect. (1998)
Public Health	To clarify and define functions of DPH and DCF regarding health care institutions providing inpatient care to infants & reports of medical neglect of infants. (1992)
Mental Retardation	To expedite DCF referrals to Birth-to-Three program. (1996) To establish intake, investigation, & reporting processes for DMR to follow to ensure children with mental retardation are free from abuse & neglect, and establish DMR & DCF responsibilities regarding mentally retarded children under 18. (1992)
Mental Health & Addiction Services	To coordinate services and transition of clients under 21 who are enrolled in education or training program from DCF to DMHAS adult mental health system. DCF will fund services until the youth reaches 21 or ceases to be a student and then DMHAS will pick up funding. (1997) To collaborate, coordinate, implement, & report on joint issues regarding substance abuse services for children, youth, & families, and to review DMHAS model of service networks. CT Alcohol & Drug Policy Council is forum for collaboration. (1996) To work collaboratively on substance abuse services for children & families with particular attention on creating a "seamless system of care" for women & children at-risk. (1997)
Judicial Branch	To reserve 20 inpatient beds at DCF's Riverview Hospital for: (1) court-ordered evaluations of children pending before the court as FWSN or delinquent; and (2) children awaiting placement but who do not need continued hospitalization. Judicial Branch will provide part-time intake & discharge staff. Both agencies will pursue funding to develop a joint treatment unit at Riverview. (1998) To establish protocol to maximize effectiveness of DCF and Judicial resources to serve FWSN cases. (1998) To develop a process for transferring non-delinquency FWSN cases needing residential treatment or placement from juvenile probation to DCF. (1999)
Source of Data: DCF	

Table VI-3. Direct Client Services Purchased by DCF		
	Out-of-Home Services	
In-Home Services	Family Model	Residential
• Intensive Family Preservation/Reunification • Parent Aide • Foster and Adoption Placement Preservation • Parenting Education • Respite Care (Biological Parents) • Child Care • Therapeutic Child Care • Extended Day Treatment • Crisis Counseling (Emergency Mobile Psychiatric) • Substance Abuse -- Supportive Housing • Substance Abuse -- Primary Caregiver Outpatient • Substance Abuse -- Adolescent • Individual and Family Counseling • Outreach and Tracking (“parole” services)	• Safe Homes • Foster Care • Foster Family Recruitment • Foster Family Retention • Specialized Foster Care • Adoption	• Temporary Shelter Care • Independent Living Programs • Residential Programs

At present there is no single, complete inventory of all providers with whom the agency contracts for direct services to children and families. The department is currently working to develop, in computerized form, a resource directory as required by the consent decree.

Not counting licensed foster families, DCF estimates it purchases services from more than 200 providers. Individual providers include a variety of care and treatment facilities as well as cities and towns, local family or youth services agencies, hospitals, community action agencies, community mental health centers, and other community organizations such as YMCAs and the Salvation Army. Some contractors are very specialized, serving a limited population or geographic area; others provide a full spectrum of services to children and adults and are a statewide resource for DCF as well as other state agencies.

In general, DCF regional offices and institutions carry out the contracting process -- defining needs, designing requirements, procuring the services, managing the contract, and evaluating the services provided -- for outside services their clients need. If a program or service is needed statewide, programmatic staff in the central office responsible for the area usually will handle these contracting functions. All contracts, however, are subject to review by the central office financial bureau staff. The bureau's contract staff must ensure that funding is available initially for the contracted service and approve any subsequent changed in the contract's spending plan. The central office staff who oversee consent decree implementation also participate in the financial bureau's review to make sure the proposed contracts do not conflict with the resource allocation (PARA) plan approved by court monitor.

In compliance with consent decree requirements and state and federal initiatives, the department is instituting a performance-based contract process for purchasing services from private providers. The first performance-based contracts were developed in 1994 and used for

some of the agency's major provider groups including residential treatment facilities, child guidance clinics, and family preservation programs. As shown in Table VI-4, they are currently used for 23 categories of service and apply to over 300 individual provider contracts.

Table VI-4. DCF Providers Subject to Performance-Based Contracts	
Contract Category	**No. Providers**
Alcohol and Drug Prevention	29
Child and Adolescent Respite Care	5
Child Guidance Clinics	27
Clinical Pediatric Liaisons	22
Day and Extended Day Treatment	16
Early Childhood Programs	4
Emergency Mobile Psychiatric Services	18
Emergency Shelters	11
Family Support Centers	7
Family Violence Outreach	9
Group Homes	18
Independent Living	13
Intensive Family Preservation	24
Juvenile Case Management Collaborative	3
Outreach Tracking and Reunification	5
Parent Aide Programs	28
Parent Education and Support Centers	16
Residential Treatment	15
Safe Homes	14
Specialized Foster Care	18
Substance Abuse Services	12
Substance Abuse Services for Families At Risk	10
Therapeutic Child Care	15

The existing performance-based contracts contain workplans developed by the providers and DCF staff that specify goals, objectives, and activities. Each quarter, providers must submit to the department workplan status reports along with performance-based criteria data and financial data. As noted in an earlier chapter, the central office, through its quality management bureau, is responsible for compiling and analyzing the data gathered from the agency's performance-based contracts. The department intends to use the contract data as a basis for deciding whether to continue funding a provider as well as to help evaluate the effectiveness of programs and services and identify needs.

Advocacy

During the past 20 years, there has been growing political and public interest in improving the lives of and services for children. Much of the attention has been the result of increased and improved advocacy for children.

Advocacy strategies vary with the specific issue and focus of the preferred outcome. The focus can be on making service systems or bureaucracies more effective and efficient, reforming existing statutes or enacting new laws, assisting an individual access a service or benefit, or bringing class action litigation to challenge unlawful or harmful patterns and practices.

Most typically, advocacy is carried out by persons and organizations outside of the systems that either provide, fund, or monitor services or enact legislation and appropriate resources. Beyond provider groups that have organized to improve children's services and strengthen their working relationships with DCF, a number of groups that lobby and advocate around children's issues have evolved over the past decade. Among the more prominent are: Connecticut Voices for Children which focuses on advocating for policy and procedural changes and improvements; the Center for Children's Advocacy, affiliated with the University of Connecticut (UCONN) School of Law, which serves the legal needs of poor children; and the Connecticut Association of Human Services, which publishes research on the condition of children in the state and provides education and outreach services.

Chapter Seven

Findings and Recommendations

By establishing a consolidated children's agency, Connecticut attempted to achieve two main goals: (1) elevate children's issues and services within state government; and (2) integrate the delivery of services to abused, neglected, mentally ill, emotionally disturbed, and delinquent children and their families. After 25 years, there has been some progress toward these goals, particularly in institutionalizing advocacy for the interests of children and families. However, for many reasons, the Department of Children and Families has been unable to effectively carry out its extensive mandates for prevention, child protection services, children's behavioral health, and juvenile justice.

As study after study has found, DCF is plagued by systemic management deficiencies. Its decision-making is reactive and crisis driven. Protective services so dominates the agency its other mandates have suffered from a serious lack of attention and resources. In fairness, DCF should not be blamed for its preoccupation with its protective services mandate. The magnitude and complexity of child abuse and neglect, coupled with the pressures of public opinion, demand protective services be a priority.

The goals of the original plan for a consolidated children's agency were farsighted and remain valid. Today it is widely agreed children and families need integrated, prevention-oriented services, individualized community-based care, and family involvement in service planning and delivery. Many states, through a variety of policies, organizational structures, and funding mechanisms, are trying to attain these ends.

The Legislative Program Review and Investigations Committee concludes it is time to look beyond trying to "fix" DCF as the way to improve the status of children and families in Connecticut. The well-being of children is not and cannot be just one department's responsibility.

Overview of Findings

From the information gathered through its research of DCF's mandates, resources, and activities, the program review committee identified the following four main themes.

First, children's services in Connecticut are not consolidated in a single state agency. The Department of Children and Families is not the only agency responsible for serving the state's children. Other departments, such as education and social services in particular as well as the judicial branch, have pivotal roles. Separate agencies will always exist for some children's functions (e.g., juvenile court, the state board of education) and many adult services that

impact children (e.g., mental health, mental retardation, etc.).

Second, DCF is dominated by protective services issues. Child safety is the driving force for the agency's mission, budget, organization, planning, and management. This focus is due to the emergency and potentially life-threatening nature of child abuse and neglect cases as well as the impact of the *Juan F.* consent decree. As a result, other DCF mandates tend to only receive attention when a crisis arises (e.g., a suicide at Long Lane School) or a lawsuit or legislative initiative is threatened.

Third, DCF's focus on protective services has made it reactive and crisis driven. DCF does not carry out long range planning or adequately address preventive services. Despite repeated efforts over many years to strengthen planning, research, quality assurance, and accountability, the department has been unable to sustain improvements in these management areas.

Fourth, the mandates consolidated in DCF almost 25 years ago still are not integrated. The department's organization remains functionally divided and its planning processes and information systems are fragmented. Conceptually, a consolidated children's agency makes sense and DCF has made some progress blending mental health into its protective services and juvenile justice treatment plan processes. Practically, however, full integration and balanced management of DCF's mandates continues to be problematic.

The following sections present specific findings related to the department's mandates and delivery of services to Connecticut's children and their families. The program review committee's recommendations for addressing each area are also included.

Children and Families Policy

The program review committee finds there is no clear statement of legislative intent guiding state government efforts to serve the best interests of the state's youngest citizens. Under current law, Connecticut's policy on children and families must be pieced together from various statutory mandates given to the Department of Children and Families, the mandates of other state departments responsible for serving children such as education, social services, public health, and mental retardation, and judicial branch mandates concerning those under the age of 18.

As discussed previously in the report, the well-being of Connecticut's children and families is not the sole responsibility of the Department of Children and Families. Meeting the needs of children and families in trouble requires a variety of public and private entities in the state to work together to provide support and services.

The program review committee finds an overarching policy that establishes a unified mission and reflects the shared responsibility for the well-being of children and families should be adopted by the General Assembly.

Therefore, the program review committee recommends the General Assembly establish in statute the following language: "It is the policy of the state of Connecticut to promote the well-being of children and families through the development of integrated, comprehensive, child-centered, family-focused, and community-based services that are

accessible, cost-effective, of good quality, and delivered in the least restrictive environment possible."

The recommended statement incorporates the many goals of current state policies and programs for children and their families -- healthy, thriving children; strong, nurturing families; positive youth development; and educational progress and success. Under the statewide policy, all branches of government, not just the state agency for children and families in crisis, will have a role in ensuring these and other positive outcomes for children.

Coordinating Structure

When client needs cross department boundaries, mechanisms for coordinating services, resources, and information are required for effective service delivery. This is the case even if child-serving agencies are guided by a unifying mission because each state department that serves children has its own priorities, areas of expertise, funding sources, professional orientation, and target population.

The incentives to work together generally are few, since coordination takes time and staff resources away from an agency's primary function and may even mean giving up control over clients or funding. In fact, there are usually stronger incentives for departments to try to shift costs or responsibility for difficult cases or expensive services to another agency.

In recent years, at least 27 states have established some type of structure to achieve coordination and some degree of integrated service delivery for children and families. The structures generally take the form of a children's cabinet, comprised of the heads of all departments with a role in children's services, or a council or commission made up of agency officials and others interested in children's issues. Their missions, powers, and duties vary, but in all cases they have one or more of the following purposes: to overcome gaps and duplication in children's services; develop innovative programs for coordinating services; or implement system reform by building community-based, integrated service delivery.

The program review and investigations committee finds Connecticut has no formal structure for coordinating the services and resources of agencies responsible for children. The primary method for achieving coordination is through interagency agreements, which were previously described in detail in this report. While many of the current agreements appear to be effective, they are limited to specific issues or categories of clients and are not a mechanism for system-wide coordination.

Further, the program review committee finds there is no entity responsible for regularly examining the "big picture," looking across categories of services to ensure the best use of resources and the best outcomes for clients. There is no agency charged with promoting wellness by tracking needs, analyzing trends across agencies, and identifying and evaluating what works to prevent the problems facing children and families in Connecticut.

The program review committee further finds state goals for children and families cannot be met without a structure that ensures coordination of policies and resources among all state entities that serve children. To foster integrated service delivery, strengthen the state's

prevention and early intervention efforts, and focus accountability for the well-being of children and families in Connecticut, authority and responsibility for coordination must be placed in one entity.

Therefore, the program review and investigations committee recommends creation of a secretary for children responsible for coordinating state efforts to implement the state's policy on children and families.

The Office of the Secretary for Children shall be an independent executive branch agency and the secretary shall be authorized to employ staff and purchase equipment, hire consultants, and convene advisory groups of public officials and private citizens as needed. The main duties of the secretary for children shall include:

- **preparing a biennial Connecticut children's budget that identifies all federal and state resources dedicated to children's services and making recommendations concerning the allocation of those resources;**
- **developing and implementing a mechanism for pooling resources from multiple state agencies to fund a community-based system of care that will deliver integrated services to children and their families based on individual needs;**
- **preparing a biennial statewide plan for promoting the well-being of children and families through preventive services;**
- **establishing benchmarks to measure the well-being of children in Connecticut and reporting annually to the governor and legislature on their status; and**
- **establishing and maintaining arrangements with local universities to conduct research and evaluations related to children's service needs and the outcomes of state policies and programs for children and families.**

Each state agency with responsibility for serving children and families shall be required to submit to the children's secretary each year: (1) an assessment of the needs of its client population under the age of 18 and their families, overall and by region; and (2) a status report of each region in terms of children's well-being benchmarks relevant to the policies and programs it administers.

In addition, each child-serving agency shall be required to forward its proposed biennial budget related to services for persons under 18 and their families to the secretary for children who will use the information to prepare the biennial children's budget. In the budget submission to the secretary, each agency shall identify all resources it allocates to preventive services for children and families. Each agency shall also identify the amount of

resources it proposes to pool with funds from other children's agencies to support an integrated, community-based care system as well as estimates of the client population to be served and the types and amount of services required to be provided by the system.

The secretary for children shall convene the heads of all state departments serving children at least two times per year, once to provide advice and assistance in planning and implementing preventive services for children and families and once to help evaluate the state's overall progress in promoting the well-being of children and families and prepare the secretary's annual children's status report to the governor and General Assembly. The secretary may convene the department heads or their designees to meet for other purposes and at other times as needed.

The secretary shall be appointed to a five-year term by the governor subject to the approval of the General Assembly. The secretary shall have the following qualifications: an advanced degree in management and administration and at least 10 years experience in a high-level management position requiring skills such as strategic planning, financial analysis, negotiations, and public relations.

Under the program review committee recommendation, preventive services, which are key to promoting the well-being of children and families, and integrated community-based service delivery, the ultimate goal of interagency coordination, will be the priorities of the secretary of children. The proposed structure assures these functions will not have to compete for attention and resources in agencies whose priorities are providing direct services to particular client populations. In addition, the children's secretary will have clear authority and responsibility for overseeing implementation of the state's policy for children and families. Accountability for the well-being of children, which now is fragmented among at least a dozen executive agencies and the judicial branch, will be centered in the secretary's office.

The secretary's purview will be broad, covering programs carried out by many child-serving entities and the courts. At a minimum, all of the major human service departments -- children and families, mental health and substance abuse, mental retardation, public health, social services, education, and the juvenile operations of the courts such as juvenile detention and juvenile probation including families with service needs and community support services programs -- should be linked to the secretary's office for the purposes of the children's budget.

Children's budget. Knowing in detail what resources are available throughout state government for children's services and how they are being used is another key element for stronger accountability and more efficient and effective service delivery. The state's first children's budget, prepared by the legislature's Office of Fiscal Analysis in February 1999, allowed policymakers to take a comprehensive look at how the state allocates resources to address children's needs. The program review committee finds a children's budget should become a regular part of the state's appropriation process. It will provide information and guidance on children's matters to legislators as they make budget decisions and help assure a comprehensive approach is taken when resources are allocated to meet children's needs.

Under the program review committee's recommendation, the children's secretary will be responsible for preparing a proposed children's budget after reviewing the funding requests for children's services from all of the child-serving agencies. The children's budget will constitute the secretary's recommendations to the General Assembly for allocating resources to meet the needs of Connecticut's children and their families.

To carry out the duties of the Office of the Secretary for Children, the program review committee recommends the children's secretary have specific authority to propose the funding level for the integrated, community-based service delivery system for children and families.

This would be a specific item in the children's budget subject to review and action by the General Assembly like any other appropriated agency program. The legislature would be able to consider the secretary's request for funding this purpose along with the proposed budgets from each child-serving agency and make the final allocation decision. The secretary would then be responsible for operating the community care system within the funding level set for these purposes through the appropriations act.

Integrated community-based care. A common goal for all children's services is "seamless" delivery of needs-based care in a way that maintains a child's relationships with family and community. There is general agreement among experts and practitioners that integrated, community-based services result in better outcomes for children and more efficient use of resources.

The optimal integrated system allows for multiple points of access -- state agencies, the courts, schools, private providers, and local child and family organizations may refer clients to the system -- but a single point of accountability for the client -- one intake process and one case manager. The services provided are based on an individualized plan of care developed by a multidisciplinary team with family participation.

Studies of human service delivery models have found integrated service delivery is not necessarily achieved through organizational changes. What is needed to provide comprehensive, needs-based services is "flexible" funding. Services can best be tailored to effectively meet the problems of a particular child and family when funding is not categorical and resources are not restricted to specific programs and client populations.

The major stumbling blocks to integrated services in Connecticut and most states include categorical federal and state funding sources, competition among programs and agencies, and the lack of effective coordinating mechanisms. Loss of control over which clients are served and how money is spent is a disincentive for state agencies and private providers to cooperate and share resources.

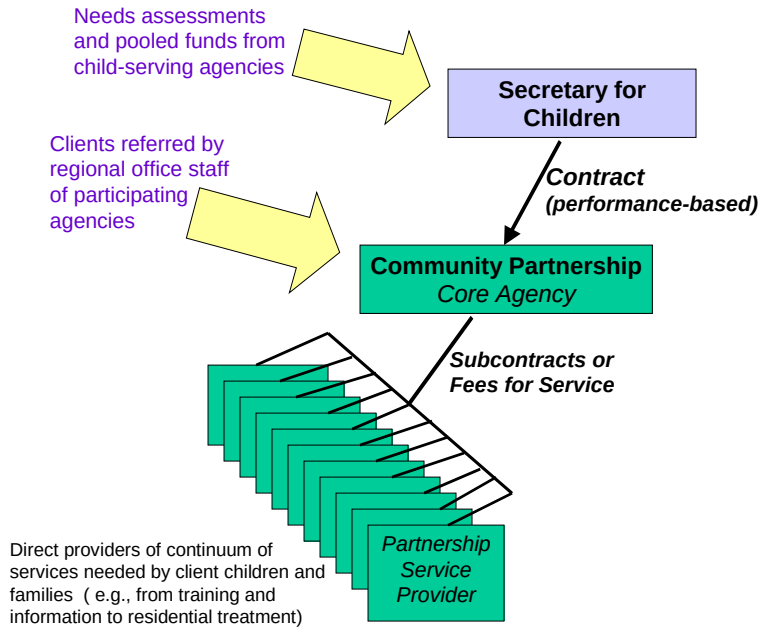
The program review committee finds the most effective incentives for interagency coordination appear to be financial. States that have had success in integrating services began by finding ways to blend funding from multiple sources to establish service delivery systems that target human needs and not the client populations (e.g., abused, delinquent, etc.). The key is to

create a consortium of categorical agencies to actually pool their funds and serve their clients through the integrated system.

The program review committee's previous recommendation seeks to move the current system in this direction by giving the secretary for children the authority and responsibility for creating an interagency pool of funds for children's services, the first step to integrating service delivery. The secretary is further required to establish a community-based system of care for children and their families in accordance with each participating agency's assessment of needs and available resources.

The program review committee envisions the community care system as partnerships of private providers formally joined together to offer a comprehensive continuum of community-based services needed by the children and their families. Figure VII-1 illustrates the key elements of the partnership structure proposed under the committee recommendations.

Figure VII-1. Overview of Partnership Structure



Each community partnership would have a core agency responsible for fiscal and administrative duties, overall case management, and arranging, through subcontracts and agreements, a network of services required by the partnership clients. Partnerships would serve clients within certain geographic areas determined by community needs and resource. For example, several partnerships might operate within a large city, while in rural area, a number of towns might be served by one partnership

Under performance-based contracts between the secretary and the core agency, the partnerships would provide a wide range of services, at capitated rates, to children and families who could be the clients of a variety of state agencies. Services would be provided to the clients

referred by participating state agencies in accordance with an individualized plan of care, developed by the core agency case manager and a team of key individuals involved in the case. The care plan team would include family members, clinicians and other service providers, and state agency staff assigned to the client's case (e.g., a protective services social worker or a juvenile parole officer).

While state agency staff would be involved in developing and monitoring their clients' care plans, the partnerships would have full responsibility for carrying out case management and treatment within the agreed upon payment rates. A state agency's role regarding clients served by community partnerships would primarily be quality assurance. State agency case workers, for example, would be responsible for determining the client's eligibility for state-funded services and ensuring the services provided are meeting the client's needs and fulfilling the agency's goals.

The partnerships would be held accountable through their performance-based contracts, which would outline expected client outcomes as well as worker caseloads, clinical and professional requirements, and other minimum quality standards. The contracts would also outline financial audit and other quality assurance requirements (e.g., administrative case reviews for DCF protective services clients) the partnerships would be expected to fulfill.

A major benefit of the recommended community partnership system is state agencies can access a network of services for their clients through a single contract. The partnership model, therefore, can significantly reduce the time and effort state agencies and private providers currently spend on contracting functions.

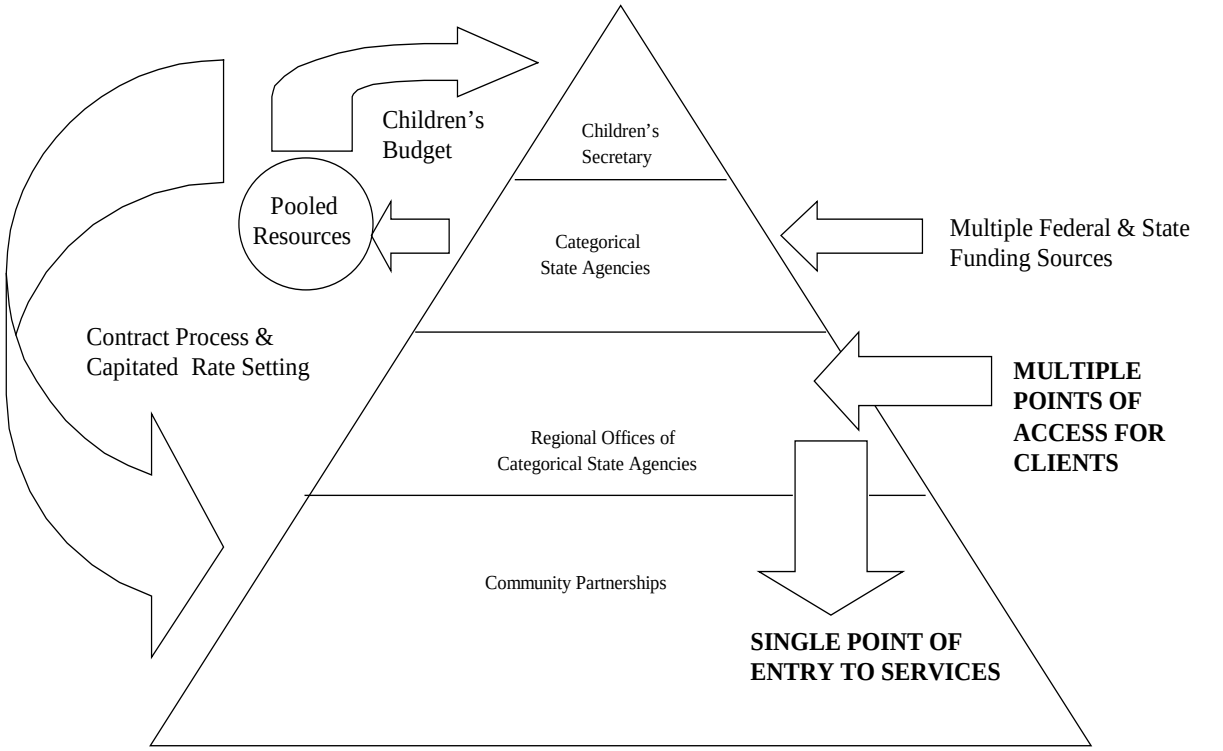
The community partnerships also offer opportunities for greater efficiency and accountability in the delivery of services to children and families. Providers are given more flexibility to control services so children and their families can receive care appropriate to their needs in a timely manner. At the same time, providers are directly responsibility for outcomes specified in their contracts. Figure VII-2 presents an overview of the roles and responsibilities of the secretary, the categorical child serving agencies and their regional offices, and the community partnerships under the committee staff recommendations.

Community-based system of care models that provide comprehensive, individualized services to children and families with flexible funding have been implemented in at least nine states (Alaska, California, Kentucky, North Carolina, Ohio, Oregon, Pennsylvania, Vermont, and Wisconsin). Typically, they began in response to federal system of care initiatives for serving seriously emotionally disturbed children and developed into more formally financed and organized service delivery structures for children and families in the early 1990s.

Similar models are under consideration or being piloted in several other states, including Connecticut. DCF is experimenting with a new integrated service delivery model with a small number of its clients as part of a five-year, federal demonstration project. The department has contracted with two provider networks to organize and manage a continuum of care for children in need of residential placement. The network receives an established case rate per child for a 15-month period in addition to a flat fee for administrative costs. An outside contractor was

hired to develop and carry out a research design to evaluate the effectiveness of the continuum of care projects. The results of the DCF demonstration projects should be very instructive to the children's secretary in developing the community partnerships.

Figure I-2. Overview of Roles and Responsibilities for Integrated Service Delivery for Children and Families



Family advocates. Many experts and practitioners believe outcomes for children are better when families are involved in the planning and delivery process for services. States are required, under federal mental health grant requirements, to promote parental involvement in service planning and delivery for children. One way DCF currently meets this requirement is to use federal funds to employ family advocates to help parents access services for their seriously emotionally disturbed children. The family advocates are parents of children with mental health needs who have been successful in navigating the mental health service system. They then provide information and support to families currently seeking or receiving services and promote the family's inclusion in all aspects of their child's care.

The program review committee finds family advocates should be a component of new community partnership system. Such advocates can enhance access to services and provide feedback on the partnership's performance from the client's point of view. **Therefore, the program review committee recommends the Office of the Secretary for Children be responsible for funding and overseeing family advocates for children services.**

Training and public education. Studies of new models of service delivery like the partnerships recommended by the program review and investigations committee have shown the value of efforts to educate agencies, providers, and the public about community-based care systems. Training and public information activities build support and gain acceptance for the concept.

The program review committee recommends the secretary develop and provide training about community partnerships to all state agencies, making sure to include both management, line staff, and private provider organizations. The secretary should also conduct public information programs to educate communities and the general public about the partnership model.

Phase-in schedule. Based on the experiences of other states, establishing an integrated community-based care system is a gradual process that can only be implemented over time. **Recognizing this, the program review committee recommends a schedule be developed by the secretary for children to phase-in implementation of the recommendations concerning the responsibilities of the secretary and the community partnerships over a five-year period.**

In the first year following passage of the enabling legislation, the secretary for children, with the advice and assistance of representatives from each child-serving agency and the Office of Policy and Management, shall establish the children's budget process, the service needs assessment process, the process for contracting with community partnerships and shall prepare a plan for phasing in community partnerships statewide over a five-year period.

During the first year, the secretary should begin by identifying all funding sources available in state agency budgets to support the community partnerships. A legislatively mandated study of Medicaid funding for children's behavioral health services was completed in February 2000. The report and recommendations relating to a system of care model contained therein should help the secretary carry out this task. The secretary, with the assistance of the state agencies, should determine if waivers from federal requirements will be required to allow federal money to be pooled for community partnership services and oversee waiver application processes.

Through the children's budget process, once the legislature authorizes funding for the community partnerships, the secretary will determine the appropriate allocation of funding among regions of the state on the basis of estimates of service and resource needs submitted by the state agencies during the budget process. To ensure comparability among agencies in terms of needs assessment, standards will be needed. **The program review committee recommends the secretary establish, and the state agencies be required to use, standards and guidelines for conducting needs assessment for community-based services.**

To contract with the community partnerships, the secretary will need to develop requests for proposals or other means for soliciting potential partnerships and standard elements for

performance-based contract documents. To accomplish this, the secretary, with the assistance of the child-serving agencies, must determine:

- minimum standards for qualifying as a community partnership for children and their families;
- minimum continuum of services to be provided;
- expected service outcomes and performance measures;
- parameters for payment rates; and
- provisions for quality assurance.

After the foundation elements have been instituted, the program review committee finds the secretary for children will need discretion and flexibility to phase-in the community partnerships network. The secretary, in consultation with child-serving state agencies and private providers, must develop a phase-in schedule during the first year of the transition and should report that schedule to the General Assembly and governor. However, the only specific requirement for the phase-in is that the community partnerships should be operating statewide, with all child-serving agencies participating and all eligible clients being served, by the end of the fifth year.

Prevention. Within the context of this study, prevention means efforts to ensure children are not exposed to or raised in an environment that has negative consequences for their health, safety, or positive emotional and social development. Under current law, the Department of Children and Families has lead responsibility for programs to prevent abuse, neglect, delinquency, and mental illness, emotional disturbance, and substance abuse among children and youth. However, the department has no coordinated system of preventive services, no unit or staff dedicated to prevention efforts, and in the past fiscal year expended about 1 percent of its total budget on prevention programs.

Prevention is an important and cross cutting function where many state agencies, the legislature, and the courts as well as local governments and communities have roles. Coordinating the state's prevention efforts for children and families needs to be one entity's main focus and the program review committee finds the Office of the Secretary for Children is the best location for this function.

Through the program review committee's recommendations for a children's budget and prevention plan, the secretary can focus the resources available to all state agencies for children's preventive services more effectively. The goal of the secretary's prevention plan should be to identify and recommend funding for services needed to promote the well-being of children and to help children and families at risk address their problems before state intervention through the protective services, behavioral health, or juvenile justice systems are required. The biennial plan should be developed by the secretary in consultation with each state agency that serves children and families and the judicial branch. The prevention planning process should include opportunities for input, review, and comment by public and private groups, individuals involved in children's issues, and the general public.

The committee's recommendations for a biennial prevention plan and a budget to implement it should make for a stronger statewide commitment to provide the services children and families need before their problems reach a crisis level. Through the planning process the secretary can address gaps, overlap, and duplication among preventive services and ensure prevention is part of the continuum of care available through the community care systems.

Benchmarks and annual status report. Establishing benchmarks to measure progress in areas related to the well-being of children is a key step in determining how well the state's policies and programs on children and families are meeting their intended purpose. **The program review committee recommends the children's secretary, in consultation with officials from the state entities that serve children and with input from the public, develop measures to serve as benchmarks of the well-being of Connecticut's children and families.**

Responsibility for monitoring indicators and reporting annually on their status will be a critical function of the secretary's office. The program review committee finds accountability for the condition of children and families will be strengthened by having specific benchmarks tracked and reported on annually. Broad participation from child-serving agencies and groups and individuals interested in children's issues should help with the development of comprehensive and meaningful benchmarks. In turn, tracking the state's success in meeting the benchmarks will assist in the development of the children's budget as well as performance-based contracting procedures.

Research and evaluation. Effective implementation of the secretary for children's planning, budgeting, and annual status reporting duties requires access to good data and strong research capabilities. At present, many state departments regularly collect information related to children's needs and the services they receive. Data are rarely compiled across agencies, however, and efforts to evaluate state children's programs tend to be sporadic and scattered. Information in a variety of forms and from multiple sources will have to be analyzed to link what children need to what services are effective.

Universities have great expertise in carrying out complex research projects. Connecticut is fortunate to be the home of several higher education institutions renowned for their research related to children and families. **The program review committee recommends the secretary for children establish formal relationships with one or more local institutions of higher education to carry out research and evaluation projects related to the well-being of children and families in Connecticut.**

Using higher education institutions for research and evaluation projects can provide more continuity than using outside consultants. It is also likely to cost less. In addition, university researchers are more likely to take a critical perspective than an agency's internal research staff or a hired consultant. University researchers also have the interest and ability to do longitudinal studies, something that is difficult for consultants, but essential for understanding children's issues.

Early in the process the secretary will need to resolve issues related to the confidentiality of the data regarding children in the care of the state and of information contained in medical

records. Funding to support the university research centers should be requested through the budget of the Office of the Secretary for Children.

Qualifications and terms. The children's secretary will be responsible for overseeing and bringing together a wide variety of organizations with different missions and professional viewpoints and for creating a totally new system for delivering state services to children and their families. The secretary's most important skills will be the ability to plan to meet a goal, put the plan into action, and lead others to follow the plan and reach the goal. For this reason, management-related education and experience are the central qualifications for the position of secretary for children. The program review committee does not consider expertise in a human service area or professional specialty to be essential for the secretary. In fact, such a background could be viewed as biasing the secretary toward a particular agency or service philosophy.

The initial five-year term for the secretary is recommended to promote stable leadership while the structural support of the secretary's office and functions is built. The term of the first secretary will coincide with the phase-in schedule for developing the office's budget and planning processes, establishing the state's benchmarks and annual report format, and creating the community-based integrated care system. After the first five-year appointment, when the office should be well-established and fully operational, standard four-year terms should be instituted. **Therefore, the program review committee recommends subsequent terms for the secretary for children be four years coterminous with the appointing governor**.

Related Children's Agencies

The Office of the Child Advocate, the Commission on Children, and the Children's Trust Fund have important roles in assuring the quality and effectiveness of the state's system of children's services. The child advocate protects the rights and interests of children by evaluating the delivery of state services and investigating complaints about programs or procedures. The children's commission serves as a policy advisor and research resource on children's matters to the legislative, executive, and judicial branches. The trust fund solicits federal funds, grants, and private monies to support its grant programs for child abuse and neglect prevention and family support services.

The program review committee finds the Office of the Child Advocate, the Commission on Children, and the Children's Trust Fund are critical components of an effective system to promote the well-being of children. However, the program review committee further finds they have not been used to their full potential by the legislature or the executive branch. In combination, their efforts can serve as a strong quality assurance mechanism for children's services and support the functions of the Office of the Secretary for Children. **To promote this connection, the program review committee recommends the Office of the Child Advocate, the Commission on Children, and the Children's Trust Fund be transferred to the Office of the Secretary for Children for administrative purposes only in accordance with C.G.S. § 4-38f.**

Quality assurance functions generally includes oversight to ensure compliance with policies and procedures, efforts to maximize resources, and activities to evaluate and improve

performance. The advocate, the commission, and the trust fund each carry out aspects of quality assurance, which can help the secretary effect change in the state children's services system.

Under current law, the commission and the trust fund each have advisory groups comprised of state agency representatives and other members. **The program review committee recommends the secretary for children replace the commissioners of children and families, mental retardation, public health, education, social services, and correction as the sole ex officio member of the Commission on Children and the commissioners of children and families, public health, social services, and education on the Children's Trust Fund Council.**

While the advocate's office also has an advisory council, it is not recommended the secretary for children be added as a member. To be effective, the advocate must retain a neutral status independent from all children's agencies including the Office of the Secretary for Children.

Organization of Children's Services

Responsibility for juvenile justice, protective services, and children's mental health as well as substance abuse service functions was consolidated in a single executive agency focused solely on children and their families in 1974. It was expected the new Department of Children and Youth Services, as a consolidated children's agency, would: be important enough to have parity with other human service agencies; increase the state's commitment to prevention of emotional, developmental, behavioral, and social problems of children; and increase the quality and effectiveness of children's services. The overall goal was to provide leadership and support in developing a comprehensive network of public and private programs and services.

Conceptually, it makes sense to consolidate mandates within a single agency to achieve integration of services. Yet, there is no overriding reason for grouping protective services, mental health, and juvenile justice and not incorporating mental retardation, health care, probation, or special education. In practical terms, no single agency can sufficiently balance the importance of every mandate for children and prioritize integration of services.

Indeed, the program review committee finds management studies produced over the past 25 years, including several by the program review committee, have repeatedly shown DCF's organization remains functionally divided along service lines and client populations; its planning and budgeting processes and its information systems remain fragmented. As shown throughout the committee's report, child protective services is the driving force in the agency's mission statements, budget, organization, planning, and management. Other DCF mandates -- juvenile justice and children's mental health and substance abuse services -- have been neglected and tend only to receive attention when a crisis arises (e.g., a suicide at Long Lane School) or a lawsuit or legislative initiative is threatened or ordered. The program review and investigations committee finds full integration of services and balanced management of mandates within the Department of Children and Families has not been achieved.

For integrated service delivery to occur, there must be parity among all children's service mandates in terms of their importance and the allocation of resources in proportion to needs.

Balance must be reached so that one mandate does not dominate as is presently occurring within DCF. As stated, the agency's concentration on protective services severely handicaps the delivery of juvenile justice, mental health, and substance abuse services.

An executive branch structure should allow state agencies to: develop and provide expertise and specialization in a service area; assure a system of quality services is available; provide funds for services; and actually provide services when they cannot be made available any other way. There will always be multiple state agencies involved in providing services that impact children and their families.

The committee's previous recommendations will achieve integrated service delivery through interagency coordination and pooled agency resources under the direction of the children's secretary. The program review committee finds what is also needed is to strengthen the policy and management of each mandate area.

Therefore, it is recommends the responsibilities of the Department of Children and Families shall be realigned as follows:

- **children's mental health and substance abuse shall be transferred to the Department of Mental Health and Addiction Services;**

- **juvenile justice shall be transferred to the Connecticut Juvenile Authority (CJA) -- a new statutorily created state agency; and**

- **protective services for abused, neglected, or abandoned children shall remain within DCF.**

The transferring of responsibilities from DCF to other state agencies brings Connecticut's child welfare system "full circle." Prior to the 1970s, DCF was solely a juvenile justice agency and mental health services for adults and children were the responsibility of a single state agency. Protective services for children were predominately provided by local communities with oversight by the state's welfare agency. There was no formal state management of substance abuse services. The chief complaint by child advocates, service providers, and clients was that children were often neglected and overshadowed by the adult service systems. It was thought that by consolidating responsibilities for children's services in a single agency -- DCF -- their needs would be brought to the forefront and given sufficient attention and resources.

The needs of children, particularly those at risk or in crisis, have received more attention and have benefited from increased resources since DCF was established. This is the result of many factors. Twenty-five years of research, medical and pharmaceutical advances, changing clinical and social work practices, lawsuits, advocacy, and political and public scrutiny have done as much for elevating the status of children as any state organizational structure.

Protecting children's interests through a single state agency structure is of less concern now because leadership for children's issues has been institutionalized. It is more important to

ensure an adequate and timely response to the various categories of children's needs. For example, the dramatic increase in the caseload of abuse and neglect was not anticipated 25 years ago, and no one could have predicted the severity and complexity of the problems faced by children and their families today. There was no way to plan for the significant impact the nation's substance abuse problem has had on the lives of children. Also, the full effects of welfare reform on children have yet to be realized.

The program review committee acknowledges that more resources can be appropriated to DCF and additional attempts can be made to strengthen its leadership, make its management more effective, and improve its service delivery systems. However, many comprehensive management studies of the department have shown innovations and organizational changes fail to be funded or fully implemented. DCF has been unable to sustain management improvements initiated with changes in its leadership. It is the conclusion of the program review committee that Connecticut can achieve the goal of integrated community-based services for children and families more effectively by giving each department mandate (i.e., juvenile justice and children's mental health and substance abuse services) equal importance and promoting parity among state agencies responsible for children's services.

Transferring children's behavioral health and juvenile justice to separate agencies and focusing DCF on protective services will ensure each mandate has leadership, advocacy, and access to resources. At the same time, all state agencies serving children and their families can participate in a system that provides for integrated, community-based service delivery. The program review committee finds imposing the recommended structure over the current service delivery system demands changes in agency mandates.

Child Protective Services

Connecticut’s child welfare problems are not unique. Like most other states, it is struggling with its function to provide child protective services. Although DCF, like similar agencies in other states, has been vested with a great deal of authority to carry out its responsibilities, its actual ability to protect all children from abuse and neglect is limited. The department cannot be expected to judge with perfect foresight which children are actually at risk of abuse or neglect. Moreover, the number of abuse and neglect cases throughout the country has dramatically increased, and the children and families involved present severe and complex problems. These factors have strained the abilities and capacities of child protective service agencies to respond effectively to abuse and neglect. However, this only underscores the need for a lead agency that can give full attention to providing protective services. The previous recommendation assures the Department of Children and Families will be in a position to accomplish this by being focused on the safety and permanence of all children who are abused, neglected, abandoned, or at risk of being harmed.

Under the recommendation, DCF will retain its current statutory protective services mandates, powers, and duties including:

- investigating reports of abuse and neglect;

- representing state and children in custody and adoption proceedings resulting from removal due to abuse, neglect, or abandonment;
- serving as the legal guardian -- or parent -- to children removed from their families;
- administering oversight and quality assurance for protective service case treatment plans and programs;
- licensing child care facilities, homes, and programs; and
- administering the Connecticut Children's Place.

Having a single mission will allow DCF to focus on the long-standing management problems that have plagued the department for years and led to the consent decree. The problems include: the department's difficulty in maintaining a skilled work force; a lack of consistency in establishing and implementing policy and procedures; the absence of useful management information; and inappropriate placements of children. Faced with these problems, DCF has been unable to comply with the staff-to-caseload ratio established by the consent decree. It has responded by attempting to hire more and more staff. This tactic has not proved effective. Realistically, the department cannot hire its way out of a crisis.

Concentrating DCF mandates, activities, and resources on protective services will also allow it to focus on fully complying with the *Juan F.* consent decree. Since 1993, it has been a primary goal of both DCF and the legislature to end the federal court's authority over the state's administration of child welfare services by implementing the requirements of the court order. While the department has made a good faith effort to comply and has improved in a few areas covered by the consent decree, it still has to address several significant issues such as its automated information system, staffing ratios, and the foster care crisis.

Management strategy. The issue facing the department, under the program review committee's recommendation, is how to be an effective child protective services agency whose management is not driven by crisis. To reach this goal, the program review committee finds DCF needs a new management strategy.

One strategy promoted by child welfare experts and implemented in several states (i.e., Florida, Missouri, Kentucky, and Iowa) is a differential response to abuse and neglect reports combined with a network of community-based family support services. The previous recommendations support this strategy in two ways. First, the structure establishes a community-based treatment system -- the community partnerships for children -- that serves the individual needs of children and their families and focuses on keeping children within their families and communities. Second, the committee's recommendations call for the establishment of a comprehensive, statewide network of prevention services available for children and families who are presenting problems that do not meet the statutory standards for abuse and neglect, but are in need of assistance.

The premise of the differential response strategy is that all protective services cases do not require the same costly, time consuming investigation, which can be coercive, intrusive, traumatic to a child, and stigmatize a family. The strategy incorporates a flexible response that

allows protective services cases to be grouped according to the nature of the allegation. It recognizes different allegations require different responses. For example, the level of investigation required to protect a child in a sexual abuse case may be unnecessary and overly reactive for a report of neglect due to missed doctor's appointments or truancy.

Current DCF system. Current DCF policy requires all allegations meeting the statutory definition for abuse or neglect, regardless of the level of risk to the child, be accepted for investigation. Approximately 73 percent of the more than 100,000 calls received by DCF's abuse and neglect hotline are accepted for investigation.

Calls accepted for investigation are categorized by the level of risk to the child's safety. The risk category determines the time in which the department must begin the investigation. For example, the investigation of a high risk case must begin within two hours whereas DCF staff have up to 24 hours to begin the investigation of a moderate risk report and 72 hours for low risk.

This procedure indicates the department has successfully implemented the first step in the differential response process, but the strategy can only be effective when cases are culled throughout the investigation phase. However, once the risk level is determine, DCF responds in the same manner to all accepted calls. Delaying the time an investigation is initiated does not negate this "one size fits all" approach to investigating abuse and neglect reports. It does not factor in the degree of risk to the child, the reasons for and extent of the family's need for intervention and support, or the family's willingness to accept help.

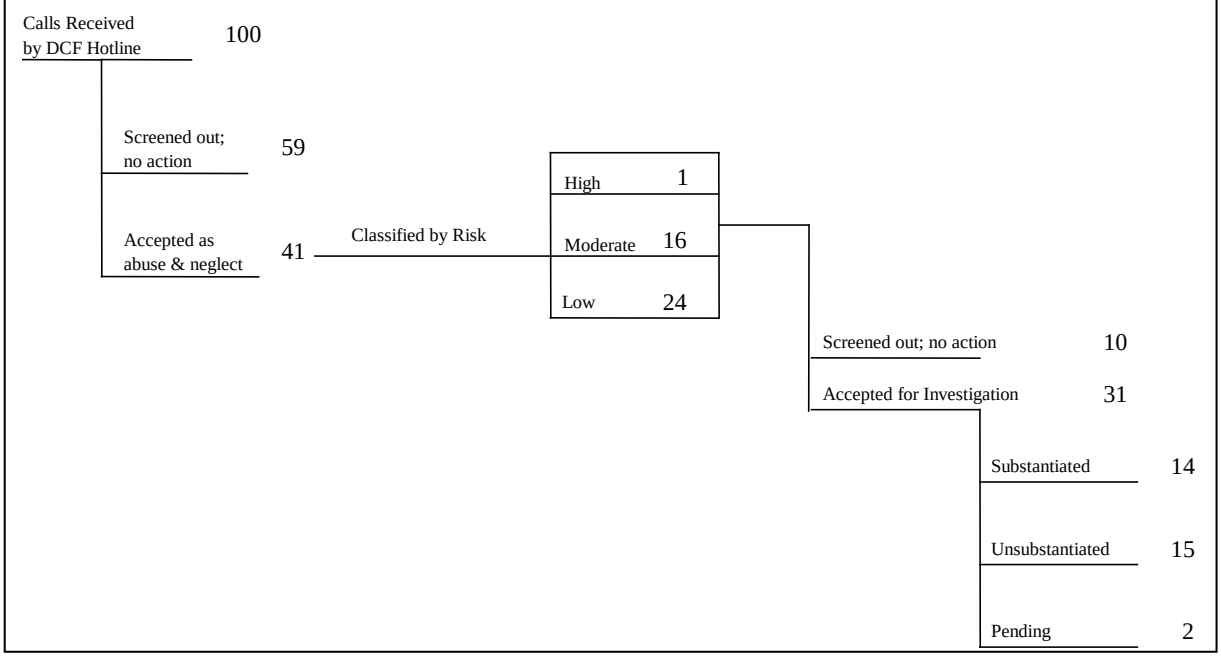
The program review committee attempted to analyze what happens to abuse and neglect reports once they are received by DCF. However, the department was unable to provide complete data because it either did not record the information or was unable to retrieve it from the automated management information system. The committee compiled an estimate of the caseload at various points in the process based on information gathered from DCF's regularly produced management reports and data DCF was able to produce.

As shown in Figure VII-3, for every 100 calls, 41were accepted as reports meeting the standard for abuse or neglect, and 59 were screened out for not meeting the standard. Of the accepted reports, 24 were classified as low risk, 16 as moderate risk, and only one was found to pose a high risk to the child involved. Most calls did not require immediate or even a 24-hour response. As shown in the flowchart, DCF did perform a risk assessment that screened out an additional 10 reports where no further action was taken. Of the 31 reports DCF accepted for investigation, the allegations were substantiated in about 50 percent of the cases. Substantiated reports are then referred within DCF for treatment.

The program review committee finds DCF can better carry out its protective services mandate and more effectively manage its resources by reducing the number of unsubstantiated reports being investigated. The key is to rely on community-based assessment and treatment for lower risk cases. **Therefore, the program review committee recommends DCF develop an assessment standard and tool to determine which calls require a full investigation response by its staff and which can be referred to a state-contracted community partnership for children for assessment and services. The differential response process shall be fully**

implemented by the fourth year of the phase-in of community partnerships that was discussed earlier in this report.

Figure VII-3. DCF Screening and Acceptance Rates for Child Abuse and Neglect Reports



The analysis of DCF's caseload shows three levels of cases need to be considered when developing the differential response policy. The first level would be comprised of those cases in which the report does not meet the statutory abuse or neglect definitions or there is no evidence to support state intervention. As previously stated, DCF seems to be adequately screening these cases and recognizing some families who are referred should not be.

The second would consist of cases drawn from reports classified as low or moderate risk. Under the differential response strategy, these cases would not be investigated by DCF as is currently the policy. Rather, these cases would be referred to a local community partnership for assessment and services. This new approach has the added benefit of making communities more responsible for children and families and allowing earlier intervention for services by eliminating the investigation phase.

The third level would be cases in which the child's safety is an immediate concern and coercive action and/or immediate intervention by DCF is required. The department can retain its existing investigation policy for these cases.

It should be noted, the committee recognizes the current classifications -- low, moderate, and high risk -- may not accurately reflect the risk levels that should be used in developing the new strategy. The program review committee concludes the department must ultimately decide

which cases do not pose an immediate safety issue for the children involved and, therefore, can be better serviced at the community level. As a result, the recommendation has been written in such a way as to give DCF flexibility in developing the process.

Other state models. Several states and large cities are implementing this reform strategy. Missouri, Iowa, and Florida limit investigations to the most serious cases of abuse or neglect and provide an assessment and service-oriented response to families referred for other child protective concerns. The states have also developed partnerships in the community to provide better-coordinated services and a more individualized response to families. Each state's legislature enacted a law to allow its protective service agency to establish two different responses to reports of child abuse or neglect. Basically, the laws require a mandatory investigation for high risk cases and voluntary assessment for lower risk cases. As a recent study found, the impetus for some legislative changes came from a consensus "that the [child protective services] agency was intervening too aggressively in families who might have been served on a voluntary basis, and that the system was not intervening effectively enough to protect children in the most serious cases because it was overwhelmed with nonserious cases and was treating serious and nonserious cases alike."[1]

Children's Behavioral Health

Since it was created in 1974, the Department of Children and Families was intended to be the lead agency for children's mental health and substance abuse. However, the program review committee finds the department has failed to provide strong leadership for children's behavioral health services.

DCF's current organizational structure does not support or prioritize its children's mental health and substance abuse responsibilities. There is no mental health bureau, headed by a deputy commissioner with clinical experience, as called for in the original 1975 plan for creating the consolidated children's agency. A total of four central office staff are responsible for planning and overseeing mental health and substance abuse services for all children in Connecticut. The department's social work staff are not required to have any background in children's behavioral health issues nor do they receive any substantive training in this area.

Without the structural supports that ensure management attention and adequate resources, the agency's mental health and substance abuse mandate has been neglected within the consolidated children's agency. Behavioral health is essentially viewed as an ancillary service in the treatment of abused and neglected children. Mental health providers funded by the department are required by contract to give priority to children committed to the agency. Substance abuse services funded by DCF typically are provided to treat the caregivers of abused and neglected children to advance protective services goals; few resources are directed at providing treatment for children's alcohol and drug abuse problems.

The department's administration of the voluntary services program, which makes mental health and substance abuse treatment available to children who are not committed to its custody,

[1] *The Future of Children, Protecting Children from Abuse and Neglect*, Center for the Future of Children (1998), p 112.

has been weak. Social workers responsible for voluntary cases have little or no training on mental health issues, policies are inconsistently applied across regions, and program regulations remain in draft form after two years. As previously discussed in this report, DCF's role in developing local systems of care for seriously emotionally disturbed children -- its major initiative for providing integrated, individualized services -- has been minimal.

DCF has not produced a comprehensive children's mental health plan as required by statute since 1986. The mental health component of the agency's current strategic plan does not identify what range of services are needed by Connecticut's children or how to fund and provide them. Behavioral health plans that have been prepared have been developed in consultation with other agencies.

In recent years, the impetus for change or specific attention to children's mental health issues or services has come from outside DCF. Recent legislation to clarify the voluntary services program and establish systems of care was initiated and pursued by advocacy groups and parent groups. Members of the State Advisory Council to DCF found it necessary to form an ad hoc committee to focus the department's attention on children's mental health problems and issues. Much of the increased attention to and funding for mental health services for children in DCF custody is the result of the *Juan F.* consent decree requirements.

The central purpose of creating a consolidated children's agency was to achieve a comprehensive, statewide network of mental health and other services that can address the multiple needs of children and families. The previous recommendations establishing the secretary's office and the community partnerships will accomplish this purpose and make mental health services more accessible to the children and families that need them regardless of their protective services status. The program review committee finds an effective management structure to carry out the state's mandate for children's behavioral health is lacking.

The program review committee recommends a Division of Children's Behavioral Health be established within the Department of Mental Health and Addiction Services. The division shall have primary responsibility for state mental health and substance abuse services for persons under the age of 18. It shall: develop policy; plan, evaluate, and assure the quality of behavioral health services for children; and oversee the establishment and maintenance of a comprehensive continuum of mental health and substance abuse services responsive to the individualized needs of children.

The children's behavioral health division shall be headed by a deputy commissioner who is a clinically competent professional experienced in the administration of children's mental health and substance abuse services. The deputy commission shall have responsibility for all children's mental health and substance abuse programs, services, and facilities.

All existing statutory requirements relating to children's mental health and substance abuse shall be transferred from DCF to DMHAS. Responsibility for the policies, procedures, administration, and operation of the state's existing children's mental health facilities, Riverview Hospital and the High Meadows residential treatment facility, shall be

transferred to the Department of Mental Health and Addiction Services. DMHAS shall be authorized to establish any other facility or program required to carry out its children's behavioral health mission.

The children's behavioral health division shall have the following specific powers and responsibilities:

- **establish policy and long-range strategic plans for children's behavioral health;**
- **develop standards and protocols for a continuum of children's mental health and substance abuse facilities, programs, and services that are responsive to the individual needs of children and their families;**
- **conduct evaluation, research, and quality assurance of behavioral health programs and services for children;**
- **establish procedures for the transition of clients from the children's system of behavioral health services to the adult system, when necessary;**
- **provide clinical and technical assistance related to children's mental health and substance abuse issues to other state agencies including the Department of Children and Families and the Connecticut Juvenile Authority;**
- **coordinate efforts with the secretary for children and the Department of Social Services to ensure the provision of medically necessary behavioral health services required by children who are mentally ill or emotionally disturbed and who are covered by the Medicaid program;**
- **assist and cooperate with the secretary for children, including submitting: (1) an annual assessment of the statewide and regional behavioral health needs of children, including those who are abused, neglected, abandoned, or delinquent; (2) a status report on the benchmarks relevant to children's behavioral health; and (3) an estimate of its client population to be served by the community partnerships for children;**
- **submit a proposed biennial budget related to services for children under 18 and their families, separate from the department's adult services budget, to the legislature and the children's secretary and fully participate in the process to pool funds with other state children's agencies to support integrated, community-based care systems and prevention services; and**
- **coordinate efforts with the judicial branch and any other state agency as necessary to effectively and efficiently provide behavioral health services to children.**

The composition of the Board of Mental Health and Addiction Services shall be amended to include representation from individuals with experience and interest in children's behavioral health as follows: four of the 10 board members who must be

experienced in substance abuse and in mental health shall have expertise in children's services in those areas including one who must be a child psychiatrist and one who must be a child psychologist. Five new members, who shall be individuals interested in children's behavioral health but not service providers and shall represent each region in the state, shall be added to the board.

The commissioner of mental health and addiction services shall be required to establish regional children's behavioral health advisory councils comprised of up to 20 individuals, with the majority being persons who earn less than 50 percent of their salaries from providing services to children and families. The regional councils shall advise the commissioner and deputy commissioner for children's behavioral health on the mental health and substance abuse needs of and services for persons under the age of 18 within their respective regions. Each council shall elect its own chair who shall not be a service provider and will serve as the regional representative to the state mental health and addiction services board.

Under the committee's recommendation, children's behavioral health will be placed within an agency that is focused on mental health and substance abuse. Policies, plans, and resource allocation decisions within DMHAS are made within a behavioral health context. To protect against domination by the adult system, the recommendation establishes in statute a clear mandate and structure for children's mental health and substance abuse services. The children's system will have its own division, budget, plan, advisory groups, and deputy commissioner.

Juvenile Justice

DCF has a limited, but important, role in the juvenile justice system. It provides the state's most punitive response -- secure custody -- to delinquent youths convicted of serious or repeat offenses. The department is, however, only responsible for a small percentage (12 percent) of all convicted delinquents. The judicial branch is responsible for the supervision and treatment of most convicted delinquents (88 percent). It is also responsible for pre-trial detention services for children charged with delinquent acts. Typically, the court supervises pre-delinquent youth (e.g., Family with Service Needs), first-time offenders, and delinquents convicted of less serious offenses who can safely remain in their communities.

The program review committee made several findings regarding the lack of integration of DCF's primary mandates (i.e., protective services, juvenile justice, and children's mental health and substance abuse services). While these findings related to the lack of integration among all of DCF's mandates, as presented below they specifically address the juvenile justice area. The committee finds the department's:

- mission statement focuses on its protective services role and responsibilities and does not specifically address juvenile justice;
- juvenile justice planning is sporadic, and related policies and procedures are not comprehensive or integrated with protective services;
- resources have been disproportionally allocated to programs that service children and families in abuse and neglect cases;

- management staffing for juvenile justice is minimal compared to protective services;
- management information system does not incorporate juvenile justice data with protective services caseload information; and
- mental health and substance abuse services are primarily provided to children involved in protective services cases and not juvenile delinquents.

In 1999, Governor Rowland appointed a project director to oversee the: (1) construction of the Connecticut Juvenile Training School facility and development of programs and services; (2) training and transfer of DCF staff from Long Lane to CJTS; and (3) transition of committed youth from Long Lane to CJTS. In addition to these duties, the director was asked to review the continuum of services for DCF-committed delinquents.

In a related matter, the project director is also the co-chair of the critical response team created in 1999 (P.A. 99-26) to report to the legislature and the governor on a range of issues, including the operation of the new juvenile training school and DCF's oversight of committed delinquents. Given both sets of responsibilities, the project director has significant authority to develop the juvenile justice policy, procedure, facilities, and programs that are eventually to be administered by DCF.

Thus, the legislature and governor have given decision-making and planning authority for the reforms currently underway to the critical response team and CJTS project director, not DCF. The program review committee finds this apparent lack of confidence by state officials in DCF's juvenile justice capabilities is significant.

Traditionally, the mission of the juvenile justice system has been to provide treatment for the juvenile offender whose rehabilitation is considered far more important than concern for public safety and punishment. Increases in juvenile crime against persons and property and the severity of violent acts committed by children during the early 1990s fueled growing public opinion that, for the most part, the juvenile justice system has been largely unsuccessful in its efforts to rehabilitate juvenile offenders. In response, Connecticut, like most other states, enacted more punitive sanctions to hold delinquent youth accountable for their criminal behavior.

The 1995 juvenile justice reorganization (P.A. 95-225) instituted a series of reforms that emphasized protecting the public from juvenile offenders and holding delinquent youth accountable for their criminal actions. The measures adopted:

- increased supervision requirements for all juvenile offenders;
- reduced barriers to transferring children who commit serious crimes to the adult criminal court for adjudication and sentencing; and
- transferred prosecutorial jurisdiction for juvenile crime from the family court to the Division of Criminal Justice.

In addition, in 1999 (P.A. 99-26), the legislature authorized $38.8 million to build a new secure detention facility -- the Connecticut Juvenile Training School -- to replace Long Lane School. The CJTS is significantly different in terms of its structural design and purpose than Long Lane. CJTS is designed to provide maximum security detention whereas Long Lane School is an open-campus setting.

The program review committee finds the goals and objectives of the recent juvenile justice reorganization inherently conflict with DCF's child protective services responsibilities. As previously discussed, the paramount concern of protective services is protecting the child from his or her family or other perpetrator, and the aim is to maintain the child's attachment to and status in the family and community. In most cases, children are the victims in protective services cases. In contrast, the juvenile delinquent is the offender who must be removed from his or her family and community for public safety reasons. Delinquent youth are placed in restrictive settings and supervising their behavior is a primary responsibility.

The program review committee further finds the disconnect between DCF and the judicial branch has led to a lack of leadership in the juvenile justice system. The committee concluded there are limited remedies to address the dual agency organizational structure unless significant legislative changes in the roles and responsibilities of the court and executive branch juvenile justice agency are initiated.

DCF and the judicial branch each have specific statutory authority and responsibilities, develop independent policies and procedures, operate separate facilities, and individually fund services and programs. Overall, the program review committee finds very little coordination between the two agencies. DCF has no involvement with a delinquent youth until he or she has been committed to its custody by the court. The court, however, retains its authority over a committed delinquent until he or she has completely served his or her sentence. (A convicted delinquent is committed to DCF for a period of up to 18 months and a serious juvenile offender for up to four years.)

In 1995, the legislature attempted to formalize a link between the department and the judicial branch as part of a series of reforms aimed at strengthening the juvenile justice system. The Juvenile Justice Reorganization Act (P.A. 95-225) required DCF and the judicial branch to coordinate efforts in several areas, including: implementing the reforms contained in the law; developing a protocol for jointly providing services to certain pre-delinquent and delinquent youth; and co-contracting for services and programs funded by both agencies. In addition, a policy group was established, comprised of DCF, the judicial branch, and the Office of Policy and Management. The group was charged with developing an interagency plan to implement a continuum of services designed to balance the need for institutional and community-based services.

The plan, submitted to the legislature and governor in 1996, did not significantly alter the existing organizational structure or authority of DCF or the judicial branch. It did result in written agreements between the two agencies to clarify and limit responsibilities for specific services and clients, such as court-ordered mental health evaluations conducted by DCF's Riverview Hospital and placement criteria for children involved in a family with service needs

case. It did not, however, develop or result in a cohesive response to treating delinquents or coordinating the efforts of DCF and the judicial branch.

The 1995 law set forth an overarching state policy for juvenile justice, which is: "to provide individualized supervision, care, accountability, and treatment to juveniles who violate the law to ensure public safety and to promote delinquency prevention." Currently, the primary responsibility for carrying out the mission rests with the judicial branch. DCF was required to incorporate the policy into its strategic plan for juvenile justice services. However, the department has not adequately addressed the policy in its current strategic plan.

The program review committee finds the changes in DCF's culture brought about by added mandates and conflicting responsibilities make it impossible for the department to ever regain the focus needed to successfully address the state's juvenile justice needs. **Therefore, the program review and investigations committee recommends the creation of the Connecticut Juvenile Authority, which shall be responsible for ensuring public safety and intervening in delinquent behavior by providing individualized supervision, care, and treatment to juveniles under 16 who require pre-trial detention or who are committed as delinquent by the court.**

The CJA shall be headed by a commissioner who is experienced and qualified as a juvenile justice administrator. The commissioner shall be appointed by the governor. The commissioner shall be assisted by two deputy commissioners, one of whom is experienced and qualified in the administration and operation of secure juvenile facilities and the other in the development and implementation of programs and services to treat delinquent youth.

Responsibility for the policies, procedures, administration, and operation of the state's existing juvenile justice detention facilities, pre-trial detention centers, Connecticut Juvenile Training School, Long Lane School, and the Wilderness Program, shall be transferred from DCF to the Connecticut Juvenile Authority. CJA shall be authorized to establish any other facility or program required to carry out its juvenile justice mission.

Further, all existing statutory requirements relating to juvenile justice shall be transferred from DCF to CJA. The CJA shall also have the following specific powers and responsibilities:

- **implement the mandates of C.G.S. 46b-121h (reorganization law);**
- **organize its facilities, programs, and services in accordance with geographical boundaries defined by the state's five human service regions;**
- **conduct intake and assessment of all youth in its custody and facilities and provide that information, when necessary, to the judicial branch and other state agencies serving the delinquent population;**
- **establish intake guidelines and protocols for pre-trial detention centers, including eligibility requirements and supervision conditions for pre-trial release supervision;**

- **develop policies and procedures for a minimum time served requirement based on a standardized risk assessment and individualized treatment plan for all committed delinquents to determine when and under what conditions the youth may be released from confinement to a residential program or the community;**
- **establish a community supervision program that includes an offender revocation unit and other specialized supervision units for specific populations (e.g., sex offender or sexually reactive youth, violent or repeat offenders, dually diagnosed offenders, etc.);**
- **assist and cooperate with the secretary for children, including submitting: (1) an annual assessment of the statewide and regional needs of the delinquent population; (2) a status report on the benchmarks relevant to juvenile justice; and (3) an estimate of its client population to be served by the community partnerships for children;**
- **submit a proposed biennial budget related to services for delinquent youth under 16 and their families to the children's secretary and fully participate in the process to pool funds with other state children's agencies to support integrated, community-based care systems and prevention services; and**
- **coordinate efforts with the judicial branch and any other state agency necessary to effectively and efficiently provide juvenile justice services.**

The program review committee concludes there are enough significant issues involved in dealing with delinquency that the state would be better served by an agency solely focused on administering juvenile justice. Interestingly, DCF was originally created as a juvenile justice agency to focus on the special needs of delinquent youth. After other child welfare responsibilities were consolidated with the juvenile justice mandate in 1973, delinquent youth quickly lost their priority within the agency. As a result, over the past 25 years, the juvenile justice system has suffered from a lack of resources and neglect.

The problems did not go unnoticed. Legislative and management studies continually found significant procedural and resource problems in DCF's juvenile justice system. However, the legislative and executive branches did not prioritize a response to the issues, either financially or administratively. Juvenile justice tended only to receive attention when a crisis arose or a lawsuit was threatened.

In addition to transferring the juvenile justice responsibilities from DCF to the new Connecticut Juvenile Authority, the program review committee's recommendation also proposes transferring the pre-trial detention centers currently administered by the judicial branch. The area in which the disconnect between DCF and the judicial branch is most apparent is in the administration of the pre-trial detention centers. In fact, during the recent reorganization of the judicial branch, it found the pre-trial detention facilities and services "do not fit into the juvenile supervision process."[2]

[2] *Judicial Branch: Court Support Services Division Design*, National Center for State Courts (January 1999), p 90.

One of the reforms of the 1995 juvenile justice reorganization was to transfer the detention centers to DCF to consolidate the state's juvenile confinement responsibilities into one agency. The policy group reviewed that plan, but recommended, in its 1996 report, leaving the responsibility within the judicial branch. The final decision to retain the status quo was based on a federal court consent decree (*Emily J.*) issued in 1996 that covered almost all operational aspects of juvenile detention centers and the problems occurring at Long Lane School.

There is a requirement, established by the 1999 law (P.A. 99-26) authorizing the Connecticut Juvenile Training School, that is contrary to the responsibilities recommended for the Connecticut Juvenile Authority. State law authorizes the court to commit a delinquent to DCF for a specific period of time. The agency is authorized to determine the specific placement and period of time spent in confinement before release to a less restrictive setting. In practice, however, the court orders DCF to confine a delinquent in either Long Lane School or a specific residential program. This practice began when overcrowding at Long Lane shortened the average length of stay for committed delinquents, and the court was concerned sufficient supervision was not being provided by DCF.

This practice was recognized in state statute in 1999 (P.A. 99-26). The new law permits the court to specify a placement facility in its commitment order to DCF. It can require a delinquent be confined at CJTS, Long Lane School, or specifically select a contracted residential placement program. The program review committee found the law will prevent the Connecticut Juvenile Authority from effectively implementing its responsibilities. **Therefore, the committee recommends this law be repealed, effective upon the establishment of the Connecticut Juvenile Authority.**

Transition Plan

The program review committee finds the recommended reorganization of DCF's mandates will involve major revisions to existing statutes as well as the reallocation of current resources, facilities, and staffing among the new agencies. **To accomplish this task, the committee recommends a team of individuals from outside state government be established to develop and oversee implementation of a transition to create realign the Department of Children and Families and create the Division of Children's Behavioral Health within the Department of Mental Health and Addication Services and the new Connecticut Juvenile Authority.**

The team shall be comprised of five public members appointed by the governor. A transition plan shall be developed by the team with the advice and assistance of the commissioners of children and families, mental health and addiction services, the chief court administrator, the secretary of policy and management, and the heads of the new juvenile authority, the children's behavioral health division, and the children's secretary, once they are appointed. The court monitor should also be invited to participate in the planning related to services for children covered under the *Juan F.* consent decree. The team shall be authorized to hire its own staff and consultants to assist in carrying out its duties.

The plan for transition shall be completed and submitted to the General Assembly for approval within one year after the reorganization legislation goes into effect.

The program review committee acknowledges a reogranization of this magnitude requires more time and attention than the heads of major state operating agencies can give it. A team of individuals from outside state government is better able to provide the sustained leadership to successfully carry out the transition. In addition, the team will be independent from the interests of any particular state agency in making resource allocations and other reoganization decisions.

Sunset Review

Finally, the program review committee finds the new children's agencies and the secretary's office and all its related functions should be evaluated at the end of five years to determine whether they are achieving their intended purposes. The legislature's sunset review process is a well-established and effective mechanism for carrying out this type of evaluation. **Therefore, the program review committee recommends the Office of the Secretary for Children, the Department of Children and Families, the Division of Children's Behavioral Health, and the Connecticut Juvenile Authority be scheduled to terminate effective July 1, 2006, unless reauthorized by the General Assembly. During the year prior to the automatic termination, the Legislative Program Review and Investigations Committee shall conduct a sunset review and report its findings and recommendations regarding the continuation, modification, or termination of each entity for consideration by the General Assembly during the regular legislative session in 2006.**

Appendix A

Historical Development of DCF Mandates for Protection Services, Juvenile Justice, and Mental Health

Historical Development of DCF Mandates

Child Protection Services

The state's initial role in traditional child welfare services -- protecting and placing children who are abandoned, abused, neglected, or uncared for -- was primarily supervisory. Beginning in the 1800s, the State Board of Charities reviewed the activities of county boards of management that were responsible for finding "temporary homes" -- the precursor of today's foster homes -- to place dependent or neglected children. Children were placed in temporary homes, however, by local welfare boards and organizations. The first significant change to the child welfare system occurred in 1921 when all welfare responsibilities of the state charities board were transferred to the newly established Department of Public Welfare.

The state public welfare department was required to have separate bureaus for adult and child welfare. Its child welfare mandate included the general supervision over those children who required care, protection, or discipline, including "dependent, defective, delinquent, abused, or neglected" children. In addition, the department was specifically required to license and monitor child-caring institutions, agencies, and persons, supervise the placing of children in foster care, and to establish policy and procedure for investigating delinquency cases. Local agencies still retained some authority to place children in out-of-home care.

In 1930, the public welfare department, rather than the county board, was given the sole authority to supervise the placement of children in state-licensed foster homes. The department was also newly authorized to supervise committed (convicted) juvenile delinquents. In 1937, the legislature abandoned the county approach to child welfare by creating branches of the state Department of Welfare. Municipal welfare departments (similar to the defunct county boards) still existed and the state delegated much of the responsibility for the day-to-day social work to the county boards.

Until the 1950s, child welfare services continued to be primarily provided by each of the eight county branches of the welfare department, with oversight by the state welfare department. However, in 1955, the state welfare department was given the sole legal custody of the state's dependent, neglected, and homeless children. The state's role in providing child welfare services was further expanded in 1965 when the welfare department was required to provide "protective services" for victims of child abuse and neglect and their families when it was deemed appropriate for the child to remain at home rather than be placed in foster care.

By the 1970s, child welfare workers, child advocacy groups, and clients were arguing before the legislature that children's services were not receiving adequate resources or attention while housed in the welfare department. In response, the mandate of the state's recently created juvenile delinquency agency (see next section) was expanded in 1974 with the transfer of child protection services from the Department of Social Services to the Department of Children and Youth Services.

During the 1980s, new statutory mandates for reporting child abuse created a constant influx of cases that DCYS was not prepared to handle. In 1989, a federal class-action lawsuit, *Juan F. v O'Neill*, was filed against DCYS that resulted in a 1991 consent decree. The consent decree covered all areas of child protection policy and provided a plan for increasing funding, staffing, and service levels within the department. Also, in 1993, the department's name was changed to the Department of Children and Families.

By the mid-1990s, after a series of events resulting in the deaths of children, whose families had been or were involved with DCF, the department responded to public and political pressure by shifting its focus from family preservation[1] to child protection. Over the next few years, highly publicized cases of child abuse heightened legislative, media, and public scrutiny on DCF. A succession of legislative actions followed aimed at improving the department's ability to investigate abuse and neglect allegations, protect children by removing them from their homes, improve the foster care system, and provide permanent placements for children as soon as possible. Checks and balances were also put into place in the form of time limits for certain DCF actions, mandatory case reviews, and the Child Fatality Review Board and Office of the Child Advocate were created. The bulk of the legislative changes were procedural. The intent was to clarify and strengthen rather than significantly change the department's child protection mandate and to comply with federal law.

Juvenile Justice

Prior to 1921, municipal authorities maintained pre-trial detention facilities (jails) for children charged with crimes. A 1921 law required the juvenile courts to provide or fund detention accommodations if the local authorities could not.

In 1969, the Department of Children and Youth Services was statutorily created as a juvenile justice agency to provide custody and rehabilitative services for delinquents, develop delinquency prevention services, and administer Long Lane School (established in 1868 as a reformatory school for girls), the Connecticut School for Boys (established in 1854), and any other reform facility. The intent of the legislation was to: better serve children whose problems were not being properly serviced through the juvenile court; to address overcrowded juvenile justice services and facilities; improve coordination between executive branch agencies, the courts, and private providers; and increase resources and staffing for children's services.

In 1972, Long Lane School became coeducational following the closing of the Meriden School for Boys. DCF was authorized, in 1973, to transfer juveniles from Long Lane School to appropriate outside facilities, such as private residential and nonresidential programs. In the following year, the legislature clarified DCF's authority to grant and revoke “parole” of juvenile delinquents committed to its custody by the court.

[1] Family preservation involves providing in-home services, support, and treatment to a family unit to prevent the out-of-home placement of the children or, in the event of an out-of-home placement, includes the planned process of reconnecting children with their birth family through a variety of services and supports.

The federal Juvenile Justice and Delinquency Prevention Act (JJDP) of 1974 was passed partially in response to the movement for deinstitutionalization. The use of adult jails and detention centers to hold an excessive number of children for status offenses, such as truancy and running away, was criticized and it was argued that court intervention in juvenile delinquency cases was not meeting the goal of rehabilitation. The intent of the act was to reduce the juvenile justice system's involvement in noncriminal misbehavior and to place juveniles in less restrictive and intrusive settings, such as community-based alternatives to incarceration. In fact, a provision of the JJDP directed states to stop placing status offenders in secure facilities or face the loss of eligibility for federal funding.

In 1979, the objectives of the federal JJDP were incorporated into a state law that became effective in 1981. Status offenses were eliminated as delinquent acts and juveniles detained for status offenses were no longer placed in secure facilities. The law defined a new category of delinquency called the "family with service needs" (FWSN). The court was mandated to become involved to prevent future legal action, help resolve the problem, and strengthen family ties. The intent was to process FWSN cases in a non-judicial manner while still affording support and structure to the family. These cases cannot directly result in placement in juvenile detention or commitment to DCF unless there is a violation of a court order leading to a delinquency action.

By the end of the 1970s, there was an increase in juvenile crimes against persons and property that fueled the growing public opinion that, for the most part, the juvenile justice system had been largely unsuccessful in its efforts to rehabilitate delinquents and juvenile offenders. Connecticut, like most other states, did not abandon the rehabilitative approach to juvenile justice but began to shift delinquency policies -- predominantly in the adjudication phase -- to expand the punishment competent. For example, in 1979, the legislature passed the Serious Juvenile Offender Act that toughened the state's approach to juveniles charged with serious offenses. A stiffer approach to treatment (penalty phase) was also mandated by extending the period of commitment to DCF for serious juvenile offenders from a maximum period of 18 months to four years. Also, in 1982, the legislature strengthened the punishment aspect of the FWSN law by authorizing several measures to deal with FWSN violators, including up to 10 days detention. In contrast, since the early 1970s, the DCF mandates for commitment of delinquents and the operation of Long Lane School have remained basically unchanged.

The most recent legislative changes (P.A. 99-26) to DCF's juvenile justice mandate have centered on relocating and building a new juvenile facility with increased security. Further, recognizing the need to focus greater attention on public safety, a 1997 public act required DCF to adopt regulations for granting leave or “parole” to committed delinquents, including the eligibility and conditions for leave or “parole”, security evaluation, identified and assigned supervision, and police notification.

Mental Health.

Until the latter part of the 19th century, care for mentally ill adults and children, like other dependent persons, was primarily a local responsibility, provided through town poor farms and almshouses. Mental diseases were also treated at privately operated hospitals like the Institute

of Living, founded as the Hartford Retreat in 1822, and through programs operated by charitable organizations to help the “insane, the feebleminded, and others with mental defects.”

The state's role in mental health services began with the opening of the Connecticut State Hospital for the Insane, operated by an independent board of trustees, in Middletown in 1867. Two additional state mental hospitals were later established in Norwich (1904) and Fairfield (1929). The state hospitals could treat any child or adult with a recognized mental illness, admitted voluntarily or committed by the courts or doctor.

Outpatient mental health services developed with little state involvement. Psychiatric clinics, including child guidance clinics, were established in the early part of the 20th century as part of a national movement led by volunteer societies for mental hygiene in Connecticut and other states. Child guidance clinics, now funded in part with DCF grants, remain the center of community-based mental health services for children and families in the state.

During the 1920s, a division of mental hygiene was established within the state health department primarily to help develop facilities in communities lacking mental health services. A separate Department of Mental Health (DMH) was created in 1953 to take charge of all matters related to mental health and mental illness. The new department assumed responsibility for the three state mental hospitals, whose boards became advisory, as well as outpatient and day treatment programs for mentally ill adults and children and forensic facilities for the criminally insane.

Throughout the 1950s and early 1960s, the development and use of medications (psychotropic drugs) that allowed mentally ill individuals to be treated in community contributed to the deinstitutionalization of hospitalized patients in Connecticut and across the country. Federal legislation enacted in 1963 provided funding for community mental health centers as part of a national effort to develop a continuum of mental health care . Connecticut's first center, operated jointly by the mental health department and Yale University opened in 1964. Throughout the 1970s, state and federal policies continued to emphasize treatment for mental health clients in the least restrictive setting possible. A regionalized system of community mental health services was mandated by state law in 1977.

During the 1960s and 1970s, children's mental health issues came to the public's attention when several national studies were released that highlighted the lack of services for mentally ill and emotionally disturbed children and the need for separate, specialized treatment for children and adolescents. In response to these concerns, the Connecticut Department of Mental Health: created two psychiatric units for adolescents; a facility for younger children; an adolescent drug treatment unit; and operated a residential treatment facility. Connecticut then became the first state to structurally separate children's mental health services from the adult system. Legislation adopted in 1975 mandating a consolidation of children's services in Connecticut provided for the transfer of psychiatric and related services for those under 18 from the Department of Mental Health to the Department of Children and Youth Services.

The emphasis on integrating mental health and related services for children and providing them in the least restrictive setting possible continues to the present. During the

1980s, federal and state legislation mandated development of comprehensive, community-based systems of services for children and youth with emotional disturbances. Most recently, under a federal law enacted in 1992, funding is provided through Mental Health Performance Partnership Grants (formerly community mental health services block grants) to Connecticut and other states to plan and implement local systems of care for seriously emotionally disturbed children and their families. The goal of the systems of care model is to improve the delivery of services by providing an array of services tailored to a child's specific needs as near to home as possible.

Substance abuse. The state's role in substance abuse services for children parallels its mental health responsibilities in many ways. Connecticut law adopted in 1874 had established the policy of treating "intemperance" as a disease, allowing alcoholics and drug addicts to be taken to inebriate asylums for treatment, care, and custody. The state mental hospitals, almost from their inception, included substance abuse treatment among their services and local agencies disseminated information on alcoholism and operated treatment clinics.

In 1961, the Department of Mental Health was given the responsibility to treat alcoholism. Concerns over drug abuse during the 1960s led to agency programs and facilities aimed at drug rehabilitation and treatment, including a creation of a specialized unit for adolescent addicts. During the 1970s, responsibility for alcohol and drug services was split between inpatient hospital programs administered by Department of Mental Health and community programs funded by the Connecticut Alcohol and Drug Abuse Council (CADAC). Also, prevention and treatment of substance abuse for those under 18 was included in the transfer of DMH services to the Department of Children and Families.

While a 1978 law made CADAC the state lead agency for substance abuse, various agencies including DCYS continued to have prevention and treatment responsibilities. Roles remained murky until the adoption of a 1988 interagency agreement among DCYS, CADAC, the Office of Policy and Management and the Department of Correction that clarified each agency's responsibilities and called for the transfer of all children's substance abuse services from the commission to the children and youth services department.

Legislation making substance abuse services for children a clear DCF mandate, however, was not enacted until 1994. By this time, CADAC had been eliminated under a 1993 public act. Its functions were first transferred to the Department of Public Health, renamed Public Health and Addiction Services, but were subsequently (in 1995) placed in the Department of Mental Health, which was renamed Mental Health and Addiction Services.

In 1997, the Connecticut Alcohol and Drug Policy Council (CADPC) was legislatively established to review the state's substance abuse policies and practices regarding treatment, prevention, referrals, and criminal justice sanctions and programs. The council is mandated to develop and coordinate a statewide, interagency plan to integrate programs, services, and sanctions. The scope of the council includes adults and children. The council is comprised of the heads of most state agencies including the commissioner of DCF, the criminal justice system, and judicial branch.

Appendix B

Summary of Federal Mandatess
Related to Children's Services

Summary of Federal Mandatess

Adoption Assistance and Child Welfare Act of 1980

- Provides a nationally uniform response to issues raised by children at risk of needing out-of-home care.
- Provides federal assistance for services enabling children to remain with birth families.
- Assures children placed out-of-home eventually return to safe birth homes or are placed in a timely manner with adoptive families.

Adoption and Safe Families Act of 1997

- Reaffirms safety of children and making reasonable efforts to preserve and reunify families.
- Clarifies instances in which states are not required to make efforts to keep children with their parents.
- Sets forth provisions establishing time limits for making permanency planning decisions and promotes adoption of children who cannot return safely to their homes.
- Authorizes financial incentives to states to increase the number of children who are adopted.
- Prohibits delay or denial of adoptive placements across state or county jurisdictions.
- Ensures that adopted children with special needs have health insurance coverage.

Child Abuse Prevention & Treatment Act

- Provides funds to support: research on the causes, prevention, and treatment of child abuse and neglect; demonstration programs to identify the best means of preventing maltreatment and treating troubled families; and development and implementation of training programs.
- Grants for these projects are provided nationwide on a competitive basis to state and local agencies and organizations.

Child and Family Service Plan: Title IV-E

- Requires states develop a five-year comprehensive Child and Family Services Plan (CFSP), annually update the plan, and submit a final report on the progress made toward implementing the plan to be eligible for Title IV-E funds.

Child and Family Services Program: Title IV-B

- Objective is to provide for supportive services to prevent out-of-home placement.

- Authorizes federal government to pay 75 percent and state 25 percent of the cost for services to protect the welfare of children.
- No federal income eligibility requirements for this program.

Child Support Performance and Incentive Act of 1998

- Mandates state implementation a statewide automated child support system.
- Creates a new federal incentive system to reward states with effective child support enforcement programs.

Community Mental Health Services Performance Partnership Block Grant

- Mandated by Part B of Title XIX of the Public Health Service Act, Center for Mental Health Services, Mental Health Performance Partnership administers state grant program, formerly known as the Community Mental Health Services Block Grant.
- Grants awarded to the states to provide community-based mental health services to people with mental disorders and to develop a State Mental Health Plan for improving community-based services and reducing reliance on hospitalization.

Independent Living Assurances Act

- Mandates Title IV-E foster care for youth 16 and older to assist transition to independent living.

Juvenile Justice and Delinquency Prevention Act

- Requires adjudicated juvenile delinquents be placed in the “least restrictive” setting in reasonable proximity to the family and the home community and are not detained or confined in any adult institution.
- Mandates juveniles treated equitably on the basis of gender, race, family income, and mentally, emotionally, or physically “handicapping conditions”.

Title IV-E Adoption Assistance

- Objective is to facilitate the placement of hard to place children in permanent adoptive homes and prevent long, inappropriate stays in foster care.
- Provides funds to states to assist in paying maintenance costs for adopted children with special needs who are AFDC or SSI eligibl and for administrative and training costs of the program.

Title IV-E Foster Care

- Objective is to help states provide proper care for children in out-of-home placement in a foster family home or an institution.

- Provides funds to states to assist with: the costs of foster care for eligible children; administrative costs to manage the foster care program; and training for state and private provider staff and foster parents.

Title IV-E: Promoting Safe and Stable Families

- Objective is to prevent the risk of abuse and promote nurturing families, assist families at-risk of having a child placed out-of-home, and assisting children return to their birth homes or permanently placed.
- Provides funds to states to provide family support, family preservation, time-limited family reunification services, and services to promote and support adoptions.

Appendix C

Summary of DCF Management Studies

Summary of DCF Management Studies		
Year	Title/Author	Key Points
1977	*A Critical Review of Mandates and Resources in the Connecticut Department of Children and Youth Services by the Review Team of the DCYS Advisory Council*	Agency problems related to: • Striking gap between department mandates and resources provided • Transfer of authority incomplete; agency lacks full control over some key management functions; no mechanism for resolving interagency conflicts • Lack of commitment on part of executive branch and legislature to improve agency performance Management issues: • Crisis management operation; no evidence of commitment to long range planning or improved service delivery • Functions not integrated; services remain three largely separate tracks • Basic management documents nonexistent; management authority ambiguous and overlapping • Staff turnover high, morale low; relationships with providers poor • Information systems inadequate; lack information needed for informed decision making; cannot assess worker, contractor performance or client progress To address management issues recommend: • Detailed management plan endorsed by governor, shared with legislature • Clear table of organization, comprehensive budget with new categories related to policy, and automated information system capable of monitoring performance • Advisory groups be given data to assess agency effectiveness, progress in implementing plan
1978	*Study of Juvenile Justice in Connecticut by the Program Review and Investigations Committee*	The committee found: • virtually no analysis is done by DCYS to indicate what treatment methods work with what kinds of delinquents • DCYS ability to oversee Youth Service Bureaus is questionable • A major problem of the Long Lane School is that of runaways and the Long Lane treatment manual contains no goal statement on the role or importance of maintaining a secure facility • Private agencies play a crucial role in addressing Connecticut's juvenile delinquency problem and are essential to the development of a continuum of needed services • DCYS reimbursement of private providers of juvenile delinquency services is inadequate and inefficient • Juvenile needs assessments are lacking • DCYS Office of Evaluation, Research, and Planning has not demonstrated its capacity to effectively evaluate programs • There are few additional standards, beyond licensing, for private providers To address these issues, the committee recommended: • More analysis of the effectiveness of various programs designed to treat juvenile offenders should be undertake by the department • The Law Enforcement Assistance Administration should provide technical assistance to DCYS to help the agency develop evaluation procedures that could be integrated into the department's system for managing funds • DCYS detention staff job classifications and salaries should be upgraded • Information about juveniles must be maintained and tracked in a more effective manner

		• DOC should be utilized by the department to provide technical assistance to Long Lane on security and custody matters • Long Lane's primary role should be limited to the treatment of a small population requiring secure custody • DCYS should articulate, as part of its master plan, clear policy on the use of private resources, including the development of programs equipped to handle difficult cases • DCYS should provide more reasonable cost related payments for private delinquency treatment services • DCYS should exercise aggressive leadership to stimulate the development of family-centered programs in the private sector • DCYS should require private programs to provide transitional aftercare services following release from residential treatment and reimbursement rates should be adjusted to reflect this additional requirement • A written plan should be developed by the DCYS Office of Evaluation, Research, and Planning which establishes priorities and specifically shows how and when major tasks will be accomplished • DCYS must update licensing standards, hire more qualified workers, and improve workers' training • DCYS must improve its communications with DSS, DMH, DMR, and the juvenile courts
1978	*DCYS: A Program Review by the Program Review and Investigations Committee*	The committee found: • DCYS managers are unable to effectively manage the operations of the department or to fully comply with statutory mandates • Management information systems are ineffective • Projections of caseloads and staffing requirements are insufficient • There are deficiencies in the child abuse and neglect reporting system • The timeliness of abuse and neglect investigations is not monitored • One in five cases has no written treatment plan and only 68% of those with treatment plans have had a current review • 50-70% of the children in DCYS care are not receiving routine medical examinations or other routine medical services • Many children are in foster care for more than two years without a permanent placement plan • The inadequacy of board and care funds for both foster and other private placements has been caused, in part, by the department's poor forecasting and budget preparation • DCYS has weak oversight, at best, of troubled youths between the ages of 16 and 18 who cannot be forced to stay in a foster home or a group home • DCYS has not fulfilled its prevention mandate To address these findings, the committee recommended: • DCYS draft a five-year rolling master plan together with a comprehensive budget • Fines be imposed for mandated reporters who intentionally fail to report suspected child abuse or neglect • DCYS implement a manual tracking system to provide more thorough information to supervisors • All DCYS foster care commitments must be limited to two years. 90 days before expiration of the commitment, DCYS should be required to file a petition with the Superior Court to either: (1) terminate parental rights, (2) revoke the commitment, or (3) extend the commitment for an additional two years based on a finding that continued commitment would be in the

		best interests of the child • DCYS must expedite the recruitment process for foster parents. The Department must recognize that foster parents make a vital contribution to the treatment of DCYS children • DCYS must not only improve its forecasting and budget preparation, but also place children in foster homes and other appropriate settings within the limits of physical, rather than fiscal resources, even if such a policy results in the need for a deficiency appropriation • DCYS must improve its supervision of difficult youth between the ages of 16 and 18
1987	*Study of Psychiatric Hospital Services for Children and Adolescents by the Program Review and Investigations Committee*	The committee found: • DCYS has not met its statutory mandate to complete a comprehensive child's mental health plan • DCYS has not assessed the demand for existing services to determine if supply of state beds was appropriately allocated among age groups, treatment needs, and regions • There is a high demand for hospital services but DCYS hospitals frequently operate under capacity • There is a lack of information on psychiatric hospital services available to children. No state or private agency maintains a centralized directory • Incomplete or sporadic compliance by hospitals with statutory client information reporting requirements is typical • The DCYS database does not provide accurate information on children treated for psychiatric problems in emergency rooms To address these issues, the committee recommended: • DCYS must meet its statutory mandate and complete a comprehensive child's mental health plan • DCYS must reassess the role of psychiatric hospitals in terms of bed space and regional services • DCYS should utilize psychiatric hospitals to their fullest if demand for psychiatric services is high • DCYS should develop and maintain a statewide telephone clearinghouse on public and private inpatient bed openings • DCYS should establish an emergency psychiatric services program to provide crisis intervention and triage in each region • DCYS should develop a plan to more thoroughly collect psychiatric emergency room information
1989	*Study of Juvenile Justice in Connecticut by the Program Review and Investigations Committee*	The committee found: • The contents of DCYS treatment plans for committed juveniles are lacking • There is an imbalance in the staff-to-client ratio between aftercare and Long Lane staff • There is an increase in the number of escapees from Long Lane and many escapees are serious juvenile offenders • Little new money, high utilization rates, rigid criteria, and lengthy acceptance processes all create a lack of private residential facilities for juvenile delinquents in the state To address these issues, the committee recommended: • DCYS include specific information in treatment plans and case files • Long Lane allocate a number of its correctional staff to aftercare services • DCYS either make Long Lane a secure facility with a fence or build a medium security unit attached to the existing structure

		• DCYS monitor treatment and care of committed children and should take care that the automatic review policy does not further constrict limited resources
1991	*Study of DCYS Child Protective Services by the Program Review and Investigations Committee*	The committee found: • The reorganization of DCYS has focused on protective services programs and case management • There is a need for an independent review of DCYS handling of cases to provide oversight. There are no random audits to ensure that practice follows policy • There are broad variations between regions in case management and an absence of uniform standards in the Department • DCYS does not follow up cases to ensure that treatment and service plans have been implemented. Reviews are only done every 6 months • Staff training is not a top priority and training is inadequate • There are a number of deficiencies in case management • DCYS is deficient in administering and funding community-based programs • DCYS social workers are an untapped resource in the evaluation of community-based programs To address these issues, the committee recommended: • The DCYS management team must evaluate measurements of program effectiveness • Program evaluations and monitoring of client outcomes should be placed in one division • DCYS create a comprehensive system for managing cases, evaluating client outcomes, and reducing administrative paperwork for social workers • DCYS should develop an independent case audit unit to monitor regional compliance with policy and procedure • DCYS should develop a Staff Development and Training Division • DCYS should reduce the caseloads of workers, particularly new workers • All protective service social workers should, within first 10 years of employment, obtain MSW • DCYS should install an on-line computer system with 24-hour access and develop outcome measures for evaluating the effectiveness of client interventions • DCYS should design a grant processing system that funds proportionate to success in treating clients and allows for the reduction of funds against ineffective programs. The success of programs should be measured against specific criteria. Data on program outcome measures should be collected and analyzed • As part of the program evaluation process, social workers and supervisors should be surveyed and asked to gauge program effectiveness • DCYS should develop and maintain a computerized database of all available community service programs
1995	*Study of DCF Foster Care by the Program Review and Investigations Committee staff*	The committee found: • DCF does not sufficiently focus on the placement of children which consumes over half of its resources and is the primary focus of its work • The DCF practice of matching and placing children does not conform to policy. The lack of information about children prohibits appropriate matching to foster homes and hinders foster parents' abilities to care for children • The certification of family relatives for foster care is a questionable practice

		with no centralized oversight • DCF practice is confusing for staff and providers. There is a repetitive effort to maintain two separate investigation units. Also, there is no scale of authority for DCF to enforce its investigation recommendations • DCF foster parents typically have a poor working relationship with the Department As a result of these findings, the committee recommended: • DCF should be reorganized to create divisions responsible for coordinating, licensing, managing, and quality assurance of all placement resources, including those specific to foster care • DCF implement a child-placing portfolio containing all relevant and necessary information and documents to adequately provide foster care to a child. A copy should be provided to foster parents • Division of Quality Assurance should have the same responsibilities for relative certification as it does for foster care licensing • There be investigations of abuse and neglect allegations against foster homes conducted by regional staff, and completed within 14 days of referral. There should also be an investigation resolution process.
1995	*Report on DCF Organization and Staffing by KPMG*	KPMG found: • There are numerous small divisions and units in DCF's organizational structure which hinder department integration and horizontal communication • The current organization structure ineffectively divides and groups some functions • Some functions currently performed in the central office can be performed more appropriately in the field or on a contracted-out basis • Central Office and staffing have grown substantially • There are a high number of managers/supervisors in central office relative to staff yet the span of control of these managers/supervisors is low • Additional layers of management exist in the functional layers than is necessary • The commissioner's span of control is too great, yet it excludes important areas of the agency such as health and mental health • Too much of the department's functional responsibility is concentrated under the deputy commissioner for programs (DCP). Combining programmatic and administration functions under the deputy commissioner for administration (DCA) may not be optimal • Planning and program development functions are lacking at a high level within DCF's organizational structure To address these issues, KPMG recommended: • DCF bring together all aspects of research, clinical planning, strategic business planning, program development, and policy development. Closely integrating these with DCF's implementation unit will strengthen DCF's implementation of the consent decree • The number of senior employees reporting directly to the commissioner should be reduced from 9 to 7 and the commissioner should hire an executive assistant. A chief of staff and a public information officer should report directly to the commissioner • DCF should eliminate both deputy commissioner positions and replace them with five equivalent-level senior managers overseeing: child welfare services; health; mental health and education services; administration and

		finance; program development and planning; and juvenile justice • The chief of staff, public information officer, and executive assistant positions should be created. The chief of staff should coordinate external relationships and interaction with the commissioner, as well as internal agency initiatives and responses to events. He/she would also supervise DCF's case investigation unit. The agency ombudsman and legislative liaison should report to the chief of staff rather directly to the commissioner as under the current structure. The public information officer should manage external communications. He/she should continue to report directly to the commissioner. The executive assistant to the commissioner should handle administrative tasks such as responding to correspondence and scheduling
1998	*Study of the DCF Bureau of Juvenile Justice by Loughran and Associates*	The consultants found: • Very little of the Juvenile Justice Reorganization Plan (mandated by PA 95-225) has been implemented, such as the reconfiguration of the Long Lane School and the development of a full continuum of community programs and parole services • Most of DCF's budget, administrative structure, and support systems are dedicated to its child welfare operations • Parole services, the community case management arm of the Juvenile Justice Bureau, suffers from its disconnection from the rest of DCF To address these issues, the consultants recommended: • The department must better integrate the Juvenile Justice Bureau • The Juvenile Justice Bureau's regional offices should be co-located with those of the Bureau of Child Welfare Services. They should be large enough and have enough computers, phones, and fax and copy machines to accommodate the number of parole officers and support staff assigned to a particular office • Administrative practices must be changed to allow for better integration of the juvenile justice function into the department • The Juvenile Justice Bureau's administration should be transferred to DCF's central office, and the bureau's director should report to the juvenile justice bureau chief rather than to the assistant superintendent of Long Lane

Appendix D

History of DCF Mission Statements

History of DCF Mission Statements

1970: DCYS was "responsible for creating, developing, operating, and administering a comprehensive and integrated state-wide program for children and youth whose behavior does not conform to the law or to acceptable community standards."

1971: "To serve the youth of Connecticut by helping them achieve a better way of life through alternative and diverse services, rather than through apathy and incarceration."

1972: "To create, develop, operate, and administer a comprehensive and integrated program of services for children and youth whose behavior does not conform to the law or to acceptable community standards."

1973: "To create, develop, operate, and administer a comprehensive and integrated program of services for children and youth whose behavior does not conform to the law or to acceptable community standards."

1974: "To create, develop, operate, and administer a comprehensive and integrated program of services for children and youth whose behavior does not conform to the law or to acceptable community standards."

1975: "To create, develop, operate, and administer a comprehensive and integrated program of services for children and youth whose behavior does not conform to the law or to acceptable community standards."

1976: "To provide leadership and support to the development of a comprehensive statewide network of governmental and non-governmental programs and services promoting the sound growth and development of all children in Connecticut. This includes prevention of dependency, abuse, neglect, delinquency, mental illness, and emotional disorder among children. It seeks to identify children at risk in these areas, to restore them to useful functioning where possible and to limit their disability where not."

1977: "To provide leadership and support to the development of a statewide network of public and private sector programs and services to identify children at risk and restore them to useful functioning where possible and limit their disability where not."

1978: "To provide leadership and support in developing a statewide network of public and private sector programs and to identify children at risk and to restore them to useful functioning where possible and limit their disability where not."

1979: "To provide leadership and support in the development of a statewide network of public and private sector programs to identify children at risk and to restore them to useful functioning where possible and limit their disability where not."

1980: “To protect children from abuse, neglect, and abandonment; to keep children in their own homes; to provide care and treatment for children who cannot remain at home; to reunite children with their families; to effect adoption of children who cannot be reunited with their own family; and to accomplish these goals cost-effectively through planning, evaluation, and allocation.”

1981: “To plan for, develop, and evaluate a comprehensive and integrated statewide system of services including preventive services, for committed and noncommitted children and youth who are abused, neglected, mentally ill, emotionally disturbed, or adjudicated delinquent.”

1982: “To plan for, develop, and evaluate a comprehensive and integrated statewide system of services including preventive services, for committed and noncommitted children and youth who are abused, neglected, mentally ill, emotionally disturbed, or adjudicated delinquent.”

1983: “To plan for, develop, and evaluate a comprehensive and integrated statewide system of services including preventive services, for committed and noncommitted children and youth who are abused, neglected, mentally ill, emotionally disturbed, or adjudicated delinquent.”

1984: “To plan for, develop, and evaluate a comprehensive and integrated statewide system of services including preventive services, for committed and noncommitted children and youth who are abused, neglected, mentally ill, emotionally disturbed, or adjudicated delinquent.”

1985: “To plan for, develop, and evaluate a comprehensive and integrated statewide system of services including preventive services, for committed and noncommitted children and youth who are abused, neglected, mentally ill, emotionally disturbed, or adjudicated delinquent.”

1986: “To plan for, develop, and evaluate a comprehensive and integrated statewide system of services including preventive services, for committed and noncommitted children and youth who are abused, neglected, mentally ill, emotionally disturbed, or adjudicated delinquent.”

1987: “To preserve and strengthen families so they may care for their children while simultaneously ensuring that children are safe and have opportunities for healthy development.”

1988: “To join with others to create the conditions within which all children in Connecticut develop as healthy, productive, and caring persons, free from harm and injury; experience enduring, nurturing relationships as members of permanent families; participate fully in community life; exercise age appropriate opportunities for decision-making; are supported in their transition to adulthood; receive services that are respectful of child time, responsive to children’s individual and developmental needs, and sensitive to their heritage.”

1989: “To join with others to create the conditions within which all children in Connecticut develop as healthy, productive, and caring persons, free from harm and injury; experience enduring, nurturing relationships as members of permanent families; participate fully in community life; exercise age appropriate opportunities for decision-making; are supported in

their transition to adulthood; receive services that are respectful of child time, responsive to children's individual and developmental needs, and sensitive to their heritage."

1990: "To join with others to create the conditions within which all children in Connecticut develop as healthy, productive, and caring persons, free from harm and injury; experience enduring, nurturing relationships as members of permanent families; participate fully in community life; exercise age appropriate opportunities for decision-making; are supported in their transition to adulthood; receive services that are respectful of child time, responsive to children's individual and developmental needs, and sensitive to their heritage."

1991: "Children are in need of protective, mental health, juvenile justice and substance abuse services, as well as permanent, stable settings, free from harm, where they are able to achieve their potential. Therefore, the DCYS, in partnership with service providers, plans, provides, funds, and coordinates the development of a continuum of integrated services for children and their families."

1992: "In partnership with service providers, DCYS plans, provides, funds, and coordinates the development of a continuum of integrated services for children in need of protection, mental health, juvenile justice, and substance abuse services. These services shall promote the development of permanent stable setting, where the children are free from harm and able to achieve their potential."

1993: "In partnership with service providers, DCYS plans, provides, funds, and coordinates the development of a continuum of integrated services for children in need of protection, mental health, juvenile justice, and substance abuse services. These services shall promote the development of permanent stable setting, where the children are free from harm and able to achieve their potential."

1994: "In partnership with service providers, DCYS plans, provides, funds, and coordinates the development of a continuum of integrated services for children in need of protection, mental health, juvenile justice, and substance abuse services. These services shall promote the development of permanent stable setting, where the children are free from harm and able to achieve their potential."

1995: "In partnership with service providers, DCYS plans, provides, funds, and coordinates the development of a continuum of integrated services for children in need of protection, mental health, juvenile justice, and substance abuse services. These services shall promote the development of permanent stable setting, where the children are free from harm and able to achieve their potential."

1996: "To protect children, strengthen families, and help young people reach their fullest potential."

1997: "To protect children, strengthen families, and help young people reach their fullest potential."

1998: “To protect children, strengthen families, and help young people reach their fullest potential.”

1999: “To protect children, achieve permanency for children in a safe environment, strengthen families, and help young people reach their fullest potential.”

Appendix E

Agency Response

DEPARTMENT
of CHILDREN
and FAMILIES

JOHN G. ROWLAND
Governor

KRISTINE D. RAGAGLIA, Esq.
Commissioner

Caring for Connecticut's Future

February 4, 2000

Michael Nauer, Director
Legislative Program Review and Investigations Committee
State Capitol, Room 506
Hartford, CT 06106

Dear Mr. Nauer,

I have enclosed the response of the Department of Children and Families to the report issued by your office. We appreciate the opportunity to offer our rebuttal.

Sincerely,

Kristine D. Ragaglia, Esq.

KDR/eb

STATE OF CONNECTICUT
(860) 550-6300
505 Hudson Street • Hartford, Connecticut 06106-7107
E-Mail: commissioner.dcf@po.state.ct.us
An Equal Opportunity Employer

While the office of the secretary perhaps would integrate the top management functions, it would do nothing to integrate services at the point where families receive actual services. That is the only point that really counts for children.

Given the responsibility to use limited taxpayer resources wisely, more administrative costs and greater redundancy cannot be justified.

Further, under the consent decree, DCF is required to provide mental health services. The federal court may continue this requirement even if another agency is given the legislative mandate. Alternatively, the court could extend requirements now placed on DCF to other state agencies. In either case, wasteful duplication will result.

3. Mental health and substance abuse treatment for children must be specialized. DCF is expanding and strengthening child-centered, family-focused and community-based programs that offer the best outcomes for children, according to national experts.

DCF is moving vigorously to build upon its already existing local systems of care that offer the best outcomes for children's behavioral health, according to national experts. A recent report by the U.S. Surgeon General documented this national research validating the local systems of care model that DCF is developing and strengthening statewide.

The recently released Department of Social Services report on children's behavioral health stated DCF's systems of care model is "recognized nationally as the best practice for delivering responsive behavioral health care . . . DCF has begun to create an infrastructure that lays the foundation for systems change."

Dr. Albert Solnit, commissioner for the Department of Mental Health and Addiction Services, a Yale professor of child psychiatry, and a nationally recognized expert in children's mental health, continues to support DCF's role as the lead agency for children's behavioral health services.

Currently, DCF spends $120 million (58 percent of total state spending) on behavioral health services for children.

Simply moving responsibilities from one agency to another will not improve services. In this case, such a change would disrupt services for children and stall momentum toward significant improvements.

B. A number of the recommendations contained in the staff report actually describe current DCF practice.

1. DCF already has moved toward child-focused, family-centered and community-based services offered in the least restrictive setting possible.

In addition to the local systems of care, DCF's use of an innovative substance abuse program called Multi-Systemic Therapy is another advance toward child-centered, family-focused and community-based services offered in the least restrictive setting.

This nationally recognized model for treating substance abuse is used by DCF's Juvenile Justice Bureau to reduce this major cause of recidivism among youth. After an initial brief period in a residential setting, treatment is completed in the community. Results from other states show MST is more effective than traditional residential programs.

Further examples of community-based services include school-based clinics, extended day treatment programs, and the multi-disciplinary teams for assessing children at DCF SAFE Homes.

DCF has been working with the Hartford community for several months to develop a Community Partnership for Protecting Children to increase local participation in the prevention and treatment of child abuse.

3. DCF is currently working with other state agencies to provide services and is working to expand the use of flexible funding and pooled resources to meet children's needs.

Examples include work with DMHAS, the Judicial Department, Corrections, and OPM to co-contract for substance abuse services. DCF also works with Judicial in a number of other areas, including families with service needs and youth placements.

DCF works with DMHAS to transition youth to adult services and to serve special population youth.

DCF is moving forward with plans to use flexible funding to provide improved behavioral health services by joining with the Department of Social Service to expand local systems of care. A recent study reports that improvements can be financed by reducing unnecessary hospitalizations and residential placements. It also estimates that an added $14 million in federal Medicaid funds can be obtained to fund community-based services.

3. DCF currently employs performance-based contracts throughout the agency. Further, private non-profit groups, such as the Fordham Institute that conducts the Social Index for the legislature, can be used to establish benchmarks for assessing future results.

C. State prevention programs are enhanced by Federal funds through the structure provided by the Children's Trust Fund. Prevention programs are spread across all of DCF's mandate areas.

1. Since FY95, funds for DCF primary prevention programs have more than doubled.

2. Programs in all of DCF's mandate areas – child protection, juvenile justice, and behavioral health – help prevent larger problems from developing.

SAFE Homes offer a secure environment to provide thorough assessments for children experiencing their first out of home placement. SAFE Homes help DCF to successfully reunify children with their families or find permanent, loving homes for them. Safe Homes help prevent multiple placements.

Connecticut's Project SAFE employs immediate substance abuse screening for families where abuse and neglect has been reported. Experts - including Columbia University scholars and National Drug Control Policy Director Barry R. McCaffrey – say DCF leads the nation in this area with this innovative approach to treat and prevent substance abuse.

Other substance abuse programs, including Multi-Systemic Therapy, help reduce recidivism in the juvenile justice system.

Community based behavioral health programs prevent more serious problems from developing that could otherwise lead to residential placements or hospitalization.

3. The state receives more than $250,000 a year in added federal funding for prevention programs by using the Children's Trust Fund structure instead of DCF to administer these programs.