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TESTIMONY OF
ATTORNEY GENERAL RICHARD BLUMENTHAL
BEFORE THE HUMAN SERVICES COMMITTEE AND THE SELECT COMMITTEE ON CHILDREN
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I appreciate the opportunity to speak at this investigatory hearing on the Department of Children and Families (DCF). I commend the interest of committee members in this critical issue and share your determination to improve this state agency whose mission is literally saving lives of children.

Nearly a decade of investigations and reports by my office and the Office of the Child Advocate have repeatedly uncovered serious and systemic structural, oversight and accountability problems at DCF. We have demanded that DCF implement the same reforms again and again, only to see our demands disregarded.

If we want real reform at DCF -- as we all do -- we need a different approach. The General Assembly should mandate:

- a partial breakup of the agency;
- a complete overhaul of existing management;
- other fundamental reforms recommended by my office and the Office of the Child Advocate and a comprehensive outside, objective review.

DCF's management structure as well as its managers desperately need an objective, top to bottom outside review. Although many DCF caseworkers and other staff are profoundly skilled and dedicated, its current organization consistently fails Connecticut's children. An independent review should be mandated by the General Assembly to ensure that the management structure is responsive and responsible, and that leaders with the right skills are in the right positions.

The legislature should require recommended changes by dictating through its appropriations authority how funds are used, linking dollars to sweeping administrative reform.

DCF must better perform in the best interests of children. Rearranging the deck chairs cannot right this leaking, listing ship.

I urge the General Assembly to use the power of the purse to require and enforce such vital reform measures as my office and the Child Advocate have recommended in seven separate reports since 2001, including one issued last week. They are:

- Remove from DCF and transfer to another agency the authority for licensing and oversight of state and state-funded facilities -- assuring their independence from the agency's administration. This action would amount to a partial breakup of an agency that has grown too big and too conflicted internally to be effectively managed;

- Create a clear, straightforward communications structure and system for abuse and mismanagement reporting with checks to guarantee that all complaints are investigated, as well as strict procedures and rules to prevent such reports from being buried, ignored or neglected;

- Establish a long-term planning unit that operates separately and independently from the agency's administration.

Legislation should include timetables and deadlines for implementation as well as require regular progress reports and updates.

Fundamental restructuring is necessary – now – to reform this massive and fundamentally conflicted state agency. Additional steps toward splitting off other DCF functions may well result from the comprehensive study I have recommended.

Vividly illustrating the depth of DCF's dysfunction is its failure year after year and tragedy after tragedy to implement reforms urged repeatedly by my office and the Child Advocate. We have made these recommendations in seven separate reports since 2001. DCF has failed to heed them -- to the detriment of Connecticut's children.

At the core of DCF's problems and our recommendations is a fatal dilemma. As we have repeatedly noted, a state agency contracting with private entities to provide appropriate services for abused or neglected children cannot effectively also regulate those private contractors. Doing both presents an inherent, inevitable conflict of interest.

DCF's dependence on private contractors makes it reluctant to scrutinize them as vigorously as it should. The agency cannot be both contractor and regulator. Time and again, my investigations have concluded that DCF regulators disregarded or dismissed failures and shortcomings of private service providers because DCF protective services desperately need the slots or beds for children. DCF funding decisions favor protective services functions -- and dramatically underfund regulatory duties.

I. Haddam Hills

In 2001, my office and the Office of the Child Advocate began a joint whistleblower investigation into the Haddam Hills Academy, a DCF-licensed private facility serving children referred by DCF, for intensive clinical intervention. The report concluded that Haddam Hills never should have been granted even a temporary license to operate, much less accept troubled youth in the custody and care of DCF.

Among our recommendations in the May, 2002 Haddam Hills report were:

- Licensing and oversight of facilities serving children should be truly independent from DCF functions associated with program development and program administration.

- Management structure and protocols for internal communication should be revamped so timely and accurate information is presented to responsible managers.

- DCF should develop a long term planning unit that operates separately from program administration.

II. Connecticut Juvenile Training School

In 2001, DCF opened the Connecticut Juvenile Training School (CJTS) in response to major problems with Long Lane School, culminating in the suicide of a child at that institution. Like Haddam Hills Academy, CJTS should never have opened. Even the DCF commissioner at the time stated that CTJS -- if privately run -- would have been denied a permit. Indeed, its architecture and design -- conceptually and physically -- was closely connected to corrupt contracting practices of the Rowland administration.

Again, the Office of the Child Advocate and my office jointly investigated the numerous problems at CJTS. Our report concluded that CJTS failed children in virtually every aspect of care: neglecting to properly monitor children on suicide watch, overusing inappropriate restraints, instituting poor quality education classes, and lacking quality management and oversight.

Our 2002 CJTS report contained 13 recommendations, many specific to CJTS. And, we reiterated the following recommendations, identical to those made in the Haddam Hills report the year before:

- Oversight of state-operated facilities serving children, such as the CJTS, should be truly independent from DCF functions associated with program development and program administration.

- Management structure and protocols for internal communication at DCF should be revamped so timely and accurate information is presented to responsible managers.

- DCF should develop a long term planning unit that operates independently of program administration.

III. Connecticut Juvenile Training School – 2003 Supplemental Report

Deeply concerned by the lack of meaningful progress at CJTS, we issued a supplemental report in February, 2003, that reviewed each substantive recommendation in our 2002 report.

We found regarding virtually every past recommendation: "Very little has been done" and "no meaningful action has been taken on this recommendation." In particular, we found that DCF's Bureau of Quality Management -- supposedly responsible for ensuring DCF meets its legal and policy goals -- is not an independent unit within DCF, has failed to provide any oversight of CJTS and has not conducted any reevaluation of CJTS in light of our report. In summary, DCF inaction and unresponsiveness across the board was sad and staggering.

IV. Connecticut Juvenile Training School – 2004 Report

In July, 2004, DCF announced new initiatives to improve CJTS operations. The Office of the Child Advocate and my office issued a report updating our findings regarding CJTS. Two years after our initial report, we found:

- DCF continued to overuse child restraints and contended that as a state agency it was not bound by state statutes limiting use of such restraints.

- Children were treated as prisoners -- punished rather than rehabilitated. Critical assessments of children were poorly focused and incomplete. Without these assessments, children failed to receive proper services necessary to allow them to function in society

- While the Bureau of Quality Management finally conducted an assessment of CJTS, its recommendations, like ours, were generally ignored.

- A communications system was established to ensure timely communication of trends and other critical data between the various bureaus and management of DCF but was not sufficiently utilized to improve responses to children's needs.

V. Community Based Mental Health Services Report

In March, 2003, the Office of the Child Advocate and the Office of the Attorney General issued a report on the astonishing and appalling lack of community-based mental health services for children. This gap led to continued institutionalization of children at places like CJTS and Long Lane School. Our report cited case studies demonstrating how community based services are more effective in treating children with emotional and psychological issues and cost much less than institutional settings. Despite the cost-effectiveness and efficacy of this model, DCF continued to plow millions of dollars into building and operating institutions for such children. Only after making this huge misinvestment, did DCF implement KIDCARE, a system of community based services. DCF failed to innovate until very late, costing millions of dollars in misdirected funds.

VI. Child Abuse and Neglect Investigation Report

The agency's failure to effectively investigate and respond to child abuse and neglect was the focus of our next report in September, 2003. Our investigation was spurred by a significant drop in the rate of substantiated reports of abuse and neglect during a time when reports to the

hotline were increasing. Our report found that DCF staff failed to follow their own suspected abuse policies and procedures with many children receiving DCF intervention and services only after multiple reports of abuse. These policies and procedures were never formally communicated to staff who were assigned to implement them. Among the recommendations:

- Management structure and protocols for internal communications at DCF must be revamped to ensure that policies and procedures are provided to staff expected to implement them and ensure and enforce accountability for compliance.

- DCF must develop a long term planning unit separate from program administration to ensure proper assessment of trends in abuse and neglect reports and responses.

- Quality control and assurance should be a key component of DCF management, ensuring that officials in authority can monitor agency performance and make changes to address any shortcomings.

VII. Lake Grove at Durham report

Finally, coming virtually full circle in 6 years, the Office of the Child Advocate and my office issued a report on Lake Grove at Durham -- a private residential program similar to Haddam Hills for children experiencing behavioral issues. Like Haddam Hills, Lake Grove failed to provide appropriate assessment and treatment for children placed there. As a regulatory agency, DCF was singularly unsuccessful at oversight and scrutiny. All the while, it continued to refer children to this facility and others like it, apparently disregarding deficiencies. Even after DCF reviewed the facility and found, for example, that the physical plant was worn and dirty -- far from therapeutic -- the agency did nothing to compel improvement.

Our recommendations -- familiar by now -- included:

- DCF oversight of state operated facilities serving children must demonstrate independence from DCF program development and administration.

- DCF must revamp its internal communications to ensure timely and accurate information is accessible to administrators, caseworkers and providers.

- DCF must develop a long term planning unit that operates separately from program administration.

The real life consequences of DCF recalcitrance and resistance to reform were demonstrated dramatically in July, 2008 by the tragic death of an infant placed by DCF in the care of a foster parent who was also a DCF employee. In a self-critical statement afterward, DCF cited a number of deficiencies in the Department's response to child abuse and neglect reports -- as if these failings were newly discovered. In fact, all these deficiencies were documented by our 2003 report on child abuse and neglect. Five long years later, there has been little progress.

As examples:

1. DCF noted in its July, 2008 statement that the quality of the Special Investigations Unit was substandard and unacceptable. Our 2003 report stated that DCF must "improve its processes of investigation and assessment. A comprehensive, ongoing, formal assessment of functioning is essential to establishing the safety of children and the treatment needs of families."

2. DCF noted that unsubstantiated allegations against DCF employees were not being entered into the database preventing the DCF licensing staff from accessing this information as part of their assessment. Our 2003 report stated that DCF's "use of informal communications and hand-me-down information results in a decision making process guided by piecemeal instructions and lack of public accountability."

3. DCF placed the Special Investigations Unit under new management and invited the Child Welfare League of America to conduct an independent review of the case to identify other systemic areas that need improvement. Our 2003 report stated that DCF must design and use quality assurance systems that "provide accurate, timely data to those responsible for policy implementation in a form that allows managers to monitor and improve the operations of the functional units who report to them."

I believe legislators share our deep concern for the fate of children in DCF's care, after DCF's years of steadfast, staunch resistance to reform. It has placed at greater potential risk children who perhaps most need protection and assistance. I urge vital, vigorous legislative action to achieve:

- a partial breakup of the agency;
- a complete overhaul of existing management;
- other fundamental reforms recommended by my office and the Office of the Child Advocate in our numerous reports and a comprehensive outside objective review.

The legislature should directly compel DCF to connect the dots between dollars and reforms, linking its appropriations to definite and distinct mandates -- and sending a compelling, unmistakable message. DCF must be restructured and reinvented to be the efficient and effective agency Connecticut's children deserve and need.

This fight is winnable. We have a common goal. DCF has many extraordinary, dedicated, skilled, hardworking professionals whose hearts and minds are fully committed to its mission. Their public service is unsurpassed in its challenge and significance. The legislature should seize this opportunity to bring a new and better day at DCF.