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Commissioner

DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

Commissioner Susan I. Hamilton, JD, MSW

Department of Children and Families

Testimony for the Joint Hearing of the

Select Committee on Children and Human Services Committee



M. Jodi Rell
Governor

October 20, 2008

My name is Susan Hamilton, and I am the Commissioner of the Department of Children and Families. I appreciate the opportunity to share my perspective about the important issues before the Select Committee on Children and the Human Services Committee at today's joint hearing, and I want to specifically thank Senators Meyer, Harris, Freedman and Kissel and Representatives McMahon, Villano, Ruwet, and Gibbons for their leadership on these committees and for their commitment to children's issues that are so vital to all of us who have devoted our careers to improving how Connecticut serves its most vulnerable citizens.

I am confident that all of us here today are genuinely invested in gaining a balanced and accurate understanding about the strengths and challenges of Connecticut's child welfare system, including the functioning and performance of the Department, in order to improve outcomes for our children and families. This focus on improvement is fundamental for me and for our entire Department, and I trust that today's hearing will underscore that focus and provide assurance that the Department is not failing in its mission to protect children, improve child and family well-being and support and preserve families despite recent reports to contrary.

As all of you know, the work we do at the Department is complex, and the families and children we serve are often struggling with a host of societal issues related to mental health, substance abuse, domestic violence, lack of financial resources, homelessness, isolation, lack of family and social supports and so many other risks and stressors. On any given day, our Department is serving approximately 32,000 children and 16,000 families across our mandate areas, with approximately 5,600 children in placement.

Given the chronic, multiple needs facing the families we serve, the outcomes they experience are impacted by a variety of complex factors and systems. Their neighborhoods, their schools, their capacity to meet the material needs of their family, the legal system, the network of service providers, the local, state and federal government agencies and systems that intervene in some form all play an important role. Along with our Department, the departments of education, mental health and addiction services, developmental services, social services, corrections and the Judicial Branch all play an integral role in the provision of services to children, youth and their families.

Because of this great complexity and the scope of issues affecting children and families, we welcome the legislature's critical role in helping to review and revise the statutory framework needed to effectively coordinate Connecticut's human service systems to improve outcomes. In addition, I fully acknowledge the legislature's important role in

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supporting resources for foundational initiatives at the Department that have led to improved outcomes, including lower caseloads for workers to support more intensive involvement with families, more clinical and wrap-around services provided to children and families in their homes and communities and more individualized services to meet their specialized needs.

With that support appropriately comes expectations and accountability, and we can demonstrate results in terms of child safety, permanency, and well-being. As discussed more fully below, these include: fewer children are victims of repeat maltreatment; fewer children have to enter state care; more intact families receive in-home services, including clinical interventions for mental health and substance abuse; and many children are experiencing more timely permanency through reunification, adoption and transfer of guardianship, particularly to relatives. Of course, along with those improvements, there are areas that we collectively believe need to improve. We remain committed to those improvements, accountability and effective and efficient use of public resources.

With that framework, it is my understanding that we are primarily here today prompted by recent reports related, in large part, to the death of a child in foster care in May, Riverview Hospital and the status of the Juan F. Exit Plan. Given that understanding, I intend to specifically cover those areas in my remarks along with the Department's systems of accountability, extensive internal/external monitoring and progress toward an outcome-driven, integrated strategic plan and organizational structure that will best position us to meet those strategic planning goals. In addition to this testimony, I have provided a more detailed Briefing Book to the committee members, which includes further background and data related to these important issues that I hope will prove useful and informative.

EXIT PLAN AND PERFORMANCE TRENDS

The Department's performance under the Exit Plan is impressive, and I am proud of our staff and all of our partners in the system for the notable progress that has been made over the last several years. The Department was meeting only 1 of the 22 outcome measures at the inception of the Exit Plan four years ago and is now achieving or nearly achieving 20 of the 22 measures. Not only have most of the measures been met, but the majority have been sustained consistently for the past two years.

This consistent quality of work has brought the Department to a final phase where we are addressing the two remaining unmet outcomes. It may surprise some listening to the public debate that the most challenging measure, how well we meet the needs of children, demonstrates considerable strengths. This outcome measure requires that 80% of the children whose cases are reviewed have 100% of their needs met as measured by the current methodology. For the 2nd quarter of 2008, 100% of the needs were met in 54.7% of cases, which does not meet the measure, and this needs to improve. However, in breaking down the data for the purpose of identifying where we need to focus efforts to effect improvements, it became clear that performance on this outcome is far more complex than one might assume from a cursory look.

When we take the needs of all of the children in the case review, we see that in the aggregate 82.9% of the needs were met in the most recent quarterly report by the Court Monitor for the 2nd quarter of this year. While this aggregate analysis does not conform with the Exit Plan's metric for this outcome, it nevertheless provides a helpful lens for evaluating how well we are meeting the needs of children.

This view is consistent with recent preliminary findings from the federal Child and Family Services Review (CFSR) that was completed in Connecticut at the end of September. As discussed more fully below, the CFSR is conducted by the Administration for Children and Families, an arm of the federal Department of Health and Human Services that evaluates all child welfare systems across the country every 5 years. Notably, along with clear areas in need of improvement, we learned at the Exit Conference that 85% of the cases reviewed showed that children were receiving appropriate services to meet their physical, dental and mental health needs.

Returning to the data we cull from an aggregated view of Outcome Measure 15 (Needs Met), I want to be careful about its use. While it provides an important perspective, we recognize that it cannot be substituted in lieu of the current methodology for evaluating compliance. Under that methodology, we are not meeting the measure and must improve. Nevertheless, meeting more than 80% of the needs of children should not fairly be characterized as failing in this area overall.

A similar analysis can be made in relation to Outcome Measure 3 (Treatment Planning). This measure requires that 90% of treatment plans reviewed meet each of the 8 criteria under the Exit Plan methodology. For the 2nd quarter of 2008, only 54.7% of the treatment plans met the standard. But, when we aggregate all criteria across the cases reviewed, more than 80% of the areas evaluated were found to be "very good" or "optimal."

While I believe that looking at this aggregate data is illustrative and puts our performance on these two measures in greater context, we are fully committed to making the improvements necessary to meet the outcomes as they are established under the Exit Plan and its methodology. We are well underway with implementation of the Stipulation we recently entered in this case and believe that this agreement will expedite improvements needed to meet these two remaining measures. This Stipulation includes four key areas: (1) special case reviews for specific cohort groups of children in order to provide timely access to necessary services; (2) a new foster care recruitment and retention plan; (3) prospective placement restrictions and improved discharge planning from congregate care settings; and (4) enhanced organizational and workforce development.

Having just addressed some of the achievements and challenges under the Exit Plan, I also want to point out some other important trends that in some instances go beyond the measures strictly contained among the 22 Exit Plan outcomes. These trends are noteworthy and evidence how significantly we have advanced as an organization over the last several years. In the most general terms, these trends show fewer removals from

home and more families being served intact. Consistent with and contributing to these two very important developments, we see Connecticut now has much more to offer in terms of in-home services for children with mental health and substance abuse treatment needs.

Whenever possible consistent with their safety, children belong at home. So, I am pleased to report to you that the number of children in care as the result of abuse or neglect has declined by almost 17% in four years. This reflects a number of positive developments including a reduction in the number of children entering care and an accompanying increase in the number of families served with their children at home. Whereas 2,930 children entered care in 2002, the three-year average for 2005 through 2007 was 2,516, and the total for 2007 was 2,137. In-home cases have increased 41% from July 2002, when there were 2,849 in-home cases, to September 2008 when there were 4,010 in-home cases.

An increase in the percentage of children exiting care to permanency in a timely manner as evidenced by the three permanency outcomes is another positive factor contributing to this overall downward trend in the number of children in care. Over the past eight quarters, the three measures of timely permanency, which include adoption, subsidized guardianship, and reunification, have met the goal in 20 of 24 possible occasions. Timely adoptions, which represented just 10.7% of all adoptions in the first quarter of the Exit Plan, has been at or over 33% in each of the last seven quarters. Finally, the number of adoptions and guardianships has risen as well. During state fiscal years 1997 to 2005, an average of 615 permanent homes (both adoptions and subsidized guardianships) were found annually for children in foster care -- more than four times the number in 1996. In FY2008, 634 adoptions were finalized and 234 subsidized guardianships granted for a total of 868 new permanent homes.

Another important indicator is the reduction in repeat maltreatment. This outcome measure is a valuable gauge for how well our interventions are working and also as a check to make sure that in striving for some of the other outcome measures, timely reunification for example, we are not subjecting children to higher rates of repeat victimization. For each of the last five quarters, this outcome has been achieved and for the last three quarters the measure has come in under 6% -- the lowest it has been since the Exit Plan began in 2004 when the baseline measure was 9.4%.

In addition, children who do have to be in care are more likely to be in a family setting, defined as a foster home, relative home or special study home. Whereas 57% of children first entering care were placed in a family setting in 2002, this grew to 72% in both 2006 and 2007.

While I am the first to say that too many children remain in congregate settings beyond the time required to meet their clinical needs, it is also unmistakable that since the inception of the Exit Plan, there has been a marked movement away from large institutional settings. The outcome measuring the use of residential care reached its best

levels in the first two quarters of FY2008 and has met the goal for nine consecutive quarters.

The reduction in children in residential care overall is attributable to a number of factors. One is that Connecticut now has the capacity to serve nearly 2,300 children a year in intensive home-based programs, which largely did not exist only a few years ago. Some of the initiatives that help children and families with mental health and substance abuse treatment needs in their homes include:

- Family Support Teams (serving 340 families annually) and therapeutic foster care;
- In-home family therapy services (serving more than 1,900 families annually);
- Wrap-around services that help both children and parents in whatever way is required, including non-traditional help such as mentoring and respite (serving 1,150 families annually); and
- Intensive in-home psychiatric services (serving 500 children annually).

Another key initiative, which has enabled children to reside in home-like community based settings, is the development of therapeutic group homes. These group homes provide intensive clinical services and allow children who would otherwise need a more institutional treatment setting to live in a home-like environment and attend school in the community. DCF has contracted for 54 therapeutic group homes with a capacity to serve 273 children and adolescents.

In the area of juvenile justice, delinquency commitments to the Department have also fallen dramatically since 1997 when more than 500 children were committed to DCF. In both 2006 and 2007, that number has been cut in half, which reflects that the State is doing a better job preventing the need to remove a child from the community and highlights the effective partnership between DCF and the Judicial Branch Court Support Services Division.

All of these trends speak to important forward movement in how Connecticut works with vulnerable children and families. They give us a solid foundation on which we can build as we focus on sustaining progress and advancing in other areas that require improvement.

RIVERVIEW HOSPITAL

As noted previously, I welcome the opportunity here today to provide a more comprehensive review of the issues recently raised by the Office of the Child Advocate (OCA) in its 2nd quarter 2008 monitoring report. This report, in part, raised concerns about the use of restraint and seclusion at Riverview. First, let me say that I appreciate and share the OCA's interest in reducing the need for restraint and seclusion at Riverview, and I will discuss our ongoing work to address this issue. However, I must respectfully challenge the sweeping conclusion she reaches about the overall safety and well-being of the children at Riverview.

Before discussing our work at Riverview, it's important to describe generally the needs of the children we serve there. The children treated by hospital staff have the highest level of need of any in the state of Connecticut. They have extreme emotional and behavioral difficulties resulting from acute psychiatric disorders, including schizophrenia, psychosis and bi-polarity that can give rise to self-injurious behavior.

In comparing the children placed at Riverview Hospital and those in other hospitals, we do not perceive the children to be different -- but the children at Riverview are at a more acute state than those in any other placement setting. This is evident by the eligibility criteria for all Riverview admissions, which are outlined in the Connecticut Behavioral Health Partnership's Child Psychiatric Level of Care Guidelines. These guidelines require that a patient must have a serious psychiatric disorder and co-occurring developmental disorder that require interventions not available in other inpatient settings in order to be eligible for admission to Riverview. In addition, the patient must have a recent history of multiple admissions to acute inpatient settings over the past ninety days, and must currently be receiving treatment in an acute inpatient setting with no appreciable improvement.

Given this level of acuity, it is critical that the hospital maintain a safe environment that supports effective treatment. Any consideration of safety in a facility serving children with the most intensive level of behavioral health needs quickly gets us to the topic of the use of restraints, which itself raises a number of complex issues. Riverview Hospital's strategic plan includes the goal of reducing restraints for very clear reasons. Restraints are related to injuries to both children and staff. It goes without saying that all unnecessary or inappropriate restraints are to be avoided. However, we need to remember that the statutory provision for the use of restraints is not a prohibition. State law expressly and appropriately allows the use of a restraint when a child presents an immediate danger to himself or others. Accordingly, there is recognition that there will in fact be instances where the safety of a child and/or staff will require the use of some form of restraint.

When looking at the data related to restrictive interventions, we need to account for the frequency of incidents that may relate to one patient only along with general trend lines. For example, during one nine month period from October 2007 to July 2008, one child accounted for approximately 700 of the physical interventions or 27% of all the physical interventions during that time period. It's important to note that in spite of all these physical interventions, Riverview Hospital staff provided excellent care to this child, and he was able to move on to a less restrictive setting.

Simply put, not all restraints are the same and not all are evidence of inappropriate intervention by child caring staff. At the same time, the Department, including Riverview staff and administration, recognize that progress toward restraint reduction has been less than anticipated. We acknowledge that recent trend lines for restraints and seclusions have increased, and we have been unable to provide a consistent downward trend over several quarters. However, there have been signs of progress. Riverview has successfully eliminated the use of mechanical restraints on four units and has not used two-point restraints anywhere on campus for over a year.

Riverview Superintendent Joyce Welch and the staff have done a good job working to address what were clear issues at the hospital a couple of years ago. Significant progress has been made in reducing tensions between management and staff, which is a prerequisite to doing good work for children. Riverview has made progress in providing a supportive supervision process that also ensures accountability to those in our care. This is evident in steps made to improve supervision processes and in the implementation of structures for accountability throughout the organization.

Riverview continually strives to integrate quality improvement throughout the organization. Notably, Riverview is fully accredited by the Joint Commission on Accreditation of Health Care Organizations, which has extensive requirements for quality improvement efforts relating to practice, data collection and analysis. In addition, the OCA monitor has participated in many of the committees and functions that produce and analyze trended data. The monitor's participation and expertise has been welcomed and respected by hospital staff. With continued partnership between hospital administration and staff, I am confident we can build on the work already done to further enhance the quality of the treatment we provide there.

With regard to cost, we know that treatment and care at the hospital is expensive. There are different ways to calculate the costs. The Comptroller's estimate reflects a complicated calculation that takes into account centralized costs independent of Riverview as well as costs based on reconciling actual and estimated costs for unrelated time periods. Our own estimate of the annual cost per patient is approximately \$700,000 for FY2008, with the overwhelming majority of expenses going to personal services. In fact, about \$27 million of the \$34 million spent at Riverview in FY2008 was for personal services. Workers compensation, which was as high as \$2.8 million in FY2006, cost \$2.2 million in FY2007 and \$2.5 million in FY2008. An important reason why per capita costs have risen substantially -- from \$25.9 million in FY04 -- is that the census decreased more than 18% during the period. This reduction in census was approved by a report jointly issued by the Department, the Juan F. Court Monitor and the OCA.

FOSTER CHILD FATALITY

I want to turn to the single event that has been the most difficult for me during my 16 months as Commissioner -- the tragic death of Michael B., an infant in foster care. His foster mother, who was also a DCF employee at the time, was arrested in connection with his death. As I said then, the death of any child for any reason is difficult to comprehend. But when it happens at the hands of someone who has been entrusted with their care by the state, it is an unspeakable and unacceptable tragedy.

Immediately upon the baby's death, we commenced an investigation into the case, including a review of the quality and thoroughness of the decision to license the foster home. During the course of the review, we found that the employee had two previous investigations in 2006 and 2007 alleging abuse of her own child whom she had previously adopted through an international adoption agency. Although the allegations

were not substantiated, the quality of those two investigations was substandard and unacceptable. Accordingly, it's unclear whether the allegations would have been substantiated if a more thorough investigation had been completed. If the allegations had been substantiated, the employee's name would have been listed in the Child Abuse and Neglect Registry when licensing staff checked the registry as part of the licensing process.

As a result of this review, I took several actions. One employee was terminated and three others were disciplined for their respective roles in these prior investigations that were of poor quality. In addition, our Special Investigations Unit (SIU) that investigates abuse and neglect cases involving employees was overhauled with new management and re-training of all staff. That re-training was completed early last month.

Further, to avoid even the perception of a conflict of interest, Department staff will no longer license our own employees as foster parents. Beginning earlier this month, employees who want to become foster parents are required to obtain licensing from an outside private agency. Finally, to correct a decade-old practice limited to the SIU, investigations of all employees are now entered into our data base whether substantiated or not.

Given that it's impossible to determine whether this death could have been avoided if the prior investigations of the foster mother were of better quality, I feel compelled to respond to public comments made by the OCA and Attorney General in the aftermath of the tragedy. As some of you may know, they asserted that recommendations they made in a 2003 report regarding investigations practice generally were never implemented, and if they had been, this tragedy would have been prevented. Respectfully and with full acknowledgement that the OCA and Attorney General are well-intentioned, the issues identified in this case do not reflect the same systemic issues that concerned them in 2003.

First, while the prior investigations of the foster mother reflect poor performance on the part of two staff and one manager in our SIU, this does not warrant a sweeping conclusion regarding the quality of the more than 27,000 investigations we conduct annually. In fact, there exists both data and independent evaluations that demonstrate that DCF investigations statewide are both timely and thorough.

In addition to the fact that Exit Plan outcome measures for the timely commencement and completion of investigations have been met for 15 consecutive quarters, data also shows that a primary indicator of child safety -- the recurrence of maltreatment -- is lower than the national median and is declining. National Child Abuse and Neglect Data System (NCANDS) trend data from 2005 notes an improvement in the recurrence of maltreatment rate in Connecticut from 2002 to 2005 of 28.8%. Our current recurrence of maltreatment rate of 5.9% is below the national median of 6.6% and has met the goal for this Exit Plan Outcome Measure for five consecutive quarters.

Equally important, two comprehensive case reviews have been conducted by the Court Monitor's office examining the quality of investigations. Both reviews concluded that our investigations were not only timely, but comprehensive and of high quality. This same finding is also likely to be confirmed in the final federal CFSR report. In the Exit Conference last month, the Administration for Children and Families noted that their preliminary findings identified that 100% of the cases reviewed met the primary safety outcome and that Connecticut is believed to be the first state to ever reach that level of performance.

In addition, the 2003 report alleges that DCF has a low substantiation rate for investigations, and that this is indicative of poor quality. However, the DCF substantiation rate for the years 2003 through 2005 was higher than the national average and in 2006 was nearly identical to that average. In addition, in Connecticut, the rate of accepted reports -- reports that will be investigated -- per 1,000 children in the population has been 9 percent higher than the national average since 2001.

Importantly, the way the Department conducts assessments and makes decisions has changed so dramatically as to make the 2003 report dated in its application to our current practice. In 2006, we trained staff and implemented statewide a nationally recognized and validated practice model known as Structured Decision Making (SDM). SDM gives staff clear criteria to use in assessing child safety and ongoing risk. It gives staff clear direction on what information must be gathered, documented and evaluated to make informed decisions. Case decision making is guided by identified factors that make decisions more consistent, more accurate, and more clearly articulated and understood by staff and managers. Decisions to open cases are made directly based on ongoing risks to children, and family needs and strengths are fully explored and addressed. While it may be premature to credit SDM specifically, it bears repeating that repeat maltreatment rates have met Exit Plan standards for five straight quarters and dipped below 6% for the first time on record during the last three quarters.

Finally, the Department's collection and use of performance data to effect practice improvements has made considerable progress since 2003. Child welfare managers have been trained in this area and our data base produces pivot tables that readily support analysis. Each area office has a Quality Improvement Program Supervisor responsible for data analysis. We established the Office of Research and Evaluation in the Bureau of Continuous Quality Improvement, and our Bureaus of Behavioral Health and Child Welfare regularly utilize information provided by the Behavioral Health Partnership. Because quantitative analysis provides only a partial picture of performance, we have initiated a qualitative review process modeled after the federal CFSR that I will discuss later in greater detail. In summary, analyzing data to assess and elevate performance has become routine at the Department, and we have improved outcomes to show for it.

Despite these improvements, nothing can or will take away from the effect Michael's death has had on all of us at the Department, and I have and will continue to hold myself, my staff and the system accountable for any and all improvements within our control that are needed to prevent this from happening again.

SYSTEMS OF ACCOUNTABILITY

While a tragedy like the death of a child or any other critical incident must always independently trigger an examination of our work, quality assurance and improvement activities are an integral part of our day-to-day operations. Our practice of improving the quality of our work is not confined to crises -- it is embedded in daily activity. The Department routinely uses data -- both quantitative and qualitative -- to evaluate our work and identify areas for improvement. For example, approximately 18,000 administrative case reviews are conducted each year on individual cases, which inform not only case specific decision making but also identify system-wide issues and trends. Exit Plan Quarterly Reports, reflecting the Department's work with the Court Monitor's Office, have served as a catalyst supporting wide-ranging improvements in both our practice and service array.

In addition, we recently completed our own qualitative case review modeled after the federal Child and Family Service Review. The Connecticut Comprehensive Outcomes Review (CCOR), also done in partnership with the Office of the Court Monitor and staff from various DCF divisions, reviewed 47 cases and interviewed approximately 150 case participants and stakeholders in four DCF Area Offices. Timed to help prepare the state for the just-completed CFSR, the purpose of the CCOR is to develop our own internal capacity to implement a comprehensive case review following the Department's exit from the Exit Plan. In addition, a risk management unit and the Service Evaluation and Enhancement Committee track and analyze significant events and critical incidents to identify trends and issues that require improvement activities. Each area office has its own quality improvement team that establishes plans to focus on areas of our work that merit particular attention in that office. Our Licensing Division and Program Review and Evaluation Division, in conjunction with staff from the Bureau of Behavioral Health, conduct program oversight of in-state and out of state congregate care settings, identify issues that warrant improvement and work with providers on improvement plans.

It is noteworthy that last year's Legislative Program Review and Investigations Committee (LPRIC) study of the Department's monitoring and evaluation identified a number of strengths, including the Exit Plan process, related DCF area office quality improvement efforts, DCF's licensing procedures, the recently revised special review process, and the activities of on-site facility monitors. The LPRIC study also identified a number of areas where improvements were called for and issued recommendations regarding mechanisms to strengthen service provider and advisory board input, external evaluations of programs, and other monitoring and evaluation enhancements. While some recommendations requiring statutory changes were not enacted by the legislature, the Department is implementing a number of them because we believe that they make an important contribution to our systems of accountability.

The federal CFSR mentioned earlier represents another important accountability tool. While a written report based on the recent review is not yet released, based on the Exit Conference we can expect that ensuring child safety will be regarded as strength, as will

quality assurance, staff and foster parent training, agency responsiveness to the community, and foster care licensing and recruitment. There will also be areas of concern related to permanency, timely court hearings and the lack of a clearly understood array of services. Like every other state, Connecticut will be required to enter in a Program Improvement Plan (PIP) to address these concerns, and we are already preparing to actively embrace this process as we did during the last CFSR in 2002. Indeed, we successfully implemented and exited from our prior PIP in August 2007.

The CFSR, the Exit Plan, our own data reporting systems, and internal qualitative case review processes give us several effective ways to evaluate and improve our performance. But I firmly believe that as a consolidated child welfare agency, we must expand these tools of accountability to ensure integration across all of our mandate areas. Effectively integrating and fulfilling the Department's child protection, behavioral health, juvenile services, and prevention mandates demands that the Department develop a strategic plan that sets goals, measurable outcomes, action steps, and timelines for each of these areas. That is the reason why I have made the development of an agency-wide strategic plan a top priority for my administration. In consultation with the National Resource Center on Organizational Improvement (NRCOI), we have been working hard with many stakeholders to establish this strategic plan.

Many of you already know about its development, which reflects input from family advocates, Department staff, and service providers among others. The plan remains in draft form, but we have outlined goals, measurable outcomes, action steps and timelines. The goals focus on prevention, having more children remain safely at home, achieving more timely permanency, improving child well-being, and improving transitions for youth as they prepare for adulthood. For each of the goals, we have set specific and measurable outcomes across our mandate areas of child protection, behavioral health, juvenile services and prevention. We are working now with others to develop action plans and timetables designed to meet those outcomes. The final plan will be consistent with the Exit Plan and PIP activities.

In addition, we are considering some organizational changes that we believe will better position the agency to meet these strategic planning goals. The primary change is a restructuring of our local area offices into a regional structure with specialized caseloads and more local control, support and authority. This change will result in more resources supporting front-line staff and a more efficient use of managerial resources. Under this proposal, we will continue to have 14 local area offices, but they will be organized into distinct regions. Each region will have lead directors in the areas of (1) Protective Services, (2) Permanency, (3) Adolescent and Voluntary Services, (4) Behavioral Health and Consultation, and (5) Administration. This, together with specialized case assignments, will support the development of expertise and specialization within each regional office and lead to improvements in our practice, outcomes and managerial oversight and accountability.

With this draft plan, we envision regional authority, including budgeting and resource management, with support staff from all bureaus assigned to regional operations to

ensure integration across all of our mandate areas. I do not anticipate that any of these proposed changes will require statutory changes. I also want to stress that many aspects of more localized work that has taken place under our area office structure, including the building of more personal relations and community connections, has been of great benefit. I hope to retain these positive components even as we move to a regional structure, and I do not see the two as mutually exclusive.

With regard to broader reorganization of the agency, I would be remiss if I didn't express my view that "carving out" any of our current mandate areas or creating separate independent agencies to oversee any of these mandates would likely give rise to unintended fragmentation with no corresponding efficiencies or improvements in outcomes. While I am fully supportive of exploring alternative structures and working with the legislature and others to evaluate the various options, I do believe that creating separate agencies for these mandate areas will create greater obstacles for families seeking services and may only frustrate efforts to obtain help for children.

Thank you again for this opportunity to present what we consider to be essential information relevant to our work. We know that there are many challenges before us and areas in need of improvement. However, we also see much important progress that is not indicative of a failing system or a system in crisis. Our systems of accountability have supported that progress and offer the promise to continue and broaden our advances. To do that, we will require your continued support and the support of many other partners and stakeholders who share the same vision. The children and families we all work to serve are counting on us, and we owe them our commitment to work together to strengthen and improve the system and to be driven by what they truly need and deserve.

Thank you for giving me this audience today and thank you for your continued support and leadership.