

Citizen Review Panels Annual Report – 2003-2004

In an effort to comply with the CAPTA requirement, the department requested existing committees expand their responsibilities and function as Connecticut's Citizen Review Panels. The three groups are as follows:

1. The Medically Complex Advisory Committee
2. The Governor's Task Force on Justice for Abused Children
3. The Statewide Advisory Council

The above groups have distinct areas of focus, disciplines and expertise in the area of child welfare and have helped to inform the department's practices and policies. The following information outlines what activities and contributions these committees have made to the department this past year:

The Medically Complex Advisory Committee was established in 1999 to address safety and quality of care for children with significant medical issues placed in the department's care. This advisory committee has primary responsibility for reviewing the departments' foster care and adoption policies related to children who have complex medical needs, review and establish practice standards and develop recommendations based on identified needs and deficiencies in practice and/or policies. This year, one of the areas of focus dealt specifically with the manner in which the department handled the death of foster children in DCF care. This area was of particular concern given the number of children placed with severe and complex medical issues. The advisory committee recommended current policy be reviewed and expanded to include role clarity, required notifications, appointment of a coordinator to orchestrate activities, a communications plan to notify parties of actions to be taken and the likely chain of events that will occur following a child's death. Although the existing policy references many of these elements, the committee recommended the process be enhanced to increase sensitivity, support and clarify expectations for all parties. This committee also recognized the need for staff to facilitate the establishment of "life plans" for children who are seriously ill.

Recognizing the importance of supporting and providing ongoing training for foster families, the committee recommended the current training curriculum be modified to include this topic and incorporate the above recommendations into the curriculum. This training would be designed to educate foster families on grief and bereavement issues, to inform them of the investigation process and to identify services in the community they can access for support.

The last recommendation of the advisory committee was to enhance respite services for foster families in order to maintain healthy and stable placements. The committee identified a number of concerns with the existing program and made the following recommendations: greater accessibility, increased payment rates to providers, shorten the time-frame to become a respite provider, develop a continuum of care that categorizes children based on their acuity to assure respite providers are capable of meeting their individualized needs and to increase the number of medically complex support groups available to families.

The Governor's Task Force on Justice for Abused Children was established in response to the Children's Justice Act. The Task Force includes parents, citizen advocates and professionals with expertise in the prevention, investigation, intervention, treatment and prosecution of serious physical/sexual abuse and neglect. The primary focus of the Task Force this year was to create mechanisms for monitoring, evaluating, and reporting on the fifteen Multidisciplinary Investigation Teams (MIT's) that were established statewide. These Teams were initially established to provide a coordinated interagency approach to enhance the investigation, intervention and prosecution of these cases, to minimize secondary trauma to child victims and to access timely service delivery for children and families. The Task Force created a Multidisciplinary Team Committee charged with developing an evaluation for the MIT's that contained the following components: the selection of the evaluator, the development of a tool, selecting a pilot site to implement the tool, modifying the tool, providing feedback to the MIT regarding evaluation results and developing a schedule for all teams to be evaluated. The evaluation entailed an assessment of team functioning and their compliance with State Statutes, the Standards and Guidelines established for all MIT's and best practice standards related to Investigation and Assessment. The plan was to conduct evaluations on five MDT's each year over a three-year cycle. The first round of evaluations began in September 2003 and were completed and presented to the Task Force in the spring of 2004. Evaluation results and recommendations were shared with the respective MIT and a corrective action plan was developed. These results have been shared with the department in an effort to address concerns, improve team functioning, enhance the investigation and delivery of services to families and expand collaboration among the various disciplines.

Developing a uniform computerized data collection system for all MIT's was also an identified need by the Task Force. This tool would provide the means to analyze trends, guide decisions, inform practice, educate the community and advocate for needed resources. The Task Force is in the process of collaborating with the department, Connecticut Children's Alliance and iNet to create a web-based data collection system that will track cases referred to the MIT.

In an effort to increase training opportunities statewide, the Task Force created the Training Committee. This committee's main responsibility is to review and evaluate curriculum, prioritize training initiatives for the MIT's and individually review/approve all requests for funding. This enables members of the Team or providers from various disciplines to have access to training funds that otherwise would not be available. Ongoing training opportunities will promote best practice standards and enhance service delivery to children and families.

There are several towns in the state of CT that are not currently covered by a MIT. The Task Force in collaboration with the department is developing a Request for Proposal (RFP) to create a new MIT to assure a coordinated response to child abuse in an area that historically has not been served by a Team. Task Force members have engaged a number of service providers in the area to begin planning for increased collaboration and partnership within that community.

The State Advisory Council is mandated by Connecticut Statute, Sec. 17a-4, and is a fifteen member Committee appointed by the governor. The primary duties of the Council are as follows: to review policies; recommend programs, legislation or other matters that will improve services for children, youth and families; review and advise the commissioner on the proposed Agency budget; perform public outreach to educate the community regarding policies, duties and programs of the department and issue any reports it deems necessary to the governor and the commissioner.

During the past year, the activities of the Statewide Advisory Council were conducted within the context of significant organizational changes in the Department of Children and Families. In October of 2003, DCF entered into an unprecedented agreement with the *Juan F. Federal Court Monitor* and State of Connecticut, in order to ensure that positive outcomes for children and families would be designed, implemented and achieved by emphasizing collaborative services, community partnerships and empowerment at local levels. This commitment culminated in a decentralized organizational structure encompassing thirteen Area Offices beginning on February 2, 2004, each one equipped with an integrated program design incorporating behavioral health, child protective services, juvenile services and continuous quality improvement. Twenty-two outcome measures reflecting family-centered and community-based principles and practices were developed, implemented, and constructed as the basis for the Department's Exit Plan from Federal oversight, projected for November of 2006.

As a result of this important philosophical and operational transition, the Statewide Advisory Council was initially utilized as a consultative network to review the change management process, implications for program and workforce development, and implementation of the Agency's revised Mission, Guiding Principles and Practices. Although the membership of the Council was variable during the past year, the core members reflected the interdisciplinary framework embedded in the Department's evolving organizational culture, with representatives from parent advocacy groups, legal services, private service providers, educational institutions and behavioral health professions.

In December of 2003, the Department issued a Request for Proposal (RFP) to conduct Child Fatality Reviews. The purpose of the RFP was to provide a greater level of independence, quality assurance and organizational learning following a critical incident, while assessing case practice, policies and procedures, and the larger systems impacting these components. Members of the Statewide Advisory Council participated on the RFP Review Panel, and were instrumental in the selection process. A contract was awarded to the Child Welfare League of America (CWLA) in April of 2004. To date, the CWLA has reviewed two cases, and is currently involved in review of a third. In March of 2004, the Statewide Advisory Council as a whole were notified of the CWLA selection, and participated in review of a Child Fatality Report issued by the Department's Office of Planning and Evaluation. Advisory Council members indicated that consistent review of Child Fatality Reports should be an on-going aspect of the group's involvement during quarterly meetings. Other particular areas of interest for future meetings includes review of the Department's progress on the *Juan F. Federal Consent Decree and Exit Outcomes*, foster care and adoption services, and juvenile justice.