



**OFFICE OF THE CHILD ADVOCATE**  
**2022-2023 ANNUAL REPORT**

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## **A MESSAGE FROM THE CHILD ADVOCATE- SARAH HEALY EAGAN, JD**

The mission of the Office of the Child Advocate (OCA) is to ensure that publicly funded agencies that serve children are accountable to the citizens and families of Connecticut, and effectively care for the most vulnerable children. During the last fiscal year, OCA responded to hundreds of complaints and requests for advocacy from across the state. OCA investigated multiple complaints that raised systemic concerns regarding the state-funded provision of care to children. OCA reviewed dozens of preventable child fatalities and issued public reports with recommendations to prevent child injury and death. OCA testified on more than 30 legislative proposals, seeking to advance the legal and human rights of children. OCA met with families, advocates, and service providers throughout the state to better understand and respond to the needs of young children at risk for maltreatment, the educational needs of children with disabilities, and solutions to support children's mental health.

### **OCA Statutory Responsibilities**

- Investigate complaints regarding services provided to children.
- Evaluate the delivery of services provided to children.
- Advocate on behalf of children in Connecticut.
- Review the circumstances of the unexpected or unexplained death of any child.
- Take all possible action necessary to secure the legal and civil rights of children.
- Review the needs of children in foster care.
- Periodically review facilities in which juveniles are placed.
- Publish biennially a comprehensive report regarding conditions of confinement for incarcerated youth.
- Publish an annual report regarding the activities of the OCA.

### **OCA Director and Staff**

Sarah Healy Eagan, JD, Child Advocate

Christina D. Ghio, JD, CWLS, Associate Child Advocate

Virginia Brown, JD, Staff Attorney

Heather Panciera, Assistant Child Advocate

Brendan Burke, MSW, Assistant Child Advocate

Maria Cruz, Ed.D., Assistant Child Advocate (retired)

Julie McKenna, Human Services Advocate

Lucinda Orellano, Human Services Advocate

Faith Vos Winkel, MSW, Assistant Child Advocate (retired, temporary worker)

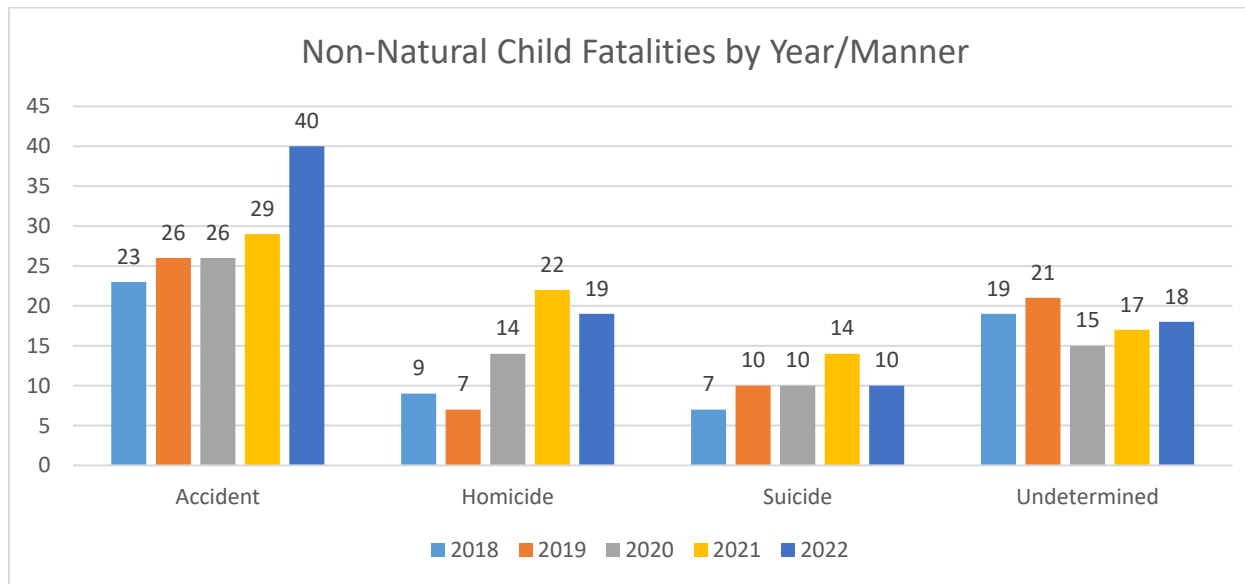
## CHILD FATALITY REVIEW JANUARY 1, 2022 TO DECEMBER 31, 2022



**The Child Fatality Review Panel (CFRP)** is statutorily tasked with reviewing the circumstances of the death of any child from unexpected or unexplained causes. The purpose of the state's fatality review process is to identify and publish patterns of risk to children and inform statewide fatality prevention strategies. The CFRP is comprised of state and community agencies from multiple disciplines (medical, mental health, law enforcement, legal). The CFRP is currently co-chaired by State Child Advocate Sarah Eagan and Dr. Kirsten Bechtel, an emergency-room pediatrician at Yale New Haven Hospital. The CFRP is staffed by OCA with support from the Office of the Chief Medical Examiner (OCME).

In Connecticut all deaths reviewed by the CFRP are entered by the OCA into the National Fatality Review–Case Reporting System, a secure, web-based, standardized case reporting tool. Connecticut is one of 47 states that participates in the national electronic child death review case reporting system. This centralized data collection system helps identify trends and patterns of child fatality in Connecticut and across the country, informing prevention efforts throughout the United States. The National CFRP has developed a Child Dynamic Analysis and Statistics Hub (Child DASH), which supports Connecticut's child fatality prevention efforts, and facilitates greater data-sharing amongst prevention stakeholders.

OCME reports unexpected and untimely deaths of children to the OCA. From January 1, 2022, to December 31, 2022, 87 child fatalities were determined to be Accidents, Homicides, Suicides or Undetermined.



## Accidental Deaths of Children (40 Total)

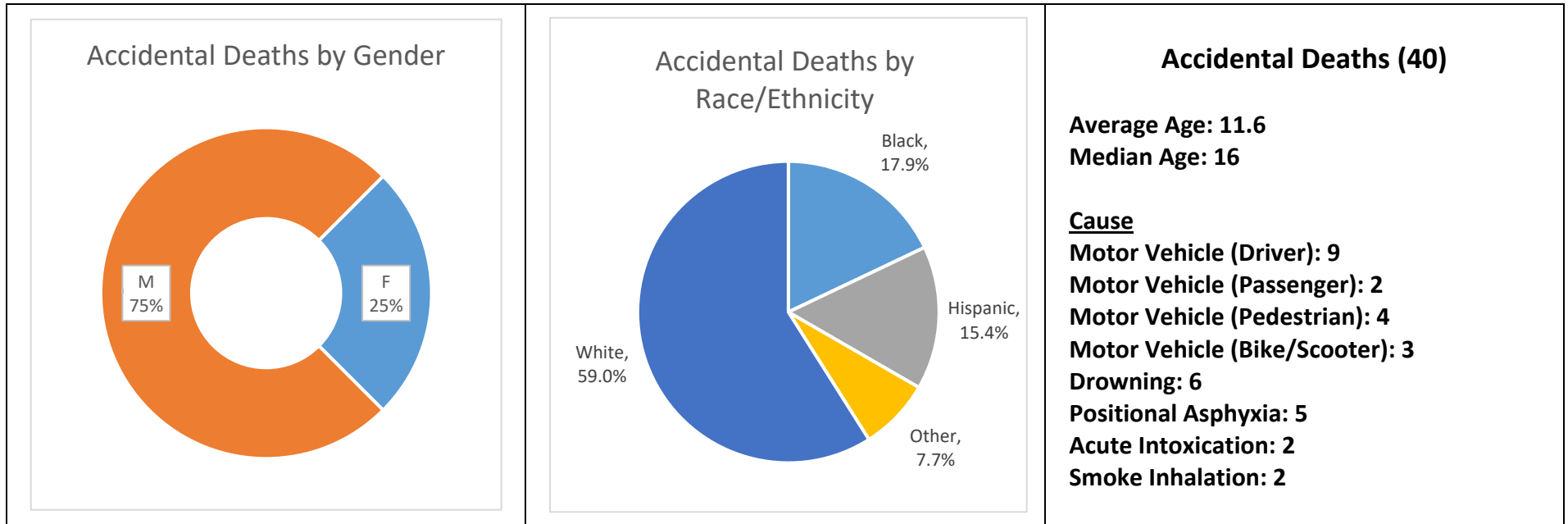
A death is categorized by OCME as “accidental” when there is little or no evidence that the injury occurred from intent to harm. **Accidental death numbers for children in 2022 increased 38% from the year prior.**

In 2022, five (5) of the accidental deaths of children under age 1 (average age: 7 weeks old) were due to an unsafe sleep environment and caused by positional asphyxia-- the insufficient intake of oxygen when breathing, most frequently the result of a compromised airway due to the child co-sleeping in adult sleep space. Death associated with unsafe sleep environment (such deaths are also classified by OCME as “Undetermined”) remains the leading cause/manner of preventable death for children in the state. Where positional asphyxia can be established by scene responders and OCME investigators, the deaths are categorized as **accidents**. In many other situations, the exact cause of death remains unknown even as unsafe sleep environment factors are identified (e.g., infant was sleeping prone, co-sleeping, sleeping with blankets and plush items), and these deaths are therefore categorized as **Undetermined** and not included here (see Section on Undetermined deaths below).

Eighteen (18) adolescents died from injuries sustained in motor vehicle accidents. Four youth were pedestrians, which was consistent with 2021 data. According to [Watchformect.org](https://www.watchformect.org), CT had a record number of pedestrian (all ages) fatalities in 2022 (75), a 33% increase from the 5-years prior average. In the nine (9) instances where the deceased youth was also the operator of the vehicle, eight (8) of the youth were male.

Six (6) children died in accidental drowning incidents in 2022, 3-fold what the state experienced in 2021. Four of the children were under age 5, and two were 16-year-old boys. Nationally, drowning is the leading cause of death for children ages 1 to 4. Drowning prevention and water safety are also public health equity issues. Ensuring that all children learn water safety skills, including how to swim safely and assess their risk in various open water situations should be a public health priority for policymakers.

OCA regularly shares and discusses data and trends regarding the accidental deaths of children with injury prevention partners around the state and country to help inform public health prevention strategies. The OCA/CFRP is engaged in a pilot program with the National Center for Fatality Review and Prevention (NCFRP) to support enhanced surveillance of drowning deaths which will inform future data collection efforts specific to drowning deaths.



### Homicide (19 Total)

A death ruled a Homicide by the OCME is a death that was caused by the act of another, typically an intentional act. Most homicides of children in Connecticut for 2022 were a result of gun violence (n= 9). [Between 2019 and 2021](#), the number of children and teens killed by gunfire in the U.S. increased 50%, with black children about 5 times more likely than white children to die from gunfire. In Connecticut, 8 of the 10 homicides of older children (15+) were children of color and all 10 were male.

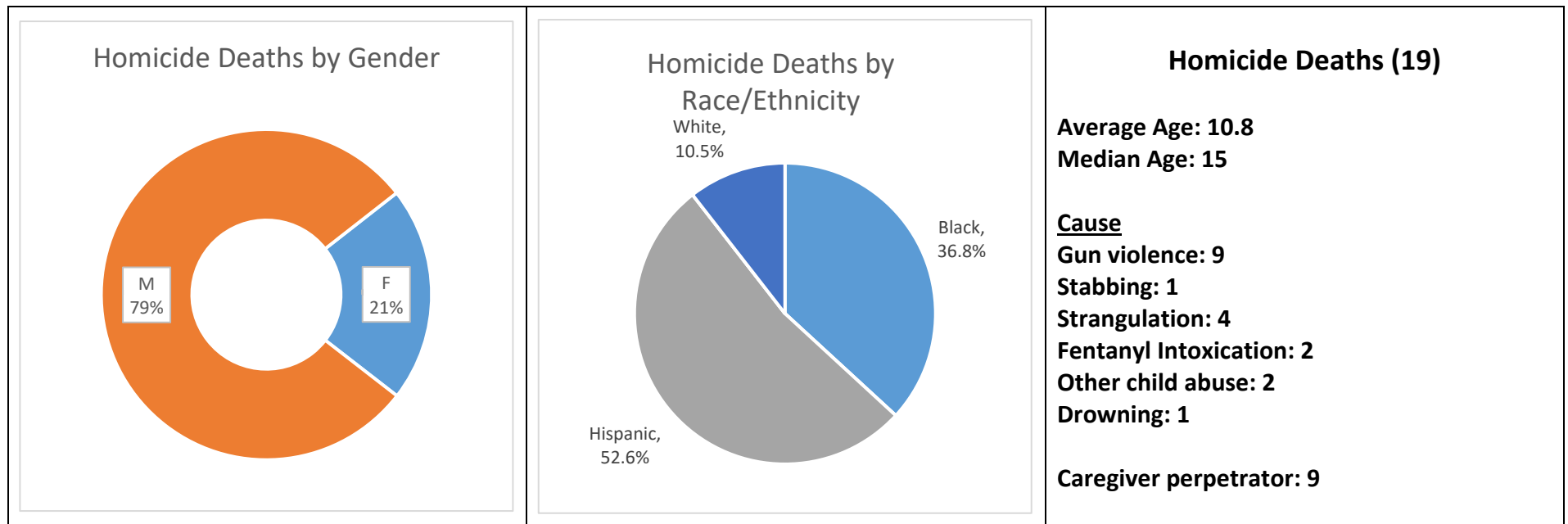
OCA supports youth gun violence prevention efforts and the development of a state taskforce dedicated to this public health priority. OCA will continue to provide data and qualitative information to gun violence prevention partners to assist with collective efforts to eliminate these deaths.

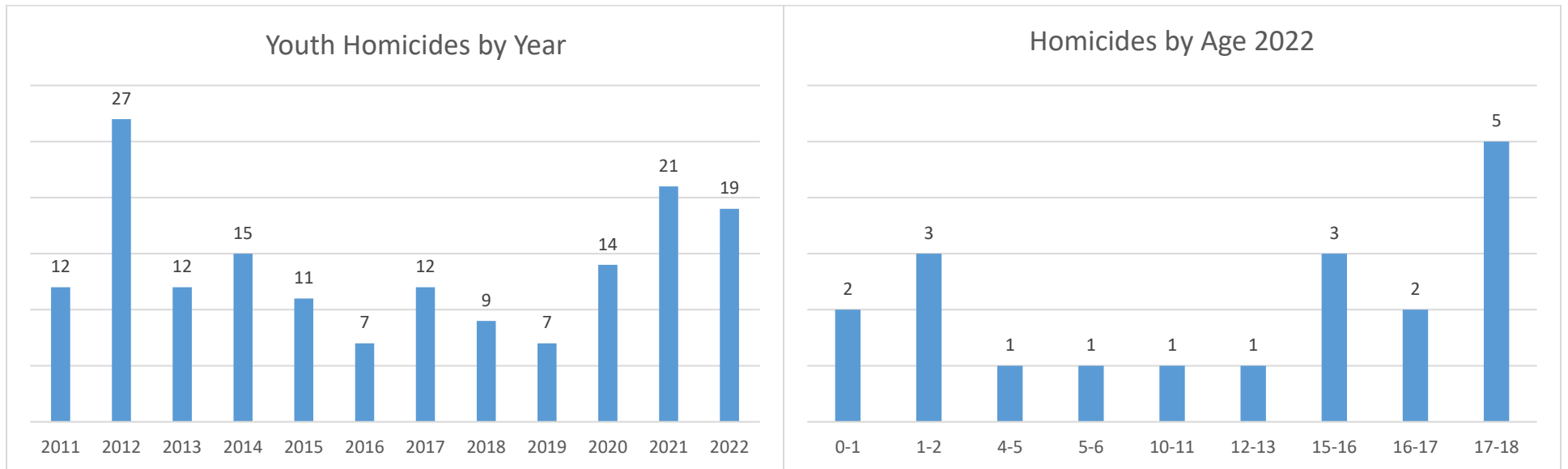
**Fentanyl intoxication deaths in young children.** In 2022, two (2) children, both just over one year of age, died from Fentanyl intoxication, a decrease from the six (6) young children that died in 2021. While fatalities decreased in 2022, they were eleven (11) critical incidents/near-fatalities reported to DCF regarding suspected ingestion of opioids by a child under the age of 3 and concerns of abuse/neglect by a caregiver. These children frequently survived the ingestions after first responders and/or health care professionals administered Naloxone. Naloxone saturation efforts throughout the state are saving the lives of children exposed to opioids. However, the threat of fatal/near-fatal opioid ingestion for children remains urgent, implicating a continued need for effective and accessible treatment options for caregivers with young children, expanded naloxone distribution/training efforts, and safe storage messaging and intervention efforts.

The OCME has explained the determination of Fentanyl intoxication deaths as Homicides for young children:

Pediatric neglect includes the failure of a caretaker to provide adequate supervision, protection, or a safe living environment necessary to meet the needs and maintain the health or safety of a child. The presence and accessibility of an illicit drug creates a clearly unsafe environment for a child. The OCME considers pediatric intoxication deaths that occur under these circumstances as a form of neglect.

OCA is working with the OCME, health care providers, and legislators to urgently respond to the concerns of Fentanyl toxicity in young children.



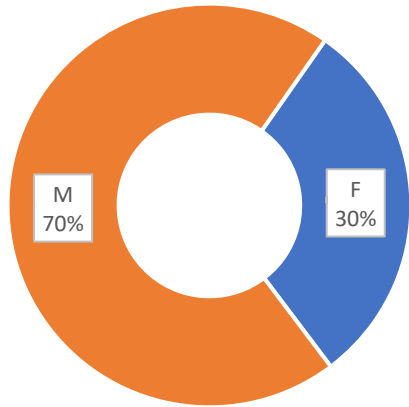


### Suicide (10 Total)

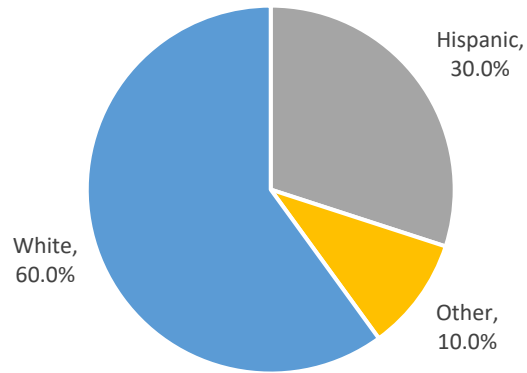
A death is ruled a suicide by the OCME when the injury to oneself is done with the intent to die. Across the country, suicide is now the second leading cause of preventable death in children starting at age 10.

The OCA participates in several groups and stakeholder meetings working on suicide prevention efforts and improving the children’s mental health system. OCA is a member of the newly created Transforming Children’s Behavioral Health Policy and Planning Committee (“TCB”, created by Public Act 23-90), which is focusing on consumer experience and data-driven improvement of our mental health system. Connecticut data continues to show waitlists throughout the state for home-based mental health supports, and children on discharge delay from Emergency Departments and inpatient hospitals waiting for appropriate services. A workforce crisis hampers efforts to deliver care to children and families. While new initiatives are rolling out across the state, including expanded access to Mobile Crisis services, psychiatric consultation services, and school-based mental health care, lack of adequate funding impacts access to services for children and families. Investment, strategic planning, and oversight by the TCB is needed to support a robust mental health care system for children.

Suicides Deaths by Gender



Suicide Deaths by Race/Ethnicity



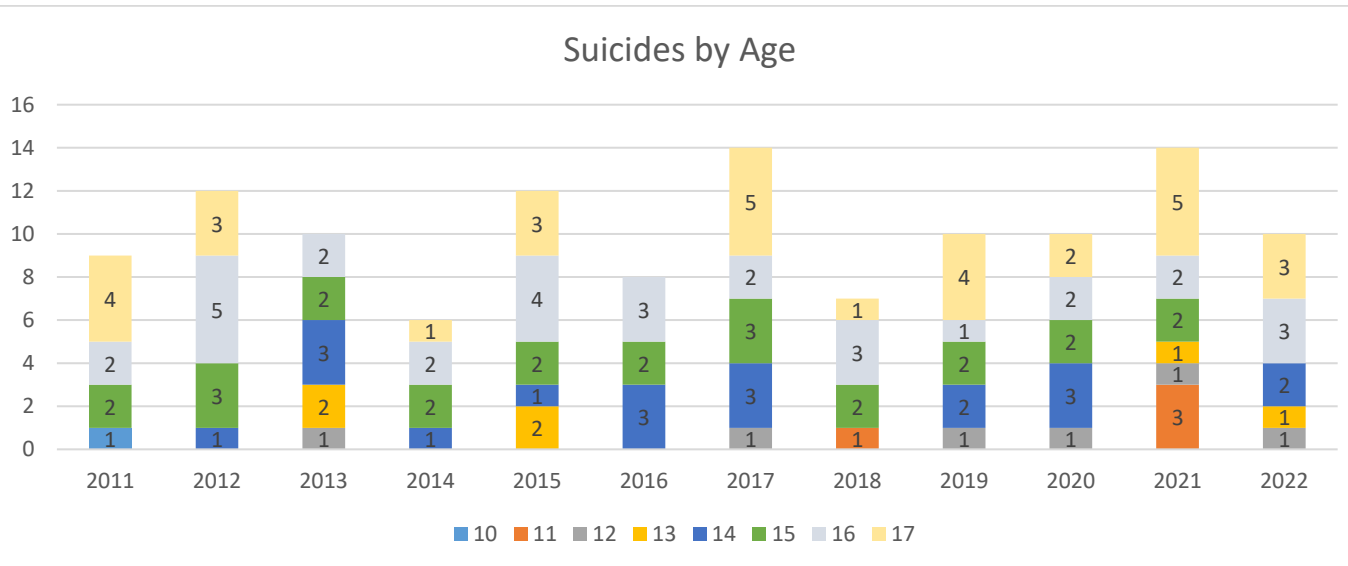
**Suicide Deaths (10)**

**Average Age: 15.7**  
**Median Age: 16**

**Cause**  
**Hanging/Asphyxia: 9**  
**Gun shot wound: 1**

**By season**  
**Spring: 5**  
**Summer: 1**  
**Fall: 1**  
**Winter: 3**

Suicides by Age

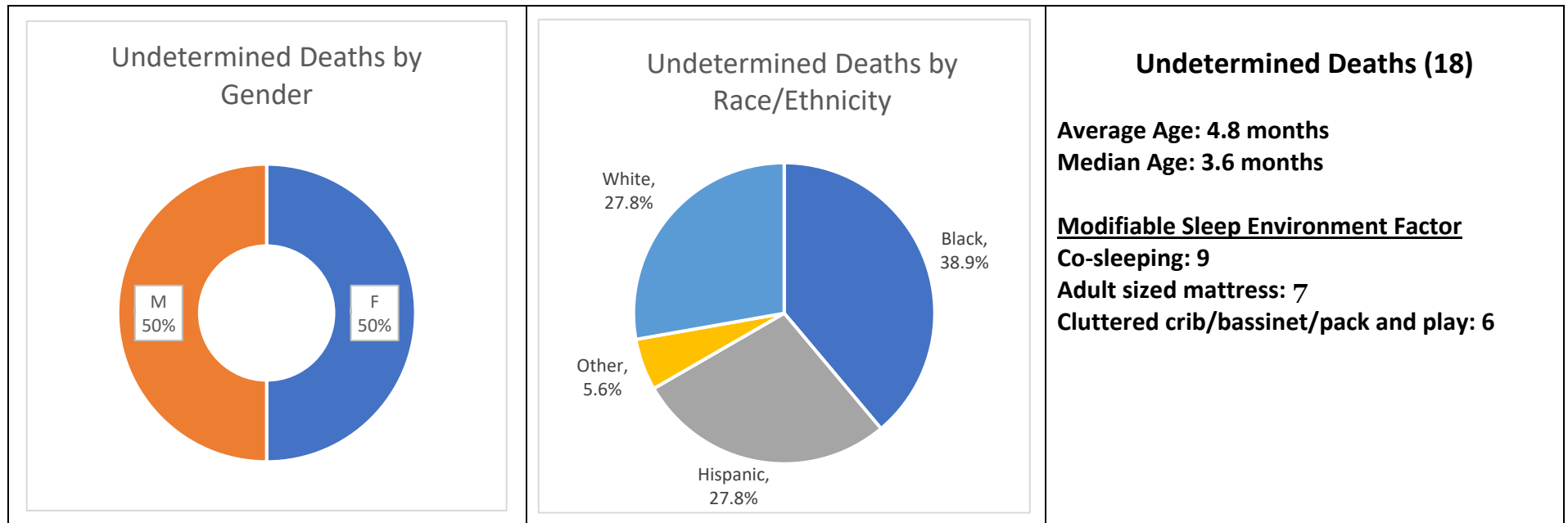




## Undetermined (18 Total)

A death is ruled Undetermined by the OCME when there is no sufficient degree of medical certainty to determine the cause of death. With these deaths there is no sign of natural disease and there is no obvious injury such as you would find in a homicide or suicide or accident. Undetermined deaths, *which are typically of infants*, have gone through a rigorous examination by OCME. Case review frequently identifies modifiable risk factors in the infant's sleep environment such as the infant being in an adult sized bed, in an adult sized bed with other children, in a sleep environment with blankets, pillows, etc. These risk factors are referred to collectively as an "unsafe sleep environment." "Unsafe sleep environment" also includes the position of the infant: i.e., infant is placed prone (on the stomach) or on their side. Unlike Accidental deaths where unsafe sleep conditions are definitively established, autopsy and scene investigation may identify unsafe sleep risk factors such as those listed above, but positional asphyxia or lay-over is not conclusively determined.

In 2022, the cause of death was classified as "undetermined" for 18 children under the age of 12 months. The median age of a child whose death was categorized as Undetermined was 3.6 months. **90% of children who died in this category (Undetermined) had modifiable risk factor/s in their sleep environment.** Children of color are disproportionately represented in this fatality category. OCA and CFRP co-chair Dr. Kirsten Bechtel co-authored an infant-toddler fatality report, published in July 2023, that examined the preventable causes of death for infants and toddlers and made several recommendations for fatality prevention, including increasing public education regarding safe sleep practices and increasing services and supports for pregnant and parenting individuals. OCA will work with the CFRP to host an Infant-Toddler Fatality Prevention Summit and propel recommendations for child injury prevention.



## **Infant and Toddler Fatality Report**

In July 2023, the Office of the Child Advocate and Dr. Kirsten Bechtel published the [Infant and Toddler Fatality Report](#), which examined deaths of children under age 3 who died between January 2019 and August 2022. OCA reviewed data from several state agencies regarding children or families' receipt of benefits, services, or supervision prior to or at the time of the child's death.

### **Brief findings from the Infant and Toddler Fatality Report**

1. There were 97 children younger than 3 years old who died from non-Natural causes between January 1, 2019, and August 8, 2022, in Connecticut. Eighty-five of these children were younger than 12 months old, and the median age of a child at the time of death was 3 months old with a mean age of 5.5 months.
2. Unsafe sleep-related deaths remain the leading factor in preventable deaths of infants in Connecticut. Despite multi-agency efforts to reduce infant fatalities associated with unsafe sleep environments, Connecticut has seen no meaningful decline in such deaths over the last 10 years.
3. Children who died were disproportionately male (63%), and more than 50 % of children were identified as Black, Hispanic, or biracial, consistent with national trends.
4. A review of state agency data shows:
  - 81% of children who died were Medicaid enrolled but not all of those children received Women, Infants, and Children (WIC) Nutrition program benefits.
  - 12.5% of children/families received benefits or services from the Office of Early Childhood (OEC) within six months of the child's death.
  - 7% of birth mothers were involved with a Department of Mental Health and Addiction Services (DMHAS) referred or licensed service within 6 months prior to the child's death.
  - 13% of birth mothers had involvement with Judicial Branch-Court Support Services Division (JB-CSSD).
  - 26% of children lived in families that had a case open with the Department of Children and Families (DCF) at the time of death or a case open within the previous 12 months.
5. Eighty-three (83) of the child fatalities were investigated by DCF. Of those deaths, 30/83 (36.2%) led to a substantiation of a caregiver for Physical Neglect, Physical Abuse, and/or Medical Neglect.
6. Eight (8) of the 97 children (8.2%), ranging from 4 weeks old to 27 months old, died due to Fentanyl intoxication, a cause not previously documented within this age group in Connecticut.

## **Discussion**

- Infants are most vulnerable to preventable death.
- The majority of infants and toddlers who died during the Period Under Review (2019-2020) lived in low-income families—more work needed to address unmet infant/toddler and caregiver needs.
- New strategies needed to prevent infant deaths associated with unsafe sleep conditions—racial/ethnic disproportionality must be meaningfully addressed.
- Fentanyl deaths and critical injuries implicate heightened need for two-generational strategies to address the opioid epidemic.
- Families with prior child welfare involvement have higher rate of subsequent child fatality from preventable causes—strong safety planning and robust services needed for higher need families with young children.

## **Recommendations**

1. Revise/Strengthen state's Safe Sleep public health messaging campaign.
2. Strengthen investment in early childhood supports and services—support universal home visiting and services for pregnant and parenting individuals.
3. Fentanyl injury prevention requires robust two-generational service array throughout the state and widespread naloxone distribution to caregivers.
4. Caregivers touching the Judicial System, including pretrial and adult probation, may need parenting supports and safety planning.
5. Statewide fatality prevention/critical injury prevention plan with clear targets/measurable goals needed.

## **Child Fatality Investigation**

In February 2023 OCA published a report regarding the death of 1 year old Kaylee from Fentanyl intoxication. Kaylee and her family had an open case with DCF at the time of her death. OCA found that DCF's safety planning, service delivery, and quality assurance framework for open cases needed improvement. OCA made several recommendations to support consistent child protection practice and promote public transparency and accountability for system improvements that support the safety and wellbeing of abused and neglected children.

OCA also made recommendations to the legislature to strengthen the provision of substance use treatment services for caregivers with opioid use disorder. A public hearing was held, and the legislature passed several of OCA’s recommendations in Public Act 23-97.

### Child Fatality Review and Panel (CFRP) Membership-Current

<b>Ex Officio Members</b>	
Office of the Chief State's Attorney:	<i>Brett Salfia, Esq.</i>
Office of the Child Advocate:	<i>Sarah Healy Eagan, J.D. (Co-Chair)</i>
Office of the Chief Medical Examiner:	<i>Gregory Vincent, M.D.</i>
Emergency Services and Public Protection:	<i>Samantha Haynes</i>
Department of Children and Families:	<i>Jodi Hill-Lilly</i>
Department of Public Health:	<i>Jody Terranova, DO, MPA</i>
<b>Statutorily Appointed Members</b>	
Pediatrician (by Governor)	<i>Kirsten Bechtel, M.D. (Co-Chair)</i>
Community Service Representative (by Speaker of the House)	<i>Pina Violano, Ph.D</i>
Social Work Professional (by House Minority Leader)	<i>Thomas C. Michalski, Jr. LCSW</i>
Injury Prevention (by House Minority Leader)	<i>Steven Rogers, M.D.</i>
Attorney (by Senate Majority Leader)	<i>Andrea Barton Reeves, J.D.</i>
Psychologist: (by House Majority Leader)	<i>Elizabeth Corley, Psy D.</i>
Law Enforcement: (by President Pro Tempore Senate)	<i>Sgt. Ivys Arroyo, Hartford PD</i>
<b>Appointed by CFRP Membership</b>	
Neonatologist:	<i>Ted Rosenkrantz, M.D</i>
Domestic Violence Representative:	<i>Tonya Johnson</i>
Pediatrician:	<i>Michael Soltis, M.D.</i>

## FACILITY OVERSIGHT

The OCA staff, within available resources, may visit with children and youth in publicly operated or regulated settings including, but not limited to, hospitals, residential treatment programs, juvenile detention, correctional institutions, and schools. OCA's facility oversight priorities are determined by a) concerns reported to the Office, b) the vulnerability of children and youth served by the program, c) legislative mandates, and d) staff resources.

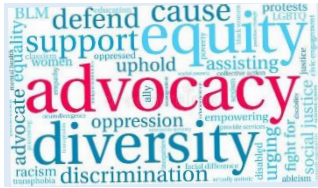
### OCA MONITORING OF CONDITIONS OF CONFINEMENT FOR DETAINED AND INCARCERATED YOUTH



Connecticut General Statutes § 46a-13l was amended in 2016 to require the OCA issue a biennial report to the legislature regarding conditions of confinement for youth detained or incarcerated in the juvenile and adult criminal justice systems. OCA published its first report in January 2019, issuing detailed findings and recommendations for system improvement. OCA's report found that certain youth were held in solitary confinement and many youth in the adult correctional system lacked access to appropriate education, rehabilitation, and mental health treatment services. Following the publication of OCA's report, the U.S. Department of Justice Civil Division (DOJ) announced its own investigation into conditions for minor boys confined at the Manson Youth Institution (MYI), run by the Department of Correction. The DOJ investigation concluded in December 2022, finding conditions at MYI, including use of solitary confinement, violated minor boys' constitutional rights to adequate care, treatment, and education. The DOJ and the State of Connecticut remain in settlement negotiations to address these constitutional violations.

During the last year, OCA participated in the state's Juvenile Justice Police and Oversight Committee, and OCA worked with members of the JJPOC's Incarceration Subcommittee to draft recommendations for an improved re-entry framework for children returning to their communities. The legislature codified these recommendations in Public Act 23-188. OCA also worked with members of the JJPOC to recommend changes to the "commissary" system for children incarcerated in Department of Correction (DOC) facilities, designed to ensure the needs of children for supplemental hygiene, food, and prosocial recreational products are met. The most recent state budget allocated resources to support developmentally appropriate commissary access for incarcerated children.

OCA staff continue to monitor conditions of confinement for incarcerated youth age 15 to 22, meeting with youth, staff, and agency administrators at the DOC and JB-CSSD. OCA is preparing an updated investigative report for late 2023. This report will include information regarding youth's access to necessary services and will add a focus on discharge planning and community reintegration.



*During one of OCA’s site visits to a correctional facility, a youth asked OCA to check on another youth in the prison. OCA was informed that this second youth, who had recently turned 18, had been transferred to a different facility due to numerous disciplinary issues. OCA tracked the youth down and reviewed his circumstances. OCA then met with the youth and administration at the correctional facility and raised concerns with the youth’s level of isolation, lack of mental health care, and lack of access to education. The facility administration worked with OCA to bring more age-appropriate care to this youth while he remained in their facility. OCA’s advocacy eventually led to the youth’s transfer to a different facility. The voice of the first youth speaking up about his concerns informed OCA’s systemic investigation and advocacy on behalf of individuals aged 18 to 21 held in restrictive housing.*

## **OCA OMBUDSMAN & SYSTEMIC ADVOCACY**

Between July 1, 2022, through June 30, 2023, the OCA responded to **360** individual and systemic complaints regarding the provision of state-funded services to children. The OCA is contacted by family members, providers of health/mental health services, school personnel, foster parents, attorneys, legislators, and employees of public agencies, as well as youth who are seeking assistance. The OCA reviews intake calls as a multi-disciplinary team and provides all callers with guidance on how to navigate the state’s often complex service systems. In the most urgent cases and where the individual complaint raises a systemic concern, OCA undertakes additional investigation and advocacy efforts, which may include record reviews, program visits, and advocacy with both state and local agencies to ensure the needs of children are appropriately met.

Issues addressed and/or investigated by the OCA this year included:

- Lack of access to appropriate special education and related services for children with disabilities in the least restrictive environment.
- Children on discharge delay in hospital emergency departments or hospitals who could not access recommended levels of care, including in-patient, psychiatric residential treatment facilities, foster care, or community-based services.
- Children awaiting appropriate mental health services, who become justice involved while waiting.
- Safety or permanency concerns for children who have experienced abuse/neglect.

- Children and older youth in the justice system who are struggling to find a place to live with a consistent and caring adult and necessary supports.
- Lack of timely and available services for children with intellectual and developmental disabilities.
- Children experiencing bullying and harassment.

*A concerned professional contacted OCA about 14-year-old “Ariana” who was under the guardianship of DCF and placed in a temporary congregate-care setting. Ariana was running away frequently and skipping school. OCA’s inquiries revealed that Ariana was in DCF custody due to unaddressed mental health, special education, and safety concerns. There were concerns that she may have been groomed for minor sex trafficking. OCA met with clinical and school-based providers, Ariana’s legal representatives, and her DCF team to expedite new evaluations of Ariana’s treatment and educational needs. Based on the recommendations of these evaluations, Ariana was connected with appropriate behavioral health treatment. Meanwhile DCF licensed a relative foster home where Ariana’s care and treatment would be supported and monitored. Once she was moved to a family home, Ariana’s risky behaviors decreased and her attendance at school improved.*

In its efforts to address systems issues arising from these concerns, OCA meets regularly with the staff and executive administrations of several state agencies and government officials, including the Departments of: Children and Families, Developmental Services, Social Services, Early Childhood, Mental Health and Addiction Services, Correction, Education, Public Health, and the Office of the Chief Public Defender, Office of the Chief Medical Examiner, the Judicial Branch Court Support Services Division, as well as the CT General Assembly.

## EDUCATIONAL ADVOCACY



Many of the community complaints received by the OCA involve educational concerns. All complaints received by the OCA are kept confidential and reviewed by OCA’s multidisciplinary staff during weekly intake meetings. The OCA is authorized to investigate individual complaints that raise a concern of a systemic problem. Some of OCA’s investigation activities result in the OCA issuing an Investigatory Report; Issue/Policy Brief, and /or Letter of Concern, which are also provided to the Connecticut State Department of Education for further investigation and corrective action, where applicable. OCA also encourages local school districts to develop remedial action plans wherever possible to address system concerns uncovered during the review. Where a local district provides a remedial action plan, OCA includes this plan on its

website.



## INDIVIDUAL EDUCATIONAL PROGRAMMING REVIEWS

During the 2022-2023 fiscal year, the OCA assisted families in accessing disability support services, summer programming, early intervention services, and delivery of services in the least restrictive environment. During its reviews, the OCA participated in Planning and Placement Team (PPT) meetings, resolutions sessions and early stages of dispute resolution as advocates for students in cases in which a public-school district's policies, procedures and/or practices were not in conformance with state and/or federal law or best practices.

*The OCA received an intake complaint from a family with concerns about their 7-year-old son with a disability classification of "Other Health Impairment" who was receiving special education and limited related services in his public school. The student was frequently subjected to restraint and often secluded in a small padded room with a closed door, with the most recent isolation resulting in the student seriously injuring himself. OCA worked with the family and the public school district to come up with a plan that would address the student's needs and safety, including conducting additional evaluations and testing, use of sensory items and comforts (weighted blanket and therapeutic touch), providing a quiet space in a resource room for the student when needed, and eliminating any future use of the padded seclusion room for the student. Consistent with OCA's authority to conduct a broader investigation, OCA is investigating the district's practices with regard to seclusion of students with disabilities.*

## SYSTEMIC EDUCATIONAL REVIEWS/INVESTIGATIONS AND ADVOCACY

During this reporting year, the OCA conducted systemic reviews/investigations of multiple public-school districts and privately run publicly funded programs that provide special education instruction. Investigations addressed issues concerning educational administration and programming; Title IX compliance; and Title VI language-based discrimination. Those systemic reviews/investigations are on-going and expected to be completed by late 2023/early 2024. All the OCA's systemic educational reviews/investigations resulting in the issuance of a formal OCA Report, Letter of Findings, and/or Program Concern are available on its website.

OCA's previous investigations into adult sexual misconduct against children in school included a recommendation that the state create a Title IX technical assistance committee and toolkit to support school districts' compliance with federal anti-discrimination and sexual abuse prevention laws. In 2023, the legislature codified this recommendation in Public Act 23-66.

This year OCA also advocated for several changes in state law to strengthen transparency for provision of special education services to children. Public Act 23-150 now requires the State Department of Education to publish summaries of complaints and corrective actions required by the Department regarding the provision of special education services by a school district.



OCA continues to monitor school-based arrests and sanctions for young children, including programs' reliance on restraint and seclusion to manage children with disabilities.

OCA participates in several committees and working groups to address systemic educational concerns affecting children throughout Connecticut, including:

- U.S. Attorneys' Disability/Education Working Group
- JJPOC Education Working Group
- JJPOC Suspension & Expulsion Workgroup
- Title IX Compliance Toolkit Working Group
- CSDE CT School Discipline Collaborative
- CSDE Special Populations Roundtable
- CT Language Access & Equity Strategic Partnership Workgroup
- CT School Climate Standards and Bullying Complaint Form Subcommittee

#### **ADVOCACY FOR CHILDREN WITH UNMET MENTAL HEALTH TREATMENT AND DISABILITY SUPPORT NEEDS**



Many calls to the OCA involve the unmet needs of children with mental health disorders or developmental disabilities. Expressed concerns may be specific to child and family safety, lack of treatment options, the adequacy of special education services being provided, or lack of access to in-home or community-based services.

In 2023, OCA worked to support the state's new Transforming Children's Behavioral Health Policy and Planning Committee (TCB), which will evaluate the children's mental health services delivery system, establish strategic and measurable goals, and make annual recommendations to the legislature to support improved access to services for children and families. The new TCB is codified in Public Act 23-90. The statute specifically requires the TCB to address the needs of chronically underserved children such as children who are justice-involved and children with developmental disabilities.

OCA testified to the legislature and co-authored multiple advocacy letters regarding the unmet needs of children with intellectual and developmental disabilities, including children with Autism, and the efforts needed to ensure services are available to all children who need them across Connecticut. Much work remains to realize children's right to adequate and timely healthcare.

*OCA received a call regarding 13-year-old "Aubrey," who was born with a genetic condition and has multiple developmental, medical, and psychiatric support needs. The family sought home- and community-based services for Aubrey, but a series of providers had discontinued*

*services or declined to work with Aubrey because she was sometimes aggressive toward them. Waiting lists for the few available providers were prohibitively long and the family was having difficulty managing Aubrey's various medical needs as well as her behavioral struggles without support. The family utilized an emergency pediatric mental health response service on an almost daily basis when Aubrey was in acute crisis. OCA contacted DDS and Carelon to facilitate the family's applications for behavioral health services, care coordination, and respite care, and so that Aubrey's parents could connect to additional community- and school-based services and increase their capacity to support Aubrey in her home.*

### **CHILD WELFARE ADVOCACY AND ACTIVITIES**

The OCA responds to individual complaints about children involved with DCF, providing advice to callers and following up with DCF regarding allegedly unmet needs of children for services, permanency, or protection. The OCA meets regularly with the DCF Executive Team to review child fatality/critical incidents involving children recently involved with or under the care/supervision of DCF, quality assurance data regarding OCA's child protection activities, foster care, and other systemic issues affecting children and youth. In the wake of the end of *Juan F.*, a federal court consent decree and federal court monitoring of DCF, OCA is regularly reviewing DCF systems data regarding core practice areas: safety, permanency, and wellbeing.

In 2023, OCA recommended to policymakers a structure for monitoring and supporting child welfare activities serving children and families. OCA has requested additional staffing resources to support facility and fatality/systems review. OCA will continue advocacy efforts to strengthen progress monitoring for the state's child welfare system.

## COMMITTEES-TASK FORCES-COUNCILS

OCA participates in multiple taskforces and working groups as part of our systemic advocacy efforts.

PREVENTION	INFANT & TODDLER	EDUCATION	CHILDREN'S HEALTH & WELL-BEING	TEEN/ADOLESCENT SAFETY	JUVENILE JUSTICE
Prevent Child Abuse America-CT Chapter	Maternal Child Health Coalition	CT School Climate Standard and Bullying Complaint Form Subcommittee	Transforming Children's Behavioral Health Planning and Policy Committee	Suicide Advisory Board	Juvenile Justice Policy and Oversight Committee (JJPOC)
National Child Fatality Review Case Reporting System	CT Perinatal Quality Collaborative	CT Language Access/Equity Strategic Partnership Workgroup	DDS Children's Services Committee Meeting	Commissioner's Advisory Committee (DMV)	Incarceration subcommittee (JJPOC)
Domestic Violence Fatality Review Task Force	Substance Exposed Pregnancy Initiative of CT (SEPI-CT)	Title IX Compliance Toolkit Workgroup	Children's Behavioral Health Plan Implementation Advisory Board	CT Teen Driving Safety Partnership	Governor's Task Force on Justice for Abused Children
Interagency Restraint & Seclusion Prevention Partnership	Alcohol/Drug Policy Council	School Discipline Collaborative	Autism Spectrum Disorder Advisory Council	Trafficking of Persons Council	JJPOC Incarceration Subcommittee
Alcohol and Drug Policy Council		U.S. Attorneys' Disability/Educational Rights Coalition Meetings	Child Support Guidelines Commission	Regionalized Human Trafficking Recovery Taskforce	JJPOC Education Workgroup/Suspension and Expulsion Workgroup

## TRAININGS

This past year OCA provided several trainings to health care professionals, social service providers, legal professionals, educators and student groups on topics ranging from child death prevention strategies, representation of vulnerable child populations, and cross-agency multidisciplinary advocacy.