

**REPORT OF THE  
CHILD ADVOCATE  
AND THE  
ATTORNEY GENERAL**

**“THE COST OF FAILURE”**

**CONSEQUENCES OF INADEQUATE COMMUNITY  
SERVICES FOR CHILDREN**

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# The Cost of Failure

During State Fiscal Year 2000, nineteen percent of the calls received by the Office of the Child Advocate concerned mental health services for children. Predominantly, callers contacted the Child Advocate to express concerns about the failure of State agencies to provide appropriate services for children. For most, complaints centered upon the lack of availability of certain types or levels of services to treat children's mental and behavioral health issues. For some, however, concerns centered largely on services provided that were neither reasonable nor effective in meeting the needs of the children receiving them.

In reviewing these reports, staff noticed a worrisome trend, i.e., *despite the inability of the services funded by the State of Connecticut to contribute to the well being of these children, the large amount of money expended for them was extraordinary.*

The cases brought to the Child Advocate's attention because of concerns about the appropriateness of the service plan were characterized by the almost exclusive use of long-term institutional and residential care. While the average annual cost of residential care as calculated by the Department of Children and Families (DCF) is about \$50,000, for many of the children brought to the attention of the Child Advocate, average annual costs ran to \$90,000 and above. When care included significant utilization of both psychiatric hospitals and State-run facilities this annual cost was triple or even quadruple the usual state average. More disturbing was that each of these children had spent or appeared destined to spend a significant proportion of their childhoods trapped in such treatment patterns. And this was the case despite the appearance in case records of periodic requests and recommendations from families and professionals that community-based services could be implemented to treat children while allowing them to remain in their homes.

During this same period the Child Advocate and the Attorney General have collaborated on a number of investigations that have explored serious allegations of shortcomings of the Department of Children and Families and Connecticut agencies at all levels responsible for the welfare of children. Through these investigations we have developed a strong mutual concern about the approaches taken by DCF and other agencies charged with planning care for children. In order to highlight these concerns we have undertaken to bring to public attention the story of one of the youngsters whose tragic personal story illustrates the tremendous costs associated with the failure to provide appropriate services in a timely fashion.<sup>1</sup>

## **I. FAILURE IS EXPENSIVE**

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<sup>1</sup> Please see "Appendix I: Methodology" for a description of how this child was selected, and how the Child Advocate has calculated costs of services.

The child who is the primary focus of the report is one who is now “aging-out” of the care of the Department of Children and Families.<sup>2</sup> While she came to the attention of the Department as a result of protective services concerns, she has ultimately received long-term assistance because of diagnosed mental and behavioral health needs. She had, through much of her time in care, an involved family, who regularly made clear that they would care for her at home if they could receive some support and assistance. Many of the community supports her family required were not available at all, or were severely limited by policy or funding. Because many community services that were delivered focused only on immediate crisis, they were withdrawn before they could be effective in meeting long-term needs. Some supports were never tried. Instead, this youngster has been the “beneficiary” of 24 institutional / residential placements spanning ten years. Over the last eight years, she has spent over 2700 days in one kind of congregate facility or another.

As you will see, the cost to the State of Connecticut of the one child featured here came to over 1.8 million dollars. Because she has spent so many years in residential and institutional placements, the total cost for her care has been predictably high. Because her treatment needs were not met by the care provided, her behavior seriously deteriorated over the years. As the demands she placed on facilities increased, finding agencies to accept her became increasingly difficult, leaving the more expensive state run facilities as placements of last resort.

But this child was not alone among the children reviewed in the level of her annual costs. She differed from several of the children only in that she had aged-out of the system. Some children’s cases reviewed had similar annual costs, but at this point were still early in the cycle that the featured child had already completed. Others, as a result of the system’s failure, came to an end of services earlier by running away or entering juvenile and adult correction programs, or, as in the case of one teenager we investigated, by committing suicide.

Despite the extremely high costs, the efforts on this child’s behalf have yielded little. Now an adult, she faces a future in which her primary mental health difficulties have never been fully or effectively addressed. Her marketable skills have never been recognized or encouraged. Her abilities to carry out basic tasks necessary for an 18 year old to begin life as an adult have never been developed. In fact, it is likely that this young woman will continue to require even larger public expenditures for mental health, income support, and, perhaps even correctional services if she is not able to function in society. If the goal of these large State expenditures was to improve the child’s prognosis, the State of Connecticut has failed.

Such situations have raised our concerns on three levels.

**First**, the children trapped in these situations, in many cases, are receiving services that are not contributing to the improvement of their mental health status, do not follow currently accepted treatment guidelines for their conditions, and, in some cases, are antithetical to the real needs of the children;

**Second**, long-term use of institutions becomes self-perpetuating. Young adults who have spent most of their childhoods in institutions re-enter communities without links to families or any other supportive systems. Public effort must then be directed toward remedying the numerous ill effects of the original public interventions; and

**Finally**, the expenditures of large sums of State monies and Federal matching funds on services that are not and cannot be successful robs the system as a whole of the funding necessary to develop and implement a system of high quality community based care.

The cost of a failed effort to the child we follow here was the diminishment of her quality of life both in her past and, now, potentially, in her future. This lost quality of life is priceless and irreplaceable. The cost to the State programs was almost 2 million dollars. The State of Connecticut cannot afford to waste either, especially when it would have cost only a portion of the money spent to provide services that had a far greater probability of improving the well being of this child.

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<sup>2</sup> Once a child turns 18 the Department of Children and Families no longer provides services. This is commonly referred to as “aging-out” of DCF’s care. Many children in DCF’s care will need mental health services when they become adults. Upon reaching 18 these individuals will often receive services from the Department of Mental Health and Addiction Services.

There are several important lessons that we can learn from this child's experience.

The first lesson is the urgent need to provide appropriate intervention and support for children in need at the earliest possible moment. Such action has great potential to preserve quality of life for the child. Failure to do this naturally leads to a vicious cycle of increasingly costly interventions that continuously fail to help the child learn how to function as a responsible member of society.

Second, the public and the children for whom the State of Connecticut is responsible are poorly served by a system that relies upon removal of children from their families and communities as merely the system's default in treating their illnesses. Hospital care, residential treatment, and group homes each are critical links in any system to care for children with mental health needs. These providers, the DCF and most horribly, the children concerned fail miserably, however, when these resources become simply a poorly thought out last resort in finding methods and places to control behaviorally difficult children.

What the story of Brittany Brown<sup>3</sup> illustrates more than anything else is that the State of Connecticut must rethink its service priorities. Services that focus on the individual needs of children and their families and treat children's issues within the social context in which they live must become the more expedient, more permanently available treatment option. Simultaneously, the agencies and public officials charged with overseeing the care of children must learn a new way of looking at ensuring the well-being and safety of those entrusted to them. We can afford no less.

## I.

## II.

## III. BRITTANY'S STORY

Brittany Brown's infancy had none of the glamour associated with being a Million Dollar Baby. Her early years saw mostly tragedy, loss, and instability. Her mother's pregnancy was complicated by the loss of Brittany's male twin at about 20 weeks of gestation, and by the reappearance of life-long symptoms of depression. Before Brittany and her mother even left the hospital, Brittany's biological father murdered one of her older sisters. Because of her father's arrest and incarceration, and her mother's incapacitation after the brutal death of her middle child, Brittany was raised for the first six months of her life by a succession of relatives. Although one older sister did participate in grief counseling to help her deal with the trauma of a sibling's violent death, Brittany's mother was left with little

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<sup>3</sup> All children referenced in this report are children who have actually received behavioral health services funded in whole or in part by the State of Connecticut. Their names and the names of their families have been changed to protect their privacy.

formal support. There appears to have been little concrete concern about newborn Brittany's arrival in this tragic, chaotic situation.

By the time she was two years old, Brittany was showing signs of serious behavioral problems. By the time she began pre-school, her mother and extended family were experiencing such difficulties with Brittany's behavior that she regularly shuttled between her home and family members in another state. Family reports as quoted in case records are filled with incidents of the young child hitting, throwing frightening tantrums, and threatening harm to those who crossed her. Particularly when sad or frustrated, Brittany was apt to strike out aggressively. Her mother and relatives would care for Brittany until her behavior became unmanageable, then she would be moved to a new home. For the first six years of Brittany's life, there are no records of any assistance from public agencies, although her mother did report intermittent attempts to secure individual treatment for her difficult daughter.

The first time Brittany appears in public records, it is because of an incident in first grade in which she threatened to stab another child with scissors. The response by the local school system was to remove her from school completely for a short time. Her mother was referred to a child guidance clinic, and she and Brittany attended outpatient therapy for several months. Eventually, special education staff placed her in an alternative education program for children with Serious Emotional Disturbance (SED).

## **I. FIRST DEPARTMENT OF CHILDREN AND FAMILIES INVOLVEMENT**

Sixteen months later, when Brittany was seven, the Department of Children and Youth Services (the predecessor of the Department of Children and Families) became involved with the family. That agency's first contact with the troubled child and her mother took place because of a report to the DCYS alleging that Brittany had been hit repeatedly with a belt. Brittany reported that her mother's boyfriend had spanked her. The preliminary review by the DCYS indicated that the boyfriend, who lived with Ms. Brown and her daughters, had indeed lost control while disciplining Brittany for destroying property in the home during a tantrum.

A caseworker from the Department conducted an investigation to determine if protective services on behalf of Brittany were necessary. During the investigation, two facts about the family emerged. First, Mr. Evans, the boyfriend, had no previous history of hurting Brittany (as reported by all members of the family, as well as therapists and doctors involved with the family). Still, he did report that caring for Brittany was trying because of her aggressiveness and impulsiveness. He clearly accepted responsibility for abusing Brittany. However, he asked that the Department's intervention not "deal with the isolated incident" and expressed that he "hoped that [DCYS] might help with the problems they were having with [Brittany]." Second, Ms. Brown also had never physically injured her child. But, she reported to the caseworker her fear that Brittany had inherited her violent father's personality and problems. She believed her difficulties with Brittany were rooted in those inherited traits. She informed the investigations caseworker that she was considering having Brittany removed from her home.

The conclusion of the month-long investigation was that the family's case was transferred to a treatment worker within the DCYS. Brittany received a psychiatric evaluation. Mr. Evans attended anger management classes as a result of the criminal charges filed in the case. The family was referred for Family Support Services from the DCYS. No petition for the State to assume custody was ever filed because the family was so willing to voluntarily participate in services.

The clinic evaluation concluded that Brittany did not suffer from SED but that she was out of control. Brittany and her family were referred for outpatient family and individual therapy. For the next three months, the entire family attended therapy at a Child Guidance Clinic. A private agency's Intensive Family Preservation (IFP) staff provided support for the family at home, and as a result things seemed to be stabilizing. Brittany remained in school, and, while she still had tantrums, Ms. Brown and Mr. Evans, with the help of parent aides and the IFP case manager, appeared able to cope. Ms. Brown retracted her earlier request to consider foster care for her daughter.

However, the improvement in the family's situation meant that, by the first case conference, the family became ineligible for IFP assistance. Because of the intensity of these services (several visits per week in the family's home)

and the concomitant costs, IFP services were provided to families only for a limited period. And, by DCYS policy, the services are focused only on families in which there is imminent risk of removal of the child. For the Brown/Evans, their movement toward healthier functioning meant IFP services were no longer deemed appropriate because Brittany was no longer considered at-risk for placement. The in-home support, which appeared to serve the family so well, was discontinued.

Four days later, Brittany threw a desk at another student in school and was suspended for several days. For the next few weeks, Ms. Brown was forced to miss work regularly because no childcare provider was willing to care for Brittany once they saw her behavior. One month after IFP was withdrawn, her mother met with the treatment caseworker to demand that her daughter be removed from her home and placed in foster care. The Department complied with this request and placed Brittany in a regular foster home.

The next day, the 8-year-old girl lost control, began screaming, threatened violence, and ran out of the foster mother's home. The foster mother brought Brittany to the psychiatric emergency room at a nearby hospital and left her there, refusing to continue caring for the explosive child. After yet another psychiatric evaluation of Brittany, this time diagnosing Oppositional Personality Disorder and Dysthymia, Ms. Brown reluctantly resumed care for her child. Her family's caseworker promised that the DCYS would find a therapeutic foster home.

## **I. THE CYCLE BEGINS**

Brittany remained at home for almost 10 months. She and her family continued to receive follow-up care with once per week visits to a therapist and in school the third grader was moved to yet another education program. She was suspended from the new classroom several times and continued to have occasional blow-ups at home. However, she remained at home with no further reports of protective issues.

Towards the end of the 10 months, Brittany lost control in front of several therapists, who immediately urged her mother to hospitalize her daughter. For the first time, the little girl was placed out of her home for an extended period. For seven weeks she remained on the pediatric psychiatry ward of a hospital. Most of her treatment at that time focused upon her symptoms of anxiety and depression. Once stable on anti-anxiety medication, she was discharged to her mother.

From the time her mother resumed care until the end of her hospitalization, Brittany and her family had little contact with the DCYS. Only two entries appear in the case record over that time. Even news of Brittany's seven-week hospitalization did not reach the caseworker until some weeks after she was discharged. While there was clear diagnostic evidence in her hospital records that Brittany's emotional and behavioral issues were becoming more serious with the approach of adolescence, the DCYS had ceased to be concerned that she was in need of protection from the actions of her mother or her mother's boyfriend. They demonstrated a willingness to cooperate with any services provided to help them deal safely and appropriately with their child. That level of safety and cooperativeness, regardless of the needs demonstrated by Brittany, became the basis for a Departmental decision to end intervention with the family. Two weeks after Brittany's discharge from the hospital, the family's case with the DCYS was closed. There is no record of the family's reaction to this decision.

For over a year, the family maintained Brittany at home despite worsening behavioral problems. Brittany remained in the special school into which her district placed her, but there is no mention of any particular support or training given to teachers and aides in the school to prepare them to deal with the particularly aggressive behavior of the nine year old child. Brittany, her sister, Ms. Brown, and Mr. Evans participated in weekly outpatient family therapy, and a psychiatrist regularly saw Brittany to monitor her medications. There is no record that the family, or any other adults who had to care for Brittany, received clinical services that directly focused upon teaching them ways to manage Brittany's behavior. Further, the record speaks not at all to work with Brittany, who is regularly described as a bright child, to help her develop useable strategies to control her temper.

At 10, as she approached puberty, Brittany's behavior began to escalate out of control. She began having increasingly violent tantrums. This behavior eventually climaxed in an episode in which Brittany held a knife to another child, threatening to kill the child and herself. Brittany was hospitalized again, this time for about 7 weeks.

For much of the hospitalization, the ten year old remained agitated and regressed, requiring restraints on several occasions. When a change in medication did reduce Brittany 's level of agitation, the hospital immediately moved to discharge her.

This time, however, Ms. Brown refused to resume care for her child without further help. As the investigations caseworker noted in the record, she did "not refuse to take [Brittany] home, but stated the child is out of control. She can't hire a babysitter to go to work because no one will care for her she is so out of control. She needs help." The mother's actions triggered the re-involvement of the child welfare agency, now renamed the Department of Children and Families (DCF). The agency filed a petition declaring Brittany "uncared for" and began its own plan for treatment of her behavioral health problems. The caseworker appeared to agree with Brittany's mother that the child would benefit from a placement in a therapeutic foster home. However, no such homes were available and the hospital and Court were demanding Brittany's discharge from the hospital bed. With no other alternatives, the DCF transferred care of Brittany to the State's psychiatric facility, Riverview Hospital for Children and Youth. What was to be an interim placement for her became the beginning of a cycle of failure.

### **...And Goes On and On**

Over the next eight years, Brittany would spend 2765 days in a total of 24 mental health, juvenile justice and correctional facilities. Despite the desire she stated regularly over the first years in hospitals and treatment centers to be at home with her family, Brittany would not return home except for short visits and one 4 month stay when no other living arrangement could be found for her. In fact, she would be placed at ever-increasing distances from her home until she wound up in residential schools as far away as Virginia and Tennessee. She might have finished her childhood in one of these facilities had not a criminal assault charge resulted in juvenile detention at Long Lane School and a return for a final two years in state juvenile justice and correctional programs.

In an evaluation done during one of her early hospitalizations, Brittany was described as a "bright and beautiful child ... somewhat shy ... but engaging." By the end of the years of institutionalization, the young woman was regularly described in court and psychiatric reports as "a manipulative, aggressive teenager," as "dangerous and self-destructive," and as "guarded and unwilling or unable to commit to treatment." At the beginning of this multi-year treatment process, her mother, mother's boyfriend, and sister all participated regularly in treatment and made it clear that, with help, all desired for Brittany to come home. By the time she was 15, Brittany was placed in out-of-state facilities that made visiting almost impossible, and Ms. Brown was too frightened for her own safety to allow her daughter home for visits. Despite a never-changing official legal plan filed with the Court for her to return home, Brittany Brown did not live permanently in her family's home again until she was discharged from the care of the State of Connecticut as an adult.

In the earlier years of her commitment to the DCF, Brittany's movement through placements followed a regular pattern. Over several weeks or months the combination of a structured environment, individual and family therapy, and medications would help stabilize her behavior. During these stays, her caseworkers and therapists changed frequently, as did the pharmaceutical regime that her ever changing cast of doctors prescribed. As she improved and the length of stay got longer, the DCF and the hospital or residential center would begin planning to move Brittany to a less intensive placement. Often, the combination of Brittany's aggressive history and lack of available treatment programs, compounded by the turnover of staff assigned to her case, caused this process to take considerable time. The uncertainty and lack of stability, as well as the knowledge that she would not be allowed to return home, would result in a period in which Brittany's behavior deteriorated. This would either significantly postpone attempts to reduce the level of care or would insure that Brittany entered the next placement in crisis.

With each new placement, Brittany showed more and more difficulty conforming to the demands of the treatment process. As she became older, stronger and capable of greater harm to herself or others, the DCF encountered enormous difficulties in finding facilities that would accept and retain the youngster. This led to a pattern of care

with several stays in private residential facilities and hospitals of 3-6 months, and extended stays (1-1 ½ years at a time) in DCF-run facilities such as Riverview Hospital and High Meadow, a residential treatment center.

Six years after Ms. Brown's request that her daughter be placed in therapeutic foster care, Brittany did finally spend four months in a regular foster home. Initially, the placement appeared successful. Both foster mother and child seemed to bond well. In reports of the first two weeks, Brittany, like many newly placed children, appeared calmer and happier, and her foster mother seemed quite capable in dealing with the oppositional behavior she sometimes displayed. After three weeks of glowing reports of the initial placement period, again the case record becomes silent for three months. Four months into the placement, the foster mother contacted the caseworker to report that the youngster had had a violent tantrum in the home and run away the day before. The foster mother informed the agency that she refused to continue care for the child. Once found, Brittany was briefly returned to her family's home for a very troubled four-month wait for a new placement. This time the only willing provider was an out-of-state residential school that focused on aggressive children.

As her time in care increased and distance from home increased, Brittany became adept at manipulating the residential system. If, in her impulsiveness, Brittany determined that she wanted to be somewhere else (usually at a site where she had previously stayed), she now grasped that aggressions or serious infractions of the rules would cause her caseworker and therapists to actively search for other treatment venues. As an added bonus, misbehavior would increase the attention, albeit negative, focused upon her. With each episode of resistance and consequence, Brittany's behavior became riskier both for herself and others. She began to engage in assaultive behavior, as one therapist put it, "almost as a form of amusement." And her aggression was not just directed at others. Threats to kill herself, or engagement in risky behaviors such as running away and dodging traffic, substance abuse, and prostitution when on the run, began to appear with increasing regularity in facility reports.

While formal documents continued to indicate that the Court and DCF intended that Brittany would eventually return home, the case records do not indicate specific actions the caseworkers or therapists took to make this plan a reality. There is evidence that her mother and family participated in family therapy with Brittany. But, as the time away from home lengthened and Brittany presented as an even more disturbed child, family participation in her treatment dwindled. The difficulty of controlling the adolescent girl without significant help made her mother hesitant to have Brittany at home. Over the years, as family members re-established relationships among themselves, even visits at the hospitals or centers became more sporadic. Once Brittany was placed out-of-state, visiting became impossible for a family of moderate means, and records speak of plans to hold family therapy sessions over the telephone that quickly fell apart. Finding alternative placements for a child who was becoming increasingly aggressive consumed the majority of the social service and legal efforts. Re-establishing family and community ties was a goal honored in legal documents only, not in reality.

At 16, Brittany crossed a line. At the time she had been a resident at an out-of-state school for about 3 ½ months. As explained to the DCF worker at intake, the program's framework was "showing appropriate and inappropriate behavior." Brittany cooperated in the plan to move to the facility initially, but almost immediately upon admission she became agitated and threatening as certain of her belongings were confiscated because they were prohibited in the program. During her stay, despite the individual therapy around her family relationships, group anger management therapy, and increasing pharmacological therapy, the teenager showed no progress in meeting the behavior management goals set for her. The longest period during which she remained aggression free was one week. She ripped out doors and put holes in walls; she regularly got into fights; and refused to cooperate in the school program. One of the underlying parts of her treatment plan was to have Brittany establish contact with the imprisoned father she never knew. As time passed and Mr. Brown failed to respond to his daughter, she became more and more anxious and depressed. This anxiety and sadness manifested itself as anger and aggression.

On the 96<sup>th</sup> day of this placement, Brittany seriously assaulted another youngster and knocked a staff member unconscious. The facility had a policy of having aggressive children arrested, and called in the sheriff to arrest the youth. The authorities in that State held Brittany as a juvenile offender. Two social workers were flown to meet her and return Brittany to Connecticut. She was found delinquent in juvenile court and committed to Long Lane School, the State's facility for delinquent girls. The child who came into care needing protection was now seen by the service system as a young woman from whom others needed to be protected. From that point until she was ultimately discharged from DCF's care at age 18, Brittany spent most of her time in settings where the primary, although not sole, focus was correction and not therapy.

At Long Lane Brittany had a probation officer as well as a social worker. After over a year in the state juvenile facility, the juvenile court system placed Brittany in several residential programs that focused upon containing her assaultive impulses while treating her growing substance abuse issues. Largely, however, she lived in youth shelters where treatment was intermittent at best. In both types of settings, Brittany was regularly out of control, ran away at will (once while DCF social workers stood looking on helplessly), and ceased attendance in any kind of educational program. On a night five months before Brittany's eighteenth birthday, she returned well after curfew to the shelter where she was staying. She was "wild and destructive" ... "threatening her roommate and staff". The staff of the shelter called the DCF Careline and the local police to get the difficult resident removed immediately. The police arrived first; they arrested Brittany. Brittany was tried as an adult, convicted of disorderly conduct and disturbing the peace, and was sent to the State Women's Correctional Facility at York

After two months, Brittany was released from York Correctional facility and within the next two months the DCF began plans to discharge her from its care. Now an adult and on probation, she returned to the home of her family once more.

In many ways, Brittany is worse off today than when the DCYS first intervened to protect her. Her behaviors that first raised concerns are still very present. Brittany has trouble controlling her anger; she is still prone to rages when she is frustrated or anxious; her behavior remains impulsive and immature. She continues to engage in self-destructive behavior using drugs and alcohol and having sex with multiple, unknown partners, and is prone to disappearing for days at a time. Although of average to above-average intelligence, Brittany's emotional difficulties precluded her from finishing high school. While imprisoned, she did manage to secure a GED, but she has not developed concrete job skills. Many of the therapists with whom she came into contact did note that even as a young child Brittany appeared to have several well-developed artistic skills such as drawing, writing lyrics, and singing but none of these have been developed, nor has anyone helped her to identify any other vocational aptitudes. More critically, because Brittany was raised for so many years in structured residential settings, any coping strategies she has learned have never been applied in a community setting. Further, she has not developed independent living skills such as managing money, finding and maintaining a place to live, and shopping. Brittany has no idea what it means to live in a home with relatives and friends, or what the routine of a "normal" day in such a home looks like. With almost half her childhood spent in congregate facilities, Brittany knows what she has lived-the institution.

As soon as there is an opening, Brittany will enter a special program for young people with mental and behavioral health problems who have left the care of the DCF. Youth in Transition is a program of the Department of Mental Health and Addiction Services, which will seek to treat Brittany where DCF has failed. The program will provide housing in a community residence, links to community and social services, and encouragement and support to ease Brittany's transition into the adult mental health system. If this transition is successful, Brittany will become a consumer of adult mental health services. If it is not, other public and philanthropic systems, ranging from corrections to services for the homeless even to DCF if Brittany should have children of her own, will be called upon to care for her.

## A. UNDERSTANDING BRITTANY'S STORY

### I.

## II. CONDUCT DISORDER

Through the most years of her treatment, psychiatrists and psychologists have diagnosed Brittany's primary difficulty as Conduct Disorder. According to the *Diagnostic and Statistical Manual for Mental Disorders*, the central feature of this disorder is a persistent behavior pattern wherein an individual violates others' rights and violates age-appropriate social norms. Children with this disorder demonstrate aggressive behavior, behavior that causes property loss or damage, deceitfulness, and serious violations of rules. They have difficulty interpreting the actions of others and frequently react to the actions of others by escalating the situation into conflict. Children with conduct disorder do not just misbehave. Their conduct clearly involves deliberate repeated aggression or other behaviors in which usual social rules are violated.<sup>4</sup> It is a pervasive disorder, the symptoms of which stretch across most areas of a child and family's life. It is the single most prevalent (2-9% of children) and costly form of child and adolescent psychopathology.<sup>5</sup>

While the etiology of conduct disorder is not yet completely clear, most research indicates that the syndrome is based upon multiple, interacting risk factors. Particularly for those children whose behavioral difficulties begin appearing in early childhood, researchers generally agree Conduct Disorder appears to have some biological roots. Such children, very early on, exhibit temperamental difficulties such as high irritability and poor attachment. From this behavior, an escalating social cycle develops in which parents negatively react to the child with anger or avoidance and resignation. The infant responds to this by learning the anger of the angry parent, or by escalating behavior to refocus the attention of the avoidant caretaker. Bonding, in such a way that allows the infant and toddler to learn normal behavioral cues and responses, never happens. If a child like Brittany is born into a chaotic social situation, the negative cycle is intensified.

The disorder has varying points of onset. Some children, like Brittany, begin to demonstrate symptoms when very young. For these children the condition is frequently chronic. Other children, whose behaviors are not manifest until adolescence, have a better prognosis.

While Conduct Disorder is difficult to treat, it is treatable if intervention comes early, is consistent, and includes mental health, medical, and educational components. The American Academy of Child and Adolescent Psychiatry (ACAP) introduces its treatment guidelines for Conduct Disorder (CD) as follows:

Treatment should be provided in a continuum of care that allows flexible application of modalities by a cohesive treatment team. Outpatient treatment of CD includes intervention in the family, school, and peer group. The predominance of externalizing symptoms in multiple domains of functioning call for ... psycho educational [methods], rather than exclusive emphasis on intrapsychic and psychopharmacological approaches. As a chronic condition, CD requires extensive treatment and long-term follow-up.<sup>6</sup>

What the Academy calls for is a set of community-based, integrated assistance to children and their families. The guidelines, based upon tested treatment approaches to conduct disorder, recommend that intervention include all of the significant parts of a child's life. These interventions should minimally contain educational efforts focused upon teaching the child

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<sup>4</sup> American Psychiatric Association. (1994) *Diagnostic and statistical manual of mental disorders*. Washington, DC, American Psychiatric Association.

<sup>5</sup> Institute of Medicine. (1989) *Research on children and adolescents with mental, behavioral, and developmental disorders*. Washington, DC: National Academy Press.

<sup>6</sup> American Academy of Child and Adolescent Psychiatry. (1997) *Practice parameters for the assessment and treatment of children and adolescents with conduct disorder*. Retrieved December 4, 2002, from <http://www.guideline.gov/VIEWS/summary.asp?guideline=000322>.

strategies to control his/her behavior in the kind of normal settings in which the child lives. Simultaneously, treatment must teach and support all significant participants in the child's life to provide the structure and guidance needed by the child to practice learned skills.

### **Brittany's Course of Treatment**

**The course of treatment followed for Brittany looked little like that outlined by the ACAP. For the first two years after she came to the attention of school and DCF case investigators, Brittany and her family were the subjects of three different treatment plans. Each bureaucracy and the clinicians they involved focused their assessment processes on the *child's* immediate problem as they saw it. The school reacted to the violence they saw which was temporarily resolved by moving Brittany out of regular schooling and into a special program. The DCYS, despite Mr. Evan's pleas, looked only at the issue of abuse. Once that risk disappeared, that agency ceased rigorous involvement with the family. The therapists evaluating Brittany's condition resolved her immediate issues with medication and counseling, but left unaddressed what Brittany, the family, school, and DCYS could do to manage behavior once the family left their offices. At no point is there evidence that any provider undertook a comprehensive assessment of the range of emotional, social, and educational issues Brittany and her family faced, or of the strengths each might contribute to the therapeutic process.**

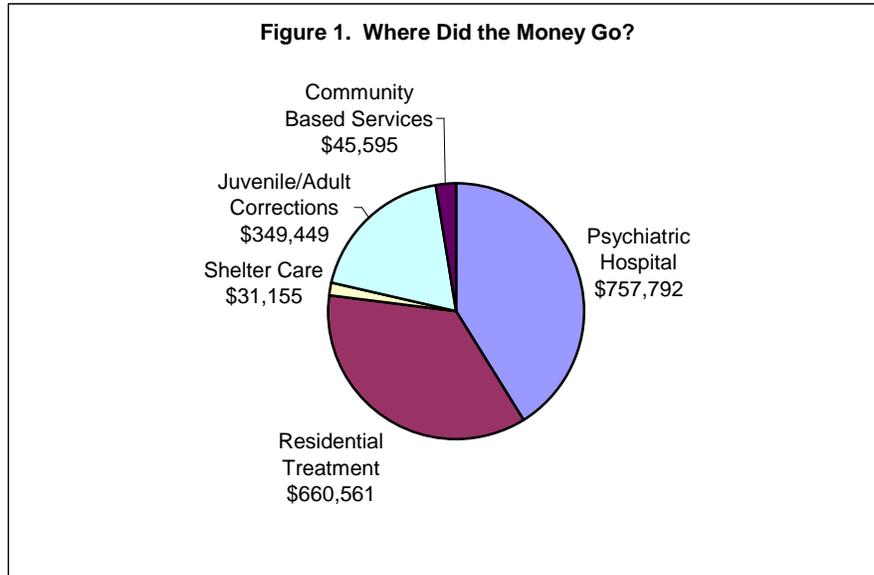
**Once her behavior and the consequences it caused for her and her family reached a crisis point, it fell to DCF and the courts to do *something*. The types of services that existed in the community were inadequate and severely limited. Many of the kinds of assistance that might have allowed the family or schools to manage Brittany's behavior in the community were limited by categorical or durational limitations specified in State and Federal policies. Finally, without the time and training to thoroughly assess and plan for Brittany's care, options that might have been used were never considered. And in the midst of this all, Ms. Brown, who had been through several of these crises before, had no reason to expect any help proposed now would really bring stability to her family, or even be available at all when family or school life spun out of control. At that point, care in a congregate facility appeared to be the only accessible, predictable treatment that the system offered.**

**All immediately seized upon institutional/residential care as the primary treatment option. Nowhere in Brittany's records, however, is there a realistic plan for what the role or goals of residential care was to be other than to get her somewhere safe. While beds in the state psychiatric facility and other residential care facilities were hard to secure, once in one, Brittany's care was never subjected to the kinds of service limitations placed on other less intrusive services. No one, therefore, was ever forced to justify why such care should continue. Brittany was only returned to the community when institutions refused to keep or accept her because of the seriousness of her behavior.**



## THE COST OF FAILURE

The State of Connecticut cannot be accused of being miserly in the treatment of Brittany Brown. Over the ten years in which Brittany was committed in some way to the care of State officials, the Department of Children and Families, State Medicaid, and local school district spent \$1.85 million in traceable, direct costs for her treatment. Of this amount, the State of Connecticut spent some \$1.81 million to maintain Brittany in institutional and residential facilities (See Figure 1). Over the same period, state agencies and her home school district spent about \$46,000 to provide support, therapy and special education services in the community. When averaged out over the 10 years, these costs equaled almost \$500 per day.



Residential and inpatient psychiatric treatment are two of the most expensive treatment approaches available to State human service agencies, yet, in Brittany's case these were almost the exclusive treatment options employed. Stays in DCF facilities, necessitated by the lack of alternative placements or direct court orders, were even more expensive than stays in comparable in-state residential treatment centers and hospitals.

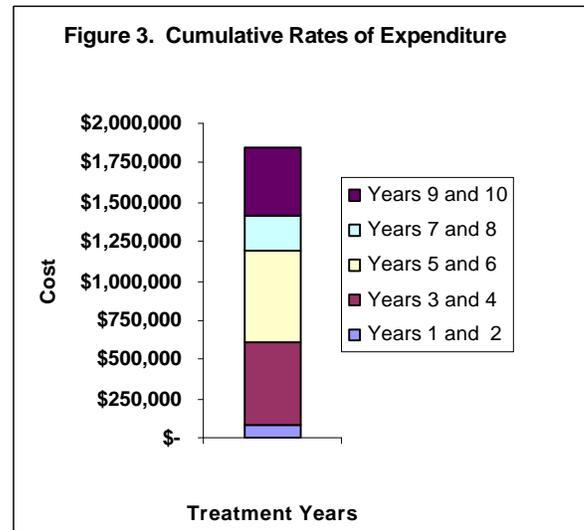
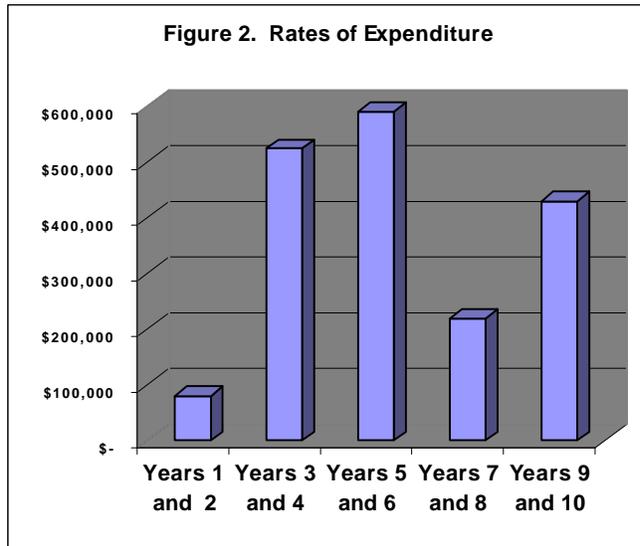
Stays in Riverview Psychiatric Hospital for Children cost the State an average of \$956 per day; Brittany spent 631 days in that hospital. Because of the difficulty in locating placements willing to accept the girl, another quarter of the time the youth spent in out-of-home care was in Department-run residential facilities other than Long Lane. These placements resulted in expenditures of one-half million dollars for board, care, and treatment. Once Brittany was adjudicated delinquent, she was placed in Long Lane School for almost 1-1/2 years; this added another \$340,000 to the residential costs (See Table A for the range of costs associated with each type of facility).

Brittany's stays in non-DCF residential facilities, both in and out of state, ranged in cost from \$104 per day to \$371 per day. While less expensive than Riverview, stays in other psychiatric hospitals or wards still averaged around \$850 per day. Stays in youth shelters, detention facilities, and prison, none of which provided more than basic counseling and rehabilitation sessions to her treatment, contributed a total of \$32,700 to the expenditures. The 4 1/2 month stay in a therapeutic foster home cost DCF approximately \$3700 total.

	Highest	Lowest
<b>DCF Psychiatric Hospital</b>	\$995	\$918
<b>Other Psychiatric Hospital</b>	\$1,066	\$854
<b>DCF Residential Treatment Facility</b>	\$792	\$774
<b>Other Residential Treatment Facility</b>	\$104	\$371
<b>Shelter</b>	\$195	\$145
<b>Juvenile Facility</b>	\$725	\$725
<b>Adult Correction Facility</b>	\$74	\$74

While the public expenditures amounted to less than \$20,000 per year during the periods when Brittany lived, by plan or by default, in community settings, it averaged annual expenditures of over \$250,000 for the years she spent in hospitals, treatment facilities, and correctional

institutions (see Figure 2). The cumulative expenditures on care for Brittany from the time she came into DCYS care at age 8 until she aged out ten years later at age 18 approached 2 million dollars (see Figure 3).



And the accumulated costs presented are only part of the story. They do not include personnel costs and staff overhead, such as the cost of the multiple caseworkers with the Department of Children and Families who held responsibility for overseeing her care and the probation officers with the local court system assigned to supervise her for two years. They do not include the costs for the educators, therapists, social workers and administrators involved in developing regular Individual Education Plans, Administrative Case Reviews, and formal Judicial Case Reviews. Nor do they include non-public costs, such as the expenditures by Ms. Brown's insurance before Brittany was committed to the Department of Children and Families; or those by Ms. Brown and Mr. Evans in lost work, transportation, and contributions to Brittany's basic needs, nor the non-reimbursed costs to providers.

More important, these sums do not contain costs for future services. Brittany's illness never has been brought under control. While the prognosis for children given appropriate treatment for conduct disorder at an early age is now seen as quite good, research on long-term outcomes for young people who have not been systematically treated until late adolescence or adulthood is far less positive.<sup>7</sup>

Shortly, Brittany will be entering the service system of the Department of Mental Health and Addiction Services. Service for young people, ages 18-21, who are referred through that agency's Youth in Transition Program (YITP) cost, on average \$60-75,000 per year; but services can run to as much as \$145,000 per year for very disturbed young people. She has left state care without the employment and living skills to live in the community. Unless the YITP course of treatment is more effective than that provided by DCF, this young adult will require even larger public expenditures for mental health, income support, and, perhaps, even correctional services in the future. Some estimates put the direct costs of providing lifetime adult remedial or corrective services to young people like Brittany as high as \$1.7million.<sup>8</sup>

<sup>7</sup> Moretti, M., Emmrys, C., Grizenko, N., Holland, R., Moore, K., Shamsie, J., and Hamilton, H. (1997) *The treatment of conduct disorder*. *Canadian Journal of Psychiatry*; 42: 637.

<sup>8</sup> Cohen, M. (1998) The monetary value of saving a high-risk youth. *Journal of Quantitative Criminology*. 14:5-33.

## I.

## II.

### III. Is Brittany Extraordinary?

During the Connecticut Fiscal Year 2002, 830 children were in residential treatment in in-state facilities primarily due to some form of behavior disorder. In fact, over half (57%) of the children in in-state residential treatment facilities have been clinically diagnosed with some type of specific behavior disorder.<sup>9</sup> With indications that aggressive and oppositional behaviors are the primary basis for placement for an even larger percentage of children placed in out-of-state facilities and psychiatric hospitals, it is likely that children and youth with issues like Brittany's form a significant proportion of those Connecticut children receiving facility-based therapies.

In the preliminary reviews for this report, we have looked at several other behaviorally difficult children whose stories have been brought to the attention of the Office of the Child Advocate. In many of these cases, the outcomes were or were becoming as dismal as those in Brittany's case, and the costs for long-term removal from the family and community were mounting. For many of these children, help was late in coming and, when the DCF did intervene, its approach was limited to the immediate presenting problems. Once the children began to show signs of oppositionality, impulsiveness, and aggression, the treatment response came to focus on control of the children's behavior, and removal from families and communities. Services that focused upon supporting the children and families in the community were frequently offered but, because of limited availability, these were frequently terminated as soon as the children showed any sign of stabilizing. In other cases, lack of sustained support to families to complement these services ended in poor results and early withdrawal of assistance. Two examples particularly illustrated this pattern.

"Karen", who committed suicide after her behavioral problems led to an arrest and incarceration, had been committed to residential treatment facilities for the last two years of her life at an average- cost of \$121,000 per year. Like Brittany, a child protection report that she had been beaten by her father had brought the teenager into care. But soon, protecting the community from her oppositional behavior consigned her to residential placements. Departmental efforts focused on control of her behavior and only perfunctorily addressed the underlying issues for Karen and her disorganized family situation. When her commitment to the DCF expired, she was released without help back to the same situation in which she lived prior to legal and social intervention. Two months later, Karen hung herself in a local jail cell.

A second child, six-year-old "Alex", came into care because his mother requested help to control his aggressive behavior. Some four years later, residential/ hospital treatment for this child resulted in public costs of \$681,000. For the last year, he has resided in the DCF facility at High Meadow at a cost of over \$700 per day, where his behavior continues to deteriorate. For this child, there is no end in sight. At 11 years old, his mother, overwhelmed and frightened for her family, has asked to voluntarily relinquish her parental rights. It is likely that Alex, like Brittany, will spend the remainder of his youth in some institutional or residential setting. Like Brittany, without a family or significant adult in his life, Alex will lose a chief motivation to get better.

What makes Alex's situation particularly disturbing is that for two years he was assigned to an experimental program that provided case management and community services to the boy and his family so that he could remain in his own home. Once that program was able to secure Alex's discharge from placement, case managers were able to put in place an intensive, coordinated, comprehensive system of help to the family that largely maintained the child in the home for over one and a half years. The cost of that effort? Less than \$100,000 per year, almost \$75,000 less than the DCF was spending on residential services. After the completion of the family's participation in the time-limited pilot program, the supportive services it provided were withdrawn because of budget limitations.

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<sup>9</sup> Research Support and Analysis Division. (2002) *Residential treatment centers: aggregate data FY2002*. Hartford, CT: Connecticut Department of Children and Families, Performance Based Contracting.

Within months Alex's mother became overwhelmed and refused to continue caring for him. He has entered the same cycle as Brittany.

## The Alternatives

The problem with the course of treatment pursued for Brittany and the other children we have reviewed was not simply that it was expensive. The larger problem was that it relied almost exclusively on highly disruptive treatment (residential or hospital treatment) that did not address the real needs and strengths of Brittany and her family. Little effort was made to provide less invasive treatment, or even to assist her and her family in benefiting from the solutions that were tried. Limited time and expertise led caseworkers to fail in implementing "comprehensive" assessment and treatment, and service provision policies misguidedly sabotaged the very cost effectiveness that they sought to impose. As a result, the types of intervention that might have helped were never, or only sporadically, put into place. In many ways, after the expenditure of such large amounts of money, Brittany's ability to deal with her condition was no better and probably worse than when she entered care. Connecticut's reliance on sustained removal from community and family may well have contributed to the deterioration of the very condition the DCF sought to treat. Moreover, Brittany's overall ability to function as a young adult was diminished by years of institutional living.

She has no real ties to family or community, no direct experience of how one lives a non-regimented, non-institutionally directed life, and, to the extent that her previous therapy has given her any insight into resolving the issues she faces, no methods for transferring what she has learned to a world of normal social interactions.

Research findings over the last ten years have identified several factors associated with effective treatment approaches:

- ? For children with an early onset of conduct disorder, the earlier treatment begins, the more promising the prognosis for the child. For many children, their behavior creates an escalating pattern of disruption and negative reaction. The earlier this pattern can be interrupted, the less damage a child will suffer.<sup>10</sup>
- ? Because the disorder affects children in all their social realms, to be effective, treatment must be coordinated among all the systems in which the child acts.<sup>11</sup>
- ? Behavioral strategies emphasizing coercion and control are clinically ineffective as are approaches that focus solely on individual therapy with the child and pharmacological treatment. Psycho-educational approaches that teach children to read social cues more accurately and control their anger, and that teach parents affective ways to manage children's behavior appear critical to positive outcomes.<sup>12</sup>
- ? Clinicians must recognize the important role of the parent-child relationship and the quality of their attachment in this disorder. Interventions must focus on rebuilding and supporting this bond.<sup>13</sup>
- ? It is more clinically useful to view conduct disorder as a chronic condition requiring long-term management with periods of intensive intervention.<sup>14</sup>

Limited knowledge of effective interventions, serious limits on the availability of resources other than residential care, policy constraints, and institutional culture, all overwhelmed consideration of these factors by the caseworkers, therapists, judges, and others in making decisions in Brittany's life. Not only are mechanisms to implement effective treatment modalities absent from her

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<sup>10</sup> Kazdin, A., (1997). Treatment of conduct disorder: Progress and directions in psychotherapy research. *Development and Psychopathology*. 5:277-310.

<sup>11</sup> National Mental Health Association.

<sup>12</sup> Kazdin, A. (1997).

<sup>13</sup> American Psychiatric Association. (1994) Diagnostic and statistical manual of mental disorders. Washington, DC, American Psychiatric Association.

<sup>14</sup> Moretti, M., et al. (1997).

treatment plan, many of the service approaches that were used (long-term residential treatment away from the child's natural systems, a pattern of placements in which the level of coerciveness escalated in response to increasing disruptive behavior by the adolescent, counseling for the family that focused almost exclusively on relationships and issues of feelings, and reduction in effort as soon as immediate symptoms receded with no longer term plan for follow-up) were antithetical to effective treatment of the disorder.

## Other Approaches to Treatment

Given what is known from research, it is clear that several different approaches might have managed or even reduced the symptoms of Brittany's condition more effectively than almost permanent residential and institutional placement. Several of these approaches demand new, upfront investments in services and would not necessarily have been inexpensive, but they clearly would have been more cost-effective in the long run than years in treatment outside the community. The approaches outlined are based upon treatment methods that have proven to be successful in research programs. All are built upon three known strengths in Brittany's situation: 1) Brittany was intellectually capable of learning and could be a socially engaging child; 2) her mother and family initially were willing to care for her if they had support; and 3) the Brown/Evans were a stable family unit whose home, while stressed, offered no threat to Brittany's safety or well-being.

Which approach of the approaches outlined below might have worked best depends on when the agencies of State government intervened. In fact a course of treatment might have included elements of all of these.

### i. Prevention

Given that research demonstrates a strong correlation between poor parent-child bonding and the development of conduct disorder, it seems reasonable to conclude that the trauma and regular separation that characterized Brittany's infancy and early childhood played a role in the development of her symptoms. The actions of her biological father do provide some evidence of a genetic link. However, a first year of life spent either with a mother who is seriously depressed and holds some resentment for her surviving child or with a regularly changing cast of caregivers could only intensify any biological/ chemical problems.

Ms. Brown was a new mother who returned home with only one of the twin children she had carried to find that her husband had murdered one of her older children. She had shown serious signs of depression through most of her life. She and her two girls were a family at risk and undeniable candidates for a neonatal home visiting program. Although not available during Brittany's infancy, since 1996, the Connecticut Children's Trust Fund has provided grants to local organizations to implement a Healthy Families home visitation program. Such programs provide nurse and/or paraprofessional home visitors to families for the first two or three years after the birth of a child. The primary purpose of the program is to assist mothers and their newborn children in bonding. These visitors provide support, encouragement, education and supervision for at-risk families; they assess family needs; and manage services to meet these needs.

In the Brown's situation, nurses or family aides might have lent support to an overwhelmed mother, identified the mother's need for therapy for her depression, and assisted both the mother and concerned family members in identifying ways in which Ms. Brown could be supported while not supplanting her role as the primary caregiver for her infant daughter. They also might have identified, much sooner, some abnormal behaviors of the baby, had these appeared.

National studies have identified the average per-family costs of such services using nurses as about \$6200 per year for three years.<sup>15</sup> The average annual cost per family in the Healthy Families program, which uses trained para-professionals, is \$3200.

a.

## b. Early Intervention

As Brittany entered her pre-school years, other help might have been made available by a school readiness intervention program. One of the factors that stands out as critical in determining the efficacy of any treatment method for conduct disorder is the age at which intervention is initiated.<sup>16</sup> By the time she was in pre-school, Brittany was already showing a high level of aggression and low-tolerance for frustration. The reaction of a regular preschool program to this behavior was to remove her and cause her yet one more cycle of loss.

If, through HeadStart or a similar early childhood education program, Brittany's behaviors had been identified as signs of a psychiatric disorder, the school program might have provided an early entry into treatment for her and her mother. Alerted early on, the educational system could have set up a structured and intensive approach, treating Brittany in the two primary contexts in which she exhibited problem behavior- school and home. With the home-school linkage that is part of such programs, Ms. Brown and the preschooler's teachers would have had the opportunity to learn strategies for managing Brittany's problem behaviors. Behavioral therapy could have taught Brittany more appropriate ways to deal with frustration, anxiety, and anger. Such intervention might have short-circuited early the escalating cycle of anger and rejection that characterized Brittany's entire childhood. While treatment at this point might not have eradicated the symptoms of the disorder, it would have provided protection against the failures and regular losses the little girl experienced from her earliest years. In fact, the Partners program, which operates in conjunction with HeadStart programs in several States across the country, has proven to be successful in reducing the level of conduct problems in HeadStart children. The Partners program supplements the traditional HeadStart school readiness goals with an initiative to work with parents and teachers around school involvement and behavior management strategies.

While local cost analyses are incomplete, several studies have been done on HeadStart and other school readiness programs. Early intervention through school or center based programs currently cost about \$6633 per year.<sup>17</sup> Programs like Partners add average annual costs of less than \$4000 per year to the basic HeadStart costs.

### 1) Treatment of Active Symptoms

Since no formal application (on record, at least) had been made by or about the family to any service system—other than Ms. Brown's approach to child guidance clinics—these early interventions remain in the realm of "If only..." By the time Brittany was 8 years old, however, two public institutions/ agencies did have the chance to intervene. Both the school system and DCYS acted in a way that solved the immediate issues that confronted their organizations. But, they left the child and family issues only temporarily contained and when the inevitable crises arose again they reacted, with the approval of frustrated and overwhelmed parents, by removing Brittany from her home and community. Both systems might have done several things differently in 1992 had the supporting policies, services, and resources been available. The approach is known as "wrap-around", the approach now embraced through the State of Connecticut's Kidcare program.

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<sup>15</sup> Karoly, L., Greenwood, P., Everingham, S., Hoube, J., Kilbourne, M., Rydell, C., Sanders, M., and Chiesa, J. (1998) *Investing in our children: what we know and don't know about the costs and benefits of early childhood intervention*. Santa Monica, CA: Rand.

<sup>16</sup> Moretti et al., p. 637.

<sup>17</sup> 2002 HeadStart factsheet. Retrieved October 15, 2002 from [http://www.acf.hhs.gov/programs/hsb/research/factsheet/02\\_hsf.htm](http://www.acf.hhs.gov/programs/hsb/research/factsheet/02_hsf.htm)

The evaluations that were done on Brittany indicated, especially early on, that most of the care Brittany required could have been delivered in a community setting. Given the multiple separations that she had already experienced, and given the potential link indicated in the research literature between these separations and her behavior, it was counter-productive to use a treatment process that centered upon yet one more separation from the familiar environment of Brittany's home and family.

The family made several specific requests that indicated they knew what they needed at that point. Mr. Evans pleaded that any help the family received include assistance in managing Brittany's behavior at home and in school. Ms. Brown asked for two things- consistent support in dealing with her troubled daughter, and help with arranging after-school care for Brittany so she would not lose her job. Brittany's ideas about what she needed are not given, except that she did make clear that she did not want to be sent from her home, and that she was in turmoil. It is possible to develop a treatment plan that meets each of these needs, and does not require long-term use of institutional and residential services.

Because Brittany's behavior problems affected her and her family through so many realms, a first step would have been to identify one consistent person who could serve as a central organizer of the care put into place. In the parlance of Kidcare, the Brown/Evans would have benefited from the assignment of a case manager. This manager would have had responsibility for comprehensively assessing the entire family system. He/she would determine not just what was wrong with Brittany (or Mr. Evans, or Ms. Brown or the school system) and how immediate behavior could be controlled, but also what strengths and problems were inherent in the family and the rest of Brittany's environment. This assessment would lead to a comprehensive plan to keep Brittany safely with her family. The case manager would assist the family in identifying how treatment of the core issues should progress.

Of even more therapeutic importance, this case manager would have served as a support for the family. The supportive relationship with the case manager could have provided the base upon which the entire treatment program was built. He/she would be available for guidance and assistance in times of crisis. The case manager would have assisted the family in negotiating multiple systems and providers; brokered and advocated for services for the family; and reassured a family under extraordinary stress that they would not be abandoned. Finally, in well-developed case management models, this case manager would have provided a stable, consistent source of assistance to families for understanding the issues they face and using the services available in the most effective ways. This individual has primary responsibility for "doing whatever it takes" to engage the family in services.

The costs for this case management approach are somewhat higher than usual casework costs because, in order to provide such intensive, individualized services, caseloads in a quality case management program are half of those now common in the DCF. In the demonstration program referenced in Alex's case above, such a case management arrangement cost the agency providing it an average of \$9,600 per year per child. Studies from a national study of other community programs that rely heavily on clinical case management, point to slightly higher annual cost projections with an average of about \$9,800.<sup>18</sup>

The initial intervention would have to focus on teaching the Browns/Evans and Brittany strategies for controlling her behavior. Recent research indicates that an approach known as Multi-Systemic Therapy (MST) has been very effective in reducing childhood and adolescent anti-social behavior. This approach relies on well-planned interventions targeting specific problems in a coordinated manner across all systems in which the child interacts. It educates all involved about how to manage specific behaviors of the child. It seeks to mobilize the strengths of the child and of the systems as levers for change. While MST would not have "cured" Brittany, it may well have enabled the youngster and those around her to manage her behaviors. Reviewing both the family dynamics and the treatment literature concerning conduct disorder, a reasonable MST treatment plan might have included behavior management training for the parents and therapy for Brittany that focused upon teaching her techniques to more correctly read social cues and methods to reduce her level of anxiety and frustration. Simultaneously, caseworkers and educators with the program would also work with teachers, other family members, and other adults who would be responsible for Brittany to teach tested methods for working with her to manage her behavior, and insure consistency in the home-school-community approach to her care.

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<sup>18</sup> Conversation with Timothy Connor, ORC Macro Inc, researcher on the Community Mental Health System, System of Care Evaluation, September, 2002.

When Brittany needed it, this type of multi-system approach was not available. With the advent of Kidcare, the DCF is currently contracting with private providers to begin offering this kind of help. While the service will be available for only four to six month periods, maintaining a child and family in the program for one year would cost approximately \$6,800.

Some of the psycho-educational work with Brittany could have taken place within a daily extended-day treatment program if such programs did not have strict time-limited funding arrangements. This would have delivered needed therapy to Brittany in a more natural social setting. Further, it would have responded to the immediate stress that caring for a difficult child created within the family, and eased concern about the ability of lay babysitters to safely supervise Brittany after school. Over time, the need for such an intensive setting might diminish, although some type of therapeutic day care and outpatient counseling might be needed for much of her childhood. The average annual cost for after-school extended day would be about \$32,000, if managed care providers allowed such a length of stay. Therapeutic, long-term after-school care is not readily available in Connecticut. Several small proprietary day care sites have arisen around the state, but these serve few children. Costs for these centers are annually about \$31,000. National studies indicate the average costs of such care in not-for-profit centers to be about \$16,860 per year.

**Table B.**

<b>Community-Based Service</b>	<b>Annual Cost</b>	<b>Estimated</b>
Healthy Families Home Visiting		
HeadStart with Parent Partnering	\$10,633	
Intensive Case Management	\$9,600	
Supportive Case Management	\$3,200	
Multi-Systemic Therapy	\$6,800	
Extended-Day Treatment	\$32,000	
Special Needs Day Care	\$31,200	
Medication and Monitoring	\$6,000	
Family/Individual Therapy	\$7,500	

The treatment plan for the Brown/Evans also would have had to include regular clinical work with the family. While psychotherapy and pharmaceutical interventions were not successful on their own, they were critical to the overall treatment of the problems of this family. Regular family and individual therapy, preferably in the home, would have assisted the family in dealing with their relationships to each other, and would assist Brittany in dealing with emotional issues that interfered with her ability to participate in behavior management programs. The DCF has recently entered into contracts with Child Guidance clinics and other providers for Intensive In-Home Child and Adolescent Services (IICAPS) that could meet this need. Costs to DCF for IICAPS services are expected to average about \$7500 per year per child.

In addition, the Conduct Disorder and the depression and anxiety Brittany experienced would be treated to some degree with proper medication. The cost of these medications, which were hidden in the overall residential costs, would probably vary significantly. In the last year of Brittany's care at High Meadow, her medical regimen cost Medicaid about \$200 per month, or about \$2400 per year. Medical oversight of her pharmacological therapy, including physician assessment and lab fees, adds additional annual costs estimated at \$3600.

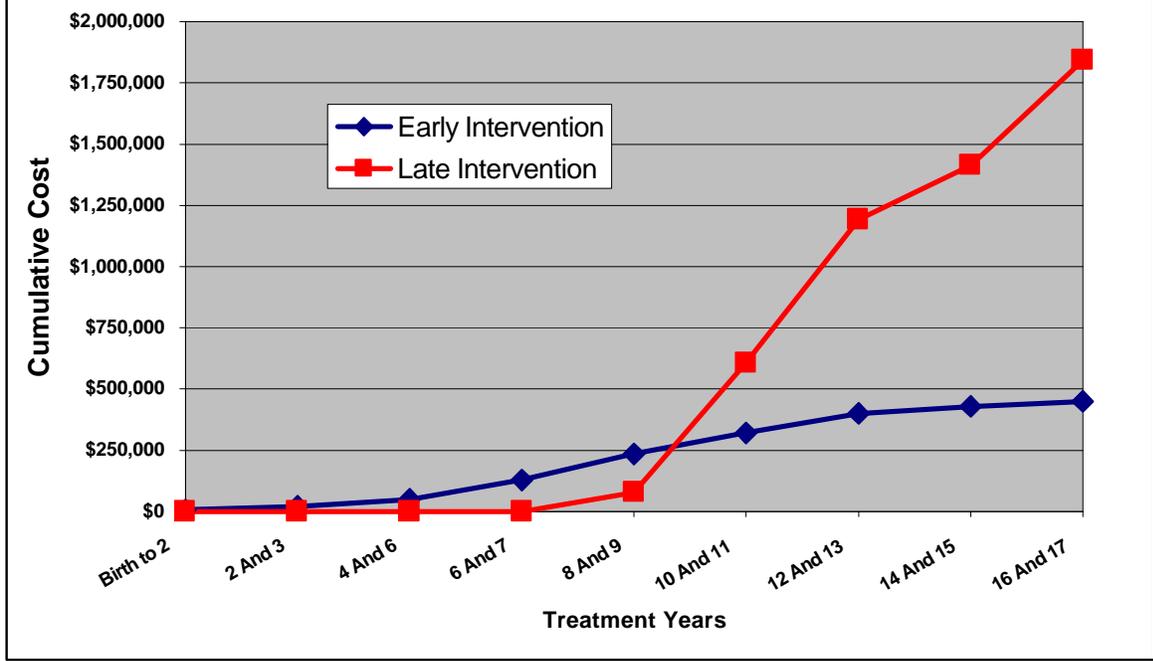
If the State of Connecticut were to have put the most intensive mix of these services in place for the first three years after DCYS became involved with Brittany Brown's family, it would have spent an average of \$56,700 each year for her care. The Local Education Authority would have spent its average \$14,000 per year to maintain her in a community classroom. Even if some level of less intensive support was needed after the first three years (e.g., a case management aide, special needs after school care, and continuing pharmaceutical therapy) it is unlikely costs for these services would have risen above about \$41,000 per year, and likely would have fallen further as the need for expensive after school care diminished (see Table B).

Within this mix, hospitalization and short-term residential treatment still have a place. They might have been needed in a crisis, when Brittany became a danger to herself or others. Or, they might serve as a structured transition in the treatment process. It would not be surprising to see Brittany and her family making use of the resource as a well-planned, goal-oriented part of the treatment mix. However, these would not comprise the sole treatment response to the family needs. Any use of services that removed Brittany from her family and community also would have to include very specific mechanisms to maintain family linkages, and formal procedures and supports to ensure smooth, effective transitions back to home, school, and community.

Assuming Brittany and her family were able to establish some level of stability within the first two to three years after a treatment plan was put into place, it would have been possible to reduce the level *but not discontinue* assistance to the family. Conduct disorder with an early onset is frequently a chronic condition, and requires regular monitoring. Periods of stability may well be interspersed with acute behavioral degeneration. Minimal levels of service may be needed through Brittany's life to keep her and those around her safe, and to give her family the support they need to manage her care. There still could be long-term costs for caring for Brittany. The young woman may need some level of therapy and support for most of her life. She may need periodic hospitalizations. She may have some limitations on her earning power because of her condition.

But Brittany Brown would not now be an institutional child. She would have had solid and consistent parenting and therapy to teach her strategies for managing her behavior instead of a long list of failures. She would be linked to a normal family and to a community in which she could practice her skills. She would have the experience and the support to enter adulthood with some knowledge of what life in a non-regulated world is like. Instead, Brittany's course of care has thus far cost her a life in a home and community. For the loss of a childhood and neglected preparation for adulthood, the state has spent nearly 2 million dollars. Early intervention and full support for Brittany and her family could have cost considerably less than the cost of failure (see Figure 4).

Figure 4. Potential Savings from Early Intervention Strategy



*a) Appendix I: Methodology*

In selecting the case highlighted in this review, Child Advocate staff chose from cases recently brought to their attention based upon concerns about the appropriateness of services provided. In general, advocates identified cases in which parents and professionals had contacted the Child Advocate because the services delivered to the reported children over several years seemed to be ineffective in meeting the children's needs, and yet no more effective assistance was being made available. From these reported situations, we selected several children's cases based upon the case handling issues raised by the original report and not upon any knowledge of costs.

We subjected these records to a more detailed review and cost calculation. For each of the children studied, we collected actual agency expenditures from the Department of Children and Families for board and care payments, from the Department of Social Services for Medicaid fee-for-service payments, from the Department of Education excess cost reimbursements to the children's home districts, and the Court Administration Offices for juvenile service and detention costs. We also collected from the Department of Education special education service utilization data from which we have projected an average annual special education costs for each child. Because the focus of this report is on public expenditures, we have not secured reimbursement data from private insurance carriers, nor have we calculated the contributions of families.

Finally, we have proposed several alternative treatment scenarios for the child featured in this report. For each of these alternatives we have estimated the costs of the particular constellation of services proposed. We have based these projections on current service costs using, if possible, Connecticut program cost averages. Where there appears to be no locally provided service, or where state agencies have done no unit of service cost projections, we have used the most recent national data available for programs that seem similar to those in the proposed treatment plan.