

EXHIBIT L

confronting the children who find themselves involved in the child protection system in Connecticut.

3. From the inception of the *Juan F* litigation, among other systemic failures, the lack of services to “at risk” children to keep families together, also known as family preservation services, was a key systemic problem. The absence of such services, especially mental health services, placed children at imminent risk of harm in terms of their deterioration and in terms of the family’s chances of remaining intact. It was not uncommon for children to have to be committed to state custody just so they could get services, as the State’s child welfare agency is the sole source of mental health treatment for children whose families are poor or who are otherwise not covered by private insurance.

4. The Consent Decree, entered in 1991, included in the class definition “at risk” children, as well as children committed to state custody as abused and neglected or abandoned. The Consent Decree created Voluntary Services Units. Voluntary Services includes the provision of casework, community referrals, and treatment services to children with behavioral health needs without requiring parents to relinquish custody or guardianship. This was a critical systemic improvement in the protection and well being of children, providing specialized and sustained mental health care while keeping children in the care of their families. The program, which started as a pilot program, was eventually implemented statewide as the Voluntary Services Program (VSP) and consistently serves approximately 1,000 families at any point in time, with new intakes added regularly.

5. The VSP includes all DCF-funded behavioral health services, including mobile crisis, care coordination, extended day treatment, home-based services, respite services, family advocacy, child guidance clinics, residential treatment, group home

placement, and other individualized services and referrals. Children in the VSP also receive critical case management services, including treatment plans and assigned social workers who must visit the children regularly to ensure their safety and well-being and so that they are progressing under their treatment plan. By definition, children eligible for VSP are “at risk” children within the meaning of the *Juan F* class.

6. The protection of “at risk” children under the *Juan F* litigation was reaffirmed in 2003 with the creation of the Exit Plan, and the Revised Exit Plans of 2004 and 2006. The class definition still includes the same definition of “at risk” children as in the Consent Decree. Many of the outcome measures in the Revised Exit Plan apply to “at risk” children in the VSP, ensuring that they will get the protection of the federal *Juan F* Consent Decree.

7. Since the Exit Plan was first entered as a court order in 2003, through the present, CCA has represented over 800 children, many of them receiving the benefits of the VSP. These services – and the imminent and irreparable harm that will result if the State and DCF proceed with their plan to eliminate new intakes into the VSP – have profound consequences in the lives of children and families. Below are descriptions of several client children whose lives have been profoundly affected by the availability of services they received after they qualified for the VSP.

- For example, Edward B.¹ was the product of a rape, born to a twelve-year-old mother, and grew up in a household where he was physically and sexually abused. At fifteen, he became involved with the juvenile justice system after inappropriately touching a younger half-sibling. As a result, Edward could no longer live with his mother and younger siblings, when he completed his juvenile justice placement and his family did not have the resources to address his mental health treatment needs. He qualified for voluntary services and was placed in group home in another city, received

¹ Pseudonyms have been used to protect the identity of the children and youth. Should the court need the real identities, counsel can provide such information.

counseling, and was enrolled in a special education placement where the smaller class sizes and structured environment allowed him to thrive academically.

- Nicholas R. is a twelve-year-old child diagnosed with ADHD and depression who had struggled with behavior in school, to the point where he had to repeat seventh grade. His family did not have the resources to meet his treatment needs. He qualified for voluntary services, and he and his mother received IICAPS² counseling in the home to help with behavior problems there and at school, and he was connected with a psychiatrist who prescribed medication for his ADHD. Teachers and administrators reported a complete change in ██████'s behavior and academic performance: He went from being almost uncontrollable in a small classroom with all special education students to mixing easily with non-special education students in a noisy cafeteria, making huge progress on recovering a lost year of reading and writing lessons in a matter of months, and emerging as a leader among his peers in defusing fights and confrontations.
- Jose G. is a 14-year-old freshman diagnosed with ADHD, who was facing major behavioral problems, compounded by linguistic and cultural difficulties because he was primarily Spanish-speaking but attended school in a predominantly white, English-speaking suburb. His family did not have the resources to address his treatment needs. He qualified for voluntary services and was connected with an IICAPS social worker who spoke Spanish and was able to serve as a strong advocate to get Jose special education services.
- Rosa T. is a 17-year-old diagnosed with depression. She has struggled in school, at home, and socially for several years. She has attempted suicide as a result of her depression. Rosa and her family are very poor immigrants. Her family did not have the resources to address her treatment needs. They do not have any health insurance. As a result, she did not have money to pay for medication or mental health services for her depression. When she began receiving voluntary services from DCF, she was provided with critical mental health services, including an FST worker from Catholic Charities.³ DCF has also paid for her medication to fight her depression. Without voluntary services, Rosa would not have been able to access her needed mental health care and medication at all.
- Seven year old Justin, even at his young age, already carried diagnoses of generalized anxiety disorder and bi-polar disorder with psychotic features,

² IICAPS stands for Intensive In-Home Child and Adolescent Psychiatric Services, which provides home-based clinical treatment to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to psychiatric, emotional, or behavioral difficulties.

³ FST stands for Family Support Teams, which are multidisciplinary teams that provide an array of intensive treatment and support services to children, youth, and families in their homes and communities.

and had been hospitalized and treated with a variety of psychoactive medications. Justin received special education services from the public school system, yet these supports were inadequate to meet his extensive needs. Justin displayed two virtually different personalities, described auditory hallucinations, labeled himself a “bad boy” and presented with periodic suicidal ideation. His family did not have the resources to address his treatment needs. He qualified for voluntary services and eventually, both his mother and the school system relied on key therapeutic wrap-around services to provide supports critical to keeping Justin in the community. Justin was able to be maintained safely in his home with the help of IICAPS, out-patient counseling, a parent-aid, and a therapeutic mentor.

8. These are truly just examples of the critical nature of the services provided by the VSP.

9. On August 31, 2009, the Connecticut State Legislature passed the FY 2010 state budget, which went into effect on September 8, 2009. Over the next few months, Governor Rell announced a series of unilateral spending cuts, called rescissions, reducing state agency budgets.

10. I recently became aware of the most recent budget rescission by the Governor, which includes an explicit plan to cease all new intakes to the VSP program. I was also recently informed that the cut-off of new intakes into the VSP will occur sometime during the week of December 7, 2009. I am unaware of any substitute plan by DCF or substitute sources that will guarantee that “at risk” children and families will receive the same critical services that they would have received under the VSP.

11. Based on my over twenty years as an attorney representing children and families in CT, my experience as counsel on the *Juan F* case for 15 years, and the numerous clients our office has represented who have received VSP services, the state’s plan to cease all new intakes to the VSP places “at risk” children at imminent risk of irreparable harm. Without the VSP, there is no obligation on the part of the state to provide

these critical services. As a result, and especially given the cuts to mental health services in the Governor's budget as approved by the legislature, and the subsequent rescissions that further cut critical services to children, many children will go without desperate needed mental health services and will suffer severe deterioration as a result, placing the family at risk of not being able to properly care for the child and forcing some families to have to place their child into DCF custody just so the same services can be provided.

12. The harm to children and their families of being forced to have a child placed in DCF custody just to get mental health services was so significant that the Connecticut legislature passed a law, Public Act 97-272, in 1997, prohibiting a child from entering DCF custody solely to receive mental health services.

Martha Stone

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Sworn to before me this *7th* day of
December, 2009.

Carroll N. Quinn

Commissioner of Superior Court