

Strategic Review of CJTS/Pueblo Girls Program Policies and Practices

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Scope of This Consultation

I began this consultation in December 2014 following initial communications with Superintendent William Rosenbeck and a meeting with DCF Commissioner Joette Katz and some of her staff. The goals of this consultation are to: (1) review policies and practices at Connecticut Juvenile Training School (CJTS) and the nearby Pueblo Girls Program (hereafter, Pueblo Unit); (2) to place the components of the juvenile justice system operated by DCF in a national context to help identify strengths and challenges; and, (3) to offer policy, operational or practice recommendations as may be helpful in addressing current needs while also crafting a “strategic road map” for DCF juvenile justice operations over the next 3 – 10 years.

I was given free access to senior DCF officials and CJTS and Pueblo Unit administrators, staff and records. I was authorized and encouraged to communicate freely with stakeholders such as persons affiliated with the Office of the Child Advocate, Center for Children’s Advocacy, Connecticut Juvenile Justice Alliance, the juvenile defense bar including the Office of the Public Defender’s post-conviction unit, family engagement advocates, current and former members of the DCF Commissioner’s Advisory Board for juvenile justice matters, and others.

As I began this consultation, I was made aware that critics of DCF have held that the policy goal of serving youth on its child protection and juvenile justice caseload in Connecticut programs and communities has been compromised by prematurely closing congregate care and residential facilities and while at the same time sharply drawing down the number of youth in programs out of state. While the return of youth from out-of-state care is widely viewed as laudable, critics have argued that one major consequence of congregate care and other out-of-home bed capacity has been

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unwarranted reliance upon deepest-end secure facilities such as CJTS and Pueblo Unit for youth who should be served elsewhere on a more adequate continuum of care.²

I was also made aware that the context of the beginning of this consultation also included controversy and media coverage regarding the management of Jane Doe³ and the reorganization by Commissioner Katz in early December 2014 of the CJTS Advisory Board.

The focus of my consultation is on CJTS and the Pueblo Unit but it is not possible to adequately identify and address issues at those facilities without taking into account the other components of the juvenile justice system in Connecticut, particularly those which are DCF juvenile justice operations. Where relevant, aspects of those and other component will be considered but this consultation is not intended as a comprehensive review of the juvenile justice system in Connecticut, or even the regionally-based juvenile justice operations of DCF.

One advantage to coming to this consultation from outside of the Connecticut juvenile justice system is that I bring a relatively naïve understanding of that system although I have more familiarity with other juvenile justice systems across the United States.

There are also disadvantages to coming to this consultation from outside of the Connecticut system. One disadvantage is that the consultation required that I come to understand the history, complexities and nuances of the juvenile justice system (and other systems) in Connecticut. I have made my best effort but appreciate that my grasp may be imperfect.

A second disadvantage—and one that I found to be problematic among the individuals and entities with interests in CJTS/Pueblo Unit—is that there are disagreements about the reliability of basic information and the nature of facility procedures which are sources of tension among interested parties. For purposes of this report, I have relied upon information which, in my judgment, was likely to be the most reliable information available while appreciating that others may have conflicting information or perceptions.

These disagreements about the reliability of information about CJTS/Pueblo Unit and its operations have contributed to contention, miscommunication and mistrust among state leadership and staff, the juvenile justice legal community, advocates, and others.

² There was a spike in admissions during 2014 but at the time of writing this report the CJTS census is at an all-time low.

³ Jane Doe is a transgendered youth whose high needs and high risks posed significant treatment and safety management challenges, and who attracted considerable professional and media attention.

As I reviewed information provided to me from a number of stakeholders, I concluded that the problem does not arise from efforts to mislead, misrepresent or “spin” information. I concluded that information I was provided from various stakeholders—particularly quantitative information more independent from individual perspectives or interpretations—was largely reliable. However, at times there were delays in gathering information due to vulnerabilities in current information technology systems or ability to readily utilize existing databases,⁴ potentials for misunderstanding the meaning of data or information, and challenges in distinguishing information reflecting routine practices or events and those that were atypical.⁵

I am convinced that each of the persons with whom I communicated in the course of this consultation are dedicated to the best interests of the youth at CJTS/Pueblo Unit. That being said, I am equally convinced that the current atmosphere is corrosive to those best interests as opportunities for good faith collaboration give way to contention.⁶

Finally, I acknowledge that I could not possibly give to all of the important issues raised the attention which they deserved although they clearly have relevance to the CJTS and the Pueblo Unit.⁷ I have identified some of these in the footnote below since they warrant ongoing attention.

The people with whom I interacted during the course of this consultation were generous with their time and with the information and perspectives they shared with me. I undoubtedly have misunderstood or miscommunicated some of what I heard and read, and for that I take complete responsibility. However, I hope that I understood well enough and deeply enough to be helpful to DCF, the legal and advocacy community, the administration and staff of CJTS and the Pueblo Unit—and through all of you and your

⁴ For example, some quantitative information needed to be individually gathered from different sources and compiled rather than being automatically gathered or available in a database.

⁵ For example, it took time and input from several sources to get a picture of the pattern of restraints and seclusions, the policies and practices involving them, and a sense of the characteristics of more routine incidents and those that were atypical.

⁶ Superintendent Rosenbeck informed me towards the end of the consultation of a meeting that included the Office of the Child Advocate and other which included discussion regarding the reliability of information, methods of data-gathering, and discussion of how to optimally utilize the CONDOIT system. He indicated that the intention is to establish a regularly scheduled meeting the OCA and other stakeholders to discuss issues of concern. I suggest that these meetings occur at least quarterly but perhaps more frequently until the currently contentious atmosphere abates.

⁷ These include: (a) how to better identify and support youth who are members of faith communities or to engage faith communities as assets for youth upon re-entry; (b) the work still to be done in communities with family engagement to lower the likelihood that a child will ever be admitted to a hardware secure juvenile justice facility, or still to be done in engaging families whose children are placed at CJTS or Pueblo Unit; (c) or addressing disincentives for experienced staff to become assistant unit leaders; (d) the particular challenges of dually-involved youth (child protection/juvenile justice); or (e) differences in regional operations and resources that impact upon admission and discharge of youth to CJTS/Pueblo Unit.

shared commitment to the well-being of these youth and the communities to which they will return.

Overview of CJTS and the Pueblo Unit

The Connecticut Department of Children and Families (DCF) operates programs and facilities to serve juveniles who have been adjudicated on delinquency cases. The two “deepest end” facilities are the Connecticut Juvenile Training School (CJTS) (males ages 12 – 20) and the Pueblo Unit (females ages 12 -20). These facilities are hardware-secure⁸ facilities in Middletown, CT.

Connecticut Juvenile Training School: CJTS is comprised of six buildings within correctional perimeter fencing and placed around a central courtyard capacity. It has bed capacity for 145 males. It is accredited by the American Correctional Association. In 2013, construction was started to renovate living units and create capacity for educational and vocational programming, especially given the entry into the juvenile justice system of 16 and 17 year olds.

On average, approximately 50% of youth have identified special educational needs and the three most common behavioral health diagnoses are Conduct Disorder, Cannabis Abuse, and Attention Deficit Hyperactivity Disorder. Approximately ninety percent⁹ of youth warrant two or more psychiatric diagnoses.¹⁰ Youth are placed on an intake unit upon admission for 30 days during which they receive assessment and case planning services before assignment to one of the housing units.¹¹

In 2013, there were 252 admissions¹² with an average daily census of 124, an average length of stay of 6.1 months, and dispositions of 72% discharged to their homes while 19% were transferred to a residential setting. That year, 203 of the 252 boys were ages

⁸ There is a range of security levels among hardware secure facilities. Unlike some juvenile justice facilities, CJTS and Pueblo Unit do not utilize armed correctional staff, razor wired perimeters, or disciplinary segregation units. The law enforcement presence has been reduced to one officer. The Pueblo Girls Program itself is a locked unit that without additional external perimeter security measures such as fencing.

⁹ Information provided to me ranged from 88% - 94% and may have reflected different points in time.

¹⁰ Nationally, research has consistently found that approximately 70% of youth involved in juvenile justice warrant a psychiatric diagnosis with some 55% warranting two or more diagnoses. National research reports that 20% of youth involved in juvenile justice have a “significant mental health disorder” while CJTS/Pueblo reported in May 2015 that 34% (30 of 89 youth) had a significant mental health disorder. The higher rates found at CJTS/Pueblo Unit may reflect a better capacity to identify behavioral health needs given the intensive intake assessment process, a consequence of disproportionate minority contact and confinement which skews youth (especially males) of color with behavioral health needs toward the juvenile justice system rather than the behavioral health system, community-based interventions insufficient to prevent delinquent youth with significant behavioral health needs from progressing towards institutional placement, and/or other factors.

¹¹ One inadvertent consequence of movement from the intake unit to a residence unit is the disruption of stabilizing or therapeutic relationships youth may have established with staff during the 30-day intake process.

¹² Forty-seven boys discharged in 2013 also were re-admitted during 2013.

15 – 17, 26 were age 18, 2 were age 19, and 21 were age 13- 14. No 12 year olds were admitted that year. Fifty-three percent were African-American, 31% were Hispanic, 11% were Caucasian and 5% were identified as Other. Fifty-two percent were new commitments, 21% were admitted from congregate care settings, and 27% were parole relocations or revocations.

Concerns regarding CJTS have primarily focused upon operational and quality assurance issues including restraint and seclusion practices, responses to youth or staff concerns and complaints, responses to youth who are failing to behaviorally stabilize, suicide prevention practices, and both data-gathering and data-analysis capacities required to create a dash-board for assessing facility operations and youth outcomes.

Pueblo Girls Program:¹³ The Pueblo Unit was opened in March 2014 nearby on the grounds of the former Riverview Hospital. It is a locked unit and has 10 beds with 2 emergency beds. The Pueblo Unit has been intensely controversial since it was proposed. DCF and other supporters of opening the unit held that this secure facility was required for a very small number of DCF-committed girls who pose significant risks of harm to themselves or others, run away from or become assaultive in other programs, and/or present with the most extreme behavioral health needs.

Critics held that the Pueblo Unit failed to address underlying problems such as girls becoming “stuck” in prolonged stays at Journey House (a 14 bed locked facility for girls) due to lack of other congregate care and community-based options, lack of adequate access to alternative services that are also sufficiently gender-specific, and lack of effective transitional programs. In many ways, the current controversy regarding the Pueblo Unit echoes the controversy about secure facility beds for delinquent girls a decade ago.¹⁴ The focus of this consultation was CJTS/Pueblo Unit rather than the system of congregate care and community-based programming. However, based upon available information, there has been a significant expansion over the past ten years of

¹³ Hereafter referred to as the Pueblo Unit for the sake of brevity.

¹⁴ An analysis of needs for a system of services for delinquent girls was reported upon in December 2005. This study considered whether or not Connecticut needed additional secure facility programs for girls. This study was prompted by a perceived crisis over lack of bed capacity for girls in need of secure facility care. This study found that lack of secure bed capacity was not really the problem and that it was “more accurate to conclude that (a) the absence of homes for girls with sufficiently intensive services wrapped around them keeps the existing secure and residential programs full of girls, many of whom do not require secure care; and, (b) the lack of gender-specific, strengths-based, trauma-informed philosophy, staff training and services in the secure and residential programs makes them ineffective for many girls. See: Marty Beyer, PhD (December 2005). *A System of Services for Girls in Connecticut*.

wrap-around services, evidence-based programming, and development of policies and practices that are gender-specific, trauma-informed and strengths-based.¹⁵

Additionally, since it opened concerns have been raised about the adequacy of educational and behavioral health services, discharge and case planning, and physical management of girls admitted to the facility.

CJTS and Pueblo Unit Within the Juvenile Justice Continuum: Most juveniles who encounter the juvenile justice system are served through Court Support Services Division (CSSD) which operates detention facilities and community-based programming. However, juvenile courts may commit a youth to the care and custody of DCF (most commonly for a period of about 18 months). All youth adjudicated delinquent and committed to DCF are under the case management of regionally-based parole staff. Committed youth are subject to regional parole oversight whether remaining in the community with parents or other caretakers, placed in congregate care settings when placement with caretakers is not feasible, if admitted to the CJTS and Pueblo Unit facilities. Regional juvenile parole operation is intended to integrate services to both the juvenile justice and the child protection populations served by DCF. The juvenile justice professionals are now referred to as Juvenile Justice Social Workers to emphasize their focus upon positive youth development rather than traditional compliance-focused juvenile parole.

Youth may be admitted to CJTS or the Pueblo Unit in three ways. First, a youth may be committed to DCF by the juvenile court for placement at CJTS or Pueblo Unit. Second, a youth may be admitted following violations of conditions of parole or new arrests and failure to stabilize through community-based services and graduated sanctions. Third, a youth may be admitted from congregate care due significant aggression, extreme and persistent non-compliance, or AWOLs. Unless directly committed by the juvenile court, youth coming from the community or congregate care are designated as being on either relocation status or revocation status. If the former, the youth must be returned to the community within 30 days. If the latter, an administrative hearing is held to determine whether the youth's parole will be revoked. If parole is revoked the youth remains at CJTS for treatment and development of a new community reintegration plan. A paroled youth who has been charged with new offenses may also be held at CJTS pending disposition of the new charges.

DCF has committed through formal policy to “strive to provide the most appropriate services in the least-restrictive, most trauma-informed environment for the Juvenile

¹⁵ Sources also indicate that the availability, capacity and sophistication of these resources vary by region but that efforts continue to develop them and to support greater regional accountability for addressing the needs of DCF youth involved with the juvenile justice system or committed to DCF by the courts as delinquents.

Justice clients they serve, with a focus on recidivism reduction.”¹⁶ The CJTS and Pueblo units are the most restrictive programming for DCF-committed youth but are also resourced for comprehensive individual assessment of youth, provision of medical and behavioral health care and interventions, provision of educational and special educational services, rehabilitative and life space programming, chaplaincy services, and specialized staff training (e.g., trauma-informed care, suicide prevention, de-escalation techniques, use of handcuffs and mechanical restraints).

There have been a number of initiatives by DCF in recent years at CJTS which have had—or will have—significant impact upon operations and youth outcomes. For example, since October 2014 there has been protocol in place to implement a target length of stay at CJTS of 5-6 months for new commitments and 10-12 months for youth designated as Serious Juvenile Offenders (SJO). From a national perspective, this length of stay protocol is a bold experiment which reflects research demonstrating (1) that juvenile incarceration tends to increase rather than decrease recidivism and movement into the adult criminal justice system; and (2) longer periods of incarceration are no more effective than shorter terms of incarceration for juveniles, and in fact, contribute to recidivism and adult criminal justice system involvement. The protocol is also intended to further implement many of the recommendations made in the June 2013 “Georgetown Report.”¹⁷

Recent and ongoing activity by external organizations and advocates have focused attention on areas including restraint and seclusion practices, suicide and self-injury prevention, responses to youth who fail to stabilize following admission, and the role of the ombudsman. Similarly, the opening and operation of the Pueblo Unit has prompted ongoing controversy and scrutiny ranging from the decision to open the unit to various aspects of the conditions of confinement, staff responses to resident behavior, adequacy of behavioral health and educational services, and transition planning. These concerns are discussed further below, as are practices and initiatives by the facilities to address them and continue a process of quality assurance and improvement.

¹⁶ DCF Juvenile Justice Policy 59-1 (Effective date March 28, 2014).

¹⁷ Center for Juvenile Justice Policy, Georgetown University (2013). *Report for the State of Connecticut*. Recommendations included: strengthening community-based parole; data-driven decision-making; implementing matrices for disposition, incentives and violations; use of validated risk assessment tools; developing a seamless continuum of care from community to facility-based services; developing data-driven management and supervision protocols with established outcome metrics to judge effectiveness and progress.

Placing Connecticut’s Juvenile Justice System in Context

Nationally, Connecticut has a well-deserved reputation as a state which has sustained effort over almost a quarter-century to substantively reform its juvenile justice system. This trajectory of reform was triggered by the landmark case known colloquially as the *Emily J.* lawsuit, filed in federal court in October 1993 by the Connecticut Civil Liberties Union as a challenge to deplorable conditions in pre-trial detention centers, poor access and quality to educational and behavioral health services, and lack of alternatives to detention for youth involved in the juvenile court. The filing of *Emily J.* prompted reform initiatives including legislation in 1995 which funded diversion programs and interventions, and authorized a juvenile justice policy group to generate a comprehensive juvenile justice reform plan.¹⁸ A consent decree in 1997 provided for five years of federal court supervision, obligated Connecticut to fund community-based alternatives to detention, and required the improvement of services (e.g., education, mental health, recreation) in detention facilities as well as staff training to reduce restraint and seclusion.

Connecticut would subsequently begin reorganization of its judicial branch in 1999 and consolidate a variety of functions (including juvenile detention, probation and alternative sanctions) into a single operation known as Court Support Services Division (CSSD) for youth under court supervision. Over time, CSSD has become known for its integration of empirically-based “best practices” and integration of data systems into policy and practice decision-making.

The Department of Children and Families (DCF) continued responsibility for court-committed youth for operation of CJTS (and subsequently the Pueblo Unit for girls), oversight of some residential facilities, and aftercare for youth re-entering communities following placement in these facilities. Construction was begun on the Connecticut Juvenile Training School (CJTS) which opened in August 2001 amid controversy about its design, operations, and the process by which it had been contracted.¹⁹

Despite federal oversight and reform initiatives, as Connecticut entered the new century its juvenile justice system had largely failed to achieve its goals. A report by Justice

¹⁸ This legislation also expanded (a) the list of enumerated offenses prompting automatic transfer of juveniles for adult prosecution, and (b) the discretion of prosecutors to transfer youth to the adult criminal justice system. Charging youth who fail to stabilize at CJTS or the Pueblo Unit with eventual movement into adult incarceration remains a possibility. The legislation also added public safety and accountability to a juvenile’s “best interests” as goals of the juvenile justice system.

¹⁹ The CJTS physical design was derived from an Ohio juvenile high security facility. Then-Governor Rowland rejected recommendations for smaller regional facilities or design as a therapeutic facility. Governor Rowland would later resign in 2004 after investigation revealed improper contract manipulation.

Policy Institute²⁰ (2012) identified several domains which remained challenging during this time. The following domains are the most relevant to this current consultation:²¹

- **Continued Overuse of Confinement**

A 2003 study by the New England Juvenile Defenders found that Connecticut had the highest youth incarceration rate in New England. Most relevant to this current consultation, CJTS at that time had an average daily census of approximately 153 which included many lower-risk youth. In March 2002, 37 youth at CJTS were confined following violent offenses (of which 21 were assaults in fights) and the rest were there with underlying non-violent offenses.

- **Inadequate Care for Confined Youth**

Detention facilities remained over-crowded with inadequate services. CJTS was described as “a dismal failure” by the state’s Child Advocate and Attorney General due to lack of programming, excessive and improper use of seclusion and restraint, and neglect and “problematic” treatment of youth. They also identified substantive problems regarding care of girls remaining in the Long Lane facility, specifically poor suicide prevention and excessive seclusion.²²

A decade later, juvenile justice reform in Connecticut had progressed significantly. Some of these reforms have had implications for CJTS and subsequently for the Pueblo Unit for girls.

- **Raising the Age**

In July 2007, a “raise the age” statute was enacted which was implemented for 16 year-olds in January 2010 and 17 year-olds in July 2012. As a result, CJTS (and subsequently Pueblo Unit upon opening in March 2014) assumed responsibility for these youth (who previously would have automatically entered the adult

²⁰ Reader is referred for details and citations to relevant research and documentation in this section to the following report: Justice Policy Institute: *Juvenile Justice Reform in Connecticut: How Collaboration and Commitment Have Improved Public Safety and Outcomes for Youth*.

²¹ Additional areas identified by the Justice Policy Institute report were: (1) Non-residential and community based programs had been created but were largely not informed by research and ineffective; (2) Connecticut remained one of three states where the age of adult criminal jurisdiction automatically included all 16 – 17 year olds; (3) Burgeoning dockets of status offense cases in juvenile court with few interventions available for status offenders and high rates of subsequent penetration into the juvenile justice system; and (4) reduction in racial disparity for being found delinquent on a serious charge but remaining disproportionately high rates of youth of color subsequently ordered into facilities-based custody.

²² In the spirit of transparency, I was engaged as a consultant to review programming and practices at CJTS following a “riot” by youth there in 2004. Ultimately, I concluded that the facility should be closed and youth requiring secure treatment be served in smaller regional centers. If CJTS was not to be closed as a juvenile justice facility, I recommended significant enhancement of educational programming, intensive retraining of staff, and substantive restructuring of clinical services.

criminal justice system) in the event that they fail to stabilize in supervision and services in the community or at lower levels of facility-based care.

- **Alternatives to Detention and Confinement In Juvenile Justice**

Average daily detention of youth in 2006 was 132 and fell to 71 during 2010. The average daily detention numbers have never regained 2006 levels despite an increase as 16 and 17 year olds entered the juvenile justice system following “raise the age” legislation. Overall, there was a 60% reduction between 2001 – 2011 of confined youth and Connecticut was the only state which had implemented all six recommended practices and policies focused upon reducing youth incarceration.²³

Total commitments to CJTS and other residential sites fell from 680 to 216 in 2011. Data from 2013 indicate that of 11,918 delinquency cases filed with the juvenile court, 3,158 resulted in formal findings of delinquency with 1,985 cases resulting in probation and 355 cases (3.5% of total cases) resulting in commitment to DCF. Of those 355 cases, 95 resulted in placement at CJTS (0.8% of total cases). DCF receives very few girls committed as delinquents from the courts (35 in 2012, 23 in 2013). This low rate of commitment of delinquent girls has contributed to criticism of maintaining 26 secure facility beds (14 at Journey House, 12 at Pueblo).

The trajectory of CJTS average daily census has been: 229 in 1993, 153 in 2001, and 109 in 2011 ten years later (including the “raise the age” 16 year olds). Average daily census spiked in 2013 to 124, the highest in many years, but as of 12.31.14 there were 94 boys at CJTS. This spike prompted concern as did the conclusion of the Georgetown University Center for Juvenile Justice in Spring 2013 that DCF had no reliable method to assess the risk-needs of delinquent youth committed to it, and therefore no reliable way to drive placement decisions or determine the effectiveness of its secure and non-secure programming or parole supervision.²⁴

At the time of this consultation, the average daily census from January through April 2015 was approximately 91 youth.

²³ National Juvenile Justice Network and Texas Public Policy Foundation (2013). *The Comeback and Coming-From-Behind States: An Update on Youth Incarceration in the United States*. The six recommended policies were: Community Alternatives, Restrictions on Use of Detention, Facility Closings and Downsizing, Less Reliance on Law Enforcement for School Discipline, Not Confining for Minor Offenses, and Statewide Realignment and Reinvestment.

²⁴ Ibid, at footnote 4.

This general trend down numbers committed to CJTS over the past fifteen years is likely the result of several factors, including: (1) a general decrease in juvenile crime rates nationally and in Connecticut; (2) more effective responses to status offenders that limit their penetration into the juvenile justice system; (3) implementation of screening, diversion, and improved probation practices that serve to limit the numbers of lower-risk youth committed to CJTS; (4) more effective practices in both community-based services and in residential facilities to which youth may be referred as alternatives to CJTS; (5) falling numbers of youth in detention facilities since youth detained prior to their court appearances are substantially more likely to be committed.

In the meantime, over the past dozen years, CSSD has committed to expanding a network of evidence-based community-based programming which has contributed to lower rates of commitment of youth to DCF juvenile justice services. Beginning with school-based diversion initiative that began in Hartford and Bridgeport in 2009, Connecticut has also become a national model in reducing school-based arrests, further limiting the number of youth who come into contact with and risk unwarranted penetration of the juvenile justice system.²⁵

There was an initial increase in admissions associated with implementation of “Raise the Age” legislation which included 16 and 17 year olds in juvenile jurisdiction. During 2014 there were some 150 admissions to CJTS—a ten year high. However, by early December 2014 the census had been reduced to approximately 90 boys and average daily census remained close to that number through the first four months in 2015.

The average length of stay of committed boys at CJTS and residential facilities declined from 304 days (approximately 10 months) in 2002 to 176 days (approximately five months) in 2011. Available information indicates that in 2014 the CJTS average length of stay was: 8.4 months for new commitments; 5.0 months for admissions from congregate care; 1.3 months for parole relocation cases; and, 4.1 months for parole revocation cases. In January through February 2015, there were 17 discharges of new commitments averaging a 6 month length of stay, 7 discharges of admissions from congregate care averaging a 3 month stay, 1 parole relocation case discharged after 15 days, and 6 parole revocation cases discharged averaging 3.5 months.

²⁵ Following project planning, Hartford had a 78 percent decrease in school-based arrests from March through June 2012 while Bridgeport saw a 40 percent decrease in school-based arrests. Subsequently, during school year 2012-2013 Hartford had a 57 percent decrease and Bridgeport had a 34 percent decrease in school-based arrests of youth of color (Center for Children’s Advocacy, 2013).

In October 2014, DCF Commissioner Joette Katz approved an initiative for CJTS to implement a presumptive 6 month length of stay for most admitted youth and a presumptive 10 month stay for Serious Juvenile Offenders (SJO). The goals were to facilitate more assertive discharge planning and decrease the number of youth whose stays were unnecessarily prolonged. Additionally, she has required that she personally review cases of youth having difficulties in congregate or residential care facilities prior to their admission to either CJTS or the Pueblo Unit.

- **Innovation in DCF Child Protection and Juvenile Justice Services**
Unlike many other states, “deeper end” juvenile justice services (such as CJTS, Pueblo Unit, and juvenile justice residential programs) are maintained by the Department of Children and Families rather than operated by a separate juvenile justice authority within the executive branch or remaining entirely within the judicial branch. Youth receiving juvenile justice services from DCF comprise approximately 3% of all youth served by DCF (with some of youth receiving juvenile justice services also in DCF custody as child protection cases, the so-called “dual status” or “dual commitment” youth).

Many youth in America’s “cradle to prison pipeline”²⁶ transverse state child protection systems into juvenile justice systems and then in to adult criminal justice and incarceration. Failure to create effective state child protection systems contributes to the disproportionate risk of impoverished youth and/or youth of color within those systems and subsequently in juvenile justice systems.

Not surprisingly, youth in state child protection systems are disproportionately more likely to have faced multiple adversities and experienced psychological trauma, less likely to have performed adequately in schools, and more likely to manifest risk behaviors (e.g., truancy, alcohol and drug use, risky sexual behaviors, delinquent misconduct) at earlier ages. This, in turn, increases the likelihood that they will come into contact with the juvenile justice system and to penetrate it more deeply than other youth.

By contrast, effective child protection practices lower the risk that they will continue down the “pipeline” into juvenile justice and then adult criminal justice systems. Over the past 12 – 15 years, DCF has developed a network of evidence-based community services administered through regional offices, including

²⁶Children’s Defense Fund (2007). *America’s Cradle to Prison Pipeline Report*. Washington, DC.

services to its committed juvenile justice population.²⁷ DCF has also initiated and continues to implement evidence-based and “best practices” approaches in facility-based services including CJTS and Pueblo Unit. This is not to suggest that the current systems are without challenges²⁸ or critics, but DCF has made substantial gains since the filing of the *Juan F.* litigation in 1989.

Commissioner Katz has made major policy shifts which have important implications for CJTS/Pueblo Unit as components of a broader system of care. These include the return of youth placed in programs out of state, the downsizing of congregate care capacity, and the regionalization of juvenile justice programming which had previously been overseen by a central office administration.

These shifts have prompted controversy. Supporters point to research regarding the better outcomes for youth when maintained in community-based services whenever consistent with public safety and the deleterious effects of facilities based care. Regional responsibility for juvenile justice program is seen as an effort to make regions more accountable for these youth and to have a stake in developing an effective continuum of care for them.²⁹ Some also point to the under-utilization of programs which have efficacy specifically for delinquent youth.

Critics hold that the downsizing of congregate care capacity was too rapid and that the community-based services still too inadequately developed to meet the needs of youth. As a result, youth got “stuck” in detention or elsewhere waiting for programs, the available congregate care beds filled up, and in their view, one inadvertent outcome was the opening of the hardware secure Pueblo Unit. Since its opening in March 2014, however, Pueblo Unit has admitted only a handful of girls and this suggests that DCF has avoided ready use of the unit as a means of holding girls who can be served at lower levels of services. Considerations for Pueblo Unit are offered below.

²⁷ DCF was an early adopter of Multi-Systemic Therapy (MST) and Multi-Dimensional Family Therapy (MFT). By 2012, Connecticut was recognized as one of five states demonstrating the most extensive implementation and expansion of a range of evidence-based practices as both DCF and CSSD continued to develop their network of services. These services are funded through a blend of state and federal dollars through the Behavioral Health Partnership. One collateral indicated that MST capacity remains under-utilized in regions.

²⁸ See, for example: *Juan F. v. Malloy* Exit Plan Quarterly Report October 1, 2014 – December 31, 2014 Civil Action No. 2:89 CV 859 (SRU)

²⁹ The concern has been that the juvenile justice population has historically received insufficient attention and programming in regions since they comprise only three percent of the DCF caseload.

Juvenile Justice Policy Oversight Committee (JJPOC)

A Juvenile Policy and Oversight Committee (JJPOC) has been legislatively established to “evaluate policies and procedures related to the juvenile justice system” with a “comprehensive mandate” requiring it to “assess state congregate care...” I have been informed that the JJPOC will be engaging in review of policies and practices relevant to conditions of confinement at DCF, CSSD and DOC programs serving youth in the juvenile justice system.

I have been further informed that this review by JJPOC will include policies and practices regarding restraint/seclusion, suicide prevention, and other conditions of confinement across these systems, including DCF, CSSD and DOC. Doing so will help inform the legislature, administrators and others regarding broad “systems issues” and development of policy and practice, something difficult to achieve without a comprehensive review of each system which provides juvenile justice services and the ways in which these systems interact.

CJTS and the Pueblo Unit

CJTS: The abysmal conditions at CJTS described in 2002 by the state’s Attorney General and Child Advocate continued to fester until a 2004 uprising led to intensified scrutiny and action to change operations of the facility. In the wake of the uprising, a national expert³⁰ was retained to review and restructure facility operations, DCF discharged lower-risk youth to the community, the high security unit was closed, intensive staff training was implemented, educational resources were improved, and efforts were made to improve family engagement and participation.

By 2009, CJTS had earned accreditation from the American Correctional Association (ACA) with extremely high performance ratings, and this accreditation was renewed in 2013. Over time, steps have been taken to improve mental health and trauma assessment of youth as well as implement evidence-based mental health interventions. A football team has been formed, a branch of the Boy’s and Girl’s Club has been opened at the facility, and educational and vocational services have been expanded.

Arrests of youth fell from 108 in 2008 to 25 in 2012. Unfortunately, in 2014 there were 44 arrests with 33 of them of among 16 – 18 year olds. Restraint and seclusion episodes occurred in 2014 with approximately 20% of youth and with 6 – 12 youth involved in a disproportionately large number of episodes.

³⁰ Donald DeVore was the retained expert. He, in turn, asked me to consult with him on CJTS with a focus upon the mental health services provided at the facility.

From a national perspective, CJTS is an exceptionally well-resourced secure juvenile justice facility with a robust general and special educational presence modified for the needs of CJTS youth,³¹ vocational offerings,³² a medical and mental health clinical staff with specific unit assignments and providing assessments and evidence-based treatments;³³ sports and recreational activities;³⁴ and, staff-youth ratios and training which meet accreditation standards.

Pueblo Unit: As noted in the introduction, the Pueblo Unit was opened in March 2014 amidst great controversy and it continues to be controversial among some stakeholders. It is intended to provide short-term stabilization for girls who have become assaultive or otherwise failed to stabilize at Journey House or other levels of programming, but also be available for longer-term intervention for girls who have the most extreme behaviors and behavioral health needs.

It is difficult to anticipate how the Pueblo Unit might develop since it has only been open a year and the number of admissions to this 12-bed facility have been relatively low with 24 unique admissions between opening in March 2014 through December 2014. The low average daily census has meant there are often few girls on the unit at any given time which makes it more difficult to provide group-formatted interventions such as Dialectical Behavior Therapy and Seven Challenges.

That being said, from a national perspective it is notable that (1) evidence-based interventions are core components of unit programming; (2) there is a strong clinical presence; (3) staff re-training in physical intervention and de-escalation techniques began after there was a spike in incidents with residents; and, (4) DCF has not referred girls for admission until beds are filled to capacity. This indicates that DCF has refrained from placing girls having difficulty stabilizing at lower levels of care largely on the basis of bed availability and thereby avoiding an “if you build it, they will come” phenomenon often seen in “deep-end” facilities in other juvenile justice systems.

³¹ The on-grounds Walter G. Cady School under jurisdiction of Unified School District #2. Modifications include an extended school year, in-school suspension so student continue to learn, credit retrieval, specialized staff training.

³² An incomplete list includes: computer graphics, culinary arts, building trades, print production technology

³³ Evidence-based Interventions include Seven Challenges, Dialectical Behavior Therapy, Aggression Replacement Therapy, Trauma-Focused Cognitive-Behavior Therapy. In 2013, 76% of youth had documented family therapy sessions. All youth are diagnostically assessed at intake for medical and behavioral health needs.

³⁴ An incomplete list includes: Football team, soccer club ,CYO basketball league, swimming, weight lifting, cooking/baking, program for young fathers, music and art therapy, Wilderness School, Boys and Girls Club

Current Challenges and Opportunities at CJTS and Pueblo Unit

Discussion about challenges and opportunities at CJTS and the Pueblo Unit should occur in the context of recognition that the available staffing, training, educational, and clinical resources are extraordinary from a national perspective. The senior leadership team members are experienced juvenile justice professionals. Commissioner Katz has closely led and supported initiatives at the facilities although the youth placed there are a smaller subset of the 3% of youth served by DCF who are committed by the courts for juvenile justice services. Her target length of stay of 6 months or less for most youth admitted to the facilities is ambitious.

The juvenile justice defense bar, Office of the Child Advocate, and various advocacy organizations are very active and assure that youth at these facilities will not become an invisible population as has occurred in other jurisdictions at times. Over the course of this consultation it has become clear that there are heated controversies over strategic issues (such as the opening of the Pueblo Unit, the timing of dropping capacities in congregate care settings while bringing youth back from out-of-state placements) as well as operational ones (such as suicide prevention practices, restraint/seclusion practices). It is also clear that there is a healthy range of voices and perspectives but also disagreements about the reliability of basic information produced by various interested parties that has contributed over time to an atmosphere of mistrust among some of them.

In practice, the operations of CJTS and Pueblo Unit currently reflect deep ambiguities and, at least at times, tensions regarding their functions and goals. Some reflect the transitions of organizational change and others reflect tensions among goals. These ambiguities and tensions have given rise to attention and action by legal counsel, advocates, and the Office of the Child Advocate. They have also led to heightened attention by the most senior leadership at DCF to the 3% of DCF-involved youth who are in their juvenile justice programming and the even significantly smaller number who are placed at CJTS and Pueblo Unit.

As indicated above, some reflect **processes of long-term organizational change** such the movement at CJTS from the traditionally correctional culture prevailing at the facility's inception to a more rehabilitative³⁵ and relational culture.³⁶ Others reflect

³⁵ Given the siting of such robust rehabilitative resources, including the clinical presence to assess, address and plan for the significant and complex behavioral health needs of youth in the facility, it is ironic that historically there has been resistance to designating CJTS as a "treatment" facility.

³⁶ At the time I was involved in a review of CJTS policies and practices following the 2004 incident of unrest, the operation of the facility mirrored closely traditional adult correctional practices. Active relational engagement by staff of youth was largely absent and even discouraged except for one unit—the one unit where the youth residents acted to protect the unit and the staff working there from assault by other youth in the facility at the time of the unrest. At that time, even minor misconduct was typically met with rapid physical management.

inherent **tensions between overarching goals**. For example, there is a tension between developing operations intended to support relatively short-term stabilization return for most youth to community-based services and developing operations for longer term rehabilitative efforts to address trauma, significant behavioral health needs, educational and/or vocational needs, and life-skill preparation). Still others involve **concerns or disagreements about operational issues** such as how best to embed behavioral health services, respond to misconduct by youth (including restraint and seclusion), prevent suicide and self-injury, support trauma-informed and strengths based approaches, investigate complaints or reports of misconduct by facility staff, and prepare youth for transition to other programs and services.

Deep organizational change takes time and persistence. It is hard to overstate how differently CJTS functions now as compared to some 12 years ago. The transformation remains ongoing. but in my opinion, there are processes in place both inside and outside of DCF to continue to advance the transformation over time—especially if there can be strategic clarity as to the strategic mission, fundamental function(s), and core goals of CJTS/Pueblo Unit so that operational policies, processes, practices and expectations can continue to development over time.

In considering challenges and opportunities for CJTS and the Pueblo Unit, the following are helpful to take into account:

1. The uneasy interplay between a juvenile corrections model with an emphasis on “accountability” and a rehabilitation model with an emphasis on “treatment” creates a deep core ambiguity and tension as to mission and methods.

For example, in traditional juvenile corrections the use of restraints and seclusions are intended to enforce compliance with institutional expectations but also are used as responses and even as sanctions for misconduct. Mental health professionals are used primarily for periodic “check-ins” on the mental status of the individual and to assess acute suicide risk. Youth on a disciplinary status are precluded from participation from program activities as a sanction even if there are minimal risks of immediate harm to self or others.

By contrast, in a rehabilitative/therapeutic model, restraints and seclusions are intended to secure basic safety, the least restrictive intervention required is relied upon, and restraints or seclusions are terminated as soon as the immediate threat to safety has passed. Mental health professionals are tasked with attempting to continuously engage with the individual and facilitate de-escalation in an effort to bring the episode of restraint or seclusion to an end as soon as possible. Youth are expected to resume participation in educational, vocational, treatment or

other program activities once the immediate significant risks to self or others have passed. Especially in a trauma-informed model, the need to use a restraint or seclusion is viewed as a clear intervention failure and so considerable effort is given following the episode to assess the process leading to restraint and seclusion with the individual and the staff involved to create alternative processes that would preclude the need for these methods in the future.

In reality, youth developmentally and socially require both age-appropriate accountability for their conduct and to have their needs met--especially needs which left unmet increase the likelihood of continued delinquent misconduct with its negative impacts upon themselves, their families and their communities. The challenge is to craft and implement an approach which can (a) provide accountability without becoming punitive; (b) effectively meet unmet educational, behavioral health, and other developmentally critical needs; and (c) communicate to youth that they are valued and can be welcomed as meaningful positive contributors to our communities.

This challenge raises fundamental questions: Given the high behavioral health needs and extensive histories of exposure to adversity/trauma of many youth admitted to CJTS and Pueblo Unit, should these facilities be fundamentally operating as sophisticated trauma-informed behavioral health facilities but with particular expertise in managing defiant and aggressive behavior? Alternatively, should they operate fundamentally as juvenile justice facilities but with particular expertise in addressing complicated behavioral health needs and the developmental impact of exposure to adversity and trauma? Or, given the actual histories and significant, complex needs of the youth who enter CJTS or Pueblo Unit, are these distinctions without a difference if effective supports, interventions and planning are to be in place for them?

In either case, how should staff respond to youth in a manner that consistently supports developmentally appropriate decision-making and accountability? And, how can staff distinguish between and respond differently to misconduct which reflects delinquent attitudes, values and beliefs and misconduct which reflects significant demoralization, anxiety, and/or significant deficits in self-regulation, perspective-taking, problem-solving?

From a public policy perspective, what are the broader systems operations which lead one group of high need/high risk youth to enter the deep end of public mental health care and another group to enter the deep end of juvenile corrections? Is there a rational basis upon which youth are being directed to one system rather than the other, or are there influences operating other than the

objective risk-need characteristics of the youth involved such as race/ethnicity, economic and social class, gender, family characteristics, or relative resources (behavioral health, child protection, juvenile justice, educational) available in their communities of origin?

Another challenge or opportunity in defining the core mission of these facilities involves whether or how to support youth in achieving educational or other goals they have identified for themselves while at the CTJS or the Pueblo Unit. In traditional juvenile corrections the availability of educational supports during secure placement is secondary to security concerns and viewed as a transitional service.

CJTS has moved well-beyond the meager educational and vocational supports of many juvenile incarceration facilities, but ironically this has resulted in another challenge in balancing its mission and methods: Some youth have asked to *voluntarily* extend their term of placement to CJTS so as to achieve educational goals such as earning their high school diploma or completing a course of vocational training. They hold that their chances of achieving these goals at CJTS are much better than if returned to their communities.

Is the rehabilitative mission of CJTS of sufficient importance that youth should be able to remain voluntarily to complete specific educational or vocational goals? Or complete a course of trauma-focused or other behavioral health treatment? Does it matter if they are correct when asserting that the community-based educational, vocational or other resources are insufficient to support their achievement or, at least a times, resist supporting them because of their juvenile justice involvement? Does recognition of youth or family “voice” include voluntary extension of secure placement to achieve educational, vocational, and/or treatment goals?

What are the public policy implications of allowing youth committed to a secure juvenile justice facility to achieve rehabilitative goals in light of research describing the negative effects of facility-based care compared to community-based services?³⁷ What would honoring a choice to remain voluntarily suggest regarding confidence in the capacities of existing community-based supports in the regions to which a youth would otherwise return?

³⁷ The research is increasingly compelling that longer terms of juvenile incarceration have little impact upon lowering recidivism rates and are associated with increased rather than reduced recidivism risk.

2. The youth placed at CJTS are a very heterogeneous population on multiple dimensions including age, cognitive capacities, learning styles and educational needs, behavioral health (mental health and substance use) needs, vulnerability to emotional dysregulation or willingness to engage in instrumental/goal-oriented violence, access to and quality of available community-based services, and family/caretaker support, availability and engagement. That being said, the boys admitted to CJTS typically have high levels of exposure to childhood adversity (although not currently well-captured through traditional assessment methods), co-morbid psychiatric and substance use diagnoses, past failures in community-based and out-of-home programming, and significant behavioral health and educational/vocational needs.
3. There have not been enough admissions yet to the Pueblo Unit to discern whether or not there are core characteristics they share other than high exposure to childhood adversity and failure in less contained/intensive levels of care. Consistent with its stated purpose, the girls who have been longer-term residents of the Pueblo Unit have been “outlier” cases with unusually high risk/high needs profiles. DCF has successfully declined to simply fill available beds with girls who could be maintained outside of this secure setting and has kept admissions relatively brief for most girls admitted.³⁸

On the one hand, this has limited the number of girls exposed to the deleterious effects of deep-end and longer-term hardware secure placement.

On the other hand, the small number of admissions has limited the ability to staff to work with the girls placed there in familiar ways involving peer processes, therapeutic and psychoeducational groups and milieu interactions. Given the significant deployment of resources required to keep Pueblo Unit operational at its current potential capacity, it is reasonable to ask whether those resources might be more effectively deployed to craft and fund highly individualized supports³⁹ for the very few girls having the kinds of difficulty stabilizing in lower levels of care that would otherwise prompt admission to Pueblo Unit.

³⁸ There have been 26 discharges to date: 16 to congregate care settings (e.g., Journey House, group homes, other RTCs) with an average length of stay of 44 days; 8 to home settings with an average length of stay of 67 days; and, 2 to other settings with an average length of stay of 44 days.

³⁹ I am aware that in the cases with which I became familiar that there were efforts made to avoid admission to Pueblo Unit that were ultimately not successful. I acknowledge that even the best efforts in services short of CJTS or Pueblo Unit may fail. I raise the issue of the resources committed to this girl’s locked unit to ask the question of whether or not other alternatives to admission to Pueblo Unit might have been successful if fiscal or other resources had been available. I also acknowledge that significant and potentially life-altering or even lethal risks to self/others—combined with difficulty engaging with or stabilizing a youth at a lower level of service—may result in

4. As the system of community-based diversion and lower levels of out-of-home programming by CSSD and/or DCF continues to operate and expand, the youth most likely to be committed by juvenile courts to DCF will be those who have failed through this “safety net” of preferred responses.

As a group, these will be youth who have failed to respond to the processes of “social learning” which lead most youth to desist from deeply penetrating into the juvenile justice system. These youth are more likely—even compared to other juvenile court-involved youth—to be characterized by (a) behavioral health disabilities, cognitive and learning disabilities, persistent problems with emotional dysregulation, and/or failure to identify developmentally appropriate and meaningful life opportunities which they believe they can attain; and/or, (b) youth whose social learning is compromised by inadequate prosocial supports by primary caretakers, primary affiliation with delinquent peers or adults engaging in criminal misconduct, and/or inadequate access to effective prosocial educational or community activities which can promote a sense of self-efficacy and competence.

Some will be sufficiently demoralized to be at significant risk of harm to themselves, at significant risk of harm to others due to emotional dysregulation or willingness to harm others to achieve desired goals (e.g., peer group status, retaliation, intimidation), or both.

5. How to best foster alignment between CJTS and Pueblo Unit operations and outcomes with broadly defined developmentally-informed systemic approaches to juvenile justice identified for federal juvenile justice initiatives,⁴⁰ specifically:
 - Accountability without criminalization⁴¹
 - Alternatives to justice-system involvement⁴²

extremely limited options, especially if alternative secure settings such as locked mental health facilities cannot be utilized.

⁴⁰ National Academy of Sciences, Committee on a Prioritized Plan to Implement a Developmental Approach in Juvenile Justice Reform (2014). *Implementing Juvenile Justice Reform: The Federal Role*.

⁴¹ For example, youth can incur additional charges for misconduct while at CJTS or Pueblo Unit which can or will result in their transfer for adult criminal justice adjudication or incarceration in adult facilities. This is a developmentally, legally and socially a severe outcome for an adolescent. Since the stakes are so high, what process is or should be in place to reliably distinguish between those youth whose incident(s) of serious institutional misconduct—most commonly physical assaults on peers or staff—reflects predatory/instrumental violence from those whose misconduct reflects extreme demoralization or desperation, emotional dysregulation, deficits in social regulation or judgment, cognitive distortions, or other need subject to rehabilitative intervention in the juvenile justice system?

⁴² How best to identify and transfer into the mental health system youth at CJTS or Pueblo Unit who manifest acute symptoms such as psychosis or mania, acute risks of suicide or persisting self-injurious behavior, or possible

- Individualized responses based upon assessment of needs and risks⁴³
- Confinement only when necessary for public safety⁴⁴
- Genuine commitment to fairness⁴⁵
- Sensitivity to disparate treatment⁴⁶
- Family engagement⁴⁷

6. How best to align juvenile justice operations under administration of the judiciary such as CSSD and those under the administration of DCF after a youth has been committed to DCF by the juvenile court?

As one example, from a multiple-systems perspective, it would be helpful if CSSD and DCF used the same evidence-based screening and risks-needs assessment tools so that populations served could be compared and so that youth-specific information could be more readily and usefully shared. Alignment of performance and quality assurance measures would also facilitate a broad “systems analysis” across all systems providing delinquency programming. It is impossible to create a coherent unified picture of juvenile justice systems in Connecticut without the ability to collect and compare reliable, commonly

emergence of a major mental illness? Youth have been transferred from these facilities to psychiatric facilities for psychiatric treatment and stabilization but several collaterals independently commented that these transfers occur on a case-by-case basis without a clear protocol or MOU with receiving psychiatric facilities and become more difficult and time-consuming than they should have to be to respond to psychotic youth or youth with other acute mental health needs. As a result there are two separate issues: First, how is that youth with psychosis, elevated risk for self-harm or other acute psychiatric needs are finding their way to a juvenile incarceration facility rather than a psychiatric facility if the youth cannot be safely maintained at a lower level of care? Second, can a reliable protocol for prompt transfer to a psychiatric facility be implemented, and is there a means by which a youth with ongoing significant psychiatric care needs can be readily transferred to the mental health system for services rather than the juvenile justice system?

⁴³ How best to craft and implement individualized risk-management and treatment planning based upon evidence-based assessment of risk-needs? What is the capacity within facility-based care for individualized case planning given the structure of institutional rules and routines to assure safety and enforce compliance with facility behavioral expectations?

⁴⁴ How best to identify and discharge from CJTS and Pueblo Unit youth who are lower-risk youth who may have been committed by courts due to repeated technical or minor violations of probation?

⁴⁵ For example, how best to respond to concerns ranging from minor complaints by youth to allegations of serious misconduct towards youth by facility staff? This factor is also implicated in the current controversy over whether the function of ombudsman is sufficiently executed by an internal ombudsman employed by DCF or warrants an independently contracted ombudsman as is the case with CSSD.

⁴⁶ Sensitivity to disparate treatment may include familiar issues such as disproportionate minority contact and confinement as well as more subtle issues such as differences in CJTS/Pueblo Unit discharge decisions or case management decisions driven (at least in part) by differences in local resources, professional practices of DCF juvenile justice professionals, or local providers across DCF regions.

⁴⁷ Effectiveness in family engagement is an important factor associated with success for juvenile offenders. Family engagement is a challenge for a secure facility where youth may be in DCF custody with limited contact with families of origin, or families may face obstacles such as transportation (for visits and clinical family meetings) or lack of access to the internet for secure electronically mediated contacts.

collected data and operational information across all systems providing programming for delinquent youth.⁴⁸

As another, it seems odd to an observer from outside of Connecticut that the Office of the Child Advocate (OCA) has authority to investigate or monitor (including direct access to data systems such as CONDOIT) for DCF juvenile justice programs but does not have a similar role for juvenile delinquency programming operated by CSSD and Department of Corrections (DOC).

7. It is striking how lack of readily accessible data--or clarity and consensus regarding what is reliable or relevant data--complicated communications and collaboration between CJTS and Pueblo Unit administrators and external organizations or advocates who were concerned about specific aspects of facility operations.⁴⁹ This was most striking in addressing concerns about restraint/seclusion practices but was also reflected in communications about youth suicide/self-injury prevention, responses to youth with significant mental health and/or developmental needs failing to stabilize at CJTS or Pueblo Unit, and access to educational and other facility programming following disciplinary incidents.⁵⁰

Elements of a Strategic Plan for DCF and Juvenile Justice Operations

Connecticut has been engaged in a long-term process of juvenile justice reform for well over a decade. This process has at times been uneven but it has yielded a broad consensus that youth who penetrate the Connecticut juvenile justice system are ordinarily best-served in community-based programming that are evidence-based and trauma-informed, alert to disproportionate minority contact and confinement, and responsive to the often-significant educational and behavioral health needs of the youth they serve. This consensus is solid and more recent controversies and tensions are largely focused upon how to best conceptualize, implement and assess the outcomes of the juvenile justice programming intended to operationalize this consensus.

There are important policy and practice decisions and adjustments to be made. Some current controversies are heated and, in fact, relationships between DCF and some

⁴⁸ I am informed as I complete this consultation that steps are being taken to address the need for common data-gathering and sharing of data/case information across DCF and CSSD.

⁴⁹ At the time of consultation, persons interviewed from DCF and from external entities pointed to disagreements about data as evidence that one or the other were "misusing," "misrepresenting," "spinning," or withholding data. These disagreements about information and the attributions made about what underlies the disagreement reflects the currently strained and mistrustful relationships among some parties.

⁵⁰ I am informed as I conclude this consultation that there are plans to address the issues with data collection and analysis is with the DCF Office of Research and Evaluation which will be finalized and implemented within coming months.

critics and advocates are currently strained. However, unlike in some other jurisdictions, these disagreements are largely about how to best achieve largely shared strategic goals and there is no meaningful call in Connecticut for a return to a system anchored by large hardware secure facilities, extensive reliance upon out-of-state programs as an alternative to developing community-based infrastructure, or relative inattention to the social, educational and behavioral health needs of juvenile justice-involved youth. The controversies and disagreements are largely about how to best achieve shared goals while working with a complex and challenging population of young people.

Critical Strategic Decisions and Objectives

1. A fundamental strategic decision needs to be made as to whether CJTS and the Pueblo Girls Program are primarily for:
 - (a) short-term stabilization for youth with the goal of return to a lower level of care as soon as possible but with a target length of stay of 6 months for most youth other than those designated as Serious Juvenile Offenders (SJO) who will have a 10 month target length of stay;
 - (b) longer-term programs to serve youth with high-risk/high-need profiles, histories of program and intervention failure, and/or who pose significant public safety risks who need longer-term and more intensive educational, clinical and/or social (including basic safety) supports than youth served at earlier points in the continuum of care; or,
 - (c) perhaps inevitably, some mix of these two cohorts given the heterogeneity of the youth who enter these secure facilities from the three pathways leading to admission.

The current focus at both CJTS and Pueblo Unit is to reduce the average length of stay. This is consistent with the emphasis upon programming outside of hardware secure facilities and shorter lengths of stay within those facilities.⁵¹ As noted above, in the first two months of 2015 the average length of stay of 17 discharged “new commitments” was six months and it was three months for 7 discharged congregate care admissions. Even 6 discharged youth admitted as parole revocation cases—presumably mostly likely to be among youth with high

⁵¹ Reader is referred to the CJTS Length of Stay/Discharge Protocol for a more detailed description of the Length of Stay targets for youth admitted under a variety of different conditions of admission.

risk/high needs since they were failing on parole—had average lengths of stay of 3.5 months.

Operation of educational, behavioral health and other services at CJTS will operate differently if average lengths of stay remain at or below approximately 6-8 months than they would if stays were longer. Even youth given four year commitments to DCF as Serious Juvenile Offenders (SJO) now have a target length of stay of 10 months before discharge.

If most youth will be discharged at or near 6-8 months after admission, mental health interventions will need to be intensive while time-limited, focused, skills-based, evidence-based and closely guided by Risk-Need-Responsivity (RNR) assessment and intervention approaches. Educational and vocational services will need to be similarly focused upon areas most associated with lowering general recidivism such as literacy and time may not permit a broader exposure to academic skills and vocational experiences.

Another cohort of youth with the highest needs/highest risks may have longer lengths of stay either because they are identified at the time of admission as comprising a separate cohort, or functionally because they fail to stabilize and remain past the target length of stay. Consideration should be given to establishing criteria (including use of a standardized risk-needs-responsivity tool) to identify these youth during the intake and admission process rather than identifying them only as they fail to stabilize over time.

Proactive identification would permit two track discharge planning can occur (one plan in the event they stabilize more rapidly than expected, one in the event that they remain past the target length of stay). Early identification of these youth may also inform residential placement decisions following the intake phase so that lower risk youth are not inadvertently placed among these highest risk youth, different services can be used to target their more significant and multiple needs, and there is more time to plan for the more intensive or specialized community-based services they are likely to need following discharge.

If identified at the outset, these youth might be placed in separate housing units so avoid life-space mixing⁵² with youth with lower risk/needs profiles and so that

⁵² Research indicates that placing lower risk youth with higher risk-needs youth tends to increase the risk of lower risk youth rather than dropping the risk of higher risk youth. Research also indicates that congregating higher risk-needs youth together increases risk and may yield a peer culture which is more resistant to intervention. This tension yields a challenge about what to do with the highest risk-needs youth while avoiding their negative impact upon lower risk-needs youth.

different milieu cultures and differentiated clinical services based upon higher risk-needs profiles can be developed.⁵³ For example, it is reasonable to anticipate that these youth will have a mix of more extensive exposures to delinquent peer culture, adversity/trauma,⁵⁴ behavioral health needs, special educational needs, and child protection needs.

More recently, some youth have asked to stay at CJTS on a *voluntary* basis after becoming eligible for discharge. They asked to do so to accomplish an educational goal (believing that they could complete high school successfully while at CJTS but would fail if returned to their communities) or a vocational goal (completing vocational modules in anticipation of securing employment upon discharge). This is an unexpected twist on “youth and family voice and choice” approaches. If these requests are granted, case tracking should occur to determine whether an extended voluntary stay appears to contribute to better outcomes.⁵⁵

Once this strategic decision is explicitly made and criteria established, it will be much easier to define the roles of staff (e.g., educational, behavioral health, unit leadership and staff, other), the likely trajectories of youth through each facility, and the resources required to meet the objectives of each facility. This decision could also lead to classification distinguishing between youth being in need of

I understand that CJTS Building 2 was originally intended for highest risk-need youth but the census was always very low and so it was used instead for special needs youth (e.g., kids with significant mental health issues, younger youth, some youth who needed 'protection' from other youth). It was eventually closed due to its low census and to allow for Boys / Girls Club programming. Since there was no valid risk-need tool utilized at CJTS while Building 2 was operational as a residential unit to make placement decisions for “highest” risk-need youth, and since after it began admitting youth with special needs/vulnerabilities it would be imprudent to mix in the highest-risk need youth (especially those with histories of significant violence), it is impossible to draw any lessons from the operation of Building 2 that would be helpful in this context.

CJTS may reasonably decide against considering a designated unit for highest risk-need but having the risk-needs profile of all admitted youth will at least allow for tracking of where youth with various risk-need profiles are being placed and their outcomes while at the facility (and perhaps subsequently).

⁵³ It may be that there are very few low risk-needs youth being admitted to CJTS or Pueblo Unit given the concerted effort to keep youth in lower levels of programming. It is difficult to know what the “risk-need” mix of admitted youth actually is until a standardized risk-need-responsivity tool is in place. It may be that there are very few low risk-need youth being admitted and so risk assignment may more reflect a differentiation of the highest risk-needs youth from high risk-needs or moderate risk-needs youth.

⁵⁴ It is reasonable to anticipate that many of these youth will be better described by the literature on outcomes of childhood exposure to adversities various called “complex trauma disorder” or “developmental trauma disorder.” Many of these youth may not meet the criteria required for a PTSD diagnosis but be well-described in this literature, particularly since a core feature of “developmental trauma disorder” is vulnerability to intense emotional dysregulation. This literature is not reflected in a DSM-5 diagnosis but is widely recognized as important to incorporate in thinking about youth with extensive childhood exposures to adversity/trauma.

⁵⁵ Research has found lengthier juvenile incarceration stays to have a deleterious impact upon youth and to increase recidivism risk but, to the best of my knowledge, this research did not include or distinguish outcomes for youth who had chosen voluntarily to remain at facilities to achieve rehabilitative or treatment goals.

“stabilization and discharge” or “treatment placement” and perhaps even assignment to different residential units with different programming.

2. In addition to assisting DCF in policy, planning and practice, strategic clarification and articulation of the fundamental function(s) and core goals of CJTS/Pueblo Girls Program in the DCF juvenile justice system will be helpful to DCF as the Juvenile Justice Policy and Oversight Committee (JJPOC) process begins. This will allow for a more focused review of these DCF programs in the broader context of the three systems (CSSD, DCF, DOC) involved in juvenile justice programming.

DCF and facility leadership report that they are committed to continued organizational culture change to facilitate operations that are trauma-informed, evidence-based, individualized to the needs of youth, and which strive to minimize the deleterious effects of incarceration by providing educational, vocational, clinical and recreational resources. Progress towards achieving this ongoing goal of deep organizational culture change will be best supported if this strategic clarification and articulation occurs in a timely manner. Ideally, the JJPOC process can support these goals of organizational culture change but is most likely to do so if these goals are explicitly articulated as part of the JJPOC process. Additionally, the JJPOC process may serve as a forum for data to be reviewed, differences in perspective aired, and a more collaborative relationship established between DCF leadership and some of its critics.

3. It is critical that DCF continue to develop the electronic infrastructure to support key aspects of policy and practice development for juvenile justice operations. This includes development of electronic capacities to support:
 - a. Basic case information and transition across levels of care
 - b. Information regarding the characteristics of youth (e.g., demographic, risk-need, clinical, educational, family/caretaker functioning, exposure to childhood adversity, placement and intervention history) across levels of care and systems of care (e.g., juvenile justice, mental health, other)
 - c. Information regarding program practices and outcomes with the ability to track both aggregate and individual outcomes both while a youth is receiving juvenile justice services and subsequently to track short-term and longer-term outcomes (e.g., recidivism, penetration into adult criminal justice or other public sector systems, education and employment)
 - d. Analysis of aggregate and individual data to examine case trajectories and outcomes with factors including: age, race/ethnicity, gender, socio-economic status, region of origin, recidivism, educational attainment,

child protection history, offense history, placement and services history, behavioral health outcomes, and youth and family perception and satisfaction.

The existing CONDOIT system has been described as “a mess” in terms of its operational utility for CJTS and Pueblo.⁵⁶ A variety of factors contribute to this situation, reportedly ranging from having only one person who as administrative rights to run and “clean up” data, to a pervasive lack of accountability for timely entering of accurate data, to some information not being available because individuals keep records separately from the CONDOIT system. Additionally, educational data is not kept in CONDOIT and so is not accessible through that system, a problem reportedly further compounded by the operating school district’s inability to give data on grade level assessments or do specific data runs on individual children.

Priority should be given to developing or revising an electronically-based “dashboards” of facility operations with progress and outcome measures to guide facility policy and practice that is updated at least monthly.⁵⁷ These progress and outcome measures should be specifically tailored to support quality assurance and improvement for trauma-informed care.⁵⁸ Steps should also be taken by DCF to track outcome measures for youth placed at the facility such as subsequent days placed in the community, recidivism rates up to three years post-discharge, any child protection contact, and educational/vocational outcomes.

4. Connecticut has chosen to create two juvenile justice authorities with the CSSD under judicial supervision and DCF responsible for juvenile justice programming following a commitment by a court to DCF. To the greatest extent feasible, CSSD and DCF should rely upon common measures for juvenile risk-need-responsivity (R-N-R) factors, exposure to adverse childhood experience (ACEs), educational and clinical needs, youth resiliency factors, status on positive youth development

⁵⁶ One collateral indicated that it is a good tool for electronic case management for the residential units but is not a good tool for running reports for analysis. As a result, reports used to track indicators are generated internally on spreadsheets and other means that are laborious and time-consuming. Another collateral reported that information entered by staff varies widely in terms of timeliness and reliability and that there is ineffective accountability for data entry. At times, this has played into differences between CJTS and OCA since information entered into CONDOIT by staff about restraints/seclusions (such as duration) may not align with information derived subsequently from viewing videotapes of incidents.

⁵⁷ One collateral reported that DCF currently working to expand its “dashboard” capacity for juvenile justice programs.

⁵⁸ If needed, there is considerable expertise in Connecticut to support design and implementation of these progress and outcome measures, including Dr. Julian Ford and his colleagues.

dimensions, offense history and subsequent status and programming, and systems and individual case outcome measures.

It will be impossible to understand the trajectory of youth through and across these two systems without a common language and common data-collection to assess populations served, program effectiveness, the effectiveness of evidence-based and other interventions or supports, and outcomes (e.g., recidivism,⁵⁹ behavioral health, and continued or subsequent involvement in state criminal justice, child protection, or mental health systems).

5. There is currently controversy as to whether CJTS/Pueblo Unit should continue to rely upon the standards of the American Correctional Association (ACA) or instead rely upon the Performance Based Standards (PbS) available through the PbS Learning Institute. A reasonable case can be made for adopting either of these quality assurance approaches and clearly having one of them is much better than having neither of them. DCF dropped use of PbS in 2008 and adopted the ACA standards in anticipation of earning ACA accreditation. The ACA standards involve periodic review by external reviewers and affords comparison across similar facilities using those standards, while the PbS system is largely a mechanism for internal monitoring, reporting and self-assessment. CSSD relies upon both ACA and PbS measures.

Strategically, consideration should be given to both CSSD and DCF adopting a single measurement approach for DCF operations that largely or exclusively serve youth with juvenile justice involvement. This would obviously pose a variety of challenges and may involve using both ACA standards (to maintain accreditation) and PbS measures (to align with CSSD) but would also facilitate quality assurance and improvement across both major state systems for juvenile justice-involved youth.

6. Compiled data from CSSD and DCF on youth are committed to DCF and subsequently committed to a hardware secure facility should be routinely subjected to a data-driven “root-cause analysis.” This root-cause analysis should be used to better describe what “systems,” programming, or other problems or failures contributed to the trajectory of each youth into—and then out of—a hardware secure facility. Given the commitment of Connecticut to community-based services and a continuum of care, gathering information about the placement of youth into a hardware secure facility (initially and upon any return)

⁵⁹ CJTS/Pueblo Unit, CSSD and DOC have reportedly adopted a common definition of “recidivism” that is being implemented across these systems.

may help policy and practice at lower levels of care. Admission of a youth into a hardware secure facility should be presumptively viewed as a systems failure warranting careful review and learning from that youth's trajectory into secure placement.

Additionally, movement of a youth previously involved with the juvenile justice system into the adult criminal justice system or an incarceration setting operated by DOC should be presumptively viewed as a catastrophic systems failure prompting detailed case review. Most youth who move through CJTS and into the criminal justice system are placed there after incurring an adult charge in the community and during court proceedings following those charges. Most collaterals report it is "unusual" or "rare" for a youth to move on to the criminal justice system due to behavior charged as criminal misconduct while at CJTS/Pueblo Unit.

From a broader systems perspective, jeopardy of criminal justice involvement for misconduct while being served by DCF in the community or in out-of-home placements warrants careful individual case review. Similarly, this kind of case review is warranted in all cases where a youth transitions into the criminal justice system for misconduct while at CJTS/Pueblo. Whenever possible, youth whose misconduct is significantly driven by a behavioral health need (such as assaults occurring during episodes of extreme emotional dysregulation related to a trauma history) and is reactive rather than instrumental/predatory should be diverted from adult criminal justice involvement.

7. Optimally, DCF should also be able to compare the characteristics of youth admitted to CJTS or Pueblo Unit with relevant characteristics of youth served at other points in its own continuum of care (e.g., community-based mental health providers) or other systems such as the providers of state and contracted services through the state public mental health authority.

For example, neither CJTS nor Pueblo Unit currently complete the Child and Adolescent Needs Assessment (CANS), a tool routinely completed for access to public sector mental health services at other points in Connecticut's system for behavioral health care. For example, CSSD reported completes a CANS to match a youth for treatment in a congregate care program (although a CANS is not used for placement at CJTS/Pueblo).

Completing the CANS at intake and then updating it as discharge approaches would both provide an assessment of youth needs and allow for comparison of DCF juvenile justice youth with youth served in community-based and deeper-

end public mental health systems if the state will allow and develop the capacity for comparative data runs. Additionally, completion of the CANS could be used for eligibility determinations and service-matching in anticipation of discharge from secure confinement. This would require clinical staff training and access to authorization to use the CANS (currently only one clinician is credentialed for use of the CANS).

8. While Connecticut has moved well beyond many states in implementing evidence-based practices, during the course of consultation it was reported to me that referrals of DCF youth with juvenile justice involvement continue to be made to “home grown” programs while evidence-based services such as Multi-Systemic Therapy are underutilized. Additionally, some DCF and external collaterals expressed concerns that although “no reject” provisions accompany DCF contracting, in practice community-based providers are reportedly reluctant to engage youth with juvenile justice involvement and African-American males are particularly difficult to get accepted by providers.⁶⁰ This, in turn, has reportedly delayed discharge of some youth from CJTS or Pueblo and/or contributed to their return when they failed to successfully re-enter their communities.⁶¹
9. As I understand it, Pueblo Unit was opened to provide services to girls who were not stabilizing in other settings, running away, self-harming and/or seriously assaultive to others, highly vulnerable to exploitation by others, and with very high risk/high need profiles. It is intended to be able to meet the needs of these girls but also serve as a “safety valve” when girls in other settings have been dangerous or highly disruptive to those settings. Pueblo has been robustly staffed with clinical resources.

Average lengths of stay in the first months of operation for the 22 girls admitted (with some returns for a total of 27 admission) were 39 days for the 11 girls discharged to congregate care settings, 67 days for the 8 discharged to home settings, and 44 days for the 2 girls discharged to “other settings.” There have been two girls with much longer lengths of stay, one of whom was discharged during the course of this consultation and the second who remains to date.

⁶⁰ It is unclear to me whether these concerns are largely anecdotal or if there is data available in Connecticut regarding patterns of referral to community-based providers and subsequent acceptance or rejection. These concerns reflect both perceptions found in other jurisdictions and research indicating that youth of color are more disproportionately represented among youth who penetrate ever more deeply into the juvenile justice system.

⁶¹ One collateral commented that CSSD offered access to MST but that many youth and families “are no longer interested in MST services” once these services were offered through DCF.

There are approximately 80 girls committed to DCF. The unit is reportedly staffed for 12 beds but typically does not have more than four girls at any time and there have been periods where there were 1 – 2 girls on the unit.

DCF is to be acknowledged for avoiding an “if you build it, they will come” press to fill empty beds. However, given the expenditure of resources,⁶² if the admissions patterns continues to reflect low admissions numbers and discharges for most girls at between 30 – 90 days, consideration should be given to downsizing capacity to perhaps three longer-term beds and three “emergency” beds for short-term stabilization if this capacity cannot be re-sited at existing facilities.

In this scenario, consideration should be given to: (a) whether or not the short stays preclude routine use of therapies provided in groups that assume that participants will be able to continue for more than 30 – 90 days; (b) how to use the small numbers admitted to highly individualize interventions and motivate the girls; (c) how to optimize trauma-informed and gender-specific supports and interventions.

Many of the comments and recommendations below are applicable to Pueblo Unit since it is embedded in the operational and resource structure of CJTS.

Immediate and Shorter-Term Objectives

1. **Suicide Prevention.** The Office of the Child Advocate (OCA) has reported that CJTS has not had a comprehensive independent audit regarding suicide prevention/self-injury policies and practices⁶³ for almost a decade and that Pueblo Unit has never had such a comprehensive audit. Additionally, collaterals from within DCF and external to DCF commented on the need for additional staff training on suicide prevention and responses to crisis when youth may threaten or become self-injurious.⁶⁴

⁶² During low census, Pueblo Unit staff are reassigned to assist at CJTS with the result that there are staff trained to work in both programs and the Pueblo Unit Assistant Superintendent is integrated into the CJTS structure (including responsibility for the Operations Post, training and faith-based services).

⁶³ Both facilities have recently implemented the Shield of Care suicide prevention curriculum developed by the Tennessee Department of Mental Health with a SAMHSA grant. It is a curriculum specifically crafted for use in juvenile justice settings and is entered into the Best Practices Registry maintained by SAMHSA.

⁶⁴ Pueblo Unit staff reportedly received additional retraining some months after opening as a result of high rates of restraint and seclusion.

If it is accurate that there had not been a comprehensive independent suicide audit (either for some years or at all), particularly in light of the convergence of opinion by both internal and external collaterals, a comprehensive independent audit be secured as soon as possible with follow-up as needed.⁶⁵ Other recommendations regarding management of situations where youth are at elevated risk of self-harm or suicide attempt are found below.

Youth in juvenile justice facilities are an at-risk group for attempting potentially lethal self-harm. Risks are elevated in the time following admission, when youth receive disappointing or bad news about circumstances outside of the facility, and as a youth approaches facility discharge (especially if there are unresolved safety or interpersonal issues which the youth will again have to face). Facility practices regarding screening for suicide once the youth has left the intake unit or in anticipation of discharge should be reviewed if they have not been reviewed recently.

2. **Trauma-Informed Care.** CJTS/Pueblo Unit leadership are in the process of implementing the Six Core Strategies process for reducing restraint/seclusion. They are to be acknowledged for adopting this national “best practices” approach to addressing restraint/seclusion in the facilities and for establishing the goal of trauma-informed care. Adoption of the Six Core Strategies is an important component to trauma-informed care⁶⁶ as is the training of some clinical staff in modalities such as Trauma-Cognitive Behavioral Therapy and Dialectical Behavior Therapy.

However, truly trauma-informed care requires significant shifts in perspective, operational design, and individual staff practices. The CJTS/Pueblo facilities have components to facilitate trauma-informed care in place but there does not appear to be an overarching vision of how to best integrate these components into a deeply trauma-informed organizational culture. Similarly, there are components of trauma-specific clinical treatment available within the facilities but these do not seem to be integrated into an overarching treatment model.⁶⁷

⁶⁵ I am informed that during the course of the consultation DCF has concluded that it will contract for an independent assessment of suicide prevention policy, practice and physical plant review for CJTS/Pueblo Unit.

⁶⁶ Effective trauma-informed care also drives down incidents involving physical management or isolation of youth in facilities, reduces injury to staff and to residents, and supports effective engagement in rehabilitation activities.

⁶⁷ I am informed as this consultation is concluding that the DCF Trauma Team will initiate a review of trauma-informed care practices at CJTS/Pueblo. This Team has been recognized by the Commission of New England States.

It is a very challenging process to establish and sustain trauma-informed care in residential and correctional facilities until it is firmly embedded into ongoing practice. This process often benefits from an external review, training and consultation with annual audit of progress for a time. CJTS/Pueblo leadership should consider retaining a consultant to conduct a “state of progress” review of facility operations with follow-up as may be recommended. Two resources to consider are Dr. Robert D. Macy (Center for Trauma Psychology) in Massachusetts and Dr. Julian Ford (University of Connecticut Health Center).

3. Restraint and Seclusion Practices. One of the most controversial areas of practice at CJTS and Pueblo Unit is the use of restraint and seclusion.

CJTS has used Safe Crisis Management as its crisis intervention program since 2004 and the Pueblo Unit also uses this program. All new staff receive this training, all staff annually receive three 2-hour sessions by facility trainers, and an annual seven-hour recertification by a national trainer. Additionally, the facilities are implementing the Six Core Strategies⁶⁸ approach to reduction of restraint and seclusion.

During this consultation, I have received information from Superintendent Rosenbeck, from the OCA, and from others regarding restraint/seclusion practices. On the one hand, data indicates that a small number of youth account for a highly disproportionate number of interventions, particularly seclusion. On the other hand, genuinely concerning information has been produced about specific cases regarding seclusion duration, responses to distressed youth, and supervision of youth during seclusion. A disproportionate number of incidents leading to restraint and seclusion reportedly occur on second shift when there are not clinicians scheduled to be on the units, and the role of clinicians during in-room placements or locked seclusion is reportedly largely limited to quick mental status assessments rather than active access and engagement.⁶⁹

It is difficult to confidently draw independent conclusions about restraint/seclusion practices without personally reviewing a large sample of incident videotapes, incident logs, and interviewing youth and staff involved. This is particularly the case given that the reliability of information variously

⁶⁸ The six core strategies are: (1) Leadership Towards Organizational Change; (2) Using Data to Inform Practice; (3) Workforce Development; (4) Use of Seclusion/Restraint Reduction Tools; (5) Consumer Role in Inpatient Settings; and (6) Debriefing Techniques.

⁶⁹ One collateral indicates that, in practice, the role of clinical staff is “more involved than is reported” and “much more active, assess[ing], and engaged” during restraint/seclusion episodes.

offered by CJTS/Pueblo Unit, the OCA, the Ombudsman, legal counsel and others has been challenged and even alleged at times to reflect deliberate misrepresentation. That being said, both internal and external collaterals referred to the need for reinforcement of training and clarity regarding incidents and more proactive responses to youth who have repeated or prolonged incidents.⁷⁰

As indicated above, data provided to me by Superintendent Rosenbeck and others indicates that a relatively small number of youth account for a significantly disproportionate incidents of restraint and seclusion.⁷¹ This suggests that these “outlier” cases can be identified by setting thresholds in restraints/seclusions for frequency, duration, precipitating circumstances, and specific behaviors (e.g., assaults, threats or attempted self-harm, extreme behaviors such as fecal smearing, indications of possible psychosis).⁷² Case examples provided by OCA suggest that youth who have prompted repeated or prolonged restraints/seclusions or program restrictions also have had significant behavioral health needs and/or were experiencing intensified demoralization, desperation and distress, and/or acute psychiatric symptoms.

A specific protocol should be created in a timely manner to identify youth at CJTS and Pueblo who are failing to stabilize with routine facility structure and services. For example, a specific duration of a single episode of seclusion or a specific number of restraint/seclusion episodes within a specified time frame should trigger a report to senior leadership. Youth identified by this protocol should be promptly reviewed⁷³ and an individualized management plan updated to reflect these crisis incidents and a response plan consistent with the Six Core Strategies approach.

⁷⁰ Comments included: (1) Staff attend trainings and “refreshers” but over time revert to the ‘unit norm’ where the practices are often set—for better or for worse—by more seasoned staff and training more effectively supported and reinforced by some unit leadership than other unit leadership.” (2) “There have been some funky definitions of what should be counted as what and so it is hard to know.” (3) “Some staff don’t understand their own roles in provoking volatile encounters.” (4) “There is no clear model about responding and problem-solving when the same kid keeps getting restrained or secluded or it keeps getting extended.”

⁷¹ One source of information indicated that during 2014 approximately one-third of restraints were of approximately 10 youth out of some 200 admissions.

⁷² I am informed as this consultation is concluding that a working group has been established at CJTS to develop criteria for identifying events of restraint/seclusion to receive immediate administrative notification and case review for urgent management, followed by follow-up meetings that would include CJTS staff, attorney for the child, and the child’s legal guardian.

⁷³ The Office of the Child Advocate suggested during the course of this consultation that there be a gathering of the treatment team, the child’s legal representative and guardian for any youth restrained or secluded more than twice in a 30 day period. Other collaterals have noted that there are many examples when youth who have been restrained/secluded have had their circumstances and needs collaboratively reviewed by facility staff, youth’s legal counsel, region staff, and others.

Additionally, units which have a disproportionate number or duration of incidents of restraints/seclusion (as defined against a facility-wide base rate) should be promptly reviewed for possible retraining of staff and unit leadership or, if the rates are elevated due to multiple responses to a small number of youth, possible deployment of additional staff or other supports as a highly individualized response plan is created and implemented for the youth.⁷⁴

The implementation of the Six Core Strategies is reportedly underway and data over time should reveal whether it is effective in reducing the precipitants, number and duration of incidents involving seclusions or restraints. CJTS/Pueblo staff with previous successful experience in similar initiatives should be involved if they are not already.

One collateral reported that a “comfort room”⁷⁵ for proactive use with youth who are beginning to show difficulties is available in the unit for the youngest CJTS residents although “staff need to be more open to using it.” These sorts of rooms are increasingly common in clinical and forensic psychiatric settings for adults and youth and often play an important role in reducing restraints/seclusions. Consideration should be given to providing such a resource on residential units and training clinical and unit staff in their use.

Review might also be given to the use of “minors” (particularly in response to common adolescent behaviors) or the use of level systems (particularly if the census continues to drop so that more individualized care can be given to youth) given research indicating that they are relatively ineffective compared to other responses to youth positive and negative conduct.

It is my understanding that the Juvenile Justice Oversight Committee (JJPOC) will be including review of restraint/seclusion practices at CJTS/Pueblo Unit, CSSD programs, and DOC as part of its detailed review of conditions of confinement. As part of its review, the JJPOC should consider that in recent months as many as 70% of court commitments to CJTS involve youth who are previously unknown to CJTS. Relevant functional information about youth who have been held in CSSD detention facilities to the point of commitment is not currently routinely provided when the youth is transferred to CJTS following

⁷⁴ There may be reasonable disagreement about where to set the “trigger” for this kind of meeting. However, is undoubtedly important to mobilize key adults involved in the life of a child who is not stabilizing and to review for unmet behavioral health or other needs, adjustments to treatment plans and crisis interventions, and consideration of the need for special support services or need for transfer to a psychiatric facility.

⁷⁵ These are sometimes also called “sensory rooms.”

commitment. It would be very helpful to CJTS to have information regarding the adjustment to detention of youth, any incidents of restraint/seclusion during detention, and any recognized strategies for de-escalating individual youth who have almost prompted or actually experienced restraint/seclusion while detained.

4. **Validated Risk Assessment Tool.** Facility leadership should facilitate immediate adoption of a validated risk assessment tool based upon Risk-Need-Responsivity principles. There is a process that has been underway since 2013 when the “Georgetown Report” criticized the existing youth COMPAS tool and plans are underway to implement the Youth Level of Service-Case Management Inventory (YLS-CMI)⁷⁶ among some regional Juvenile Justice Social Workers. Development of a tool to be shared between CSSD and DCF is underway with a target date of June 2017 for implementation with all juvenile justice staff.⁷⁷

The youth at CJTS cannot wait any longer for implementation of a validated risk tool, particularly since the YLS-CMI is literally an “off the shelf” tool which is inexpensive, easy to train, and easy to incorporate into more comprehensive assessments. As this consultation was concluding, I was informed that CJTS will serve as a pilot site for implementation of the YLS/CMI during Fall 2015. Youth spend thirty days for intake assessment and most of the information required to complete the YLS-CMI (or LS/CMI for older youth) would be obtained in the course of a comprehensive assessment.⁷⁸

As one internal collateral commented: “We need a risk assessment tool—we don’t have a tool and without it we are *just guessing*” about youth recidivism risk, risk and protective factors, and areas of need associated with recidivism.⁷⁹ The view of this collateral was echoed by others both internal and external to the facilities. Without a validated risk tool universally used with all youth admitted to the facilities, it will be extremely difficult if not impossible to reliably track the risk-need profiles relevant to general recidivism risk of the youth served.

⁷⁶ Use of the Level of Service-Case Management Inventory (LS/CMI) is recommended for older youth that are within the recommended age ranges for this tool.

⁷⁷ One collateral reported that all youth coming from CSSD will have the risk tool included in the referral packet if it was completed by CSSD. In any case, “risk” is dynamic and can change over time so routine risk-needs assessment during intake at CJTS/Pueblo Unit can update a youth’s risk-needs profile and be incorporated into facility case-management and treatment as well as discharge planning.

⁷⁸ Research over the past twenty years has consistently demonstrated that unstructured clinical judgment, particularly of violence risk, is unreliable (often less reliable than flipping a coin) with poor inter-rater reliability (agreement) and subject to a number of cognitive and implicit biases. Neither amount of professional experience nor subjective confidence by the person providing the assessment in the risk assessment correlate with reliability.

⁷⁹ Internal and external collaterals agreed that it is not adequate to rely for risk assessment and management purposes upon the Youth COMPAS tool.

In short, the YLS-CMI should promptly be adopted for routine assessment of youth at CJTS and Pueblo Unit with an update as the youth nears discharge to assess for any significant changes on dynamic (changeable) factors which may need to be taken into account for re-entry planning.

5. **A Classification Grid.** As I understand it, assignment of youth to residence units is largely determined by age although some placements take into account factors such as conflicts among youth or special vulnerabilities. Consideration might be given to using a classification grid for residential assignment that includes other factors, especially if some youth are to be identified for longer-term placement based upon their risk/needs and/or designation as a SJO. Classification might reflect decisions regarding nature, duration and intensive of services an individual youth may need and assignment to a unit with practices devised specifically for the needs of youth residing there. Factors⁸⁰ might include:
 - Age and developmental stage of the youth
 - Risk-Needs-Responsivity profile on a validated tool
 - Educational needs and goals
 - Behavioral and/or physical health needs
 - Prior responses to services and interventions at CJTS
 - Individual characteristics (e.g., gang involvement, lower IQ, high trauma)

6. **The Clinical Services Department.** The Clinical Services Department at CJTS/Pueblo Unit is a robust presence with an experienced multidisciplinary presence that is enviable from a national perspective.⁸¹ The following considerations are offered in the spirit of enhancing already significant contributions rather than in the spirit of criticism. Both the current activities of the clinical staff and its potential as a core component of pervasively trauma-informed care are impressive. Based upon information gathered during the course of this consultation, the following recommendations are offered for consideration:

⁸⁰ One collateral indicated that some of these factors are often used informally to place a youth within a unit inside of buildings where placement is defined by age. This collateral suggested explicitly referencing these factors in documenting a unit placement decision although I would suggest creating a concrete grid as a decision-tool to be used with each youth to minimize unfounded individual discretion and to assure that all relevant factors are considered in each case.

⁸¹ This Department includes a licensed psychologist as Clinical Director, a supervising psychologist, 2 supervising clinicians, a full-time and a part time psychiatrist, and a staff of 18 licensed clinical social workers and clinical psychologists. In June 2015 an additional part time psychiatrist will join the Department for a total of 3 psychiatrists. Clinicians are trained in a variety of evidence-based practices.

- Currently, all mental health professionals are assigned to first shift although there are a disproportionate number of youth who go into crisis in second shift and on weekends and/or whose crisis starting on first shift result in behavioral management (e.g., restraints/seclusions) that continue into second ⁸²shift. Shift assignments of mental health staff should be made to provide adequate coverage on second shifts and weekends.⁸³ This would also permit more engagement with youth across more time and increase availability of clinicians for family visits.⁸⁴
- The Assessment Unit (4-B) which provides intake assessments is widely viewed as providing a very helpful and comprehensive assessment⁸⁵ of youth before they are transitioned to an assigned residence unit. However, collaterals observed that the organizational culture at CJTS is often “if the youth did OK in intake then they get assigned to a unit where the YSO’s treat all the kids the same.” For many youth, this may be adequate but youth who stabilized in intake with the very experienced and attentive staff working there may run into difficulties when on residential units.

Collaterals suggested that assessments incorporate concrete descriptions of symptoms, learning disabilities and learning styles, or other youth characteristics/needs in highly individualized plans. Diagnoses are reportedly not particularly helpful for non-clinical unit staff and others, but descriptions of how youth function and how to concretely respond to manifestations of their behavioral health and other needs are viewed as very helpful.

Assessments should also routinely include descriptions of youth triggers, how they look and behave when they are become distressed, what works to help them re-regulate, and the individualized essential elements of a crisis response safety planning. These plans, paired with unit staff training on understanding and consistently implementing them, would help staff understand and support youth.⁸⁶ These assessments and individualized plans based upon them would also allow for more proactive responses to youth before they go into crisis.

⁸² Some clinical staff reportedly now flex their schedules to stay until 6 pm.

⁸³ There is reportedly one clinical staff member on site on Saturdays and Sundays. I do not know during what hours this staff member is present. Clinical staff are also reportedly “on call” to respond if needed.

⁸⁴ I am informed as this consultation is concluding that CJTS is considering shift changes which would have 2 clinicians on-site to 8 or 9 pm.

⁸⁵ One collateral suggested that assessments routinely identify youth who are engaged with a faith community since their faith may be an avenue for constructive engagement and faith communities may be assets to include in re-entry planning.

⁸⁶ One collateral gave as an example: “YSO use a lot of prompts about behavior on units—the plan should say ‘this kid is intellectually limited—if youth are sanctioned for something after 4 prompts, this youth may need 8 prompts before a sanction.’”

Additionally, assessments would reportedly be more helpful if they included detailed descriptions of family functioning, peer group relationships and dynamics of youth when they are in the community, presence or absence of positive youth development assets in their communities, and specifically what—if any—links exist between behavioral health needs (e.g. mental disorders, substance use disorders) and delinquent misconduct.

- Many youth with histories of childhood exposure to adverse experiences/trauma will not accurately self-report their histories of exposure to adversities or meet criteria for PTSD even if they do. More recent research based upon the groundbreaking Adverse Childhood Experiences study (ACEs)⁸⁷ indicates that childhood exposures to a specific adversities correlates with emergence of a variety of risky health-related behaviors (e.g., earlier onset of sexual experimentation and more risky sexual behavior, engaging earlier in other risk-taking behavior, earlier onset of substance use), behavioral health problems (e.g., depression, anxiety, onset of psychosis, substance abuse), and poorer health and medical outcomes over the life course. Subsequent research has linked higher ACEs scores with probation failures, school underachievement and failure, self-harm and suicide, victimization, and other factors.

The ACEs tool can be easily completed based on collateral reports, documents, or youth self-reports. Aggregate results would be very informative about the frequency and distribution of adverse childhood experiences of the youth admitted to CJTS and Pueblo Unit and potentially helpful in matching services to individual youth.

For example, a youth who did not self-report adverse experiences of post-traumatic symptoms might nonetheless be assigned to a trauma-informed intervention due to presenting with a high ACEs score. This trauma-informed intervention may not be a trauma-specific treatment such as T-CBT if the youth is not inclined to talk about their histories of adversity, but emerging research increasingly shows that interventions such as mindfulness exercises, yoga, routine exercise, music and art therapy⁸⁸, and other interventions which do not require verbalizing the trauma explicitly can have positive impact (especially on emotional self-regulation).

⁸⁷ Reader is referred to the webpage for the federal Centers for Disease Control. The ground-breaking ACEs research and subsequent research can be accessed by entering “Adverse Childhood Experiences” into that home webpage’s internal search function.

⁸⁸ Some of these, like drumming and yoga, have been available at CJTS at various times but were never operationally integrated and so ended over time.

One collateral reported that CJTS/Pueblo Unit will be implementing the Child Response of Post-traumatic Symptoms (CRPT) and the Behavior Assessment System for Children (BASC) as part of the JJPOC conditions of confinement initiative. This collateral suggested that if CJTS/Pueblo Unit adopt the ACEs tool that it be adopted by CSSD and DOC as well.

Similarly, research increasingly indicates that the characteristics of “systems” in which youth are embedded (e.g., family, peers, school, community) and the interventions intended to assist them have outcomes mediated through their capacities (helped or not by these other factors) for *resilience*. Until relatively recently, there were no validated tools to assess youth resilience factors over time. Now such tools exist such as the Child and Youth Resilience Measure (CYRM-28). This is a validated brief tool (20 minute administration) which can be adapted to include site-specific questions and could be included in the 30-day assessment process at intake and might be completed again close to discharge to assess whether improvements in resilience have been made since admission.

Consideration should be given to reviewing Moral Conation Therapy or other evidence-based treatments that have been developed in recent years specifically for correctional populations and/or modified for juvenile justice populations. This review should include Project BUILD Violence Intervention Curriculum (evidence-based 10 session intervention originally developed for detained youth), Equipping Youth to Help One Another (developed for incarcerated youth and rated as “promising” by National Institute of Justice that incorporates elements of Positive Peer Culture and Aggression Replacement Training interventions).

- While there are considerable clinical resources, there is not an overall integrated treatment model or definition of role. All youth are offered individual treatment sessions once a week but what is provided in individual sessions is a reportedly matter of each clinician’s training and preferences. Clinical staff are not directly involved in unit behavior management incidents but the nature and level of clinician engagement following a restraint or during a room-placement or seclusion varies by clinician and by unit. Some staff have received DBT training but there has not been success in bringing it to scale on units and the initiative to do so has reportedly significantly faltered.

As the strategic decision is made as to what the function(s) of CJTS/Pueblo Unit shall be (short-term stabilization, longer-term treatment, both), the Clinical Department should take that opportunity to consider developing an integrated treatment model with corresponding clinical skill sets, processes for effective

individualized treatment-matching to specific modalities, and specific attention to risk-need-responsivity factors most relevant to each youth's recidivism risk.

Resources have been expended to train clinicians in Dialectical Behavior Therapy (DBT) but efforts to disseminate this modality on a unit-level basis have faltered over the years. Consideration should be given to identifying a residential unit to operate as a DBT unit as a pilot program and to track outcomes of youth assigned to that unit compared to other units. The Massachusetts Department of Youth Services (DYS) piloted DBT in its girl's secure treatment unit over a decade ago and has expanded the model into its boy's secure treatment units due to its effectiveness. Communication with DHS regarding its experience with DBT on its secure treatment units and the specifics of its program evaluation/outcome tools might be helpful in developing this pilot unit. Senior facility leadership will have to support this initiative given its history of faltering in the past.

- Reportedly, CONDOIT data reflects in *inverse* relationship between a youth whose behavior prompts a behavioral management intervention and number of clinical contacts of any kind. In short, the data indicates that *more challenging youth on units actually prompt fewer clinical contacts than more stable youth*. If accurate, patterns of utilization of clinical staff on units should be reviewed to refocus clinical resources to support the most behaviorally unstable youth.
- Review of incident reports and other documentation as well as information from persons interviewed suggests that clinicians have a relatively limited role when a youth is on room restriction or in seclusion. This role reportedly is often limited to conducting brief mental status and suicide assessments during periods of restricted movement or seclusions. If accurate,⁸⁹ reconsideration and retraining is recommended regarding the role of clinicians during crisis⁹⁰ and interventions. "Best practices" approaches to youth in crisis call for more clinical engagement during episodes rather than less engagement, active use of de-escalation strategies, and access to "sensory rooms" to facilitate self-soothing rather than traditional seclusion or room restriction.

⁸⁹ One collateral reports that, in fact, clinical staff do respond to all crisis interventions (and some of been injured in doing so), and continue to work with the youth following the incident to review treatment plans and create behavior chains to support more effective de-escalation. If so, and admittedly I did not review all incident reports and CONDOIT entries for all incidents, this level of staff engagement was not reflected in the documentation of incidents I reviewed and clinicians should more consistently document their engagement with youth.

⁹⁰ Available information suggests that some unit clinicians are very active and skilled at de-escalation at times of crisis while others tend not to get involved or do not have effective de-escalation skills. Steps can be taken to explicitly empower clinicians to become more involved in crisis resolution, provide them the skills to do so, and to consistently expect their participation except in immediate physical management.

- Clinical team meetings occur routinely for youth but are reportedly relatively traditional case reviews that: (a) do not routinely frame data or outcomes in terms of a Risk-Need-Responsivity model focused upon behavioral health contributions specifically to match interventions to reductions of recidivism risk; (b) in practice, information from educational records or psychological testing (e.g., auditory processing problems, poor working memory, lower cognitive capacities) is often either unavailable and/or unincorporated into clinical formulations or reflected in individual management strategies; and, (c) common adaptations to frequent adversity or trauma such as emotional dysregulation, dissociation, hypervigilance and over-perception of threat are not routinely incorporated into clinical formulations or individual management strategies, especially if the youth is not given a PTSD diagnosis.
- One internal collateral reported that a point-in-time review indicated that 37% of CJTS youth were specifically on antipsychotics but that none of those youth had any of the usual supporting diagnoses. External collaterals also raised concerns regarding medication practices at CJTS/Pueblo Unit. Data subsequently supplied by Superintendent Rosenbeck indicates that of the 77 youth admitted to date in 2015 that 21 youth (28%) were admitted already prescribed psychotropic medications. As of May 2015, 23 (30%) were on psychotropic medication with 5 youth (6%) on an antipsychotic medication. Of the 84 youth at the facilities on 05.21.15, 37 youth (44%) were on psychotropic medication with 10 (12%) on an antipsychotic medication. Only one of the youth prescribed antipsychotics had only Conduct Disorder diagnosed with the others variably diagnosed as having primary mood disorders, PTSD, ADHD, or Schizoaffective Disorder.

The difference between the information reported by the internal collateral and the information subsequently provided by Superintendent Rosenbeck suggests the need for better internal communication regarding clinical operations given the organizational role of the internal collateral, and the need for more effective communication with external interested parties regarding medication practice. More importantly, the pattern of prescribing psychiatric medications reflects both the prevalence and the acuity of behavioral health needs of youth within the facilities. Youth declining to take medications once discharged was identified as an ongoing problem by several collaterals and suggests that youth would benefit from explicit attention to “treatment readiness” measures and steps to counter the stigma associated with mental illness of the kind found in more sophisticated psychiatric and substance abuse treatment settings.

- Unit staff generally reported that clinicians are well-integrated and respected with the units where they work. This allows for close work together but also

makes it very disruptive for both the staff and the youth when clinicians are “switched out” across units. They felt that this was a decision of sufficient impact that it should only be made following significant input from unit leadership. Unit staff also reported that at times decisions made by the unit team were reversed by clinical and facility administration without any or sufficient input from the unit leadership, even when a unit clinician was part of the decision-making that was altered.⁹¹

- An internal DCF collateral noted that the clinical staff have fairly traditional mental health training and skill sets, suggesting that should a position open or resources be allotted that a staff member skilled in functional behavioral analysis be hired to supplement the clinical skill sets. These skills would be particularly helpful in crafting individualized management and intervention strategies for youth who are failing to stabilize in response to the usual structure and services.
 - One “systems” issue to be addressed is the difficulty arranging transfers of youth with acute psychiatric symptoms requiring urgent management to inpatient psychiatric units. These situations reportedly require often challenging case-by-case problem-solving rather than relying upon reliable protocols to facilitate admission to a psychiatric facility.
7. **Educational and special educational services.** The educational, special educational, and vocational services at CJTS/Pueblo Unity are exceptionally rich and strong and reportedly yield valuable outcomes such as improving reading levels, preparing for state standardized testing, and supporting academic and vocational readiness.

The greatest challenges identified by the education leadership and staff interviewed were: (1) facilitating the return of youth to community schools upon discharge since so many local schools simply don’t want these youth back; and, (2) keeping up with technology and software that engages and educates youth. The first motivates them and many of the youth to “educate as much as possible” in the time available,⁹² and the second is now receiving greater attention.

⁹¹ One collateral reported that unit teams are “always consulted and their views taken into consideration.” Other collaterals reported that this consultation may be minimal, subsequent to a decision already having been made, or did not occur at all.

⁹² The educators interviewed reported that most youth have multiple learning gaps due to poor school attendance. School engagement may initially be slow as “the first thirty days they are getting the ‘street’ and the drugs out of their system before they become kids again” but many youth feel supported by the PBIS behavior system and become motivated to learn.

Recommendations include; (a) support for the effort to open a night program to extended the academic and vocational learning day; (b) consideration of the impact on educational attainment (a major protective factor for youth) if average lengths of stay drop; (c) consideration of allowing a short-term *voluntary* extension of placement for a youth to achieve specific educational goals such as sitting for the SAT, graduating from high school⁹³ or completing vocational training programs.

Additionally, some collaterals inaccurately believed that all youth who are on “unit restricted” status do not receive educational services while on that status. These youth reportedly receive school work daily and then receive direct teacher instruction if the unit restriction lasts more than three days. CJTS may want to take more assertive steps to provide this information about when youth do or do not receive educational services when in the facility.

Several collaterals expressed concern that information known to school staff (e.g., cognitive limitations, significant learning disability, atypical learning style) was not consistently shared with clinical or other staff, or was not incorporated into clinical assessment or individual management/treatment plans. A small time-limited working group of clinical, school and unit staff might look to see whether or not this is really a problem and to make recommendations as may be needed to assure routine information-sharing and incorporation of this information in clinical and unit planning and management.

8. Perhaps one concrete indicator of the shift from a juvenile correctional model to an explicit adoption of a treatment/rehabilitative model has been the reduction of police officers at CJTS from approximately 10 some years ago to a single police officer now. Another is the decision that only unit leaders may carry handcuffs rather than having all unit Youth Service Officers carry them. Clinicians have been trained to provide trauma-informed cognitive-behavioral therapies and unit staff and leadership have moved over time to a more relational model of youth engagement.

However, making a shift from a traditional correctional model to a rehabilitative model itself does not assure consistent and reliable dissemination of trauma-informed practices. This involves deep organizational change and focused effort over time.⁹⁴ Collaterals from both inside and outside DCF opined that efforts to develop consistent trauma-informed rehabilitative practices at DCF and Pueblo

⁹³ Approximately 43 CJTS youth completed high school during the last fiscal year.

⁹⁴ Implementation of the Six Core Strategies is instructive in that the first strategy is Leadership Towards Organizational Change.

Units remain incomplete although it was generally acknowledged by most that significant gains have been made in recent years and there is increasingly “buy-in” from unit staff and others.

Examples cited included:⁹⁵

- variability across units or staff shifts of use of de-escalation strategies;
- a tendency to focus upon crisis episodes and their management once the crisis begins to unfold with less subsequent focus upon factors contributing to the crisis and how those might have been proactively addressed (e.g., determinations that staff acted properly rather than discussion or instruction about what staff might have done instead that might have de-escalated a situation);
- dress⁹⁶ and behavior by staff which implicitly communicates that “the street” and its dangers is also present in the facility, or difficulty consistently addressing behavior by staff that would reasonably be perceived as provocative or disrespectful;⁹⁷
- reports of high rates of sleep disturbances among youth with prescription of medications for sleep but no little if any behavioral health intervention to facilitate sleep;⁹⁸
- seclusion episodes that go over hours to days; and,
- lack of clarity about how to consistently distinguish misconduct warranting a disciplinary response from manifestations of trauma or behavioral health disorder; holding back youth from educational/vocational or clinical activities as a routine part of “out of program” sanctions.

Both internal and external collaterals gave examples where youth with significant trauma histories, program failures, and behavior prompting multiple physical interventions and sanctions failed to receive significant modifications to their treatment plan. Some of these youth failed to stabilize and incurred charges which either precipitated their transfer into the adult system or puts them at risk for doing so. These cases may be a very small number of the most challenging and high risk/high need youth, but they were offered as examples how trauma-

⁹⁵ I report these as descriptions or perspectives from collaterals. They are offered so that DCF and facility leadership are aware of them.

⁹⁶ One collateral reports that consideration is being given to having YSOs have uniforms.

⁹⁷ For example, a media report indicates that a CJTS staff member described another staff member as characterizing youth as “porch monkeys.”

⁹⁸ Information suggests that as of the writing of this report there are three youth prescribed Trazadone specifically for sleep and some additional youth prescribed Benadryl. CJTS reports that youth with sleep difficulties are clinically reviewed and provided with behavioral interventions before being prescribed medications to facilitate sleep.

informed practice was not effectively applied in practice to youth in serious trouble.

9. **Links to Behavioral Health Services in the Community.** It is my understanding that when youth are in congregate care and nearing time for transition that a case review is done by Value Options to determine clinical needs and match the youth with community-based services which can meet those needs. This review is done by mental health professionals and takes into account the youth's profile on the Child and Adolescent Needs Assessment (CANS) tool.

By contrast, youth at CJTS and Pueblo are not subject to this Value Options review and the CANS⁹⁹ is not completed for them. As a result, the decisions about matching needs to services following secure facility discharge involves the DCF Juvenile Justice Social Workers (who provide case management but who are not necessarily credentialed as social workers¹⁰⁰ or have particular expertise in treatment matching) and persons at the secure facilities (who may or may not have any particular information about the nature or effectiveness of services in the communities to which the youth will be returning).

I recommend consideration of completing the CANS at intake to CJTS and Pueblo, updating it within the 30 days prior to discharge, and subjecting case planning and intervention-matching to the same review process with Value Options as occurs with youth leaving congregate care for family or community-based services, or for matching youth with a congregate level of care.

Additionally, given the complex needs of youth who move through CJTS and Pueblo, "flexible funding" options outside of standard contracts may be useful in creating options that meet the needs of youth.

10. **Internal or External Ombudsman.** There was controversy during this consultation about whether DCF should continue to use an internal ombudsman

⁹⁹ It was explained to me that the CANS is not administered for CJTS/Pueblo Unit youth since they are not "officially" there to receive mental health services. If accurate, this would be a striking disconnect with the robust clinical assessment and treatment resources there, the prevalence of formally diagnosed behavioral health needs of the youth in the facilities, the description of CJTS in its own mission statement as providing "a safe, secure and therapeutic environment," and the overall shift from a traditional correctional focus to an explicitly rehabilitative focus.

¹⁰⁰ One collateral reports that the Juvenile Justice Social Workers receive the same training as do other social workers through the DCF Training Academy. Arguably, this may not be the equivalent of a bachelor's degree or master's degree in social work with subsequent credentialing, and social work training geared for DCF staff who are attending to the 97% of DCF children/families who are *not* juvenile justice cases may be insufficient for those who are attending to the 3% who are.

process or shift to a contracted external ombudsman as has CSSD. Indeed, legislation was filed which would create an ombudsman function that is not housed within DCF operations.¹⁰¹ Philosophically, I am personally inclined to have persons serving that function operating as independently as possible from the organization. That being said, I have seen both internal and external ombudsmen operate effectively or ineffectively, depending often upon the commitment of the individual to the role and their felt sense of freedom to communicate candidly.

I recommend at this point that the ombudsman function be monitored in light of changes in the youth grievance process¹⁰² and the assumption of the ombudsman responsibilities for CJTS/Pueblo by Ken Mysogland in late Spring of 2014. Much of the documentation given to me reflecting an extremely high rate of findings of “no merit” predate these changes and can be used to compare the results of grievance outcomes with the new process in place over the past year.

Additionally, Mr. Mysogland has instituted practices such as personally meeting with all youth during their intake phase, proactively engaging with youth who have filed multiple grievances, and supporting the youth in effective advocacy. He also indicated to me that he is particularly interested in restraint incidents since they often prompt grievances, and is focused on ways the facility can respond more proactively and effectively in cases where youth are experiencing multiple restraint incidents. If not already occurring, consideration should be given to involvement of the attorney for each youth as part of the ombudsman investigation or review process.

11. **Policy Continuity Planning.** Commissioner Katz and the DCF juvenile justice leadership have launched bold reform of the juvenile justice programming offered through DCF for some of the most challenging and vulnerable youth in Connecticut. More time will need to pass before the final outcomes of this reform initiative become apparent although there already have been major changes in the child and family-serving systems of DCF. The consequences of these changes are still in flux and there are ongoing and significant policy and practice issues still at play.

¹⁰¹ Mr. Mysogland reports approximately 3,000 total annual inquiries/grievances covered by the Office of the Ombudsman within DCF, with 172 from CJTS and 17 from Pueblo Unit. He reports that 7 residents filed 35% of the grievances.

¹⁰² For example, Commissioner Katz has reportedly approved of sending grievances to the public defender of record for the youth and to the Office of the Child Advocate at the same time that it is reported to facility administration. Mr. Mysogland will also receive reports of any child protection Special Investigations prompted by reports from either facility. He will take lead responsibility for more significant grievances while facility unit administrators will respond to more minor grievances.

Future governors and the legislature should recognize that Commissioner Katz has taken an unusually intense interest in DCF juvenile justice operations. There is no assurance that a future DCF Commissioner would have the same degree of focus on this *three percent of the youth served* by DCF.

From a strategic perspective, consideration should be given about how to best institutionalize policy and practice initiatives so that the best of them can endure a change of administration or a shift in public policy focus. This recommendation is not personal to Commissioner Katz. Rather, it is an acknowledgement of (a) the “systems” impact occasioned when any Commissioner assigns an unusual degree of attention to policy and practice to part of a state agency; and (b) the time and sustained attention required to develop and implement policies and practices intended to result in deep organizational change.

The elimination of a specific office in DCF central office operations for juvenile justice was part of an initiative to engage the regions in more adequately meeting the needs of its juvenile justice youth and create a culture of accountability. My impression is that at this point the accountability of regions for youth in its juvenile justice programming is largely a function of DCF central senior administration rather than broad enthusiasm and commitment among regional administrators to devote resources and attention to this very small percentage of youth served by DCF.

To the extent to which this is accurate, the initiatives underway for youth involved in DCF juvenile justice programming may be vulnerable to the vicissitudes of interest in juvenile justice of future Commissioners, gubernatorial administrations, and/or regional administrators. In reality, the priorities of civil service personnel tend to outlast those of Governors and Commissioners in the absence of an ongoing internal point of leadership and accountability for specific policies, programs or populations.

It may not be that a specific DFC office for juvenile justice is required to continue to support and advance reforms which will take years to fully implement and embed into routine practice. That being said, identification of a specific entity responsible for statewide DCF juvenile justice programming is the best assurance that there will be sustained and well-informed attention to these youth over years to come. Indeed, the long and still incomplete process of deep culture change at CJTS reminds us of how long these processes can take.

It is promising that the Juvenile Justice Policy Oversight Committee (JJPOC)¹⁰³ will be reviewing the conditions of confinement of juveniles in DCF, CSSD and DOC programs. If balanced and dispassionate, the activities of the JJPOC may also provide a forum and framework for reducing the current level of mistrust existing among DCF, OCA, and various stakeholders and interested parties.

The reform initiatives underway--especially if successful--will mark another chapter in Connecticut's long process of juvenile justice reform. Consideration is warranted about how to best create structural, administrative and operational infrastructure to sustain policy and operational initiatives over coming years.

Thank you for the opportunity to provide this consultation. I imagine that it will not be uniformly received by all given the current controversies at play. However, I hope that it is helpful in aligning policy and practice to support positive outcomes of youth in DCF juvenile justice program, or perhaps even that it can serve as a common point of departure for persons committed to the well-being of these youth, their families and the communities to which they will return.

¹⁰³ Under the leadership of the subject matter experts affiliated with the University of New Haven and the Tow Foundation Youth Justice Division.

Individuals and Groups Interviewed During Consultation

(* indicates a Board Member of CJTS Advisory Board at time of consultation)

I offer my sincere gratitude to the following individuals and groups for their participation in this consultation process:

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Abigail Anderson, Executive Director, CT Juvenile Justice Alliance*

Debra Bond, Director of Mental Health Services, CJTS/Pueblo Unit

CJTS Student Council representatives

CJTS Unit Leaders and Assistant Unit Leaders

CJTS educational program administrators and staff

Jim Connolly, Post-Adjudication Unit, Public Defender's Office

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Sarah Eagan, Director, Office of the Child Advocate

Donald Highsmith, Chaplain for CJTS/Pueblo Unit

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