

A SYSTEM OF SERVICES FOR GIRLS IN CONNECTICUT

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The landscape of Connecticut girls' services is much like the girls themselves: extraordinary strengths coupled with widespread, seemingly insurmountable challenges. Connecticut has islands of excellence in girls' services:

- A state plan that requires gender-specific services, methods for assuring that every girls' program adheres to approaches that fit girls, and evidence-based family treatment, intensive home-based services and treatment foster care
- A psychiatric hospital where girls make remarkable gains
- Residential centers where girls make progress and communication with families improves when there is a good fit between staff and a girl
- Washington Street girls detention center that has exceptional staff practices and quality of life for girls
- The involvement of the University of Connecticut that, unlike other such trauma programs nationally, focuses on children in child welfare and juvenile justice for whom recovery requires that clinicians, direct care staff, family, foster/adoptive parents, and school staff change their behavior in response to the continuing effects of trauma on girls
- Documentation of how behavior management systems do not fit girls and of effective methods for supporting behavior change in girls
- A collaborative girls network of staff from several government agencies, public and private providers of girls services, and advocates who understand quality individual treatment and the systems elements necessary to support it

Each of these islands is ahead of what other states offer girls.

Yet, desert surrounds the islands of excellence: there is no system of gender specific, strengths-based, trauma-informed, culturally competent, relationship-driven girls' services in Connecticut. In public and private residential and non-residential services, including parole and child welfare, practice lags far behind the islands of excellence. Public and private providers appear to have ignored the benefits of changing staff behavior and continue to struggle with physical and relational aggression between girls, injuries to staff and girls, and use of restraints that have almost been eliminated at Washington Street detention center.¹ Providers apparently do not believe that behavior management systems fail with girls, and point systems trigger girls across the state every day.² Most girls do not

receive effective trauma treatment, and when a therapist skillfully helps a girl face the demons of her past, other staff unintentionally sabotage her progress with punitive care guaranteed to trigger traumatized girls.³ The language of caring for girls through relationship informs the state plan, the detention staff training and the network, but girls who desperately need attachment lose relationships with every move (and frequent moves are a built-in feature of programming).

The lack of agreement about girls' needs within and across programs is astounding: diagnostic disputes among clinicians and individual staff interpretations of the purpose of their work seriously undermine consistent treatment even within small programs. There is also a divisive dispute about accountability, with some insisting that girls must be held responsible and punished for running away or being assaultive while others argue that most girls have not matured enough to think before acting and adult standards of accountability cannot be applied to them. Every week the state releases lists that include girls waiting for residential placement, sometimes for months in detention, and girls awaiting space at Riverview. The collaborative network, given too few services that meet the needs of girls, has a slot mentality, forcing girls into one-size-fits-all programs where they are unlikely to be successful. The Plan for a Continuum of Community Based Services for Female Status Offenders and Delinquents (3/05) was supposed to be for all girls, but it has been seen as a plan for committed girls, and the follow-up standards project to make DCF and CSSD practices consistent has met with resistance. School, a crucial element of success for girls, is seldom part of the dialogue at the individual or systems levels and girls' learning disabilities and language barriers that were ignored in public school are not effectively addressed in treatment programs.⁴ State legislation treating girls at 16 as adults, which is not developmentally sound and goes against the accepted wisdom about adolescents relied on by the U.S. Supreme Court, results in girls being sent to prison for running away from programs at the point when real therapeutic gains are being made.⁵

No one articulates these systemic problems more effectively than the girls themselves, who tell us that restraint is cruel, disrespectful staff antagonize them, parole is part of a punitive mindset that undermines treatment, multiple placements are a replay of their childhood rejections, and waiting endlessly for permanent homes makes them hopeless and angry.

Every state in the country is struggling to have enough in-state residential and secure beds for traumatized female delinquents and status offenders. While there has been national interest in gender-specific care for almost 10 years, no state has demonstrated a system of effective services for girls and no residential program for girls has been identified as a model.⁶ Perhaps the failure to serve girls is linked to the emphasis on building beds rather than meeting individual needs and encouraging talents.

This analysis of the system of services for girls in Connecticut, and the question of whether the state should build a secure juvenile facility for girls, is based on 14 girls who would have been recommended for a secure state program had one existed in 2005. This proposed design of a system of girl services is based on the strengths and needs of the girls and their families. Record review, interviews with girls in the programs where they were placed, interviews with a few of their families, and meetings with staff who work with girls across the state were completed in November and early December, 2005. The 14 case summaries can be found in the Appendix (the girls' names, but no other details, have been changed to protect their confidentiality).

THE GIRLS' STRENGTHS

These 14 girls are extraordinary. They are articulate, outspoken, funny, sensitive, and talented athletically, artistically, and academically. They have affection and empathy for family and friends. Some are leaders. Some are college-bound and others have skills and interests that make them employable. Although their survival skills sometimes cause the girls to be described as “unmanageable,” they are remarkably resilient.

THEMES IN THE GIRLS' HISTORIES

These 14 girls range in age from 14-17. Four are Latina, four are African-American, four are Caucasian and two are bi-racial (African-American/Caucasian and Native American/Caucasian). Four are from New Britain, two from Hartford, two from Bridgeport, two from Windsor Locks, two from Waterbury, one from New Haven and one from New Milford. Two were born in Puerto Rico and one was born in Jamaica.

Their stories are tragic. Ten of the 14 had significant behavior problems before the age of 10, yet school and outpatient interventions were inadequate to address their irritability, poor frustration tolerance, sexualized behaviors, and difficulty adjusting to change. All of the girls experienced extreme and repeated trauma: documented sexual abuse (8), physical abuse (7), parent separation (9), and exposure to domestic violence (9) and parental substance abuse (10). At least eight of the 14 girls had teenage mothers. At least three experienced prenatal substance exposure and three had significant birth complications. Ten girls described feeling abandoned by one or both of their parents; several lost grandparents and for one the suicide of a friend precipitated problem behaviors. Case records documented both early problems of attachment (attributed to the mother's youth and instability) and attunement (friction between the parent's characteristics and the child's early personality, with the child described as “difficult” and the parent experiencing their relationship as a battle). Three of the girls were the problem child in the family and felt disliked. Six had a difficult adjustment to the birth of a younger sibling, nine moved among family members, and eight had conflicts with a stepparent (or parent's live-in partner). Nine of the girls had early school difficulties, struggling with below grade level functioning and behavior problems. Nine have serious learning disabilities which were unidentified or untreated, including two with language barriers. Four had tested IQs of 77 or below. Five had tested IQs of 104 or higher and reported being bored in school. At least five of the girls had problems adjusting to middle school. Early negative peer involvement was a common problem, with at least five having a sexual relationship and five using marijuana by age 12.

Early physical maturing and absence of father in early childhood, both known elements in the development of behavior problems in girls, are not well-documented in the girls' records. Chronic medical problems, such as asthma, are documented, but girls' requests for more medical attention than boys for physical health concerns does not stand out despite these findings elsewhere.

These girls have been failed by adults. They have not received adequate support for significant early school problems or trauma, often after child welfare intervention. Status offenses bring them into court, with schools and families being unable to control them. Most are committed and placed because their runaway behavior and truancy put them at risk, not to protect the public (later they are charged with assaults in their programs).⁷

THE GIRLS' NEEDS

Before designing services for each girl, we have to understand the unique weaving together of immaturity, trauma and disabilities that explains her behavior. Too often, a girl is plugged into a program without her needs being clarified, with the expectation that universal services will change a range of behaviors in girls. If the underlying needs below the behaviors are identified, it becomes apparent that some services would not meet those needs and services not provided by the program would be necessary.

An important first step in designing a seamless system of services is agreeing on a developmental framework for understanding the behavior of the girls. It is so easy to forget that a 14 year old thinks immaturity and is a fairness fanatic and that some of her behavior is typically adolescent rather than pathological. Thinking immaturity includes not being able to anticipate consequences and not seeing the worst thing that could happen, which allows her to take risks that she minimizes. Having an immature identity may mean, even at 17, being a follower and so desperate for attention or a sense of belonging that friends are chosen indiscriminately. These behaviors are further complicated if the girl has a learning disability, which affects her all the time (not just in school), impairing her ability to accurately perceive cues, digest information, and learn from her mistakes. If she has covered up her learning disability, she is unlikely to ask for help when she does not understand. The overlay of trauma also affects her behavior. She may be on the alert for victimization and over-react to perceived threat. Because of traumatic experiences, disabilities and immaturity, she may misconstrue communication or body language, see hostility others do not perceive, and be overwhelmed by stimulation, the demands of transitions, or ambiguity. She may not be able to label her feelings and explode in anger or sadness from the past that does not fit present provocations. She may not want to experience the feelings leftover from trauma and may use substances or runaway to escape them. Still having a childhood sense of blame for the trauma, she may dislike herself, adding to the pressure to be accepted. Wanting nurturing, she may have trouble trusting or depending on others because of past disappointments. Finally, each girl's family and culture are an important context for understanding her development and designing services.

These 14 girls each have different needs, and services must be individually tailored to build on their strengths and meet their unique needs. Looking across all 14 needs lists, themes emerge that can assist in the design of a system of girls' services.

→ To be treated respectfully

Girls say that they are provoked by adults. Because they are teenagers, they insist that everything has to be fair and a double standard for adults and girls is intolerable (e.g., adults yell at the girls, but girls are punished for raising their voices). Because of past trauma, they may be extremely sensitive to the abuse of power by adults and misinterpret "No" as victimization (as one girl said, a look can trigger her). If a girl has a disability, her brain may process communication differently, adding to this misinterpretation.

DESIGNING SERVICES TO MEET THIS NEED: Adult personal style and training are important: not reacting, not getting angry or defensive, not becoming controlling, not taking girls' behavior personally. A community process for defining mutual respect and standards that are the same for adults and girls is necessary. Girls also have to be helped to see when they over-react even though an adult is treating them respectfully.

→ *To have some control over what happens to her*

These girls are more controlling than adults can tolerate. They want to have a voice in everyday matters as well as their futures. They may have typical teenage “one right way thinking” and are often sure they know better than adults. It may be a positive part of recovery to insist that they will not let anyone be powerful over them again. Multiple placements have made them both hopeless about and desperate for belonging (although their records blame the girls for causing placement disruptions by running away or being unmanageable). Disabilities may make it more difficult for a girl to be part of a planning process. Having some control is a need for girls who are returning to family, who cannot return to family, and whose family members are too inflexible or too unstable for return to be certain.

DESIGNING SERVICES TO MEET THIS NEED: Personal style and training are important so adults do not respond by being controlling or engaging in power struggles. Families and foster families must learn democratic decision-making with girls. Services are required to teach girls how to take charge without being argumentative or aggressive and to recognize them for using effective self-talk and self-soothing to avoid confrontations. Each girl must be involved with her family and staff in designing a fair, consistent method to address inequities before she escalates. To ensure she has a voice in planning her future, a girl should be involved in a process of honestly appraising various family and other permanent homes, connected to her trauma treatment. If she discovers her family cannot meet her needs, she will require help making peace with having continuing close relationships and visits with her family but living in another home. For one girl, this was described as the “saddening realization that her parents are motivated by their own concerns—she could have gone home months ago if her parents had been willing to address their issues.”

→ *To be supported to make attachments and have them continue*

Girls’ decompensation after making progress is interpreted as being fearful of success, but an additional perspective would be that because of past losses, they cannot tolerate another separation—loss and change often undermine their progress. With an immature identity, they may not feel lovable. Because of repeated disappointments, they are easily hurt when they experience any loss. Attaching and loss of relationship may be more confusing to a girl with disabilities who has difficulty with sequencing and processing information. One girl’s need was “to have a family where she belongs and not have to meet that need by having a baby.” Another girl’s need was “to learn how to get what she craves in relationships without becoming so intense or possessive it is difficult for her or the other person to stay involved.”

DESIGNING SERVICES TO MEET THIS NEED: A system of services that encourages continuity of relationships is essential—a girl should not be moved from place to place; progress should not achieve a move that separates her from the attachments that supported that progress. Perhaps programs should offer financial incentives for staff to make long commitments to girls. When creating staffed homes or permanent foster homes, staff to whom she is attached should be considered, with the agency being able to backfill the position. These are girls who have difficulty trusting—they need to learn ways to cope with the vulnerability they feel when they accept help. As one girl was described, “she is desperate to connect with someone as a parent figure, but has little trust in adults... [instead of] secure

residential treatment, she will ultimately benefit more from a long-term relationship in a good foster home.”

→ To learn self-soothing

Girls experience frequent high levels of anxiety, that often they do not recognize. Adults sometimes react to the intense emotions/behavior that are driven by the anxiety. Each girl has to learn how it feels when she is just starting to be anxious, and adults must know how that looks in each girl. Until they are able to tell themselves to start self-soothing, adults, without being punitive or threatening, must gently guide the girl into relaxation. Adults have to learn to navigate the teenage responses “There’s nothing wrong with me.” and “Don’t tell me what to do.” If she has been repeatedly victimized, the girl’s anxiety may be a reflex, often with no thought (they may not use words to say to themselves, “This situation makes me feel like I did when I was being abused or rejected at home. I need to prevent having the physical feelings I had when I was victimized. I don’t have to be anxious that abuse is going to happen to me now”). Processing internal reactions quickly may be more difficult for the girl with disabilities. For one girl, it was apparent that her hopelessness and anxiety fueled her impulsivity. Another girl who had low frustration tolerance since childhood was described as quickly escalating to an explosion without knowing how to prevent it.

DESIGNING SERVICES TO MEET THIS NEED: Group instruction and individual coaching in music relaxation, pets, yoga, meditation, etc. will ensure that all the girls become aware of their anxiety. Several of the girls were taught to use hot baths, special teas, and crocheting effectively for relaxation. Adults must learn to remind a girl of the self-soothing that has worked for her before. For the girl with asthma we don’t say “Your breathing is annoying others. Take a time out to stop that bad behavior.” Instead, we say, “You are starting toward an asthma attack. You want to stop it before it gets really bad. Take a puff of your inhaler.” Taking safe space has come to mean a disciplinary time-out, even when self-imposed, which tells the girl she is bad and has to separate from others rather than that she has an anxiety reaction that she can use a self-soothing technique to reduce. Learning self-soothing must be in the context of her trauma treatment, including helping a girl connect her substance abuse to anxiety or memory-avoiding.

→ To learn to be less hypervigilant/To learn to see less hostility from others

These girls learned at an early age to constantly scan their environment for possible threat—it was a self-protective mechanism that now causes her problems. Because she was hurt and had to become hypervigilant, since childhood she may have seen hostility in actions or body language that seem benign to others. As one girl was described, “she invariably personalized feedback as criticism...saw all problems as external...any efforts to help identify triggers or alternate perspectives led to intense anger.”

DESIGNING SERVICES TO MEET THIS NEED: Adult personal style and training are important: do not make threats; when giving an instruction preface it with statements like “I don’t mean this to be hostile. It’s not directed just at you. This is the rule for everyone. I am not picking on you.” A girl has to be taught to notice her oversensitivity and how to use self-talk to persuade herself she is not being threatened or someone is not hostile.

→ To learn to be less reactive to threat/ To learn how to express fear or anger safely

Even when a girl has reduced her hypervigilance, people may make threatening statements or actions. She has to learn how to reduce the intensity of her anger or fear when threat is perceived, which might be greater during high activity times or transitions. If she has disabilities, she may be weak in picking up the nuances in speech or body language that would inform her about whether a threat is serious. For example, a cognitively limited girl “rapidly escalated because she was unable to maintain her side of verbal arguments.”

DESIGNING SERVICES TO MEET THIS NEED: Girls irritate adults by being so loud. Her protest is important to her. Adults trying to quiet her are often misperceived as not liking her or taking away her free speech, thus antagonizing her more. She may lose track of what she was angry about in the first place. Small provocations may evoke explosions from a volcano of feelings left over from trauma or she may get angry to avoid pain from the past. Staff must be trained to validate feelings, encourage self-soothing, teach her to assess how much feeling fits the threatening or angering situation, and new self-talk: as one girl said, “Not to let small stuff get to me.”

→ To learn how to identify her feelings in the present and the past

One girl was characterized as “anxious, depressed and has internalized significant painful emotions which she has been unable to share with others. She vacillates between emotional and intellectual ways of dealing with events, leading to misguided decision-making, strained relationships, simple, reactive, primitive solutions to complex problems.” Another girl was “essentially immobilized by her overwhelming emotions...[she] tends to misinterpret actions and intentions of others...[and] does not know how to resolve anger provoking conflicts.” For girls with expressive language disorders, stating feelings is even more challenging.

DESIGNING SERVICES TO MEET THIS NEED: Adults must validate her feelings. Adults must remain calm and non-reactive and offer her simple choices to remain safe while giving her recognition for expressing her feelings in words. Learning to face feelings from the past and in the present helps a girl change her habit of running away when overwhelmed, especially in conflict situations: running away is an effective way to avoid feelings in the present, and for a girl with immature thinking, the negative consequences of running away may not be apparent at the time.

→ To learn how to compensate for her disabilities

More than half the girls had disabilities. While some were placed in special education for emotional disturbance, they did not have effective specialized instruction for their learning disabilities. Girls with learning disabilities may misunderstand what others want, the nuances of social situations, and the feelings of others. One girl was described as covering up her significant cognitive limitations, and it was a challenge for staff to provide her with an environment that was not confusing or overwhelming.

DESIGNING SERVICES TO MEET THIS NEED: Girls must have instruction on how their disability affects them both in and out of school and skills to compensate for their disability. Problems in sequencing and inferring cause and effect due to prenatal substance exposure require specialized teaching techniques for a girl to learn how to anticipate the worst things that could happen.

→ *To be praised rather than punished*

To develop a positive stable identity, girls have to be good at something. They are talented but for years their negative behavior may have gotten more attention than when they excelled. As one girl was described, “she has a low estimate of personal worth and little self-confidence. . .feels embarrassed in social situations and anxious about being ignored or rejected.” They desperately want to be liked and in almost every interview stressed that they needed more attention from adults. Their parents have other children, partners, and financial, substance abuse and domestic violence problems, so they cannot be as attentive as their daughters want.. As a result, as one girl said, they seek “negative people” who give them attention; they wish they were successful finding positive friends and doing productive activities without being “pulled into sex or getting high” to feel a sense of belonging or acceptance.

DESIGNING SERVICES TO MEET THIS NEED: Services must guarantee success experiences for girls. The message “You are good. You are smart. You are lovable. You make a positive contribution to others/ community” is crucial if a therapeutic goal is a stable, positive identity to prevent self-destructiveness. Daily opportunities must be provided to excel in athletics, the arts, academics, and interpersonal talents. For girls who failed in school, learning to read, being recognized for their writing, and feeling competent enough in calculations for self-sufficiency are crucial. For girls who are bright and alienated from school, an academic program that challenges them, as well as college preparation and assistance once in college are necessary. Adult personal style and training are important: their primary job is positive individual attention; their main interaction with a girl should not be to correct rule violations. Instead of the ineffective points and levels behavior management system, an affirmation-oriented behavior motivation approach focusing on relationships, responsibilities, and privileges through teaching rather than punishment is essential.

PROPOSED SYSTEM OF SERVICES FOR GIRLS IN CONNECTICUT USING SEVERAL PROGRAM HUBS

A system of services for girls must build on each girl’s strengths. A system of services for girls must not be deficit-driven. A system of services for girls must guarantee that every girl is successful. Each public and private provider must be accountable for designing services that recognize girls for being articulate, outspoken, funny, sensitive, and talented athletically, artistically, and academically.

A system of services for girls must meet each girl’s unique needs. This means a developmentally-sound approach that recognizes the role of immaturity, trauma and disabilities in the girl’s behavior.⁸ Each public and private provider must be accountable for services that are specifically designed to:

- Treat girls respectfully
- Give girls some control over what happens to them
- Support girls to make attachments and have them continue
- Teach girls self-soothing
- Teach girls to be less hypervigilant and to see less hostility from others
- Teach girls to be less reactive to threat and to express fear or anger safely
- Teach girls to identify feelings in the present and the past
- Teach girls to compensate for her disabilities
- Praise girls rather than punish them

To build on girls' strengths and meet girls' needs requires a system of services with staff who demonstrate competency in:

- *giving gender-specific, culturally competent, relationship-driven care*
- *celebrating each girl's strengths*
- *tailoring their efforts with each girl to make sure her needs are met*
- *guiding each girl's recovery from trauma*
- *using gender-specific behavior motivation*
- *supporting each girl to become successful in a permanent home*

These staff competencies are an aspiration now, but do not all exist in any treatment program for girls in the state. Programs want to be strengths-based, but purposefully bringing out a girl's talents gets lost in the day-to-day efforts to control her deficits. Programs want to provide individualized services, but often identical treatment plans focus on program goals rather than the unique combination of immaturity, disabilities and trauma in each girl; programs are reluctant to treat girls differently because they may respond that staff are being unfair. Programs want girls to commit themselves to change, but rely on levels and points systems that are part of a "doing to" approach that alienates girls.

Without investing in significant change in core beliefs and practices in child welfare, behavioral health, probation, and parole staff, public and private provider staff, and schools, Connecticut will continue to produce girls in crisis who are seen as requiring a move to a secure state-run facility to prevent harming others or running away.

Investing in several hubs for diversified arrays of residential and community-based gender specific, strengths-based, trauma-informed, culturally competent, relationship-driven services is one way Connecticut could meet the needs of girls in the least restrictive settings. The goal would be for a girl entering any hub to keep her connections to staff during her transitions among levels of care within the program. Each service array would have to include:

- individual and group trauma treatment and a language of making peace with the past used by all staff, girls and families during the residential phase and as girls move to the community; much work is required in this area given new conceptualizations of trauma treatment, the fears adults have of girls facing past abuse and neglect and the low priority given to family treatment for delinquents in accountability-oriented programs⁹

- the capacity to set up a staffed home for one girl as well as finding permanent non-relative homes using different recruitment, training and payment methods than traditional foster care, all supported by residential staff and community-based staff; the unique specialized homes developed for violent youth in North Carolina (the Willie M. program) are an example of an approach the hubs might use¹⁰

- the capacity to work intensively with families, wrapping services around relatives and non-relative homes, including daily coaching for the girl and the family;¹¹ intensive home-based services at MHYSP, a nationally-recognized Massachusetts program, have demonstrated positive outcomes and might serve as a model for the hubs¹²

- a school program designed to meet her needs while in residential and as she moves into the community¹³

Since there is no evidence base for residential care,¹⁴ shorter residential stays would be an advantage of hubs developing a full array of intensive home-based services for girls with their families or in other homes. This approach has been demonstrated by Wayside, an innovative Massachusetts program, which has a small short-term residence with intensive home-based services. Wayside has a unique billing system that allows their staff to have continuity with children and families regardless of program/funding source.¹⁵ The hubs might train clinical and other staff to be inside/outside caregivers, initially working with a girl in the residential program and continuing to support her while she makes a transition to her permanent home. Using innovative approaches for scheduling and clinical supervision, each inside/outside staff person could be working in the residence with one or more girls and working in transition in the community with one or more girls. Such an approach would also rest on altering the split between clinical and other staff common in residential programs. Staff have different roles, but it essential that all staff operate with the same philosophy of care and that girls' attachments to all adults are honored.

The hub design process would address the systemic problem that these girls had multiple assessments, multiple referrals, and multiple stays in detention. An integrated system of gender-specific girls' services would utilize a girl's detention stay as the first opportunity to invite her to a strengths/needs-based self-assessment, with the assistance of family and professionals. She and her family could be involved in the design of services if she is on probation or if she gets committed. A hub might start with a girl in detention in a girl-centered strengths/needs-based service planning process, initiating the girl-family-staff team that will support the girl during all phases of services. Then the girl might move to the residential phase, in a program that purposefully built on her talents and helped her meet the needs she and the team had identified. Trauma groups and the "talk" of the program around sensitivity to threat and expressing anger safely, self-soothing, having success in school (and building compensatory skills if she has disabilities), and bringing her family into the process of meeting her needs would be initiated in the residence. This would lead to early planning for her permanent home, including a girl-centered process of assessing whether family members can meet her needs and, if not, finding a foster parent (including possibly a staff member). The girl might continue in the residence school as she began transitioning to her home, with staff support to move to a community school when she, the school and her family were ready. The intensity of services required in the first 6-12 months of the girl's transition is likely to be costly and staff intensive, done by a combination of inside/outside staff and community-based staff: a girl who is getting the full-time support of staff in a residential program cannot be expected to make it at home with outpatient services or even two or three times a week interventions. The girl's needs must be the guide for designing the intensity of services necessary to meet those needs.

While training, technical assistance, quality assurance, financing and guidance for the hub development process might be centrally-managed, the hubs would not necessarily have identical service arrays. It would be crucial that each hub go through a process of designing services based on girls' needs, with sufficient funds to support continuity in caregiving for each girl. That process should also be part of the training and coaching for all staff to develop competencies in gender specific, strengths-based, trauma-informed, culturally competent, relationship-driven care.

Large group training on meeting girls' needs with gender-specific services is not likely to produce consistent statewide practice. Instead, a combination of staff coaching and practical sessions involving clinicians and other staff, based on the strengths and needs of the girls and families they are serving, has been shown to be more successful in developing competencies. Because staff believe they are doing the best they can to help difficult girls now, it is necessary for them to experience first-hand greater effectiveness with a different way of thinking. As the training/technical assistance combination unfolds, new approaches to supervision and employee evaluation criteria should be developed based on the gender-specific competencies being strengthened. In the process, some staff who do not want to work with girls in a gender-specific system of services will decide to change settings.

Two secure programs—Stepping Stone and Natchaug—as well as CCP--which could develop secure girls' space—could be the hubs for diversified arrays of residential and community-based gender-specific services. To some extent NAFI has developed this array of services, but reportedly girls in their residential programs seldom go into their foster homes or receive their in-home services; it is a positive step that girls can move from Touchstone to Lighthouse and continue with the same therapist. CCP has plans to develop nearby housing which fits well with the idea of an array of services. Natchaug appears to have the least diversity of services and support would have to be provided for Natchaug to develop non-secure programming. If NAFI, Natchaug and/or CCP elected not to implement their own intensive home-based services, contracting with a provider should include the agreement that their staff to whom a girl had an attachment could continue with her in some capacity during her transition. Wraparound and MST programs that are not gender-specific are unlikely to offer intensive enough home-based services to meet the needs of girls described above, so the services developed by the hubs to support girls in the community would not only have to be individually designed but might be more intensive than previously offered in the state. The inclusion of behavior health group homes, such as New Hope (which is successfully meeting the needs of one of the 14 studied girls although it ejected another), in the array of services might make sense. However, many girls are easily triggered and overstimulated when they live in groups and do better in homes where they are the only child. As Connecticut works with the Oregon Social Learning Center to develop multidimensional treatment foster homes, which have been successful with girls in juvenile justice who run away, some of these homes could be specifically located within the service arrays of each hub. Treatment foster care is designed to be less than a year with careful preparation for girls returning to their families, so Connecticut must also develop a new way to recruit and train permanent homes for girls who are not returning to their families. Expecting the child welfare system to find these homes is unrealistic. Ideally recruiting and training permanent homes for girls would be done by each hub, in conjunction with the OSLC training for treatment foster homes, applying the MTFC methodology in other permanent homes.

Girls should not be transported in shackles across the state. Each hub would have to address the function of secure beds within its system of services for girls. The goal would be, through staff training and greater involvement of girls in identifying their needs, that, as has been proven at the detention center, the number of incidents requiring a girl's move to secure care would be dramatically reduced. If her strengths are being built on and her needs met, a girl's self-soothing should reduce her escalation to harming herself or others. For example, if providers changed staff training and expectations in order to ensure that each

girl receives a significant amount of individual attention and physical activities each hour, aggression, running away and self-harming behavior would be reduced. If a girl did escalate, a program has to have the capacity to continue to care for her—moving girls in crisis is risky, causes them to lose their attachments and sets back their treatment. If other residents or staff could not be kept safe or a girl could not be kept from running away without resorting to secure care, she should be able to be in secure care within the program and subsequently placed in the program's nonsecure care without losing connections.

Occasionally a girl will be unable to prepare for a transition to family or another permanent home in a group setting. For these girls, it may be necessary to create a home by staffing it with residential staff (with the same training and continuing supervision and with whom the girl may have a positive relationship), sometimes by covering that staff's position with a new hire. The girl might still attend school and/or group sessions at the hub. She would still benefit from the intensive home-based services wrapped around her family or other home when she can make this move.

Occasionally a girl might require hospitalization due to suicidal risk, but these incidents are likely to decrease in programs where girls are more in charge of their needs and get more adult attention. Riverview then could function more as a front-end assessment service for girls entering the juvenile justice system in a state of crisis.

Having Natchaug, NAFI and CCP serve as hubs with secure beds and a system of residential and intensive in-home services might underserve girls from Bridgeport and New Haven. Possible options for including a fourth system of girls' services are: (1) Identify a program that could develop an array of gender specific services, including a few secure beds, in Bridgeport; (2) Designate a Riverview program as another hub for a service array specifically for downstate girls, including the capacity to staff homes, recruit permanent homes and provide intensive supports to families; or (3) Develop a Girls Court (based on the successes of such a court in Hawai'i) and girls detention in New Haven as the hub for an array of services specifically for girls who require intensive services but would not be put on parole to receive them (other states have financed such services for youth on probation through Medicaid). The CARE program in New Haven might also fit well into such an array of services. Staffed homes under behavioral health in New Haven and Bridgeport could be an important part of either of these three options.

The strengths/needs-based plan below is an example of how a gender-specific system of services would be more effective for a girl moving from residential to intensive services in her family (or another permanent home). Ronni, a 15-year old African American has made significant progress at Riverview, but twice deteriorated into harming staff and peers as she was about to be transferred to another program. Family treatment has had success, although parental inconsistencies and regional staff differing with the hospital about whether family placement was feasible have been problematic.

RONNI'S STRENGTHS

Intelligent & articulate

Socially perceptive (and knows a lot of details about a lot of people)

A leader, especially for justice

Feels loved by her family

Admired by her peers

Has strong relationships with adults

Excellent athlete & great singer and dancer

RONNI'S NEEDS (age 15)

- To be treated respectfully (which she defines differently than adults)
- To not get a defensive or angry response when she insists that rules should be adhered to and that there should not be a double standard for adults and kids
- To be helped to get clearer on the “half the problem is me;” since she was child, she has not liked change, has been irritable, has gotten frustrated quickly, did not tolerate powerlessness, and has reacted to ambiguity
- To figure out ways to be assertive in righting wrongs that are not argumentative or aggressive and how to be calm enough at the time her passion is being provoked to be assertive
- To have a justice cause she can fight for outside the place she is living
- To appreciate all the good in her extended family and at the same time not feel she is being disloyal to recognize hurt from the past and family limitations
- To understand why she has such strong verbal skills but struggles to make progress in reading and figure out what special teaching techniques help her the most
- To have opportunities to use her unusual social perceptiveness and remarkable memory for details about people
- To continue her connection to Riverview staff
- To have daily opportunities to excel in athletics, singing and dancing

POSSIBLE SUPPORTS TO MEET THESE NEEDS

- A community process for defining mutual respect & standards that are the same for adults & kids that Ronni takes a leadership role in (which might include questioning if some rules should change)
- To participate with her therapist, staff, her family & an advocate in designing a fair, consistent method to address inequities before Ronni escalates
- To decide that these are not bad parts of her, but are characteristics that affect how quickly & strongly she reacts to unfairness—each characteristic may require new self-talk so she can immediately take charge of calming herself so she can assertively solve the inequity of the moment. Arguing or being aggressive shows that self-calming was not effective enough to support an effective assertive response. Every use of effective self-talk & self-calming & assertiveness should be recognized.
- Work with an advocate to become a spokesperson for young people; form a public speaking club
- Participate in a process of evaluating the pros & cons of each family home she might live in, including defining the nurturing & rules she will need at home; use this process to set up her permanent family with important family members working with Ronni in making peace with the past
- With 1:1 instruction using material of high interest to Ronni, including her community rules, self-talk & public speaking projects, have her success in reading and writing improvement get recognized
- Possibly writing projects, designing a staff and youth awards program, or writing a play about her life
- Progressing to another place to live should not cause a loss of attachment
- Possibly helping with talent shows/athletic events

By identifying her needs, this plan helps adults avoid unintentionally triggering Ronni with limit-setting by being clear and concise, not giving ambiguous body language, and resisting the desire to correct her distortions as she is escalating (which is a time she has to cling to her own perspective being the only right one). This plan entails many hours a week with Ronni, with and without family members, assessing each family home, deciding what she needs from a family home, and negotiating with family members (which includes trauma recovery with family who have harmed and disappointed her in the past). That would also involve arranging intensive home-based therapy, coaching and other supports to wrap

around her family home (which might include Riverview staff being paid to continue to work with her during the transition). Riverview, or a residential program had she been placed in one instead, would have to be able to connect the self-soothing techniques, self-talk, and compensatory skills (for her disabilities) she learned there to a family process and continue both the techniques and effective family treatment during the transition to home (or to another permanent home) without a loss of connection to staff.

If during this process, Ronni's aggression increased despite strengths/needs-based interventions, an alternative to consider would be a staffed apartment with at least one Riverview staff on loan plus recruiting other staff, with maximum involvement of Ronni in the design process. A staffed home is a hybrid of a foster home and residential treatment, with trained staff instead of a foster parent. The goal is to increase participation in community activities, so staff would go with her to sports, singing and family activities and in the home, cooking, crafts, and homework are also opportunities for assertiveness and self-talk training. Trauma treatment and family treatment are closely connected to everyday life so all staff actively support self-soothing and self-talk about making peace with the past. Staff also help locate a community school she can transition to near her family, and they support her gradual transition from the Riverview school to that school.

Although Ronni and staff working with her were interviewed, this particular plan was developed for this report and was not created with Ronni or her family. The principle of girl-centered, family-friendly strengths/needs-based service design is to support a girl in taking charge of her own change process. These girls need to feel in charge of at least some of what happens to them, and empowering her is part of the treatment process. Of course, her voice is not the only one in the service planning process. Professionals and families support a girl through self-assessment so she appreciates her strengths and recognizes that her behavior is driven by her past experiences, her (immature) thinking, her (immature) identity, and her disabilities. In this process, we also engage her family—even if it is unknown whether she will live with them in the future—so they celebrate her strengths, recognize her needs instead of focusing on her behavior, and contribute to the service design process. A strengths/needs-based service plan will be refined as a girl makes progress and more is learned about her needs and what effectively meets her needs and builds on her strengths. Strengths and needs is not just what gets written on a plan—it is a way of thinking about girls and their families.

SHOULD CONNECTICUT BUILD A SECURE GIRLS' FACILITY?

There are many arguments for and against building a secure state-operated facility for girls. Those who argue against it say it will be another Long Lane, a punishment-oriented correctional facility where every bed will always be full because it is a dumping ground for girls who cannot return to family. Those who insist that Connecticut must have a state-run secure facility for girls argue that (a) girls who run away must be locked up to be safe; (b) girls who are aggressive toward peers or staff must be locked up to keep others safe; and (c) Long Lane was a good placement for girls and since it closed, Riverview has had to replace it. Others believe the state should not build a secure facility, but should temporarily operate secure beds for girls while providers develop their capacity to meet the needs of girls. They say there is no way to stop admissions in programs to give them time to train staff and develop new services, and that it is unacceptable to use an adult prison or a psychiatric hospital for secure beds for girls while the system improves. The response by some is that

once the state has a secure girls program, it will be impossible to close it or bring it into a system of gender-specific services.

Two other questions must be answered before deciding about building a new secure facility for girls:

- Why aren't the state's current secure programs for girls (Natchaug, Stepping Stone, and Riverview) sufficient?
- Are there ways to add secure capacity to current secure programs or to other programs for girls, incorporating them into a system of gender specific, strengths-based, trauma-informed, culturally competent, relationship-driven services for girls that would be more cost effective and be available sooner than building a new facility?

About 5,000 girls were referred to Juvenile Court in Connecticut last year, with over 1,700 referred as FWSN as their most serious charge. About 500 girls were sent to detention. In November, 2005, there were 109 girls on parole in the Connecticut juvenile system, 13 of whom were dually committed. About 56% were Caucasian, 33% African-American, and 23% Latina. About 19% were from, Bridgeport, 15% from Waterbury, 15% from Hartford, 12% from Torrington, 11% from New Britain, 9% from Danbury, and 5% from New Haven. Over 75 girls on parole were in placement, including Stepping Stone (21), Touchstone (19), New Hope (9), Natchaug (9), CCP (4) and Riverview (4); it is commendable the Connecticut has very few girls in out-of-state placement.

The current crisis in Connecticut over the lack of beds for girls is blamed on the absence of a secure state facility. But it is more accurate to conclude both 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. With a full array of sufficiently intensive services that did not necessitate the loss of connections as girls progressed into the community within the same gender-specific program, girls' strengths would be built on and girls' needs would be met without the system being too full to admit another girl. This conclusion can be drawn just from the 14 girls who were studied, at least half of whom are stuck in beds that should be made available to girls waiting for placement and others whose needs are not being met in their programs.

Two examples of girls stuck in beds because of the lack of an array of gender-specific services demonstrate different reasons for this problem:

“CHERISE”

Cherise, a 16-year old African American, has been at Natchaug for more than a year. She has made significant progress, using her trusting relationship with staff to learn the connection between her emotions and behaviors and improve her social skills. But, “she has worked extremely hard and there is no change in family dynamics and no home to discharge her to.”

CHERISE'S STRENGTHS

Intelligent

Positive

Has friends who really like her

Interested in theater and dance

CHERISE'S NEEDS (age 16)

To continue her current attachments to Natchaug staff, her mother and grandmother

To form new enduring attachments

To choose her next home, which should be a permanent home (possibly not her mother or grandmother)—to feel she's not "stuck in the system"

To have her perspective heard and validated before another point-of-view is proposed

To learn self-soothing, other than marijuana, when she starts to feel anxious or moody

To understand how her irritability, hopelessness and anxiety are connected to feeling chronically unloved

To learn the give-and-take of friendship (even when she gets worried about being liked) with someone who might not go more than halfway to reach out to her

To feel successful in a part-time job, dance classes and fashion shows

To understand how going to dangerous places puts her at risk

The plan for Cherise has been to move from Natchaug to Touchstone, but Touchstone would not be able to meet her need to continue her current attachment to Natchaug staff because of distance. Touchstone would not be able to meet her need to form new enduring attachments because it is not a long-term placement. A therapeutic foster home would not meet her need for a permanent home because it is short-term. Cherise wants to return to her mother, although her grandmother is her guardian. A pre-adoptive home (with the possibility of reunification with her mother in the future) near Natchaug, ideally so she could continue at the Natchaug school and continue in therapy might build on Cherise's strengths and meet her needs best. Connected to her trauma treatment, a special process should be initiated with Cherise, her mother and grandmother to assist her in evaluating whether either can provide her with the loving home she wants; and if not, working through how they can still be her family if she lives happily in another permanent home. Cherise should be involved in interviewing prospective special recruit foster homes. Intensive wraparound services to coach (as much as daily) the foster parent and Cherise's family and to make sure Cherise's needs are met, might be done by paying Natchaug staff to provide these services.

"ANDREA"

Andrea is a 15-year old born in Jamaica. She has been at Riverview, her 12th placement since she was 13, since August, 2005. Her mother reported that Andrea has made progress with her therapist at Riverview. But because of trauma, Andrea's immature self-centeredness makes it difficult for her to live in a group of girls. The obstacle to maintaining her gains after discharge is summarized in a recent hospital report: "The early separation from her mother leading to inadequate bonding as a child seems to reflect in ongoing conflicts between them and Andrea not being able to accept her mother's

authority.” Her mother and stepfather are employed, and her mother says her other children have no problems, she is not planning to change her parenting, and she expects Andrea to comply with family standards.

ANDREA’S STRENGTHS

Bright
Articulate
Reads at the 12th grade level
Writes well

ANDREA’S NEEDS (age 15)

- To learn how to be satisfied with what she can control, especially when she feels people get in her way
- To learn what to do in the battle of wills with her mother since each describes the other as stubborn, inflexible and controlling
- To learn new self-talk when her mother’s insistence on the rules or other adults seem unfair
- To have support to face the pain of the past: early abandonment by her mother; abuse; return to her mother when her “perfect” older brothers had been with her longer; treated as “difficult” when she was reacting to trauma; resenting her mother’s pleasure from her younger sister’s compliance
- To have a friend who likes her
- To participate in democratic decision-making at home and in school

Andrea is eager to return home and seems willing to have therapy and continue her medication, but minimizes problems likely to develop at home and in school. Although she is intelligent, Andrea is immature and does not see that she lacks adult problem-solving skills. Her mother does not want Andrea home anytime soon, is reluctant to continue family therapy, and does not want people intruding in their home. The risk is that Andrea will be discharged home from the hospital with insufficient outpatient services and a school that is not challenging and Andrea will have to be placed again. Would Andrea do better in a foster home near a small, college preparatory school? If the hospital was part of a system of services so that Andrea’s strong relationships at the hospital and her mother’s positive view of treatment there could be continued in their home with a trusted person becoming her daily coach and therapeutic arbiter between Andrea and her mother, Andrea would be most likely to succeed.

When strengths/needs-based gender-specific services are not provided, girls do not make progress. Yvette is an example of a girl whose needs are not being met in her placement (Candace, a 14-year old Latina at Natchaug described in the Appendix is similar to Yvette in her needs not being met):

“YVETTE”

Yvette is a biracial 16-year old who spent more than a year at Touchstone where she was described as “unfocused, inconsistent, and unable to move past level 2.” She was placed at Stepping Stone in 10/05 where she began by walking out of individual and family

therapy sessions. Her treatment plan at Stepping Stone reads like a list of rules: healthy relationships; attend school; no running away; no substance abuse; strengthen relationship with mother; and anger and communication. She said she hated school, which is not surprising since her last testing showed she was reading and doing math at the 3rd grade level and her learning disabilities had not been addressed.

Yvette's progress has been hindered by a dispute over whether she should be dually committed because her mother, even with support, may be unable to learn to parent Yvette especially if her stepfather does not want her at home. Yvette's treatment has floundered with a lack of clarity about the role of immaturity, trauma and disabilities in her behavior. In their interviews, both Yvette and her mother focused on the unfairness of her being in placement for three years. Yvette insists she should return home, and she believes she does not require much assistance with family, in school or in avoiding negative peers. A significant alteration in the treatment approach is necessary to involve her in defining her needs and engage Yvette, her mother and stepfather in what it would take to meet her needs, especially because Yvette has the immature thinking and immature identity typical of a younger teenager and her decision-making is impaired by processing and concentration problems.

YVETTE'S STRENGTHS

Sociable, outgoing and friendly
Good at swimming, dancing and singing

YVETTE'S NEEDS (age 16)

- To learn new self-talk to help her anticipate outcomes, plan ahead, and recognize situations that make her reactive or impulsive
- To talk about how violence at home, moving among family members, the death of her grandfather, the birth of her brother, physical and sexual abuse, and rejection by her father and stepfather continue to make her angry and not want anyone to control her
- To be successful in school by understanding how to compensate for her disabilities and concentration difficulties
- To have positive activities, including part-time work, that build on her sociable and outgoing characteristics
- To be supported on her goal of having "healthy relationships," especially how to keep the ups and downs of romance from getting her into trouble
- To be supported on her goal of "not smoking weed," especially if getting high is an important part of socializing and/or not feeling angry or sad

Getting Yvette's involvement in meeting these needs is unlikely to occur in a level system or in traditional family therapy. Instead, starting with how she digests information best, she should be helped to design a practical plan for going home that helps her increase her understanding of her complex needs and supports her in teaching her mother and stepfather about her needs. This method would have to continue in day treatment and intensive home-based services, preferably with a staff person who had participated in it while Yvette is in residential.

Yvette has occupied a treatment bed for three years. Had an effective array of gender-specific residential and intensive home-based services been available, several other girls could have been placed in those programs instead of Yvette. A secure state-run facility would not have altered Yvette's lack of progress or that of other girls taking up residential space without their needs being met. A secure state-run facility would not address Cherise and Andrea's needs either—they are in secure beds already and cannot safely be moved because their programs are not embedded in a system of gender-specific services that could be wrapped around them with their families or other permanent homes.

Two of the 14 girls were sent to adult prison while this study was being done. As another girl's removal from Riverview was insisted on by staff who feel the hospital has "become a dumping ground for juvenile justice girls," punishing her assaults with adult prison time was suggested. All three girls had made significant progress, but their programs were not able to meet their needs. These are the responses of an exasperated juvenile system trying to rid itself of girls whose behaviors the state has played a role in creating. While it might be argued that a secure state-run facility would be preferable to prison or an out-of-state placement for these three girls, an effective array of gender-specific developmentally-sound residential and intensive home-based services is required to meet their needs.

Building a secure state-operated facility for girls will be costly and time-consuming. A state-of-the art secure juvenile facility, typically designed on an adult correctional model, would be difficult to turn into a gender specific program. If Connecticut decided to revise the Missouri small juvenile treatment facility model with a gender specific philosophy, would it be possible to build relationships with girls and avoid further traumatizing them in such a program? If Connecticut planned to train and support staff in a secure state-operated girls facility in gender-specific care, that philosophy will be undermined by the reality of girls being removed from programs and punished by placement in the secure facility and being moved again when they make progress.

Estimating the number of secure girls beds required in Connecticut is impossible. At both Natchaug and Stepping Stone currently, there are secure beds housing girls whose risk of running away or harming others is significantly reduced. The lack of intensive community-based services to wrap around their families, the lack of capacity for specialized recruitment of foster parents or to develop staffed homes and the lack of gender-specific services within the residential programs means that an unknown smaller number of girls actually require secure care than the full beds would suggest.

Incorporating a few additional secure beds within existing programs which serve as hubs for arrays of gender-specific services for girls is more consistent with the state's philosophy than building a free-standing girls' secure juvenile facility. The planning for additional secure beds should start with embedding secure care into each array of gender-specific services. For example, if CCP planned a 1-4 bed secure girls space, it could be an initial placement for girls with runaway behaviors, or girls with runaway histories could go to Natchaug or Stepping Stone and CCP use its secure space for girls who become assaultive on other CCP units. Whether secure space at CCP would entail putting a fence around a building or locked doors, and would include self-contained food, school and activities should be planned starting with the goal of gender-specific care that supports girls' relationships. These questions can only be answered as all girls' programs implement evidence-based trauma/substance abuse treatment and services specifically designed to

reduce runaway behavior by girls. Extensive, consistent training and technical assistance at all girls programs will be essential to making secure care, nonsecure residential care, and intensive services wrapped around families, foster families and staffed apartments effective in building on the strengths and meeting the needs of girls.

CONCLUSION

Connecticut's islands of excellence can be expanded into the nation's first statewide system of gender-specific services for girls. By committing resources to build into full systems of services, the state can go beyond the aspirations of the past year to actually meeting girls needs to be treated respectfully, have some control over what happens to them, make attachments and have them continue, become self-soothing, be less hypervigilant, be less reactive to threat, identify feelings in the present and the past, compensate for their disabilities, and be praised.

The Connecticut state-of-the-art system of girls' services could meet the safety needs that secure care is purported to meet without loss of connection or the punitive orientation of a freestanding state-run secure girls' facility. At this point, the number of additional secure beds perceived to be required for girls is greater than would be the case if there were gender-specific systems of services for girls, including services designed specifically to reduce aggression, running away and self-harming behavior systematically provided to girls on probation, in detention and after commitment.

To achieve a statewide system of services for girls, every public and private provider would have to adopt consistent approaches to:

- active involvement of girls in their own strengths and needs identification
- encouragement of relationship continuity for every girl
- a combination of staff coaching and training in gender-specific practice
- trauma treatment throughout programs
- gender-specific behavior motivation approaches
- intensive home-based services for girls with their families and other permanent homes
- recruitment, training and support of specialized foster families and staffed homes

One hundred committed girls are a tiny, easily-overlooked population in DCF, with thousands of children in child welfare and behavioral health and boys in juvenile justice. On the other hand, Connecticut is in a better position to integrate state-of-the-art care across public and private agencies than other states with more children at risk: 500 girls who go to detention, 100 girls who get committed, and several hundred girls in child welfare and behavioral health whose increasing problems make them likely to become FWSNs are a manageable number for achieving a statewide system of gender-specific services. Building hubs with innovative systems of services that meet girls' needs and implementing a huge statewide training/ technical assistance effort for all public and private girl-serving staff across detention, probation, parole, child welfare, behavioral health and schools may be a level of support for its own staff and providers that DCF has not previously attempted. But the state is fortunate to have a group of individuals in leadership positions and committed providers who are capable of leading this change process. They believe that truly individualized interventions will be driven by a new focus

on each girls' unique strengths and needs, rather than planning constricted by the services that currently exist.

Providers may require special individual budgets to implement services that will build on the strengths and meet the needs of some of these 14 girls. Providers will require reallocation of current resources as well as additional funds to implement the hubs. But if the hubs start with strengths/needs-based planning with every entering girl using gender-specific approaches, they are likely to discover that many innovations can be accomplished within current budgets especially as girls and families are engaged in the process in detention and then before they get to detention. As other systems have found, the initial cost and stress of “fixing the bicycle while riding it” are high, but even within a year, the benefits to children, families and staff from greater effectiveness, shorter residential stays, and fewer crises will be remarkable.¹⁶

APPENDIX

ANDREA

“Andrea” is a bright, articulate 15-year old from West Hartford who writes well and can be a leader. Andrea was born in Jamaica and lived with her 26-year old mother until she was 9 months old, when her mother came to the U.S. leaving Andrea with friends. Andrea was physically abused by her caretakers before she joined her mother and older brothers at age 4. Two years later her mother married her stepfather, and when she was about 7 her stepsister was born. She was described as a very needy child who had multiple babysitters, and screamed and banged her head wanting her mother. Her mother said her stubbornness was a problem in elementary school. She was referred to special education at age 11; she left special education two years later. But her behavior problems escalated in 8th grade when Andrea was moved from public to Catholic school; she said she lost her friends. She lived with her father in Hartford for part of the summer after 8th grade. At age 13 she had two inpatient hospitalizations at the Institute for Living, with referral to outpatient treatment. She was charged with FWSN in 9/03; her mother said MST was ineffective. She was resentful of her mother for being controlling and uncaring. Reportedly she threatened to kill family members in their sleep, so everyone had locks on their doors. She was hospitalized at Waterbury Hospital for suicidal threats in 5/04. She was hospitalized at Riverview in 4/05, prescribed Geodon and Lexapro and placed at Stepping Stone. She was arrested for assaulting Stepping Stone staff in 5/05 and sent to CCP. In 6/05 she was returned to Stepping Stone, then was hospitalized at Waterbury Hospital for aggression at Stepping Stone. Andrea was described as demanding, provocative to adults and children, grandiose and condescending and not well-liked, with low frustration tolerance (and when frustrated, prone to explode). She frequently complained of her rights being denied, and repeatedly reported staff abuse. Stepping Stone concluded she required trauma treatment and help developing internal controls. Her mother did not understand Andrea’s problems and wanted her to conform to the family. She was arrested at RAP and sent to CCP.

In 8/05 Andrea was admitted to Riverview for a second time. Her tested FSIQ was 92, but she was reading at the 12th grade level and doing math at the 9th grade level. The Riverview evaluation concluded that she was stuck in a self-defeating cycle of feeling burdened by the expectations of others, feeling coerced to submit to rules, going into a narcissistic rage, which prevents empathy for others, thus triggering her feeling burdened. She was described as having a narrow, narcissistic focus on immediate gratification and seeing others as getting in her way. She viewed everyone as impossible to please and said her anger problem was the result of being unable to control her own life and trying to get attention from her mother. She was diagnosed with Dysthymic Disorder, Parent Child Relational Problem and Impulse Control Disorder. Riverview reported success when staff did not let Andrea’s demands engage them in her anger. The psychiatrist was optimistic that Andrea was responding to the Riverview program, doing better with impulse control and that family therapy was going better. “The early separation from her mother leading to inadequate bonding as a child seems to reflect in ongoing conflicts between them and Andrea not being able to accept her mother’s authority or directions.” Her mother was described as not understanding why they should participate in family therapy as her other children had no problems, she was not planning to change her parenting, and she expects Andrea to comply with family standards of respect and cooperation.

In the interview, Andrea said that bouncing around 12 different programs had been a waste of time for her. She argued that “The state should get rid of parole. Parole services don’t do what they’re supposed to do—I told parole I shouldn’t be at residential and I said it wasn’t helping—they did nothing about abuse at the programs. Eighteen months on parole is too long. Placements made me suicidal. Placement isn’t sane—people don’t care about other people’s feelings...I just want to be with family—that’s what makes me most mad, that I can’t go home. Separation hurts people—they cut and hurt themselves, they have no choice. Parole stands in the way of going home or achieving my goal—that gets me mad...I’m totally going home, I’m not letting staff antagonize me any more.”

Andrea complained that she was bored in school and was never asked if she wanted AP/honors classes to challenge her, but “the real problem was a family problem. My Mom and I have issues—on probation, we never had family therapy.” Asked about family therapy when she returns home, Andrea said she would want to have it.

She articulated her view of herself well: “I have my own uniqueness. I don’t care what others think—my Mom says that, but she doesn’t mean it—I do better at that than my Mom.” Andrea has a goal—

she wants to be a mortician and plans to go to college in business and cosmetology in New Hampshire where her relatives live.

On a visit to their lovely home, I met Andrea's older brothers and younger half-sister. Andrea's mother is an articulate woman originally from Jamaica who has clear ideas about being a strict parent. The children were quiet, polite and obviously are required to keep the house neat. Their mother is grieving the death of her father recently. Andrea had long weekend passes to travel with her family to New York for the funeral and then, shortly after, to New Hampshire where her aunt lives and the whole family gathered to recognize the second anniversary of her mother's brother's death. On the two passes, her mother said Andrea's behavior was much better than a year ago. However, when she complained in family therapy about Andrea's rudeness to the hospital staff person who said a urine test and search was required when she returned, she got very angry at her mother. Her mother is worried that after two weekend passes Andrea thinks she will make rapid progress to discharge home, but her mother says they have to continue family therapy and have her spend time at home very gradually. Her parents will not tolerate her old behavior, and neither will the school. "She has to learn that she will not always be accommodated...I am not going to change the way I run this home." Her mother is worried about Andrea's psychiatrist at Riverview going on maternity leave at this crucial time. She said the psychiatrist had done very good work with Andrea. For a long time her mother was against medications, but she has seen that the medication has helped Andrea. On the weekend passes Andrea was reminding her mother about the medication, which she thought showed she thinks it benefits her.

Her mother said she disagrees with Andrea about being discharged to "regular school. She had a lot of trouble in school and alternative school is more realistic." Asked what other services, would be necessary when Andrea returns home, her mother said she wanted her to continue with the psychiatrist. Asked about intensive home-based services, her mother said "we are a very private family. We don't like people coming into our home." She said she would have to talk with her husband about what services they would accept.

Asked about services she wished they had in the past, Andrea's mother was critical that System of Care had a waitlist and they did not get those services. She was angry that DCF had authorized mental health services, which should be the parent's right; she said she is still paying large co-pay bills for services she never approved. She was angry that DCF interviewed Andrea without her permission and then took her to the hospital. "They robbed me of my parental rights to decide about hospitalization." She was critical that Andrea was moved around from placement to placement, with different psychiatrists: "They all had a different strategy." Her mother was critical of "the court driving it all too much." She said the court and the police did not believe her that Andrea was out of control. She disagreed with the court's too liberal restrictions: she wanted Andrea home immediately after school; her mother did not approve of the court's curfew, but Andrea took advantage of it to get more freedom.

ANDREA'S NEEDS (age 15)

- To learn how to be satisfied with what she can control, especially when she feels people get in her way
- To learn what do in the battle of wills with her mother since each describes the other as stubborn, inflexible and controlling
- To learn new self-talk when her mother's insistence on the rules or other adults seem unfair
- To have support to face the pain of the past: early abandonment by her mother; abuse; return to her mother when her "perfect" older brothers had been with her longer; treated as "difficult" when she was reacting to trauma; resenting her mother's pleasure from her younger sister's compliance
- To have a friend who likes her
- To participate in democratic decision-making at home and in school

CANDACE

"Candace" is a childlike, sensitive 14-year old Latina born in Puerto Rico who expresses her feelings and forms relationships well. She has a good sense of humor and enjoys music. She loves animals and wants a volunteer job with animals.

Her mother lives in New Britain and was 19 when Candace was born. Her father also lives in New Britain and was much older when she was born. They moved from Puerto Rico in 1995. Her father abused her mother during and after the pregnancy; at age 6, Candace started protecting her mother from him. She went to

one elementary school for 1st-5th grade; it is unknown whether she had effective bilingual services. She has a brother a year younger in residential and a sister 2 ½ years younger in a foster home. DCF has been involved since 1996 (when the children were 2-years old), due to mother's substance abuse and father's physical abuse. All three children were removed in 1998 (and Candace saw a therapist once a month) and returned in 1999 with intensive family preservation services. Her aggression and truancy increased when she was returned to her mother after a series of failed foster home placements (8/98-7/99). Candace was traumatized at age 8 when police came into the home breaking furniture to arrest her mother for drugs, and she had behavior problems in foster care. That same year she had an appendectomy. When seen by CMHA in 2002 after she had returned to her mother, they said her problems were too severe for outpatient. In 2004, Candace and her brother had over 100 absences from school—their mother could not make them attend school or obey curfews.

The Village for Families and Children Multidisciplinary Evaluation (9/04) was a thoughtful 26 page report. Candace's FS IQ was 72 (borderline); her verbal comprehension was 23 points lower than her perceptual reasoning. She had deficiencies in her working memory; she could process at an average speed, but could not hold information long enough to be encoded. She could not respond to questions with two parts. Candace, age 13, was characterized as a "creative youth [with] a warm and sensitive side...clearly struggling with intense and overpowering anger and frustration which seems to be longstanding. Much of her anger appears to be projected toward her father and has now become internalized... when she is upset, she is essentially immobilized by her overwhelming emotions...[she] tends to misinterpret actions and intentions of others...[and] does not know how to resolve anger provoking conflicts. She and her brother fight a lot—he gets angry real easily and can't control it. Her mother said Candace is always angry, especially when she can't do what she wants. She runs away because she is bored... Upon returning to her mother from foster care she was panicking and having flashbacks of the police taking her mother away. The foster home was also traumatic—no nurturing or predictability when she needed it most." Her diagnoses were PTSD, major depressive disorder, and conduct disorder; it was unclear if she had an eating disorder. She was described as needing intensive in-home services immediately, focusing on parenting education, support and empowerment, individual therapy to address alternative coping skills to deal with anger and sadness, processing feelings about father and safety with mother, and increasing self-esteem, and family therapy to alter ineffective family dynamics (possibly MST or IICAPS which has a long waitlist). Candace also needed a specialized school program "such as CCMC or Northwest Village School: she learns best through nonverbal hands-on instruction and consolidates information only after several practices." She was interested in animals, and a referral was made to the animal shelter.

After Candace was detained in 11/04 for breach of peace, her siblings were removed. Her mother was in a methadone program and not visiting regularly with any of the children. Candace refuses to see or talk about her father. She described the low-income housing where she lived with her siblings, mother and her mother's boyfriend as a dangerous neighborhood with a lot of shootouts and drug dealers.

The Central Placement Team request (11/04) listed diagnoses of Depressive Disorder, Oppositional Defiant Disorder, R/O PTSD, R/O Mixed receptive-expressive language disorder. Candace was in 6th grade special education; her strong subject was math. She had trouble focusing and staying on task, low frustration tolerance, and poor coping abilities. She was described as "minimizing her responsibility for defiance and impulsivity." She refused to take antidepressants. Complete speech and language testing was recommended. Because of her close emotional bond with her mother, family treatment was seen as necessary.

Candace had her first psychiatric hospitalization in 12/04 at age 13, court-ordered after a suicide attempt in detention. The Riverview evaluation said she had a history of self-mutilation (visible scars), drug abuse and promiscuity. She liked doing many activities. Testing showed she had a significant deficit in language, with average performance in non-verbal processing, and needed individual instruction and speech and language services. Traumatic life experiences left her mistrustful of adults and she tended to defend herself in a violent manner. Riverview recommended Stepping Stone, with transition home with intensive in-home services, including a lot of support for her mother to educate her about parenting and limit setting.

The PPT convened on 3/29/05 reported that 13-year old Candace was reading at the 2nd grade level and doing math at the 3rd grade level, a PIQ of 101 and a VIQ of 55. Unbelievably, the PPT noted the 11/04 speech and language evaluation recommendation (apparently still not done). The following special education goals were written for Candace, as if she had no language disability despite the huge difference between her verbal and performance IQs: Increase reading skills; Increase written expression skills; Improve her math skills; Good attendance and complete homework; Improve social skills; and Improved emotional management.

In 3/05 Candace went to Natchaug. Her treatment plan focused on: improvement in depressive symptoms, anger and frustration tolerance; reduction of verbally abuse and disrespect of staff; demonstration of adaptive, prosocial behaviors; improved relationship with family; positive peer relationships; good school attendance and promotion to the next grade level; and not incurring legal charges. During a 5/05 Natchaug psychological evaluation the inventories were invalid because Candace did not complete a 346-item questionnaire and responded randomly on others. The assessment showed her strong attachment to family and focus on returning to them and her anxiety about death. She was described as “experiencing a great deal of anger and frustration over her life circumstances, yet minimizes or is unaware of significant sadness.” More than six months after placement, casenotes indicate she continues to fluctuate in her behavior, still being confrontational with staff, threatening residents, and not making it to school on time. Limit-setting and teaching her lessons through punishment are emphasized, apparently, without trauma treatment. Candace has not formed a close relationship with staff, and she is struggling with her mother’s infrequent visits and what she perceives as having to protect herself from others.

In her interview, Candace articulated “a lot of problems at Natchaug. They use a lot of restraint. They drag you across the floor. They don’t care. They should have video cameras to video restraints. Girls misbehave and need consequences. But the consequences are so long they trigger girls. Consequences should be limited to 1-2 hours of having no music or something. The consequences should be fair. If you slap someone, they arrest you and you can’t go to any activities. If you hit someone, it should be a seven day restriction. There are way too many restrictions. We should have the same bedtimes. The timeout room is way too small. It escalates your anger. You have no one to talk to. It would be better if staff listened to us instead of timeout or restraint. When I’m angry there are a couple of staff I’ll talk to, or my mother. Going outside or crocheting when I’m mad helps; crocheting will calm you down. but they don’t let us have the crochet needle. I can’t talk to my counselor. You have to trust your therapist. I don’t like how they talk to us. I did have a good therapist. I used to sign a contract, go to school for a week and got a reward.” Candace does not feel she is getting proper medical attention. She showed lots of large swollen scabs on her legs and arms she said were flea bites that are not getting the right treatment: “it really itches and hurts.” She wishes the program would help her get a job or a volunteer position working with animals. She wishes the program had a recreation area where they could play volleyball and do other activities. She says it has been a month since she hit anyone, and she does not seem to think she is getting enough recognition for this accomplishment. At home, if she gets angry, she says she goes to her room, punches a pillow, and listens to music.

Candace wants “a program that is not residential but helps me at home.” But she doesn’t think family therapy helps. She thinks a family can work on things together. She said her sister is in foster care for no reason. Her brother is in residential. It took four months for them to arrange visits for her with her brother and sister: that put a lot of stress on her not to see them, and she cried a lot; now she sees them once a month. Candace wants to go home. She wants to play volleyball and have a mentor take her roller skating and to the movies. She does not care what high school she goes to; she wants to go to college or nursing school so she can help children or old people or work in a pet store. It was apparent that at 14, some of Candace’s behavior is the result of immaturity—she cannot anticipate consequences, plan, see the risks of her behavior like an older teenager: “When I go home, I will listen to my mother. When you’re younger you don’t really know that your friends are not your friends. When I’m home I’ll listen to music and not go out. My mother and I are working on a lot of things. We’re getting the family back together. We have to move out of the projects. It’s real bad to live there. But DCF is not helping my mother move.” She was critical of parole for not helping her go home and “never answering their phone.”

CANDACE’S NEEDS (age 14)

- To be listened to; to have someone she can talk to
- To be talked to respectfully
- To be encouraged to crochet to keep herself calm
- To spend time with animals
- To understand her learning disability, to have opportunities for learning through hands-on activities, and through special instruction in how to compensate for her disability, to raise her reading level above 2nd grade and her math above 3rd grade level
- To be positively reinforced for expressing her feelings in words
- To live in neighborhood she thinks is safe (her mother would have to have help to move if Candace is going to return to her)

- To participate in determining rules, rewards and fair consequences for rule violations
- Not to be restrained
- To continue to feel successful at talking about her anger and going to her room, punching a pillow, and listening to music.
- To understand the sources of her anger and to recover from physical abuse, multiple placements, seeing her mother forcibly arrested, not being able to keep up in school, separation from her siblings
- To be supportive to enjoy spending time with positive peers
- To be on a volleyball team at school

CHERISE

“Cherise” is an intelligent, positive 16-year old African American who is a leader and has friends who really like her. She is interested in theater and dance.

Cherise was born in Waterbury. Her mother is Jamaican, was raised in England, and came to U.S. as a child. Since adolescence, her mother has struggled with depression and suicidal thinking—she was a FSWN before returning to England to live with her father. Cherise’s mother was 16 and her father was 14 when she was born. Cherise moved around among extended family and her mother; at age 3, her pediatrician suspected sexual abuse by her mother’s boyfriend but it is unknown whether this was investigated. She also had asthma. She is the only child born to her parents; she is the oldest of seven children, maternal and paternal half-siblings, one of whom lives with her mother. Her father and his girlfriend live with two of his children and her two children. At age 10, Cherise and her younger brother were removed by DCF when they were discovered left alone by their mother. She had multiple placements, first with relatives and then foster homes where she was unmanageable. She was placed with her paternal grandmother (who became her guardian) at age 11 (2000), but quickly became out of control. She had poor grades and was expelled from middle school after suspensions for disruptive behavior, fighting and threatening. A psychological evaluation (5/01) found that Cherise had a FSIQ of 80 (V 82 P 81) and diagnosed Adjustment disorder with disturbance in mood and behavior, Dysthymia and Oppositional Defiant Disorder. The evaluator recommended that she not be removed from home: “will cause depression and acting out; testing limits of placement with paternal grandmother, but will settle down.” The evaluator suggested individual therapy to focus on abandonment issues and her mother’s inappropriate modeling, which will “tax the clinician, but she wants to be understood.” Group counseling for anger management and moving to an alternative school were also recommended. The same psychologist evaluated her again, seven months later (12/01), noted her worsening depression and indicated that residential placement might be necessary. At age 12, Cherise had her second psychiatric hospitalization at Riverview. The 5/02 Riverview report noted that Cherise moved around a lot, and had been moody and reclusive since early childhood. Her parents were in a bitter custody dispute, and she had recently lived with a paternal great aunt. She was described as narcissistic, entitled and demanding, which interfered significantly with relationships: “her inner resources are impaired to a degree that leaves her vulnerable to regression in ordinary circumstances...frequently misinterprets events, distorts, does not recognize possible consequences of her actions or what is socially appropriate behavior. Antidepressant and neuroleptic medication can be helpful to address some symptoms, but impaired judgment and relationships call for long-term treatment.” Back at Riverview in 8/03 her relationships with family members were described as “anxious and ambivalent. Feels chronically unloved, but acts in ways to get further abandoned...diffuse boundaries...[she] and her mother interact as peers. She idealizes her father who also interacts with her as a peer. She says all her family members use marijuana and alcohol, but it’s not a problem...paternal grandmother unwilling to have her... Depression includes an anxious and irritated state with feelings of low self-worth [and] hopelessness...Runs away to dangerous areas without regard for her personal safety...daily marijuana user...Living out mother’s negative life script.”

Cherise was placed at Natchaug in 7/04, diagnosed with Reactive attachment disorder and Depressive disorder. Her Natchaug therapist wrote: “At the beginning, she invariably personalized feedback as criticism...saw all problems as external...any efforts to help identify triggers or alternate perspectives led to intense anger. Over time she developed attachments to staff, and is now receptive to feedback after her perspective is heard and validated...Still has thinking errors and difficulty viewing situations from any point of view other than her own. Still struggling with peers—vulnerable to emotional dysregulation when those around her are not able to meet her more than halfway.” In the school at Natchaug, she struggled with math, but was getting Bs and Cs: “easily frustrated and often demands her needs be met immediately...difficulty

waiting her turn for assistance.” At Natchaug, she has had “patterns of monthly decompensation, typically precipitated by successes and home passes...Developing a vocabulary for her feelings and understanding the connection between emotions and behaviors...much greater willingness to trust staff. Her mood instability remains a problem, exacerbated by refusal of medication, mixed messages from family, and ambivalence about entering DCF custody rather than remain under care of guardian. But she is better able to manage her emotions without significant behavioral outbursts...No self-harming behaviors since 2002 No arrests since 1/05 and 3/05 (in the program).” The plan for Cherise has been to move to Touchstone. The 7/05 Natchaug treatment summary described Cherise as beginning to discuss her desire for a new guardian, using her attachment to staff and trusting relationship with her therapist as a “safe base.” She still had the egocentricity of a younger child and lacked appropriate social skills. She was discussing her thinking errors and had a rudimentary understanding of the connection between her emotions and behaviors, but still had daily tantrums. She still would not consider medication because “she is too vulnerable to see self as depressed or dependent.” The report concluded, “She has worked extremely hard and there is no change in family dynamics and no home to discharge her to.”

Cherise started off the interview angrily by saying she had been at Natchaug for a year and she hadn’t changed. “This place is ridiculous. It doesn’t help me. I get restrictions and have to sit in my room for seven days and can’t eat with everyone else. The staff are all old. We never go anywhere. I act out when it’s unfair. I can’t go on home passes because of my grandmother. I’ve been out of school for days for refusing. The classes are too easy...Everything was better at the Graham School in New York. It was a good program. It was co-ed which is better. There was more freedom. The school program was much better.” Cherise said, “No therapist anywhere has helped me.” She says her only need is to be placed with her mother: “I’ll be all right when I leave. Everything is good at home. My brothers and sisters are at home. DCF is stupid—they should have taken me away from my grandma a long time ago.” Cherise was angry that parole just re-committed her: “My parole is up in April, 2006 but I have no where to go. I haven’t learned anything, I’m just stuck in the system...The system sucks.”

At the Girls’ Network meeting on November 17, 2005, the region said her mother’s criminal history and lack of stability make her an unacceptable placement for Cherise (“the parent-child bond was poor from the beginning”). They want to get her grandmother out of the guardianship (“grandmother doesn’t think she has mental health needs”). The goal discussed at the meeting was for Cherise to accept going to Touchstone. At Touchstone she could examine her relationship with her grandmother, “who is unlikely to be nurturing enough.” She was described as increasingly hopeless and angry: “she is starting to decompensate as she sees the only plan available is not what she wants.” She is attached to her therapist, has a good relationship with another Natchaug staff, and does not want to leave those attachments. “She wants a home.”

CHERISE’S NEEDS (age 16)

- To continue her current attachments to Natchaug staff, her mother and grandmother
- To form new enduring attachments
- To choose her next home, which should be a permanent home (possibly not her mother or grandmother)—to feel she’s not “stuck in the system”
- To have her perspective heard and validated before another point-of-view is proposed
- To learn self-soothing, other than marijuana, when she starts to feel anxious or moody
- To understand how her irritability, hopelessness and anxiety are connected to feeling chronically unloved
- To learn the give-and-take of friendship (even when she gets worried about being liked) with someone who might not go more than halfway to reach out to her
- To feel successful in a part-time job, dance classes and fashion shows
- To understand how going to dangerous places puts her at risk

ILONA

“Ilona” is a 14-year old Latina from Bridgeport who responds well to positive reinforcement and uses her drawing and writing to express herself. She has formed strong relationships with several agency and program staff.

Reportedly, her mother was the victim of severe physical abuse, was raped and had a baby at age 12 who was sent to Puerto Rico, she had another child, was 15 and had been homeless and living in abandoned cars when Ilona was born. Her mother suffered severe violence by boyfriends, including while pregnant, and

abused alcohol and cocaine during her pregnancy; Ilona also had birth complications. Ilona later described her mother as “a crackhead and prostitute.” Reportedly, Ilona lived off and on with a friend of her mother’s, who also has children of her own and may have been caring for Ilona’s older brother. Her mother would come and go in her life, but she has not seen either biological parent for years. There is confusion in the record about living for some periods in Florida and New Jersey, but her mother’s friend, who she thought was her mother until she was in elementary school, was known to DCF in Bridgeport for abuse and lack of supervision when Ilona was 4. She was awarded guardianship when Ilona was 7, and that same year abuse was substantiated when she slapped Ilona in the face. Ilona was sexually abused by an uncle, requiring surgical correction of internal injuries (no documentation available)—about the time that was disclosed, at age 6 in first grade, Ilona had tantrums, sexualized behavior, aggression toward adults, siblings and pets, poor social skills, bedwetting, and head banging. In 2nd grade she was suspended from school for aggression and held a knife to her cousin; a psychological evaluation reported severe emotional disturbance with high level of anxiety and no friends. She was in special education in Bridgeport as emotionally disturbed. She was diagnosed with PTSD at Bridgeport Hospital and Mid-Fairfield Clinic at age 8. In 2000, when Ilona was 9 and her brother was 10, their guardian requested their removal. In the following year, she asked for their two younger siblings to be removed. In 2003, all but the youngest child, who was doing well in a DCF foster home, had serious emotional and behavioral problems and were traumatized by sexual and physical abuse and abandonment; the second youngest had stabilized in a therapeutic foster home. At that point, DCF sought a TPR and adoption for Ilona’s two younger siblings. Their former guardian had moved out of state, and that state’s agency recommended against reunification due to substantiated physical abuse against one of her own children. Consequently, when Ilona was 12 she had a permanency plan of long-term foster care.

Ilona was at CCP age 10-12 (7/01-7/03). In 2003, an evaluator at CCP said Ilona’s treatment should be focused on her impulsive, aggressive and antisocial behavior, not on the consequences of her physical and sexual abuse. At age 12, Ilona was charged with Assault 3 and Disorderly and was placed on probation. At age 13, she was committed delinquent for Disorderly and placed at High Meadows (7/03). A 2/04 report described her as a 6th grade student functioning at the 3rd grade (at age 13), with PTSD, Disruptive Behavior Disorder, Dysthymic Disorder, and borderline intellectual functioning. She was prescribed Seroquel and Pamelor. A 5/04 PPT indicated Ilona had made academic and behavioral gains this year, but still got overwhelmed by feelings and required frequent time outs; she was no longer aggressive in school. But her 5/04 IEP was simplistic: Improve language arts; Improve skills in math; Improve social interaction skills; and Improve self-concept and coping skills. She deteriorated at High Meadows after being taken off all medications as a result of an accelerated heart rate. Although her test scores were in the borderline to MMR range, her adaptive behavior was described as not impaired.

A 7/04 Riverview report described Ilona as “a traumatized and depressed female with severe conduct and behavior disorder symptoms and attachment pathology...with a murky caregiver history and multiple placements.” At her admission to Riverview, with Conduct Disorder, Depressive Disorder, Borderline Intellectual functioning, and Borderline traits diagnoses, she was pessimistically characterized as remote, unpredictable, with fixed attitudes and no remorse for her “seriously antisocial” actions, for which she should be held accountable. But at Riverview Ilona met twice weekly with a therapist who she trusted who helped her identify her triggers (hypersensitivity to insults of her family), learn impulse control and how to manage her angry and sad internal states before getting agitated, and alternatives to ruminating about past trauma. At the time of discharge, she was safe and stable and was well-liked by staff and peers. Her therapist noted that Ilona covered up her cognitive limitations: “she is an extremely limited girl who has developed methods of functioning that conceal these limitations. She would rapidly escalate because she was unable to maintain her side of a verbal argument.” Over the years, Ilona had been prescribed multiple psychotropics, antidepressants, neuroleptics, and stimulants. At Riverview, Geodone, and Klonopin seemed to help her manage her behavior.

In 9/04, Ilona was discharged to Natchaug. She was noted to be attached to her parole officer and DCF worker. She was described as “becoming dissociative at times and intermittently experiencing intense flashbacks that can result in aggressive and assaultive behavior, due to a history of trauma. She had very intense relationships, then sabotaged them to defend against hurt.” Her diagnoses were PTSD, major depressive disorder, conduct disorder, and borderline intellectual functioning. Her parole officer arranged to sanction her for bad behavior at Natchaug with community services hours, not returning to court just to get re-committed again. Her simplistic 2/05 Service Plan was: Continue exploring pros and cons of discharge to a foster home; Stabilization in mood and behavior; Attend school daily and advance; Maintenance of healthy peer relationships; and Holistic health care to remain free of allergic reactions. She spent three months at Riverview after assaulting her social worker and a peer at Natchaug.

In 9/05, Ilona returned to CCP. She asked not to have 1:1 staff assigned to her to protect against her assaultiveness because it made her nervous, and CCP negotiated agreements with her that when she was getting angry she would seek help from staff and separate herself from peers. She was not willing to talk about her past with her therapist. She ran away from CCP and returned after having unprotected sex. Ilona was described as having “longstanding social skills deficits, probably arriving from attachment pathology, limited intelligence and extremely poor modeling during her childhood. She seeks older female peers and becomes very possessive of them...[and] is very much interested in sexual intimacy with boys. She desperately wants a family and she may be interested in becoming pregnant so she can have someone of her own.” She was described as being able to be well-spoken and sociable and getting along well with others most of the time. She “had a tendency to run away or fight to defend herself from what she thought of as bad talk against her. She was prescribed Seroquel and Trazadone for explosive behavior, anxiety and sleep. The asthma, severe food allergies, and diabetes noted at other placements (the allergies being a prominent care issue while at Natchaug) were no longer of concern at CCP. She was seen as having adaptive behavior deficits, was recently accepted for DMR services, and was awaiting a special build group home with five other residents that CCP hopes would meet her need for family. Ilona ran away from CCP and could not be interviewed so she did not participate in defining her needs.

ILONA’S NEEDS (age 14½)

- To have a pet that loves her and a family where she belongs and not have to meet that need by having a baby—to evaluate the pros and cons of a foster home versus group home at age 14 (a specially-recruited foster home would have to have training and support for working with a young person with developmental disabilities and high need for nurturing but fears about relying on others because of her traumatic experiences; not living in a group would be better for her)
- To learn how to get what she craves in relationships without becoming so intense or possessive it is difficult for her or the other person to stay involved
- To learn not to see hostility in others when it is not intended; learn how to read cues
- To have reminders that as she is getting anxious or angry it helps to calm herself down by talking to someone, writing her feelings in her journal, drawing, or taking space for herself; having predictability in her environment
- To be supported to talk about her past abuse, neglect, abandonment and other traumatic experiences so she can separate the present from the past and learn how to respond to flashbacks or perceived mistreatment without becoming aggressive
- To use relaxation techniques to help her go to sleep
- To continue her progress in adaptive behavior and social skills, in part so she can feel confident she can hold her own in discussions
- To have special instruction—in school and at home—that helps her compensate for her cognitive limitations—she was prenatally substance exposed which might account for better social skills under some circumstances and running away in others; with limited comprehension of cause and effect, she may find it much more difficult to see the reasons not to run away, or have a baby
- Safety from putting herself in risky situations

JESSICA

“Jessica” is an almost 18-year old bi-racial Native American-Caucasian who is a strong-willed, intelligent, self-motivated, above average student with a compassionate attitude toward others and ability to empathize. Jessica enjoys acting, singing, and dancing and wants to become an entertainer.

She was born in Waterbury where her father still lives. Her mother, who was 23 when Jessica was born, lives in Thomaston. She was the middle of three children and was described as stubborn as a young child. She was exposed to domestic violence, but reportedly her father (who had mental health problems) was not abusive to the children. He left when Jessica was 3 years old and she had no contact with him until she located him on the internet as a teenager. Her mother later remarried and had two children, 7 and 10 years younger than Jessica; her mother and stepfather were reportedly alcoholic. Jessica was expected to do much of the childcare. Her older brother had mental health problems, but was an honor roll student. Jessica was an A/B student in regular education through sixth grade (her FS IQ of 104 was considered an underestimate).

At age 12, Jessica was raped by 18- and 19-year old males. Her grades dropped in 7th grade. Jessica said her problems started in 2001 when a 17-year old male friend committed suicide. After that she started running away, did not work in school, and was getting high. She said her friend's suicide had a major effect on her life. Her friend listened, she missed him and felt guilty that she had not shown how much she valued him. Hospitalized at Waterbury Hospital (3/01), she said she was thinking about death daily. She had difficulty getting along with her mother who was busy caring for other family members and had no time for her. Her mother was described as overbearing, and Jessica had difficulty expressing herself. She had been close to her grandmother, but felt she disappointed her. Grief counseling, treatment for her mood disorder and family treatment were recommended.

Between 7th and 8th grades, Jessica's out-of-control behavior increased with several FWSN referrals; in 11/01 she was placed on non-judicial supervision, but ran away again. She was charged with criminal mischief and sent to detention (3/02). She was hospitalized at Riverview after carving on herself. She was returned home, and after six weeks her risky sexual behaviors and self-mutilation resulted in a lengthy hospitalization at Riverview (4/02-8/02). She was diagnosed with Bipolar Disorder. Her acting out behaviors and mood lability "appeared to be under control with a combination of pharmacotherapy and psychotherapy, but regrettably upon her return home, her medication regimen was not followed and her symptoms, including voices, returned; when medicated, she is compliant and able to evaluate courses of action." Jessica's mother and stepfather were described as not understanding "the serious nature of her illness." She was able to tell her mother that her older brother had been abusive toward her and she was afraid to live with him. Jessica was characterized as "anxious, depressed and has internalized significant painful emotions which she has been unable to share with others. She vacillates between emotional and intellectual ways of dealing with events, leading to misguided decision-making, strained relationships, simple, reactive, primitive solutions to complex problems...low estimate of personal worth and little self-confidence...feels embarrassed in social situations and anxious about being ignored or rejected." The Riverview evaluation cautioned that her behavior should "not be interpreted as a matter of criminality or antisocial behavior. Jessica needs structure and supervision, not incarceration." She was discharged from Riverview on Zyprexa and Wellbutrin with outpatient individual and family therapy.

The pre-disposition study (4/03) oddly concluded: "Jessica's court involvement coincided with the presentation of her Bipolar Disorder...The family dynamics, with its size and her mother's divided attention amongst Jessica and her siblings [mother is a homemaker with three other children at home] is a major contributing factor to her poor behavior and her inability to manage her Bipolar Disorder...her bipolar disorder is manageable, but not at home. Jessica is an excellent student and even during the chaotic times she managed to maintain good grades." In 5/03 she was doing well at home, but her mother took her off her medication. The plan outlined by the Central Placement Team (5/03) for residential was simplistic: eliminate runaway behavior; eliminate all illegal and antisocial behaviors; confirm or rule out existence of chemical dependence; and demonstrate marked improvement in impulse control.

In 8/03, Jessica went to CCP and then in 10/03 to St. Chris, Inc. in Valhalla, N.Y. She took a staff member's car, crashed it, and was charged and detained in N.Y. She returned to CCP in 12/03 and was successfully discharged home with MST in 6/04. She had repeated runaways and was re-admitted to CCP in 11/04 and then to Maloney RAP until the program closed. Back at CCP in 12/04, she ran away, and in 2/05 went to Stepping Stone where her diagnoses were ODD, Mood Disorder, Alcohol Abuse, and Cannabis Abuse. She had four individual therapy, two family therapy and eight group therapy sessions/month and the universal Stepping Stone treatment goals: Develop, utilize and maintain positive and productive communication skills leading to an increase in coping skills and ability to manage impulses, mood swings and anger more effectively; Actively participate in behavior modification program, individual therapy, family therapy and group therapy to ensure successful off-grounds passes and eventual discharge to guardian; Actively participate in specialized substance abuse group/seeking safety group, as well as in-house NA group, and eventually participate in NA when on off-grounds passes with the support and supervision of family; and Maintain a respectful and honest relationship with all family specifically mother who is guardian regardless of permanency plan. Her tested IQ in 1/04 was almost identical to 2/02 (FS IQ 104, V-105, P-102). While at Stepping Stone, Jessica made remarkable improvements and was planning a move to Touchstone, but "became impatient with program expectations," showed a significant change in demeanor (becoming labile, irritable, and unfocused) and ran away. It was noted that she needed "techniques to address hopelessness and anxiety, which seem to fuel her impulsivity. Overstimulation occurs at home...maybe reunification is not possible, but her family would still be important to her." It appeared that once again, her choices were dominated by seeking drugs. Jessica was arrested in 5/05 for Breach of Peace and in 6/05 for Disorderly, and

was sent to York in 6/05 for three months. A psychological report (7/05) described Jessica's fears about her safety at York. When she was anxious she had obsessive behaviors such as taking several showers a day, and when she experienced a lot of anxiety it was difficult for her to soothe herself. When she got depressed, she thought about running away. Her hopelessness and anxiety drove her impulsiveness. She returned to CCP for fourth admission on 10/14/05 and ran away two weeks later. She was arrested for prostitution, returned to CCP on 11/7/05, ran and was remanded back to York. Her delinquency commitment expires on her 18th birthday on 12/5/05. She may be given another adult sentence. She acknowledged her substance abuse problems. She wrote a letter requesting continuation in DCF custody (so she could pursue her goal of college?), but her case was closed in the DCF area office. When last at CCP she was also interested in Young Adult Services at DMHAS. In the most recent CCP report her mother had given permission for Geodon, but it was unknown whether Jessica was going to agree because she had been opposed to all medications due to weight gain from them in the past. She had relationships with her maternal grandmother and paternal aunt—could they be involved in a process of being considered possible homes, with Jessica defining what she wanted in her home?

Unfortunately because Jessica was at York she could not be interviewed so she did not participate in defining her needs.

JESSICA'S NEEDS (age 17½)

- To learn alternative choices to substance abuse when she is feeling anxious in social situations and/or sad and/or hopeless
- To be assisted in applying to college and supported while she adjusts to college
- To learn independent living skills, and job preparation and to be supported to keep her job so she does not have to resort to prostitution
- * To learn how to anticipate the worst things that could happen and not minimize risky situations, through specialized teaching techniques for her sequencing problems
- To recover from rape, suicide of a friend, other traumatic experiences while on runaway, and her disappointment with her parents who care about her but both are substance abusers and cannot offer her a safe home
- To learn the various theories about the causes of her behavior (bipolar disorder versus unresolved trauma, immaturity and possible brain damage) so she can be an informed consumer of services and can improve the choices she makes about protecting herself from deteriorating

KELLY

“Kelly” is an almost 17 -year old Caucasian from Windsor Locks who is a bright, insightful, articulate, talented poet and artist with a good sense of humor who wants to attend college. She has shown remarkable progress.

DCF first intervened with Kelly's family in 1984, before she was born, due to physical abuse, domestic violence and homelessness; her three oldest siblings were young children when the DCF case was opened, another sister was born, and they were in and out of foster care. At age 19 her mother met the father of her four older children (he was Kelly's psychological father). Her mother conceived Kelly and her twin (who are the youngest of her six children) with a former high school sweetheart. The twins were born six weeks premature. Her mother said, unlike her twin brother, since birth Kelly was difficult to console, screaming for no reason, refusing to be held, no eye contact, and did not like touch. DCF documents indicate that while her twin brother was doted on, Kelly was neglected, her siblings taunted and hit her, her diapers went unchanged, and she was often left alone or locked in a closet. Her mother said she needed constant supervision and by age four was defiant. In kindergarten, Kelly had peer difficulties and temper outbursts. When Kelly was five, her mother and the person she thought was her father separated after domestic violence. She repeated 2nd grade. Her mother's abuse was reportedly triggered by Kelly's bedwetting until age 7. Neglect was substantiated and the mother and her six children moved out-of-state. Her mother's fiancé moved in. Kelly said her negative behaviors toward her mother started at age 9, and she was placed in a TLC group home (1997). In 1998, when Kelly was 10, the family was involved with DCF when her mother was arrested for pulling her hair and slapping her in public: she was in treatment with her mother and a parent aide was

assigned to help her mother control Kelly. She learned that the father of her older siblings was not her father, and she met her biological father. She had increasing school problems and aggression; her sister's three children entered DCF custody between 2000-3. She repeated 7th grade, and her mother criticized her for being in 7th, when her twin was in 9th. In 4/02 she was charged for bringing her mother's Vicoden to school for another girl and in 7/02 she was placed in a SAFE home when her mother refused to take her home.

A 7/02 psychological evaluation described Kelly as appearing much younger than her age, shy and soft-spoken, covering her face when her "forceful" mother spoke. Her mother had stopped counseling after five sessions and said, "rules did not apply to her. Every day has been a constant battle with her." She had a FSIQ 117, and was diagnosed with Oppositional Defiant Disorder and conduct disorder; she was recommended for partial hospitalization. She had not had mental health treatment for four years, and the evaluator said participation by her mother in treatment was essential, plus an in-home aide for her mother; if no improvement, the evaluator recommended a foster home with expertise with troubled teens. An 8/02 psychological evaluation described Kelly as wanting to work things out with her mother, but her mother did not want her home, and wanting to go to college to become a missionary. She said she and her mother argued a lot. Kelly felt her mother never listened to her—arguing seemed to be the only way to talk and get her to listen. They usually argued over things Kelly thought were unfair. "Most of the time she is able to control the feelings, but when involved with family issues she becomes less reasonable. Her impulsiveness adds to problems, and there is a strong need to be liked... When she does express problems they are likely to be described as boredom, restlessness and discontent... the diagnosis of ODD seems to generally fit. However, it does not reflect the competing positive characteristics and qualities that may be overlooked. That evaluation recommended a foster home with an "understanding of behaviors and moods but willing to set parameters for her. She may challenge the authority, but if approached in a manner that permits her to express herself, she may be more compliant. Must take into account her high level of activity and need for stimulation." She had two foster home placements, one for a week and one for almost two months. In a YMCA shelter (11/02-1/03), Kelly was severely beaten up by two peers she ran with from shelter and brutally sexually assaulted by a friend of one of the peers. Then she spent five months in detention (1/03-6/03 due to aggression). A 4/03 psychological evaluation described Kelly as "a difficult child," poorly attached to her mother who had mental health problems herself, sensitive to criticism, and repeatedly said no one listens to her. Her favorite person was her sister who she wanted to live with. She wanted to return to the foster home in Stafford: she said she really got along with the foster mother, but a kid there hit her; the official reason she was asked to leave was marijuana use. The evaluator commented that Kelly was "desperate to connect with someone as a parent figure, but had little trust in adults and difficulty abiding by foster home rules." The evaluation recommended secure residential treatment, but "she will ultimately benefit more from a long-term relationship with a parent figure... a good foster home as soon as she has achieved a level of frustration tolerance and self-control." In 2004, two years after DCF got custody of Kelly on a neglect petition, she was committed as a delinquent. Placed at CCP (4/04), diagnosed with conduct disorder, substance abuse disorder and parent-child relational problem, Kelly was placed in a residential program in Massachusetts in 11/04. Prior to this placement, she was a RAP in Hartford for two months, and before that for months in Hartford detention. She was not doing well in the school in Massachusetts. It was not until 3/05 that a PPT was held to determine that she was in need of special education as a seriously emotionally disturbed student, and she was moved to a more appropriate school. She was admitted to Riverview after being AWOL for two months when she was in NYC prostituting and selling drugs and then being aggressive during her two month stay at Maloney RAP. She was described as having early attachment difficulties plus "severe and protracted history of physical and verbal abuse;" her history of abuse and neglect from mother and grandmother and mistreatment by her siblings led to a negative sense of self and extreme distrust of others, which isolated her. She had a problem of shifting from idealizing staff to devaluing them. Only recently had she been talking about anger at mother; because not self-injurious, staff ignore her trauma. She had had 22 placements since 1997.

Kelly was placed at Riverview in 8/05 with the goal of focusing on 1) her difficulty forming trusting relationships and excessive suspiciousness of the motives of others; and 2) her tendency to handle problems through aggressive acting out. When Kelly felt something was unfair, she had difficulty allowing the system to correct itself and felt she had to take matters into her own hands. She had difficulty identifying with other patients, at times making fun of them for not grasping things as quickly as she does; she did not want to be labeled "a mental patient." She presented her sense of identity as having "good" and "bad" aspects. Her "bad" elements could be engaged to confront whatever she believed to be unjust and could keep others at bay and make her feel safe. After events, she demonstrated an excellent ability to process in a logical fashion, making an accurate assessment of her behavior and identifying things she could have done differently. She utilized

writing in her journal and drawing as coping skills. Before discharge, she had an increased number of positive relationships, demonstrated an ability to accept feedback and did not display aggressive behavior.

Kelly moved from Riverview to Touchstone in 11/05, and she and staff were pleased about her adjustment in the first week (her placement was controversial, with some arguing she required a locked facility because if she runs she will get an adult charge). She does not like “being in the system” and had many criticisms of it. “Kids are moved around too much. Kids should be able to stay in foster homes.” Kelly explains that she ran a lot because she “wanted to be free and wanted time to myself. No one has the right to lock another person up. Locks are a punishment. At CCP you can go for a walk with staff. You can be outside. You can ask for time to yourself. CCP is a great place. A lot of activities, a good level system.” She thinks most programs should have more staff, especially “staff who can relate to us, talk to us on a normal level, more laid back. Girls needs attention right away or else they escalate. A lot of needy kids with valid complaints need attention. Staff use restraints too much. Kids at Riverview have been traumatized and when they get tied to a bed [4-point restraint], that traumatizes them.” She thinks there should be therapeutic foster care with one or two kids only and foster parents who “specialize in real needy kids.”

Kelly says that Touchstone “gives you a chance to show you can make the right decisions. There are a lot more mature people here.” She wonders whether most Riverview kids would be able to make it at Touchstone. “It’s hard to get your levels here. It is very strict. They keep it very professional 24/7.” She likes the idea of an advocate who is a regular staff person who gives you extra time or help. She thinks once a week therapy is fine, but she would do more if it was offered. So far, the school is below her level, but she has been making assignments for herself and she and the teacher are okay with this.

Kelly says she will do what she wants to do. She feels strongly that kids should have a say in what happens to them, which almost never occurs. For example, she wants to live in a foster home (she says any foster home would do, although she has a previous foster home in mind). She says after her parole expires she does not want to be at Touchstone. But she thinks it would be wise to stay in DCF custody because they will pay for college. She has visited Smith and would like to go there. She wants to be either an artist or work with teenagers.

KELLY’S NEEDS (age 17)

- To be actively involved in selecting a foster home (a foster parent who is real, gives a lot of attention, is tolerant of her moods, and supports Kelly in adhering to limits she helps to define)
- To be actively involved in finding a school program that challenges her and helps her prepare for college
- To have time to herself
- To get recognition for making the right choices
- To continue to find other pleasure or other ways to cope with painful memories/feelings than marijuana, maybe by building on her art interests
- To practice new self-talk to become less sensitive to criticism, so she is not triggered by “a look” (in the past, adults who think she doesn’t like them don’t like her); to have adults remind her when they set a limit that they are not picking on her
- To continue to face her sadness and anger about years of abuse by family, rape two years ago, and 22 placements and learn how they are connected to her aggression
- To learn what to do when her sense of justice is violated
- To have a lot of positive reinforcement for self-control and self-talk to avoid risky situations

KIA

“Kia” is a funny, smart, personable 16-year old Latina born and raised in Bridgeport. Her mother said her mother abandoned her and her five siblings in Puerto Rico; her paternal grandfather sexually abused her mother. Her father sent the children to Connecticut to their mother who was physically abusive. When she was 16, Kia’s mother married to get away from her mother; they had two children in the three years they were married. In 1989, her mother was divorced and Kia, who had a different father, was born. Kia’s parents were together for three years, with domestic violence, and Kia’s little brother was born (her mother had four children in five years). Her father had a history of substance abuse and criminal convictions, and both parents had mood disorders. Kia’s older half-brother and half-sister have been in residential treatment. Kia and her sister said that their mother’s boyfriend sexually abused them.

In 3/98, Kia's 12-year old brother Jorge was hospitalized for a suicide attempt (he had a FSIQ of 67, ADHD, and was explosive). In 5/98 their mother reported to DCF that he was sexually molesting his younger brother; later reports say he molested his siblings and cousin. In 3/99, 9 ½ -year old Kia was referred to Child Guidance Center after she burned her cousin with matches; the CGC was very concerned, but her mother did not follow through. A month later, Kia was suspended from school for fighting; neither she nor her older sister were doing well academically or behaviorally at school, but special education services were not provided. Her mother said she could not control the children, three of whom were prescribed Ritalin. Her mother worked evenings and sent the children to their aunt, but Kia and her sister did not get along with their aunt. Her mother said at age 12 Kia was associating with older males in the neighborhood, sleeping until noon, and getting high in the afternoon with her cousins. She failed 5th grade and was expelled in 6th grade for having marijuana in school. A psychological evaluation (8/02) found that Kia had a FS IQ of 64 and recommended special education for learning disabilities and residential placement. While she was at New Beginnings School (11/02-5/03) she made progress in all academic areas, but was easily distracted, encouraged peers to engage in negative behaviors, and was defiant. A 6/03 psychiatric diagnosed Bi-polar Disorder, ADD, and Conduct Disorder and described Kia as anxious, insecure, and socially immature: "she adopts a streetwise demeanor to fit in and be accepted...uses attractiveness to compensate for insecurities. She is extremely needy for emotional nurturance...vulnerable and susceptible to being taken advantage of by predators." In 7/03 she was committed as a delinquent for violating probation and was admitted to CCP for impulsivity, poor anger management, lack of boundaries, promiscuity, and truancy. An 8/03 report indicates that at the CCP school Kia, age 14, was functioning at the 8th grade level in language arts and 7th grade level in math. The psychiatrist at CCP urged that her learning disabilities and multiple dental problems which had been neglected be addressed.

Kia was sent to the Pines Kenbridge program for developmentally disabled emotionally disturbed youth in Virginia in 11/03. Their testing showed she was reading at the 7th grade level and doing math at the 4th grade level. The Pines treatment plan probably could not have been understood by Kia: Will learn to accept and respond to appropriate adult authority (respond to redirection, pleasant voice, accept responsibility for actions, brainstorm alternatives to self-defeating behaviors). Will develop a euthymic mood and be able to sustain this with help of medication. Will develop an understanding of positive peer relations and gain insight into the consequences of involvement with negative influences. Will establish a trusting and appropriately close relationship with her mother (explore sense of rejection by family, identification with incarcerated family members, in therapy family will develop improved communication; talk about past disappointments, hopes for future). Will attend school regularly and be able to function academically to the best of her ability. Will gain insight into the negative impact of substance abuse in her life, and commit to abstinence from substance abuse. To achieve these goals, Kia was scheduled for once weekly individual therapy and a social skills group five times weekly; once weekly family therapy by phone never happened because of her mother's unavailability. Kia was prescribed Depakote for Bipolar and Adderall and Strattera for ADHD. The Pines concluded that Kia was not MMR, but had borderline intellectual functioning and staff wanted her to move to another Pines program because she functioned higher cognitively than the residents in her program; she visited the program, but declined. She finally earned her first 5-day home visit in 5/04. In 6/04 Kia returned to her mother in Bridgeport. For a month, she did well and stayed on her medication. In 9/04 she was placed in Stepping Stone and in 3/05 she returned home. Within 10 days she stayed out all night, and outreach and tracking reported she was not at home and was not making her call-ins; the psychiatrist was unable to see her to assess whether she was taking her medication. She was returned to CCP, ran, and the judge sent her to York. In 7/05, Kia was "emotionally labile when feeling hopeless and typically acts out with threats or superficial bravado. She has been molested by adult men, but does not talk about it, maybe to protect perpetrators. At York her aggressive behavior is a response to her anxiety—she needs treatment for her symptoms, not incarceration, and should be immediately removed from York to be placed in a residential program that can provide the trauma work she needs." Kia was placed at New Hope in 7/05, and "after a month became more responsive to staff directives, improved in verbalizing her feelings to get her needs met, and was continuing to work on her ability to manage her frustrations with peers and staff." The New Hope treatment plan has complicated, standardized deficit-driven goals, but the progress reviews are positive and detail strengths. The progress reports do not provide information about Kia's academic progress and steps being taken to remedy her 7th grade reading or her past problems with concentration (mystery of MMR diagnosis). In a 9/05 letter to the court, the New Hope director wrote, "the changes in Kia's behaviors are astronomical She has been compliant with where she is supposed to be all of the time. She has been compliant with directions, with not more than one prompt, 90% of the time. She has been participating

appropriately in groups. She is confronting negative behaviors in her peers. She has been a leader on many occasions, in a positive way. Kia's behaviors have changed so much that she was Citizen of the Week this past week."

In the interview, Kia was remarkable: articulate, outspoken and poised. She talked about being in and out of residential programs since age 11, and that being locked up in adult prison made her change. "I used to fake it to make it. Now I'm taking it serious and really working on my problems. A person has to decide to change. I used to be the ring leader of negativity here. Now a 13-year old looks up to me. My anger was my big problem. I used to let small stuff get to me. Anger can take over you. I had to learn to walk away if something makes me angry. I don't have to be the center of attention like before, but I still really like having one person to talk to. My communication is better for the first time My relationship to my mother is a lot better. If you set your mind to it, nothing should get in your way."

Now that she has improved so much, Kia is thinking about her worries about leaving. "Everyone needs something to look forward to. Before, why should I work hard when I've got no home, no where to go?" She said having a family therapist who drove her home and talked with her and her mother in her mother's home has made a big difference. Now school, friends, and getting high are what she is focusing on. "I smoked weed to get away from problems, but it just makes your problems worse." She worries that she does know how to make positive friends—although she proudly reports that she has not called negative friends. She wants a weekend job that she could start when she is on weekend home visits, and she hopes she will meet positive friends at work. She says she needs help to find a job. Kia wants to finish high school, go to Southern, and become social worker. But she is afraid to go to regular school: "I'm too nervous to go to a big school. I have real problems in concentration. I'm getting all As here."

Kia thinks there should be more day programs for girls. She also thinks they should make Stepping Stone better: "There was no one there to listen. The girls have to act out for attention. The staff is not so professional. If a girl returns from running in less than three days, the program should take her back so she can learn. The staff look down on us. They don't know how it would feel to be in our shoes. Staff should share what happened to them. Girls want younger staff who can listen, not just a therapist. There are not enough staff." She says, "It's wrong how much they judge girls by paper. You should understand the girl."

KIA'S NEEDS (age 16)

- To continue her progress in verbalizing her feelings to get her needs met
- To continue to improve her ability to manage her frustrations with peers and staff.
- To build on her personal skills and bilingual abilities for future job goals
- To maintain her gains in expressing her anger effectively
- To recover from years of trauma (mother's mood disorder, domestic violence, four children in five years; sexual abuse, York, and all the trauma along the way)

Kia has taken many positive steps, but when she is promised something by "the system" it does not happen. She wanted to go to Job Corps but was told she had to live at home first, She plans to live with her mother because "I'm too scared to be by myself." She hadn't thought about sharing an apartment at college with another girl. How close is she to graduating from high school? Are her reading skills strong enough for college? Would her abilities fit a vocational better? Is there a school where she could excel and not be scared? Is it best for her to live with her mother? Would it be better to continue at the New Hope school and live in an apartment with another girl and staff? Would this stepdown be too frustrating to her? Would this stepdown help her finish school and start part-time work and learn how to choose positive friends and continue to improve things with mother without the pressure to live with her?

LISA

"Lisa" is a dynamic, articulate 17-year old Caucasian who is a good student, has a lot of friends, and enjoys music, playing the guitar, and horseback riding.

Lisa lived in Windsor Locks, the only child of divorced parents; her father moved to Stafford Springs Her mother was 28 and her father 24 when she was born. Her mother had one other child in a previous marriage who was killed (by the stepfather), a tragedy that affected her relationship with Lisa's father and Lisa. At age 6, Lisa was sexually abused by an 11 year old; she reported being raped at age 11, and having a miscarriage at age 13 due to physical abuse by her 17-year old boyfriend. Drug use, a suicide

attempt, running away, and truancy began when she was 11 in part due to her anger at her parents for the breakup of the family. Her father left her behind, she saw little of him for years, and she was resentful. Lisa had stress-related headaches. She started using marijuana at age 11, and was a daily user at age 13. Lisa had a difficult transition to middle school; she was a 6th grader with 8th grade friends, tried to be cool, and lost interest in school. At age 12 she was described as a formerly perfect child who her mother thought was gifted, becoming rebellious against her mother's rules. In 2002, her mother dropped her off at her father's home because she could not manage Lisa, who liked to dye her hair pink or black and preferred gothic attire. They were involved with DCF when Lisa was 13½, for her father's physical abuse. Lisa said she knew she was lesbian at age 11; she came out at 14. In 7/03 she had numerous school suspensions and out of control behavior; her father filed FWSN in 9/03. Lisa said she ran away when her father kicked her out; he and her stepmother were intoxicated a lot. Her mother said Lisa was smoking marijuana with her father's fiancé and had been exposed to domestic violence in her father's home. She was taken to the ER after threatening suicide. Both parents said they were unwilling to have her return to their homes, and DCF became her custodian in 10/03. A thorough psychological assessment of Lisa and both her parents (12/03), recommended a foster home and an "intense program of outpatient counseling that occurs at a minimum of two times a week and that includes her parents for strategically scheduled sessions to deal with the historic and current relational issues." Lisa ran away from two foster homes, and in 3/04 the court direct placed her at New Hope Manor; she ran away a month later. She went to CCP, and then spent more than six months at Stepping Stone (5/04-1/05) where she was the first resident to achieve Level 4 in over a year and was president of community council. She was diagnosed with Oppositional Defiant Disorder, Dysthymic Disorder, Cannabis Dependence, and parent child relational problem. Her standard Stepping Stone Treatment Plan was: Decrease incidents of oppositional/defiant behavior. Strengthen family relationships. No incidents of running away. Successfully earn credits toward HS diploma "Lisa needs to apply herself at changing her ineffective and maladaptive manners of coping. She needs to gain better insight into the severity of her problems. She also needs to work on her problems with substance dependence." Stepping Stone said she did not require a locked facility and recommended a group home. Stepping Stone progress notes recorded Lisa's "saddening realization that her parents are motivated by their own concerns—she could have gone home months ago if her parents had been willing to address their issues... An extremely intelligent young woman, Lisa is adept at and was accustomed to being able to explain, legitimize, rationalize, justify or argue her way into a more favorable position and avoid consequences." Lisa was successful at learning better ways to manage her anger, improved self-expression and diminished impulsivity, invested in focusing on independence, and learning how to tolerate parents' neediness and inconsistency. Stepping Stone shifted their family work to attempt to get her parents to support their daughter's independence. Lisa ran away, used drugs, was sexually active with multiple partners, and said running was a desperate act when the promised group home did not materialize. In 1/05 she was returned to New Hope; in April, 2005, her mother was asked to leave New Hope for making inappropriate comments, and Lisa ran away later that month. Her mother did not participate in family therapy at Stepping Stone, but at New Hope her father was involved. At age 15, she was on a FWSN, which she violated at age 16 by running away from a foster home, giving her an adult charge of escape from custody.

When Lisa was admitted to Riverview (8/05) she requested help for flashbacks, depression, and an eating disorder. Her admission diagnosis was PTSD, Dysthymic Disorder, Polysubstance Abuse, and Bulemia. She had a tested FSIQ 111, with her verbal reasoning in superior range; her short-term working memory was apparently impaired due to emotional distress. She was reading at the 10th grade level and doing math at the 8th grade level. She was hypervigilant when threatened, leading to perceptual distortions and impaired judgment as she justified her "self-defense." She felt emotionally isolated and was depressed, with irritability, low self-esteem and alienation. Lisa was seen as a "chronic risk for substance abuse to support avoidance and reckless self-destructiveness in response to feeling hurt." Her repeated running away was seen as a "dysfunctional learned pattern to cope with stressful situations borne out of peer conflicts, rejection by mother and despondency over her future. These precipitants were in turn created because of her significant past experiences where she was emotionally abused, neglected...[and] sexually abused." Two weeks after admission with a PTSD diagnosis, her diagnosis was changed to Depressive Disorder, Cannabis Abuse, Eating Disorder R/O PTSD, R/O ADD, narcissistic and borderline personality traits. Referral to DMHAS services after 18 was denied because she lacked significant psychiatric symptoms.

Lisa was very articulate, but it was disturbing to hear her parrot staff beliefs. She said Riverview is "a dumping ground. It's a great hospital, with great treatment, Kids with psychiatric issues can get help." Asked what a kid with a psychiatric issue was, she said, "Self-harming, with a diagnosis. If they're here just for anger management, then they're not psychiatric. You can't mix kids who like to make people feel bad with kids who

feel bad. Kids who like to assault are dumped here because it's a holding facility. No one thinks I belong here. They had to give me a diagnosis, so they said PTSD, but it's just a diagnosis." Asked how the trauma she has experienced still affects her, she said it does not.

Lisa feels it is discriminatory for Riverview to have a stepdown program for boys but not for girls. "There are not enough group homes for girls. I waited three years for a group home. There are long waitlists when kids are ready to leave. There ought to be more group homes for kids with issues. That way they could separate the self-harm girls from the anger management girls." She says Stepping Stone and Touchstone are good programs, for "behavior needs, not treatment needs."

Lisa is excited about going to a GLBT group home. She will be able to get a job, go to public school, have GLBT resources, and "a great atmosphere". She's not unhappy about 12 kids being in the group home—she said it seemed like a big family when she visited. She is supposed to be in 12th grade, but she does not know if she will be able to graduate this year. She wants to go to college but she has not thought about where: "I haven't been out in the real world. I don't know what college." She wishes the group home was in CT, instead of near Boston. "It's going to be a long bus ride to visit my friends." Lisa said she could live in a group home with straight kids, but not if the staff and clinicians are "homo-ignorant who think my sexual preference is something that should be fixed." She said her sexual preference has been the reason for treatment in the past.

Lisa said that foster homes do not want teenagers. "Like people who buy dogs, they want a puppy." That's one of the reasons she intends to become a foster parent. "Foster homes never worked for me. Then when it doesn't work out, they put you in Marshall House in an awful neighborhood in Hartford and send you to Hartford HS which isn't safe. Because I felt uncomfortable in a place they shouldn't have put me in, I ran and they put me on parole. Stepping Stone and Touchstone don't work on family abuse issues. They focus on acting out. They scare you into being good—there are restraints everyday. Instead of focusing on assaultive behavior, they should focus on emotional issues from family therapy or if the girl is self-destructive. I learned how to respect people and how to behave in public. My Mom left, so I didn't have family therapy." She said the anger management groups she has attended are all below her; she knows all the coping skills and can recite them. She has a parole officer who is great, who tried for a long time to get her a group home placement. She read the article in the paper and agrees with it: she has been driven around all night in shackles being taken to the ER, going to the bathroom in Dunkin Doughnuts, until they could place her in CCP.

LISA'S NEEDS (age 17)

- Recognizing that her chronic sadness, irritability and low self-esteem are the continuing effects of a lifetime of trauma: sexual abuse at age 6, 11, 13 and 14; witnessing domestic violence between parents and father and girlfriend; parents' separation and loss of father; difficult transition to middle school; miscarriage; abandonment by mother; physical abuse by father, stepmother and numerous relationships; using drugs and multiple partners; guilt over girlfriend cutting self with Lisa's razor; continued disappointment in parents and having to accept they are not able to meet her needs.
- Learning new self-talk to reduce her hypervigilance, which causes distorted thinking when threatened
- Support for completing high school and going on to college
- Help in completing college applications and preparing for college
- Not to feel picked on for being a lesbian
- To maintain her gains in expressing anger effectively
- To maintain her gains in not resorting to her old habit of running when under stress

MALIKA

"Malika" is a bright 15-year old African American who draws, writes poetry and songs, loves animals, enjoys gardening, likes to read and wants to become a model or fashion designer. She is good at forming relationships.

Malika was born in New Haven, where her mother, who was 19 when Malika was born, continues to live. She has never met her father who also lives in New Haven and was 24 when she was born. Malika remembers being happier when she and her mother lived with her grandparents. She had asthma. She attended

five elementary schools. In 2nd grade, she was described as being disobedient and lying. In 4th grade, she was expelled for bringing a knife to school. Her first mental health contact was in 5th grade. Malika said her problems began when she was 10 and her mother and her live-in boyfriend had a baby (2002). She became depressed. She did not like having to babysit so much. She thought it was unfair that her mother's boyfriend expected Malika to wash his dishes. She and her mother argued about chores, curfew and clothes. She had difficulty adjusting to middle school, and her grades fell from average in 5th grade to failing in 6th grade. She was sexually active and used marijuana at age 12. Her mother quit her job because Malika had a boy over when her mother was at work. In 2002-3 she repeated 6th grade. Malika went to the St. Raphael partial program due to numerous school suspensions (abusive language to teacher), staying out at night with older males, lying, and stealing. In 3/03 a FWSN was filed and she was detained after running away. She returned home, threatened to burn down the house, and was detained again.

In a psychological evaluation (4/03) Malika said she did not like her attitude and wanted to learn to speak proper English, as her mother had told her. She said she and her mother disagree on a lot of things and did not have much in common; she also did not get along with her mother's boyfriend. She got along best with her maternal grandmother. At age 13, she had a FSIQ of 89 (V-97 P-82) and was reading at the 8th grade level and doing math at the 3rd grade level. She had average verbal skills, and the evaluator thought it was likely she had a learning disability and would find it easier to solve problems using thoughts and words than by action; she was weak in sequencing and nuances of social relationships. She was passive, lacked assertiveness and had low self-esteem and a poorly developed ability to appreciate and understand the feelings of others. The evaluator recommended special education for a learning disability. She was on a long waitlist for outpatient therapy. In 6/03 the MST program reported that she was attending school and compliant with electronic monitoring. In 7/03 Malika was admitted to the ER after setting a rug on fire when her mother did not allow her to socialize with males. In 9/03 she was admitted to YPH after firesetting.

Another psychological evaluation (9/03) debated a bipolar versus PTSD diagnosis for Malika: "her mood changes several times a day...nervous, usually when angry... limited frustration tolerance and minimal self-control...easily offended and prone to sulk, much of her time and mental energy is spent dwelling on perceived inequities of her life and situation...feels misunderstood and mistreated, a rationale for acting out. She feels an almost desperate need to be nurtured, on the other hand her experience tells her that most of her relations will end poorly and that those she attracts are likely to be as fickle as she...seldom understands others' motivations and intentions...tendency to use sexuality as a means of manipulating others...feels trapped and hopeless...preoccupied with somatic functioning and prone to somaticize in response to stress...her worldliness and bad girl image belie her considerable naivete, and it appears likely that she misunderstands what others want...Mother does not see her role in the complexities of the situation. She is preoccupied with order and routine...not flexible...Mother cares but is wary". The evaluator recommended a residential setting, possibly out-of-state, commenting "Mother will have to learn new disciplinary techniques and be part of a supportive network."

In 10/03 Malika was ordered to Riverview for a 30 day evaluation because she appeared to be psychotic. She returned to detention and in 11/03 was hospitalized at YPH after threatening suicide; at YPH she set a blanket on fire. In 12/03 Malika returned to Riverview. A psychological evaluation at Riverview (1/04) indicated she considered only a single dimension when making decisions. Her focus on immediate gratification and limited coping skills made her like a child several years younger. She was sad and hopeless and viewed others as untrustworthy. Her thinking was concrete. She had difficulty coping with new situations. She continued making homicidal threats to her mother and staff and Riverview asked to have her go back to detention. She was adjudicated FWSN in 5/04, was committed in 7/04 and sent to Grey Lodge. That placement disrupted after five days because she said all the girls were bisexual. Malika returned to Riverview. She was prescribed Zoloft, Depakote and Risperdal. "Historically she has been diagnosed with Bipolar disorder and treated with mood stabilizers but there is no evidence at present or from documentation that she experienced any hypomanic symptoms although her irritability and impulsivity may qualify for consideration. Some of her symptoms hold true for PTSD...She is motivated to return home. Residential placement may actually discourage her from working on her behavior...The team is working on positive reinforcement for reduction of her anger and increase in frustration tolerance." At Riverview Malika was seen as needing intensive individual therapy and group work especially on impulse control training, as well as therapy with her mother to address mutual respect, supervision, sexual boundaries, and psychoeducation about her illness with a goal of discharge home with IICAPS and a specialized school.

Malika was committed delinquent in 7/05 for an Assault 3. She was placed at Natchaug in 7/05. Her physical aggression, property destruction and extremely poor peer relations were problematic. She was

assaulted by peers after making racist and sexually inappropriate comments. She improved with the structure of the school day and did well academically. Several months after she arrived, Malika started decompensating, mistrusting others, being overly sensitive to perceived slights and misconstruing social situations. Her therapist skillfully defined proactive strategies for helping Malika in thorough guidelines for other staff, reminding staff to “remain calm and non-reactive and offer her simple choices to remain safe. The goal is to slowly increase her tolerance of painful feelings without negative behaviors.”

- She needs repeated encouragement--every hour, give her 10 minutes of individual staff time
- She desperately wants to be liked but thinks she is too ugly, sad, damaged to be liked
- She is constantly in a state of hyperarousal, scanning the environment for threat cues
- She becomes intensely sad or angry even with small perceived threats and urgently needs to decrease threat
- She is easily overwhelmed during high activity, transition
- Limits may be triggers—be clear and concise—avoid nonverbals that may be misperceived
- Help her identify emotions and validate that having her feelings is okay
- She has difficulty with ambiguity—she sees things from her own distorted perspective—don’t try to correct the distortions, simply validate her feelings
- Remove the audience—too much attention increases behavior
- Encourage her to calm herself—remind herself of what’s been calming before

In her interview, Malika was pleased to report that she was most improved resident of the week and got level 4 in school. She likes her Delta T mentor. But she says her therapist does not have time for her. She had a nightmare about an old trauma and her therapist had not time to talk to her about it. Malika is also having side effects since her recent change to Abilify that bother her and she thinks she should get more attention for them.

“I’ve been here six months and I don’t even know when I’m being discharged and where I’m going.” She wants a therapist and a mentor when she leaves. She would prefer not to go to a regular school—she will need a tutor. She’s 15 but thinks she’ll move into 11th grade. She would like to return to the Children’s School in Hamden—“I got along very well there.” But she did not have a therapist she liked in the community. She has had family therapy three times which has been “okay.” When she leaves, she wants a mentor to help her get a job so she can earn money for clothes and makeup and to take her to Macy’s to get makeup. “I really need a job, I really want to help my Mom.” She says her self-esteem has improved because she is getting on track in school and is having normal teen personal relationships.

“If we’ve been traumatized by rape, we should not have four male staff restraining you and no one should hurt you. None of the women staff do restraints. Everywhere I go they treat me differently, but staff restraint is at every facility.”

“I don’t want to go to the time-out room. It gives me trauma memories. I would go to my own room if staff asked me.”

Malika thinks that girls in residential need a recreation center with an exercise room, beauty salon for make-up, hair and nails, a place to do sports and socialize with other kids. At Natchaug, she doesn’t like the food. The cook is not good, and she thinks they should be able choose alternative menus. She likes making brunch and dinner. And she likes it when food from other cultures is served so she can taste it.

MALIKA’S NEEDS (age 15½)

- To have repeated encouragement, frequent adult individual attention
- To feel liked; not to feel others will reject her because of her appearance or demeanor
- To reduce her state of hyperarousal and not expect threat at any moment
- To be guided to calm herself and remind herself of what’s been calming before when she feels at all threatened, before she becomes intensely sad or angry
- To be helped not to get overwhelmed during high activity or transition times
- To learn how to identify her feelings
- To have her feelings validated when she is having difficulty with ambiguity and seeing things from her own perspective (she cannot hear a correction of her distortions then)

- To avoid being triggered by “No” by having clear and concise limit-setting
- To have adults who remain calm and non-reactive and offer her simple choices to remain safe
- To slowly increase her tolerance of painful feelings without negative behaviors, including as she talks about her past abuse and feeling rejected by her mother
- To have success, possibly in a job
- To learn how to compensate for her learning disability so she understands what others want, appreciates the feelings of others, and does not get stuck dwelling on things

RONNI

“Ronni” is an almost 15-year old African American who is intelligent and articulate. She is a great singer and dancer and excellent athlete. She is unusually socially perceptive. She is a leader, especially for justice, and is admired by her peers. She has developed strong relationships with adults while in care. Ronni feels loved by her nurturing family, and is respectful and affectionate toward family members. It is extraordinary how much detail she remembers about many individuals she knows in her program.

Ronni was born in Hartford, where her father lives, and raised in New Britain where her mother lives. Her mother was 16 and her father was 21 when she was born. She spent her first three or four years with her maternal grandmother, until after her brother was born and she moved in with her parents; her second brother was born six years later. Her family is described as close-knit, with paternal and maternal grandparents living nearby; she was exposed to domestic violence and her father’s substance abuse. When Ronni was 8, physical abuse by her father was substantiated. In 2nd or 3rd grade, she became aggressive and lied a lot, around the time her parents separated (which is when her mother said her emotional problems started). Her parents’ breakup exposed her to loyalty conflicts (blaming her father) and inconsistent parenting (her father is much stricter than her mother). At age 11 (7/02) she had her first arrest (charges were dropped). Although behavior problems were noted beginning in kindergarten, Ronni was not evaluated for special education until she was 11. A school psychological resulted in her placement in a special classroom, but outside of school, treatment was not arranged for the many emotional needs identified in that evaluation (including irritability, poor frustration tolerance and difficulty adjusting to changes in routine). When her mother was arrested for shoplifting (2/03), Ronni moved to her father. In 3/03, she was placed in a foster home overnight, Salvation Army shelter for a night, and YMCA shelter. Her first conviction, for breach of peace when she was 12 resulted in probation (9/03); she said she was attacked by another girl. Her paternal grandmother said that Ronni had a temper problem, but also had a lot of potential and was respectful at home, did not use drugs, and has friends who are “pretty good kids.” Ronni enjoyed attending church, basketball, working with computers, and taking care of children. She had not adjusted well when she moved from New Britain (where she had attendance problems) to Hartford Transitional Learning Academy, despite her ability to do the work. Her father, described as disabled, was living with his mother; Ronni had a good relationship with both of them. She had infrequent contact with her mother and two younger brothers. She had not had a mental health evaluation or treatment; her MAYSI profile in intake (8/03) was elevated on anger, irritability and somatic complaints. While on probation she was arrested twice at HTLA.

In 11/03 Hartford Public Schools convened a PPT to develop an IEP for Ronni. She had been classified with ED, with no assessment of her learning disabilities (she had no cognitive testing in the previous year, but was “two years below grade level”). She was described as not making transitions well, becoming disrespectful when given directions in her former placement, and having difficulty working with female staff. She was placed in a self-contained classroom with once a week counseling. The IEP goals included skill improvement in language arts, pre-algebra, biology, history, and health, as well as self-control. The simplistic functional behavior assessment identified “no ability to accept re-direction without becoming loud and disrespectful, especially during transition times. The purpose of the behavior was described as “avoid accepting consequences and responsibility for actions” (she was 13). The coping skills she was seen as needing to learn were calming herself and expressing herself calmly and respectfully. At age 13, she was again placed on probation for possession of marijuana (2/04). In the next few months she had a series of arrests for disorderly conduct for incidents with her father, her social worker, and in detention; neither her father or her mother could manage her at home. The Juvenile Justice Intermediate Evaluation through Catholic Family Services was not reliable because it was given in detention where she was easily distracted,

did not put forward her best effort, and did not complete. The evaluation did not attempt to figure out the source of Ronni's "intense and overwhelming anger" that she did not know how to handle. "She will act out if she senses the slightest transgressions. She goes to great lengths to present herself as a strong and resilient individual...she is also very sensitive...[and] depressed...which appears to be longstanding. ...her negative perception of the world disturbs her ability to form deeper bonds. From a treatment standpoint, she is likely to be engaged at a superficial level, but when the real work needs to be done, addressing more vulnerable issues, [she] is likely to withdraw and even act out behaviorally to avoid dealing with her sadness and pain." In 4/04 she ran away from a shelter. A 4/04 psychological evaluation concluded that Ronni had "failed out" of multiple settings, including her mother's, father's, and grandmother's homes and foster homes and could not be in the community. She was depressed, with social problems and feeling that most peers did not like her. A 4/04 psychiatric evaluation commented that "she has had precious little in the way of psychological treatment," even though she loses her temper at least daily and is easily provoked. Her drawing strongly suggested a non-verbal learning disability for which she should be evaluated for special education. The psychiatric concluded she required a residential placement because she would be in danger in the community with her "high degree of irritability and sense of entitlement about the use of violence as a strategy to deal with angry feelings." Both evaluators indicated she refused to say why she is so angry.

In 3/04 DCF stopped Ronni from returning to either parent's home, a prohibition that remains in effect (she is dually committed). Ronni's DCF commitment at age 13 for an Assault-3 (8/04) was her third conviction in less than a year. Her probation officer wrote, "Whenever her parents get overwhelmed and frustrated with her, they send her to live with the other or her grandmother...[she is] a very angry adolescent who needs some guidance, structure and support...she is very oppositional, does not like to be told what to do...She needs to learn to deal with her anger in a positive way rather than using violence." Ronni was placed at Stepping Stone where the goals assigned to her were: "not resort to physical or verbal abuse by improving communications skills, build a trustful relationship with her clinician, strengthen her relationship with her family, and attend school daily." In 8/04 she was charged with assault at Stepping Stone. In 10/04 she was charged with four other girls with breach of peace at Stepping Stone. She was placed at CCP in 10/04, ran, and was detained. In detention in 11/04 she was described as a bully, assaulting staff members and a peer. She was sent to CPA for an assessment, and when CPA was closed, she had an emergency placement in High Meadows. She was described as disrupting the Stepping Stone and High Meadows communities. In 1/05 she refused to go to Natchaug, telling the interviewer she would be assaultive. The judge asked, "Where is a training school for girls when we need it?" She was placed at CCP in 1/05 and ran. The 1/05 out-of-state placement request lists her as having borderline intellectual functioning, but the 4/04 psychological indicated that the testing was not a reliable indication of her intelligence because of her attitude. The 1/05 request listed her behaviors that had to change as: deal with her severe anger issues in an appropriate manner; prevent aggressive and assaultive behavior; accept consequences without presenting as argumentative; accept responsibility for her actions; and respect her parents, teachers and all adults involved in her life. In 3/05 Stepping Stone responded to a request to take Ronni by saying they would a separate bedroom and constant 1:1 because previously she was assaultive and abusive to staff and peers, refused to attend school, and when Ronni was engaged, her mother repeatedly sabotaged treatment efforts, for example regarding medication and aligning with Ronni about disliking the program. The 4/05 DCF Child in Placement Treatment Plan (11 page protocol, not a real plan) indicated that the permanency goal is reunification with her mother, but her mother's inability to provide for and supervise Ronni and her increasingly serious problems with out of control and assaultive behavior were described as obstacles. She was returned to detention, and DCF requested that the judge order her placement at Riverview because in ten months she had been in two foster homes, two emergency shelters, two DCF facilities, two private residential programs, and three stays in detention (27 placements since age 11), and without an updated evaluation of her behavior, it was unlikely the cycle of placements would end.

In 4/05 Ronni was placed at Riverview and began to make real progress. At Riverview she is receiving coaching on anger management and DBT/trauma-informed approach in individual therapy to explore the causes of her anger. She is quick to defend herself or a peer from perceived insults, which she often assumes is racially driven, and acknowledges she has problems controlling her anger. Ronni cannot tolerate ambiguity. She is hypervigilant, and is outspoken about any inconsistencies or injustice she notices. She is quick to passion and sometimes loses the point she starting fighting for. Family treatment with her mother was designed as a structural approach to enhance parent/child boundaries. The goal at Riverview was to work with Ronni's mother toward reunification with a combination of clinical, school and community-based support services. Ronni wants to return to her mother, who is sober and out of prison, has a strong

connection to Ronni and is motivated. But regional staff cut off contact with Ronni's mother; her father tells staff negative things about her mother. DCF is planning to change Ronni's permanency goal to long-term foster care "with the hope of kinship care." A goal in sending her to Natchaug is that they will do "excellent extended family work" to help Ronni figure out which family member can offer her the most nurturing stable home. Because she has such negative feelings about psychological assessment, it has been difficult to clarify what disabilities could account for Ronni's excellent verbal skills and continuing to function at least three grades below her chronological age (about 5th grade in reading and math in 5/05).

After Ronni backed away from a discharge to Natchaug, Riverview decided that instead of the emphasis they put on her saying goodbye, they should have facilitated Ronni making connections with staff and peers at Natchaug. A process of visits with that purpose is now underway. Riverview was willing to consider continuing involvement of a Riverview staff person after she moves to Natchaug. At the Girls' Network Meeting on November 17, 2005, the question was raised about why only a locked setting is being considered for Ronni. The answer was because Riverview is the only place she has been successful.

In her interview, Ronni was clear about how staff at Riverview provoke girls, and how quickly she and others react. "It's 50-50, us half, staff half. They say negative things in front of us, but if we do it, 'Go to your room.' The reason we do stupid things is that staff antagonize us. I started yelling when I wasn't allowed to call my grandmother and it's on my treatment plan." But she also reported that she had learned "there's no point in fighting people just if they look at me wrong." She described differences among the units at Riverview, criticizing one unit where she felt powerless: "We were in our rooms all the time while staff eat and play ping pong." On another unit she said "staff listen and compromise with you."

Ronni thinks programs should be co-ed. "Co-ed is better like CCP or CHOC." She liked the dancing, drilling, and singing at Stepping Stone, but thought the program had too many girls and would be better if it was coed. She also felt strongly that "We should be allowed back in detention when we're on parole. Staff are good at detention, it's co-ed, there's better food. Judges shouldn't limit the time in detention. Parole is wack. I should have stayed on probation. I only went to Stepping Stone because I thought I could go back on probation."

In preparation for going to Natchaug where there is a girl Ronni knows does not like her, she said she would not attack the other girls and would not respond to her if she only said things to her. Ronni expressed an interest in having staff mediate between them.

RONNI'S STRENGTHS

Intelligent & articulate

Socially perceptive (and knows a lot of details about a lot of people)

A leader, especially for justice

Feels loved by her nurturing family

Admired by her peers

Has strong relationships with adults

Excellent athlete & great singer and dancer

RONNI'S NEEDS (age 15)

To be treated respectfully (which she might define differently than adults)

To not get a defensive or angry response when she insists that rules should be adhered to and that there should not be a double standard for adults and kids

To be helped to get clearer on the "half the problem is me;" since she was child, she has not liked change, has been irritable, has gotten frustrated quickly, did not tolerate powerlessness, and has reacted to ambiguity

To figure out ways to be assertive in righting wrongs that are not argumentative or

POSSIBLE SUPPORTS TO MEET THESE NEEDS

A community process for defining mutual respect & standards that are the same for adults & kids that Ronni takes a leadership role in (which might include questioning if some rules should change)

To participate with her therapist, staff, her family & an advocate in designing a fair, consistent method to address inequities before Ronni escalates

To decide that these are not bad parts of her, but are characteristics that affect how quickly & strongly she reacts to unfairness—each characteristic may require new self-talk so she can immediately take charge of calming herself so she can assertively solve the inequity of the moment. Thus, arguing or being aggressive is not being bad but shows that

aggressive and how to be calm enough at the time her passion is being provoked to assertively fight for her cause	self-calming was not effective enough to support an effective assertive response. Every use of effective self-talk & self-calming & assertive response should be celebrated.
To have a justice cause she can fight for outside the place she is living	Work with an advocate to become a spokesperson for young people; form a public speaking club
To appreciate all the good in her extended family and at the same time not feel she is being disloyal to recognize hurt from the past and family limitations	Participate in a process of evaluating the pros & cons of each family home she might live in, including defining the nurturing & rules she will need at home; use this process to set up her permanent family with important family members working with Ronni in making peace with the past
To understand why she has such strong verbal skills and struggles to make progress in reading and figure out what special teaching techniques help her the most	With 1:1 instruction using material of high interest to Ronni, including her community rules, self-talk & public speaking projects, have her success in reading and writing improvement get recognized
To have opportunities to use her unusual social perceptiveness and remarkable memory for details about people	Writing projects? Design a staff and youth awards program? Write a play about her life?
To continue her connection to Riverview staff	Progressing to another place to live should not cause a loss of attachment
To have daily opportunities to excel in athletics, singing and dancing	Organize weekly talent shows? Athletic events? Organize events for children in community?

What need dictates a secure program for Ronni? Is Ronni a run risk? Would she put herself at risk on the street or if she ran to a family member? Is there a safety need that Ronni would agree to? Has success at Riverview been in part because she was not allowed to leave?

Could the new Sachem program meet these needs and build on these strengths? Would the goal of her placement in that program be that it is a transitional step to going to a family home, with many hours a week being spent on Ronni, with and without family members, assessing each family home, deciding what she needs from a family home, and negotiating with family members (which includes trauma recovery with family who have harmed and disappointed her in the past)? That would also involve arranging intensive home-based therapy, coaching and other supports top wrap around her family home (which might include Riverview staff being paid to continue to work with her in the transition home)

Another alternative is a transition home between Riverview and a move to her family. What I would suggest is a staffed apartment with at least one Riverview staff on loan plus recruiting other staff, with maximum involvement of Ronni in the design process. If she continued at the Riverview school, you could have 2 staff working with her during the hours she is not in school. Basically a staffed home is a foster home where you hire and train staff. It is usually cheaper than residential care. The goal is to increase participation in community activities, so staff is going with her to sports and singing and family as well as living with her. Cooking, cleaning, homework are all opportunities to implement assertiveness and self-talk training, on the praise not punishment model. Individual and family therapy are closely connected to everyday life so all staff can talk the same talk, and as more work happens in family homes, the staff schedule in the apartment changes (this means a lot of clinical staff hours). Staff also are essential in helping her find a community school she can transition to near her family, and they support her gradual transition to that school as well.

Staff have to see that they do things, including limit-setting, that they don't intend trigger her but they do—so they have to change (e.g., being clear and concise, not giving ambiguous body language, resisting the desire

to correct her distortions as she is escalating, which is a time she has to cling to her own perspective being the only right one). Questions that could guide changes in her needs lists or steps staff could take: How much of the time is her acute social perceptiveness working as hypervigilance for personal slights/injustice? If so, does she recognize it and have self-talk that could help her? Is this worse in ambiguous situations? Is it worse during transitions or when others are getting a lot of attention? Does she have methods of calming herself, space to go to be calm, that work for her and what inconvenience is it for staff to help her choose that before she escalates?

SYLVIA

“Sylvia” is a likeable 16-year old Latina who was born in Puerto Rico, and came to the mainland at age 2. She lived with her family in New Britain. Her biological parents separated when she was 5 years old. Her father had a history of substance abuse and Sylvia was abused by him as a child. She was described as a moody child who had asthma and ear surgery. DCF was involved because of lack of supervision and medical neglect. Reportedly, she and her mother related “like sisters.” One DCF report indicated that when her stepfather moved in in 1999, he added chaos to an already chaotic home. The family moved into “the projects,” which reportedly resulted in Sylvia becoming involved with negative people. . She was hospitalized in 2001 (no record found). Sylvia said she did not like her mother and her mother was treating her worse than her siblings. Sylvia’s younger brother had serious psychiatric problems. In 4/01, her tested FSIQ was 68 (v-64; P-75). She started in special education in 6th grade. Her mother filed a FWSN in 2001 and 2002 due to truancy, oppositional behaviors, aggression, lying, stealing and unprotected sex at age 12. There was no follow-through on services by the family. In 2003 she was admitted to YPI for suicidal ideation. From 1/03-4/03 she was at Stonington Institute, but was discharged after assaulting staff. In 5/03 she was admitted to Riverview. Sylvia said she liked sex, alcohol, and marijuana while she was on the run. She said she was a good girl before the family moved to the projects. Riverview noted that at almost age 14, Sylvia had not consistent treatment, despite problems for years. She was very immature and diagnosed with PTSD and depression. She needed help with problems solving, coping skills for her anxiety and anger. She had learning disabilities with an expressive language disorder and was reading at the 5th grade level and doing arithmetic at the 2nd grade level (6/03). She did well at the Riverview school. She was stable at Riverview, and the recommendation was for long-term residential treatment. She joined her brother at the Bennington center in 11/03, but was discharged for assaulting staff. She returned home, went to detention, and was re-admitted to Riverview in 2/04. Her tested FSIQ was 60 and her adaptive functioning was low, especially in expressing herself and peer relationships. With Risperdol she showed decreased aggression. She was discharged to High Meadows, assaulted staff and was sent to detention. She was readmitted to Riverview in 9/04 with diagnoses of Depressive Disorder, PTSD, Alcohol and Cannabis Abuse, Conduct Disorder and Mild MR. Sylvia was placed at Lake Grove for a year and reportedly did well for awhile. She was self-injurious when upset. After assaulting staff, she was moved to YPH in 10/05 and then had her 3rd hospitalization at Riverview in two years, her 8th psychiatric admission in four years (10/05). Her diagnoses changed at Riverview to Mood Disorder, Bipolar Disorder, R/O PTSD, Alcohol and Cannabis Abuse, Conduct Disorder and Mild MR. Sylvia got easily overwhelmed, which interfered with her problem solving. Impulsivity and misperceptions contributed. In intelligence testing, she gave up easily. Her verbal IQ was 59, with a significant split between verbal and performance, indicating an expressive language disability. Testing was done in Spanish and English, so her low verbal scores did not appear to be the result of bilingualism. She has two brothers at CJTS and three sisters living at home with her mother and stepfather. Her plan was to go to a foster home, but DCF worker decided on independent living and Sylvia is struggling to accept this change.

Sylvia came into the interview liking the idea of giving suggestions for services for girls. She felt strongly that she didn’t want to be in a hospital. It was hard for her to drive into the driveway with the hospital sign. It would be better to drive in and see a sign saying “This is Elizabeth’s Town” (made up quickly off the top of her head). She thinks it is very embarrassing to be taken to the ER in shackles. “I was crying when everyone saw me in handcuffs.” She thinks there should be different houses for runaways, suicidal girls, kids who hit. She liked the buildings at CCP, but thought the CCP staff were rude and complained that second shift staff hit them. She wants respectful, honest staff. “If your mom wants to visit, she should be able to come anytime.”

Since girls run, Sylvia thinks the first 60 days should be locked. She thinks girls should have two chances of running before they are sent to detention. "I ran to be in my house. But my friends are negative. I like to follow. I have a new me. I don't run away anymore because I was hurt. My doctor helped me with a lot of feelings. I used to hit people in Lake Grove because the staff were rude, and they stole from me. I felt bad about hurting staff, but she said 'Shut the f--- up.' I used to fight anybody. Now I think before I act. I take a time out, listen to music, talk to someone about my feelings. When I was at Yale and Lake Grove, we had groups and groups, but not coping skills. Here I've learned coping skills. I've learned to say what my feelings are, my anger. My mother comes to family sessions." Her plan is to go to a group home. "I want a nice clinician. When I'm mad I want someone I trust to talk to." She wants to return to the ACE program, a school in Hamden. "There are 2-3 teachers there who would help me through high school. They were nice to me."

SYLVIA'S NEEDS (age 16)

- To continue her progress in saying what her feelings are, talking to someone when she is angry, thinking before she fights or runs away, and asking for help before she gets overwhelmed
- To be treated respectfully
- She does best when things are not confusing or overwhelming
- To understand her learning disability, to have opportunities for learning through hands-on activities, and through special instruction in how to compensate for her disability, to raise her reading level above 2^{5th} grade and her math above 2nd grade level, and improve her ability to express herself, which is an important element in her immaturity and limited social skills
- To participate in a process of figuring out whether a foster/adoptive home, a group home, or independent living would meet her needs and build on her strengths by defining what she wants and assisting in recruiting the right home. If she can return to the school in Hamden and it will meet her educational needs, the home she helps recruit should be in close proximity to that school
- To learn about the connection between her depression and anger to years of abuse and neglect at home
- To be successful finding a positive friend and doing positive activities without being pulled into sex or getting high just to feel a sense of belonging or acceptance

TERRI

"Terri" is an almost 15-year old Caucasian who is a strong leader, warms up to people easily and cares for her family. She has worked hard in therapy; she has been at Stepping Stone longer than any other resident, and she has made progress toward several possible discharge plans over the past 11 months.

Terri was born in New Milford, where her mother still lives. Her mother was 17, and her father was 20 when she was born. Her parents separated when Terri was a year old. Her mother moved in with her boyfriend—both were alcoholic, physically and verbally abusive, and Terri was left at home by herself. Her mother was involved in multiple relationships and continued substance abuse. Terri's father is employed, married, and has a son six years younger than Terri and a stepdaughter three years younger than Terri who live together in Torrington. Terri attended kindergarten through 5th grade in Woodbury while living with her mother. At the end of 5th grade, her mother dropped her off with her father. Her father says she was harmed by living with her mother who went from one abusive relationship to another, and he refused to let her visit. In 6th grade Terri had problems with the adjustment to middle school in a new community. Her father said she was "doing okay in 7th grade, but started therapy because she had an attitude problem like her mother." Her father described her as easily frustrated, argumentative, defiant, and irritable with temper problems. Terri was charged with running away at age 12 in 5/03; her father thought she ran away to get attention from mother. She used marijuana while on runaway. She had a lot of arguments with her father and stepmother. She was spending some weekends with her mother who was described as an alcoholic. After appearing in court for a second FWSN in 10/03, Terri improved, although she was on a long waiting list for therapy.

A psychological evaluation (11/03) concluded that Terri was "exhibiting problem behaviors that stem from inadequate and ineffective coping strategies, impoverished social relationships and a sense of hopelessness about her ability to control her situation, especially at home and in school. She appears immature and impulsive. Despite average intelligence (FS IQ 106), she views herself as inferior... significant

levels of internalized anger and despair...significant depression...maternal rejection...strong dislike of stepsister... doesn't feel her parents understand her...desperate underlying need for both parental and peer acceptance and nurturance." She was diagnosed with Oppositional Defiant Disorder, Dysthymic Disorder and Parent and Child Relational Problem. The evaluator recommended therapy for mother's rejection and perception of her unimportance in blended family, formalized social skills training, family therapy, an educational program to address emotional/social insecurities as well as academic, and possibly medication for depression and ADHD.

Terri was arrested in school for possession of drug paraphernalia and distribution of a narcotic, committed, and placed at the Children's Home of Cromwell in 8/04. She ran away and was placed at Stepping Stone in 12/04. Her "child specific therapeutic goals" (which were identical to another girl) were evidently not informed by the findings or recommendations of the psychological evaluation the previous year: Develop, utilize and maintain positive and productive communication skills leading to an increase in coping skills and ability to manage anger more effectively; Actively participate in behavior modification program, individual therapy, family therapy and group therapy to ensure successful off-grounds passes and eventual discharge to guardian; Actively participate in specialized substance abuse/seeking safety group, as well as in-house NA group, and eventually participate in NA when on off-grounds passes with the support and supervision of family. She was receiving the standard four individual therapy, four group therapy and two family therapy sessions a month.

Terri made progress, talking about being hurt by her mother's rejection, feeling jealous of her mother's new baby and discouraged by her mother's treatment of the new baby. She used writing to identify traumatic experiences in her life. She became supportive to peers and improved communication with her father and stepmother. She regressed before she could move to Touchstone. At the end of the summer, her attention-seeking behavior had increased and she ran away. She took her anger about her upbringing by her mother out on her father and stepmother and they withdrew from treatment for awhile. She attributed her downward spiral at Stepping Stone to the death of her grandfather. In a 9/05 Stepping Stone review, she was described as having boundary issues that continued to impair building trusting relationships. She was doing well in the Stepping Stone school. She identified drug use as her most difficult treatment area, and was still ambivalent about whether she was "ready to give up partying and drugs." In therapy she was questioning what she gets from drugs and prostituting herself and why she had so much difficulty relying on anyone for help. She was grieving her mother, who is alive "but it is as if she is dead," and not having what she called a normal family. It was hard for her to consider placement at Lighthouse or a group home because her parents cannot provide a home, and in the interview, she said she wants to return to her mother, go to public high school, continue with substance abuse treatment and therapy. "My mother just had a baby—I love kids."

Terri commented on how the school at Stepping Stone is better than it was and she enjoys the new evening group counseling. She had many ideas about improvements that should be made at Stepping Stone, some of which showed her need for basic nurturing:

"Hugging is not a boundary issue. We should be able to get hugs. It's for comfort. We should be able to horseplay because it's what we're used to."

"There should be more staff on. There have been a lot of fights and girls get jumped."

"We have medical issues and need more medical staff."

"I don't like my advocate. I want other staff to be able to write notes in my book not just my advocate."

"Staff should listen. They should have an open mind. They think they're higher than us. We can't say what we want."

"I want more support groups. They really support me."

"There should be more visits. Two days for visiting get filled up fast. I have a big family—more than three people should be allowed to visit."

"We should have birthday parties, with a cake and music."

"We should have more outdoor activities—double dutch, volleyball, raking leaves and throwing them like little kids, making scarecrows, playing in the snow and making snowmen. We should do more skits and exercise. The drill team and the dancing here are really good."

Terri would like to be in a coed program: "I can't live with all girls."

She was positive about the help she is getting: "I was in detention for seven months for violating my [electronic] bracelet. I'm not violent anymore. There's treatment here. They give you objectives. The writing assignments really help me. We had family therapy every other week and my Mom and I don't hate each other anymore."

She regrets that she ran away, and says she is “doing bad,” She ran because she “got a thrill out of it.” She was on the street doing drugs, but drug treatment has helped her. “I found out other girls had a worse life than I did. I realized if I stop now I won’t get to the point they are.”

TERRI’S NEEDS (age 15)

- To feel nurtured, with hugs and a lot of individual attention, from staff, friends and family
- To appreciate her intelligence and be in a school that challenges her and gives her recognition for her abilities
- To have fun being a child: birthdays, playing in leaves and snow, skits, volleyball, double dutch
- To make peace with the past and develop confidence that she won’t be rejected in the future (trauma treatment, with writing assignments, should include parent separation, exposure to substance abuse and domestic violence, abandonment by her mother (who feels is dead to her), feeling overlooked in her father’s blended family, the death of her grandfather, feeling jealous of her mother’s new baby and discouraged by her mother’s treatment of the new baby, not having “a normal family”).
- To learn the connections between trauma and drug use, continuing to question what she gets from drugs and prostituting herself, facing her ambivalence about giving up partying and drugs, and developing a relapse prevention plan that fits her and she has confidence in
- To learn how to soothe herself when she is feeling anxious, depressed or angry in more effective ways than substance abuse
- If neither parent’s home can meet her needs, make peace with having continuing close relationships and visit with family and participate in a process of designing another permanent home, including assisting in interviewing prospective foster parents and learn how to have realistic expectations of the foster home and communicate instead of shutting down if she is disappointed or hurt
- To learn ways to cope with the vulnerability she feels when she accepts help without sabotaging the relationship or herself

YVETTE

“Yvette” is a bubbly biracial 16-year old who is good at swimming, dancing, and singing, and enjoys helping people, which is why she wanted to work in the Fire Department.

Yvette was born in New Britain where her Caucasian mother and African American stepfather live; her African American father lived in Meriden. Her mother was 18, and father was 17 when Yvette was born premature, weighing less than five pounds. Her father has been in and out of jail since age 16; her mother says his absence affected Yvette. She was raised by her mother for her first three years; then her maternal grandmother gained custody because her mother was in an abusive relationship with another man. Reportedly Yvette witnessed domestic violence, sexual acts and drug use. Yvette lived with her grandmother in Cromwell until she was 10. In 1999, Yvette returned to her mother in New Britain, and apparently she had little contact with her grandmother afterwards; her mother also gave birth to her second child that year. The following year her grandfather, to whom Yvette was close, died. Her mother attributes her behavior problems to the birth of her half-brother and the death of her grandfather. In 2001, Yvette moved in with her father, stepmother and four young half-siblings; her father was then incarcerated, but she remained with her stepmother. Yvette reported that her stepmother physically abused and father sexually abused her repeatedly at age 12 (in 2002), so she returned to her mother.

Yvette does not like therapy—she says she has been in counseling in many different places since age 5 and “it never helped.” When she was 13, a pre-disposition report (11/02) spelled her name wrong and ridiculously concluded: “she must understand how to control her anger when she gets upset...[she] must understand that a good attitude can take her a long way in life.” A few months later, in an unacceptable psychological evaluation in which Yvette put forth minimal effort (so her low IQ score was described as not valid), was very guarded and her family was not interviewed, the evaluator diagnosed a conduct disorder and impulse control disorder and recommended residential treatment. A CCP report in 8/03 when Yvette was 14 indicated that she showed “a lot of lying, stealing, immature behaviors, inconsistent progress because she fluctuates on follow through and consistency. She has an attitude. She constantly flip flops from being

oppositional to being very pleasant. Although sociable, outgoing, and friendly at times, she has poor hygiene, overeating problems, is a follower of negative peers, easily infatuated with boys, not accepting criticism, needs work on anger management.” Obesity had been a chronic problem and she lost weight at CCP. In 10/03 at CCP, a psychiatrist repeated the previous unreliable IQ scores, and diagnosed ODD, Substance Abuse, Dysthymic Mild, and ADHD. She was continued on the same medication for ADHD, although a 10/03 psychological evaluation at CCP found that she did not have ratings high enough for an ADHD diagnosis. In the CCP school she was in special education in 9th grade and had trouble focusing in class or following the teacher’s instructions. Her IEP goals were: Develop impulse control, including controlling temper, maintain self-control when faced with failure or disappointment, relate appropriately; Develop interpersonal relationship skills, including positive attention, not fighting, ignore offensive peers. At a PPT meeting it was noted that her reading and math tested at 3rd grade level—she said her skills were too low for 9th grade and she asked to be placed in 7th grade

At 14, Yvette’s treatment plan (3/04) said: Decrease oppositional behaviors, increase proactive behaviors, compliance with residential treatment, reduction in risky behaviors; Acquire social skills necessary to engage pro-socially with her environment; Follow instructions, accepting no; Acquire independent living skills; Develop suitable transition plan for reunification with family; Develop and maintain good health habits. Her family situation was described as strained with her mother being easily frustrated, her stepfather not liking the negative influence Yvette has on their developmentally delayed son, and her mother and stepfather not getting along well. She had no family visits while at CCP.

Yvette ran repeatedly from Tri-County. The Central Placement Team Request listed absurd goals: Become more compliant and accepting of rules and authority; Respond to behavior management system to control inappropriate actions; Learn positive coping skills to deal with her childhood trauma; Participate in family therapy; Learn more appropriate and effective parenting skills (presumably this was a goal for her mother and stepfather). Yvette was placed at Touchstone in 8/04 where she was described as “unfocused, inconsistent, unable to move past level 2” and her commitment was extended. She had two minor runaways at Touchstone in 13 months. The judge punished her for laughing in court by sending her to York for three weeks. She was placed at Stepping Stone in 10/05. Initial reports describe walking out of individual and family therapy (the program transported her mother and brother), a preoccupation with romantic relationships, and consideration of medication to increase concentration in the classroom. Her treatment plan at Stepping Stone reads more like a list of rules: trust and healthy relationships; attend school; no running away; no substance abuse; strengthen relationship with mother; anger and communication. She said she hated school and told staff that when she runs away she feels free and likes that feeling.

Interviewed at Stepping Stone, Yvette’s focus is on the unfairness of being away from home for so many years in placements she is critical of. “I shouldn’t have been placed. A place like this keeps us locked up 24/7 but doesn’t help us. Putting all these girls together doesn’t make sense. With girls there is always going to be chaos and drama.” Yvette says she does not talk to her advocate or therapist. She believes that her only need is to go home: “My real issues are on the outside. We’re not working on substance abuse here. I can say I’m not going to smoke weed, but when I go out, that will be hard to do.” She realizes that she has family problems, but she does not think family therapy would help her. She simply wants to go home and work on things with her family. “I can have family therapy in here with clinicians who think it’s helping, but it’s just talk. When I go home and my mom says ‘No,’ and I get an attitude, we’re going to have to learn.” She thinks she will be successful at home: “In the last five years I been in trouble and moved place to place. I’m sick of it. I won’t get in trouble anymore.” Yvette reported that she has improved because she “used to beat up other girls and stopped that. I always caused my unhealthy relationships.” But she goes on to say that she cannot have healthy relationships while she is in a residential program. She does not think she needs help to have good relationships when she gets out: “If we think it’s an unhealthy relationship, we have to work on it.” She wants to go to a “regular high school,” and she does not think she needs assistance in adjusting to school. Yvette says, “I should be finishing 11th grade now. I’ve been locked up since 8th grade.” At first she said she did not want any services when she went home. Then she said she would like a mentor to teach her how to drive and help her get her driver’s license (because her mother does not drive) and find a job. She says, “we need to learn from our mistakes. You have to send us home. That’s why we run. We want to live our lives. We want to go home, get a job.”

Yvette says her parole officer “irks me. The first time she came up here, I didn’t talk to her. The next four times she came [to see other residents], she refused to talk to me because she said I wouldn’t talk to her the first time.” Yvette says that an 8-bed group home would be much better than a large program like Stepping Stone.

The interview with Yvette's mother was discouraging because of the similarity between their perspectives and tendency to blame. Yvette's mother is a depressed woman who is not employed, does not drive, and has difficulty getting out of her home. She expressed a lot of dissatisfaction with DCF and the residential programs her daughter has been in: "Yvette has been in the system for three years over nothing—she ran away with her bracelet. It's not fair. She hasn't seen her grandmother in three years. She hasn't been home for three Christmases. Her medication isn't helping. She's being denied her levels just for being silly. She is getting frustrated. She followed another resident and ran in order to go home. Yvette is tired of the system. She just wants to come home." Her mother believes living with girls has been harmful: "she says she is gay from being in residential. She might get a charge for touching another girl. She's been restrained for having relationships with girls." On the other hand, Yvette's mother was ambivalent about her daughter returning home: "Her mind is like a 3-year old. She follows people. She makes the wrong decisions. She does not accept being on a leash. She has a lot of energy. She doesn't like being controlled. If you don't give her her way, she gets out-of-control. She has a lot of anger. She needs anger management. She would have to have a lot of 1:1 attention in special education." Her husband "doesn't deal with Yvette at all because she is rude and disrespectful." He was out during the interview, but when he came back, he anxiously asked whether we were there because we were thinking about returning Yvette.

YVETTE'S NEEDS (age 16)

To learn new self-talk to help her anticipate outcomes, plan ahead, and recognize situations that make her reactive or impulsive

To talk about how violence at home, moving among family members, the death of her grandfather, the birth of her brother, physical and sexual abuse, and rejection by her father and stepfather continue to make her angry and not want anyone to control her

To be successful in school by understanding how to compensate for her disabilities and concentration difficulties

To have positive activities, including part-time work, that build on her sociable and outgoing characteristics

To be supported on her goal of having "healthy relationships," especially how to keep the ups and downs of romance from getting her into trouble

To be supported on her goal of "not smoking weed," especially if getting high is an important part of socializing and/or not feeling angry or sad

ZENA

"Zena" is a likeable, outspoken 17-year old Latina. She likes to please others. She was proud to report her improvements.

Zena lived with her mother in New Britain. She was exposed to domestic violence between her parents until she was 1½ years old when they separated. Her father has been incarcerated with little contact with her. She again experienced parental substance abuse and domestic violence between her stepfather and mother. Zena's behavior difficulties started at age 5. She was enuretic, head banging, pulling hair out, played with fire and burned herself with a lighter. When she was 6, she gave her infant brother so much Tylenol he had to be hospitalized. At age 7 she tried to cut her brother's penis off. Reportedly, her younger sister was so afraid she refused to sleep in the same room with Zena. She was cruel to the family dog Her mother called DCF and asked for her to be removed.

Zena had school suspensions since 2000 for fighting and threatening teachers and peers; she was expelled for being dangerous. A psychological evaluation in 4/02 reported auditory and visual hallucinations, commanding her to to be aggressive. She had no internal behavioral controls, was quick to anger, impulsive, overanxious and paranoid. In 9th grade, her FS IQ was 77. In 1/03 while living at the YMCA shelter she was involved with two teen males raping a teen girl at someone's home—Zena was charged with conspiracy for assisting in setting up the rape and physically assaulting victim herself. She spent two years in prison for the offense.

In planning for her placement from prison to residential, the following program-centered goals were proposed: Refrain from engaging in aggressive/threatening behavior and comply with rules and expectations of residential placement; Demonstrate an acceptance and respect for authority figures; Be forthcoming in therapy and address her inappropriate sexual offending/aggressive behavior; Cooperate with program rules

and requirements; Participate fully with educational component of placement and eliminate any defiance, beyond control and non-compliant behavior; Utilize appropriate behavior management and social skills; eliminate all instigating and anti-social behavioral tendencies; Address issues of self-esteem and develop a positive and healthy attitude about herself; and Acknowledge her mental health issues and address them in therapy and accept treatment as recommended.

In 9/05 Zena was presented at the Girls Network. There had been much bureaucratic maneuvering, because her mother, who had not seen her since 12/04, did not want her at home so Zena could not be released from Niantic without DCF involvement. Whether the residential programs would consider accepting her from the adult system was an issue. She was released to New Hope in 10/05.

In her interview, Zena was proud to report on the improvements she sees in her self-understanding, anger management, and relationship with her mother. "Two years ago I didn't accept myself. I was wrapped up in negativity. I was so depressed and hopeless." After a relatively short time in the program, she felt good about her work on family communication, addiction, better self-esteem, accepting herself as bisexual, and steering her own life. She articulately explained that she had learned that if a person is abused, they will either continue to be abused or become an abuser; she did not want to be like her abused mother, but she became an abuser. She said she is getting help to "learn from the past and don't be abused in the present." At New Hope she said she has learned how to express her feelings and how to support others. She knows her self-esteem still needs to improve because she does not like her weight or acne--she once wanted to go into a modeling program. "I can now talk to my mother. My mother used to judge me a lot. The program is also helping my Mom. Both of us are accepting our past, the harm from it."

She likes activities like swimming and AA/NA. She wished they went out more. "In a house of 10 girls, it is hard to avoid all the gossip, but you have to. Even if I am not gossiping, there is gossip about me. You have to remind yourself, misery loves company and stay out of it."

Zena wants a more stimulating school program. She is not satisfied with the school at the program, but she says public schools are worse. "They just hand you the work. I want real teaching. I like hands-on. Science is my favorite subject, and I'm doing a project." She hopes to graduate from high school at New Hope and go on to college.

She said she is not ready to think about next steps. "Some girls do well at the program, but bad at home. They go back in the negative world. There is no one to help you at your house after you leave." She said she does not want to go to another program, but she knows she would need a lot of attention (and she and her mother would need support) if she went home. Asked if she was thinking about an independent living program, she said she was ineligible because "it's only for DCF."

She says the state should not build a locked program because "what's needed is rehabilitation. Girls run away because of something wrong in their past. They should be allowed to come back to the program if they run away." She said the most needed service for girls is prevention of abuse, especially for 11-15 year olds. She said girls get abused because men manipulate them. She wants to open a shelter for runaway teens.

Despite all this progress and not having behavior problems since she arrived, unbeknownst to Zena, a controversy was brewing about her remaining at New Hope. Staff fear that once girls find out she is a registered sex offender, they will not feel safe. In addition, a girl she fought with at detention (whose parents are pushing for Zena's discharge) could antagonize her which could result in Zena having to do her ten year prison sentence. The program did not appear to be considering a mediation process, both between the girls and with all the residents around being safe and appreciating change in someone.

ZENA'S NEEDS (age 17)

- To successfully avoid doing additional prison time
- To continue to improve her communication with her mother without feeling pressured that she has to live with her mother again or disloyal if she decides to live independently
- To set realistic academic and employment goals and have guidance in how to achieve them
- To make a specific plan for a transition to independent living, develop confidence in her ability to live on her own, and have continuing support
- To make peace with the loss of her father, unavailability of her mother, and her anger about the abuse she was exposed to

- By putting the maltreatment of the past behind her, learn how to express her anger effectively at present provocations
- To learn self-talk to reduce her hopelessness and depression
- To continue the process of defining her sexual values: What are the characteristics of the partner she wants; What kind of a partner does she want to be? What worries does she have about being an abuser or being abused? What does learning from the past mean specifically about her behavior in the future and setting up a safe way to practice having a non-abusive romantic relationship?
- To learn how to live with being on the registry, and what she wants to say to people who ask or ridicule her about it
- To improve her self-esteem by getting to her desired weight (maybe in part through a swimming program) and getting rid of her acne

ENDNOTES

¹ CORE Associates and the Connecticut Judicial Branch Court Support Services Division (CSSD) collaborated to create a gender-specific detention system at Washington Street Girls Juvenile Detention Center in 2004. CORE provided training and technical assistance to develop and maintain a gender-specific milieu. Successes include: significant reductions in injury of staff and clients; significant reductions in client restraints and elimination of the use of mechanical restraints; elimination of the use of room time as a behavioral intervention or sanction; significant reductions in incidents of physical and relational aggression between clients and accompanying increases in supportive client-client interactions; improved staff member attitudes regarding work with girls, improved staff member knowledge regarding gender-specific programming and approaches, and improved staff member interactions with clients (e.g., consistent utilization of relational and strengths-based approaches); improved staff member perception of physical and emotional safety; improved client perception of physical and emotional safety; and improved client engagement in services and the milieu.

It should be pointed out that Washington Street detention uses the state detention facilities as a back-up for girls that are extremely aggressive.

² “Traditional behavior management approaches often unwittingly emphasize program compliance without elucidating the application of success in those systems to life success. They may also foster blind compliance rather than the internalized effective decision making processes essential for female clients...Level systems, specifically those that rely on the giving and taking away of points, are widely criticized throughout the literature on gender-specific programming for females. By nature, the systems encourage competition, are status-driven and subjective. Girls are not motivated to ‘buy-in’ to the level systems, and the systems ultimately do not ‘modify behavior’ for females, but instead allow females to self-victimize by sabotaging opportunities for success...Implementing a gender-specific *behavior motivation approach* for girls at any program requires...[that] all staff understand/ embrace an overall gender-specific approach – one that creates a safe, therapeutic and productive program culture every day, and one that facilitates successful client self-management. A gender-specific behavior motivation approach for females must be relational, strengths-based, trauma-informed, holistic and culturally competent in its orientation, and flexible enough to meet individual client needs.” (Benedict, 2003, *Creating a Gender Responsive Justice System for Girls in the State of Rhode Island*)

The CORE Behavior Motivation Approaches for Girls are: prioritize physical and emotional safety, and utilize an expanded definition of safety that includes physical AND psychological/emotional; emphasize individual safety first, then safety with others/ community; are relationship-based, strengths-based, trauma-informed, holistic, and culturally competent; utilize gender- and culturally-specific motivators (relationships, responsibilities, relevant privileges); emphasize females’ increasing access to relationships, responsibilities and relevant privileges (circular) as they demonstrate safe, responsible and effective behaviors; allow girls to safely exercise power and control (girls have voice and choice); emphasize individual, relational and community learning; emphasize acts of discipline (acts of teaching), not punishment (acts that temporarily suppress behaviors; are affirmation-focused;

include components that are relevant to real life, where possible, and prepare girls for real life (avoidance of points); focus on earning, not losing; avoid use of words such as “positive,” “negative,” “good,” “bad,” “appropriate,” and “inappropriate” to describe behavior and instead use descriptive, specific phraseology and words such as “safe,” “effective,” “supportive,” and “readiness;” and de-emphasize status, hierarchy (e.g., levels). CORE Behavior Management Pamphlet, 2005.

³ TARGET and Voices are two approaches to trauma treatment in Connecticut. CORE worked with Dr. Julian Ford and Dr. Geraldine Pearson of the University of Connecticut Health Center Department of Psychiatry to combine the CORE and TARGET models ([which] “draw from the same theoretical and conceptual philosophy that an optimal approach to service delivery includes relational, strengths-based, empowering and trauma-informed practices...the *CORE Cultural Safety Tools* emphasize the intentional creation of a safe, gender-specific milieu while the TARGET model emphasizes teaching clients skills that will help them to create safety for themselves...TARGET is a strengths-based, present-centered, biopsychosocial approach to teaching trauma survivors self-regulation skills. It teaches a simple sequence of practical skills to enable trauma survivors from a variety of backgrounds and skill levels to safely process current stressful experiences. This can be accomplished without avoidance, hypervigilance, decompensation or acute crisis, and with control over emotional self-regulation and relational engagement. These skills result in reduced frequency of high risk and violent behaviors by girls and improved staff sense of hope and efficacy in empowering girls by helping them understand, recognize and overcome the effects of trauma.”

Voices, a program of self-discovery and empowerment for girls, by Stephanie Covington is a group therapy program used at CCP to help girls look at themselves and their pasts, learn about power and control, explore feelings, friends and family, stress, making good decisions and thinking about the future.

⁴ Based on a review of the educational records of 27 children, the Hartford Truancy Court Prevention Program (Center for Children’s Advocacy report, April, 2005) found that children with truancy problems were disproportionately Hispanic (81%), with more than three times as many Hispanic females (77%) as males (23%); have received bilingual services (63%) that terminated or transitioned to LTSS prior to Grade 7; showed patterns of absenteeism as early as kindergarten and first grade (37%); were retained or promoted by exception at least once (93%); and/or demonstrated significant academic delays that were never evaluated (30%). Nearly three-quarters of the truants were girls. The individual cases studied demonstrated a failure to assess the strengths and weaknesses of the children’s learning and to develop compensatory strategies for expressive language difficulties, processing problems, memory and organizational problems, attentional weaknesses, visual motor deficits and social skills weaknesses. These learning disabilities should have warranted experiential, hands-on, multimedia instruction. Some children received bilingual special education, only to be exited at Grade 4 when language and performance expectations were increasing.

⁵ In an *amici curiae* brief in *Roper v. Simmons* (the United States Supreme Court 2005 opinion against the death penalty for juveniles), the American Medical Association and

the American Academy of Child and Adolescent Psychiatry (with other organizations) distinguished the brain development and maturity of 17-year olds from adults: “Older adolescents behave differently than adults because their minds operate differently, their emotions are more volatile and their brains are anatomically immature...These behavioral differences are pervasive and scientifically documented... Their judgments, thought patterns, and emotions are different from adults, and their brains are physiologically underdeveloped in the areas that control impulses, foresee consequences, and temper emotions. They handle information processing and the management of emotions differently from adults... Brain studies establish an anatomical basis for adolescent behavior. Adolescents’ behavioral immaturity mirrors the anatomical immaturity of their brains. To a degree never before understood, scientists can now demonstrate that adolescents are immature, not only to the observer’s naked eyes, but in the very fibers of their brains...First, adolescents rely for certain tasks, more than adults, on the amygdala, the area of the brain associated with primitive impulses of aggression, anger, and fear. Adults, on the other hand, tend to process similar information through the frontal cortex, a cerebral area associated with impulse control and good judgment. Second, the regions of the brain associated with impulse control, risk assessment, and moral reasoning develop last, after late adolescence...as teenagers grow into adults, they increasingly shift the overall focus of brain activity to the frontal lobes...[responsible for] decision making, risk assessment, ability to judge future consequences, evaluating reward and punishment, behavioral inhibition, impulse control...and making moral judgments. Adolescents are inherently more prone to risk-taking behavior and less capable of resisting impulses...Adolescents as a group are risk takers [and] ... exhibit a disproportionate amount of reckless behavior, sensation seeking and risk taking...it is statistically aberrant to refrain from such [risk-taking] behavior during adolescence. In short, teenagers are prone to making bad judgments. Cognitive experts have shown that the difference between teenage and adult behavior is not the adolescent’s inability to distinguish right from wrong... Rather, the difference lies in what scientists have characterized as deficiencies in the way adolescents think, an inability to perceive and weigh risks and benefits accurately... Adolescents score lower on measures of self-reliance and other aspects of personal responsibility, they have more difficulty seeing things in long-term perspective, they are less likely to look at things from the perspective of others, and they have more difficulty restraining their aggressive impulses. Researchers have found that the deficiencies in the adolescent mind and emotional and social development are especially pronounced when other factors—such as stress, emotions and peer pressure—enter the equation. These factors affect everyone’s cognitive functioning, but they operate on the adolescent differently and with special force. The interplay among stress, emotions and cognition in teenagers is particularly complex—and different from adults. Stress affects cognitive abilities, including the ability to weigh costs and benefits and override impulses with rational thought. But adolescents are more susceptible to stress from daily events than adults, which translates into further distortions of the already skewed cost-benefit analysis...The typical adolescent is also more vulnerable to peer pressure than an adult...Adolescents spend twice as much time with peers as with adults. The pronounced importance of approval and acceptance by friends will make an

already risk-prone or impulsive adolescent even more so. Adolescents not only are more susceptible to peer pressure, but they gravitate toward peers who reinforce their own predilections...an adolescent who spends time with risk-prone friends is more likely to engage in risky behavior. Normal adolescents cannot be expected to operate with the level of maturity, judgment, risk aversion or impulse control of an adult... an adolescent who has suffered brain trauma, a dysfunctional family life, violence, or abuse cannot be presumed to operate even at standard levels for adolescents.” (pp. 4-20; citations omitted).

⁶ The federal Office of Juvenile Justice and Delinquency Prevention’s program information is not girl-specific: OJJDP Model Programs Guide (an online database of evidence-based successes in delinquency prevention and intervention which can be searched for girls’ programs; http://www.dsgonline.com/mpg2.5/mpg_index.htm). It lists no residential programs for girls (Girls and Boys Town, Mendota Juvenile Treatment Center, Phoenix House, and VisionQuest are residential programs cited for both females and males). Relevant prevention programs listed include Urban Women Against Substance Abuse (UWASA, a school-based program targeting Puerto Rican, Latina, African-American, and Caribbean-American girls (ages 9–11), and their female caregivers, and the Girls’ Circle, a structured support group for girls ages 9–18 that integrates relational–cultural theory (RCT), resiliency practices, and skills training

OJJDP publications are outdated (available at www.ojjdp.ncjrs.org/pubs):

Guiding Principles for Promising Female Programming: An Inventory of Best Practices, 1998. Reviews studies on at-risk girls and presents effective gender-specific programming strategies for girls, within the juvenile justice system and in the community.

Juvenile Female Offenders: A Status of the States, 1998. Describes state efforts to develop and implement programs and policies to address issues related to female juvenile offenders and female juveniles at risk of delinquency and status offenses.

What About Girls? 1998. Discusses OJJDP’s approach to the needs of juvenile female offenders and at-risk girls.

Female Offenders in the Juvenile Justice System: Statistics Summary, 1996.

Analyzes patterns in the arrests, judicial management, and correctional placement of female juvenile offenders and notes that females are entering the juvenile justice system more often and at younger ages than in past years.

In part to update these documents, last year OJJDP funded the Girls’ Study Group (GSG) at the Research Triangle to report on patterns of girls’ delinquency, risk and protective factors, and gaps in research and to assist in disseminating effective service models. CSG has done the literature review and three OJJDP bulletins are pending. They are working on secondary analyses of major datasets, both longitudinal and cross-sectional. Next year they plan to complete a comprehensive database of programs developed specifically for girls; as of summer 2005, GSG had catalogued 43 girls’ programs. CSG will select at least three model programs and provide training/technical assistance in implementing them. They are also reviewing screening and assessment tools to determine their applicability to girls.

OJJDP funded a training curriculum, Gender Responsive Programming for Girls, in 2005 (<http://jabg.nttac.org/curriculum/gender.cfm>). Another curriculum, Managing and

Supervising Justice-Involved Girls, was released by the National Center for Mental Health and Juvenile Justice (<http://www.ncmhjj.com/training/default.asp>).

The National Criminal Justice Reference Service also has available the following publications: Female Delinquency and the Juvenile Justice System: Delinquency Among Girls, University of Nevada-Las Vegas, 2004; Mental Health and Girls in the Juvenile Justice System, National Mental Health Association, 2003; Profile of the Female Juvenile Offender, Virginia Commission on Youth, 2002; and Adolescent Girls: The Role of Depression in the Development of Delinquency, National Institute of Justice, 1999.

The Child Welfare League of America published Girls in the Juvenile Justice System: The Need for More Gender-Responsive Policies (2004).

⁷ The high rate of incarceration of girls for status offenses in Connecticut has been documented. In calendar year 1999, 3,530 of the 10,435 juveniles with court cases disposed were girls. Court-involved girls in Connecticut were referred to court for the first time at age 13 or 14, first referred for Families with Services Needs (FWSN)- 37% or a minor misdemeanor-38%. Almost of fifth of girls spent more than 30 days in detention. Most girls in detention (83%) and most girls at Long Lane (88%) had a history of FWSN referrals; 79% of girls were sent to Long Lane for public order offenses. Lyon, Eleanor and Robin Spath, "Court Involved Girls in Connecticut, University of Connecticut School of Social Work, March 2002. CSSD and DCF are collaborating on diversion programs for FWSN girls and their families to access respite beds, with voluntary services, with the goal of diverting status offenders out of court and detention. Nevertheless, court-ordered evaluations of status offenders continue to recommend locked placement, with a control or punishment perspective rather than a strengths/needs-based approach to individualizing services. In addition, it remains a serious concern that Latinas and African-America girls are overrepresented in programs in comparison to their percentage in the child population in Connecticut.

⁸ The design of services to build on strengths and meet needs must be culturally competent, with particular attention to Latinas and African American girls. There are sharp differences in self-esteem among girls from different racial and ethnic groups. African American girls have higher self-esteem than other girls, except in areas related to school, and have higher athletic and social self-concepts and more satisfied with their appearance. Latinas experience the biggest drop in self-esteem, after starting with the highest levels. Latinas and Caucasian girls are more likely to engage in risky behaviors than African American girls. Latinas have high rates of suicide and substance abuse, and greater acculturation among Latinas is tied to school dropout and pregnancy. In describing how to "cultivate hardiness" in girls, the authors comment, "Connection to parents, significant adults, school and perhaps some greater sense of purpose... fosters resilience. A dilemma of connection, a forced choice between competing loyalties, is often what girls face. What connection means for a girl is far more complex than providing her with a mentor. ... This suggests a need for a new concept of health and stress resistance that locates the struggle between a girl and her world, and that holds the adults in girls' environments accountable." Johnson, Norine, Roberts, Michael, and Judith Worell, Beyond Appearance: A new Look at Adolescent Girls, Washington, D.C.: American Psychological Association, 1999.

“Racism and sexism are pervasive forces in the lives of African American adolescent girls. Yet, many African American girls create healthy self-concepts and thrive...How do African American girls mediate demeaning and exclusionary societal messages? How might helping professionals, educators, and parents recognize culturally sanctioned resiliency strategies used by African American girls in this navigation process as being normative developmental aspects of socialization influenced by the interaction of gender, race, ethnicity, and social class?” The authors recommend: “Seek to understand the importance of racial identity and racial socialization as a central aspect of social identity development. African American girls will need to determine for themselves what it means to be African American and the value they place on that meaning. This exploration will require a knowledgeable guide...Notice how behaviors typically labeled as "resistant" might in fact be better conceptualized as adaptive responses to high-risk environments...In the minds of some African American adolescent girls, educational systems function more like educational hospices (i.e., places where, because of limited or no expectations for them, they simply go to die spiritually, academically, and emotionally) rather than learning centers.” Jo-Ann Lipford Sanders and Carla Bradley, *Multiple-Lens Paradigm Evaluating African American Girls and their Development*. Journal of Counseling and Development, Vol. 83, 2005. “Because of the demands placed on the daughter in acculturating to a dominant culture that presents definitions of women's roles different from those familiar to the immigrant Hispanic mother, the mother's capacity to mentor her daughter also may be strained. As the Hispanic female adolescent struggles to have her mother or mother surrogate see her for who she is and not for what her mother assumes she is, conflicts emerge. The mother--daughter struggle between self-affirmation and acquiescence and between original culture and new culture, and connection create a relational breach. This dilemma rests on the mother's ambivalence (that is, daughter's desire for autonomy threatens cultural and family ties and reminds mother of her own situation) and daughter's ambivalence and distress (that is, connection to mother means a loss of her own "voice," but to disconnect means a loss of the mutuality that is buttressed by the powerful cultural emphasis on familism.” Gonzalez-Ramos, Gladys, Kaplan, Carol, Romano, Kathleen, Turner, Sandra and Luis H. Zayas, *Understanding Suicide Attempts by Adolescent Hispanic Females*. Social Work, Vol. 45, 2000.

⁹ Allan Schore has written about therapy with traumatized children as a process of treating the right brain which has been affected by early relational trauma. He reports that dysregulation of the right brain is a fundamental mechanism of traumatic attachment and stress responses and that relational trauma causes severe states of threat, leading to hyperarousal and dissociation. He points out that processing physical and emotional pain is right brain activity. He emphasizes that therapy for traumatized children is “not what to say to the child, but how to be with the child who has experienced attachment trauma and utilizes defensive pathological dissociation. This is not teaching coping skills, but teaching how to be, especially in moments of stress. Attuning into the child’s state is necessary to help regulate it.” Being with a girl in her angry, hopeless state is painful for the therapist. Schore criticizes the evidence-based practice movement for ignoring the universal aspects of therapeutic process: over half the beneficial effects of psychotherapy are linked to the quality of therapeutic alliance, regardless of treatment method. Schore, Allan, Affect

Regulation and the Repair of the Self, 2003. “The number and extent of the losses that these children have experienced are frequently not recognized by others and often unacknowledged even by the children. At times the children have the cognitive awareness of their losses, but the affect is disconnected...One way to conceptualize therapy with these children is to think of it as helping them to regain their voices...When the repeated losses of children are not adequately responded to, and their grief is unsupported or not recognized, the losses lead to anger and ultimately rage...It is difficult for therapists to witness and accompany children through the deep rage and profound sorrow...when they confront the traumatic events of their young lives...unless such in-depth emotional processing and working through are undertaken, the cycle of violence cannot be broken. Anger management alone does not reach the level of the complicated emotional process...’anger management’ as the term implies helps children to manage their anger—but it does little for the profound unmourned losses...” p. 186 in Webb, Nancy, Working with Traumatized Youth in Child Welfare. New York: Guilford, 2005. Webb indicates that some approaches to trauma treatment require training “beyond the usual preparation of masters-level clinicians. In addition, important tensions among clinicians impact on treatment selection: the tension between empirically supported treatment and other therapies; the polarization between supporters of psychotherapy and advocates of pharmacotherapy in the treatment of traumatized children; and the lack of adequate attention to the impact of racial and cultural factors in the assessment and treatment of trauma. Some professionals in the trauma field maintain that there have not been enough empirically supported studies completed to date to select one method for treating traumatized children, and some other apparently effective methods have not been studied in controlled outcome research. Culturally diverse children and adolescents are frequently misdiagnosed and improperly treated because of a lack of understanding of cultural differences. Children in foster care constitute a substantial and underserved pool of child trauma cases and more than half these children are from minority groups.” She goes on to describe Eye Movement Desensitization and Reprocessing, Play/Art and other expressive therapies, and animal-assisted therapies that have been successful with traumatized children. Webb, Nancy Boyd, Working with Traumatized Youth in Child Welfare. New York: Guilford, 2005. One of the trauma treatment approaches in the SAMHSA website for evidence-based services is Judith Cohen’s 16-session parallel groups of children and parents, with some joint session, including stress inoculation methods (such as relaxation, thought stopping, cognitive coping, and increasing a sense of safety), gradual discussion of trauma without negative emotions of terror and rage, and cognitive processing of thoughts about the trauma, including correcting inaccurate cognitions (www.modelprograms.samhsa.gov). Included in helping girls face their feelings of being hurt in the past is making them aware of and reducing relational aggression. Crick et.al. conclude that relational aggression in girls has harmful short- and long-term effects on both perpetrator and victim and begins much earlier than originally assumed. Being the victim of relational aggression is associated with significant adjustment problems, including depressive symptoms, social anxiety, loneliness, peer rejection and externalizing difficulties. Relationally aggressive children are at risk of adjustment problems, including peer rejection, internalizing difficulties, and externalizing problems. Relational aggression is the most frequent form of aggression exhibited by siblings toward each other, and may be learned within the family, pp. 71-89 in Putallas, Martha and Karen Bierman, eds. Aggression,

Antisocial Behavior and Violence Among Girls. New York: Guilford Press, 2004. See also, Ford, Julian, "Traumatic Victimization in Childhood and Persistent Problems with Oppositional-Defiance," in Greenwald, Ricky (ed.), Trauma and Juvenile Delinquency. New York: Haworth, 2002.

¹⁰ The Willie M. Program in North Carolina "reduced the assaultive behavior...in children who no one wanted and who were often on the verge of incarceration because of the fear that they would trample their home neighborhoods, were indeed able to be maintained in least restrictive settings. Furthermore, the residential restrictiveness score for children in the program decreased over time, indicating that they were being moved gradually toward less restrictiveness.

The child-centeredness of the Willie M. Program fostered innovation in services planning and delivery. One of the innovations was the wide-scale use of paraprofessionals in treatment, as mentors and case managers under the supervision of more experienced and credentialed professionals...The Willie M. Program utilized this concept because those paraprofessionals provided the best treatment. Other innovations include the delivery of services in home and school contexts, the development of novel models of residential care such as small group homes and therapeutic foster care, and the focus on training children in problem-solving skills, especially while they are in the middle of emotion-filled situations.

The Willie M. Program took ownership of children that nobody else wanted. These are the children who generate trouble for others rather than seeming to be the victims of trouble, although the reality is that their traumatic early lives makes their sympathetic plight obvious. Previously, these children had been expelled from school and rejected by the educational system, turned down by the mental health system as 'untreatable,' and labeled by the corrections system as 'incorrigible.' With the Willie M. Program, the education, mental health, and corrections systems came to own these children.

The Willie M. Program created a new approach to treatment, one that is child centered rather than service centered. [It was a] revolutionary approach to the treatment philosophy for violent youth. This approach is more holistic and less compartmentalized than its predecessors, more developmental and educational and less psychiatric, and oriented more toward building competence and less oriented toward rectifying deficits... skills that range broadly from social problem-solving to piano playing...are necessary to competent behavior and fend off the risks that these children constantly face. Nothing defeats the hopelessness that a physically abused child faces every night as he or she goes to sleep like the feeling of self-pride in genuine competence...Another indicator of this new approach is the location of the treatment programs that are directed toward children. Treatment occurs less frequently in the psychiatrist's office and more frequently in the home, on the playground, in the school classroom, or among a group of peers. The essence of this new approach is that it is child centered rather than service centered. Old approaches started with services and then found children to receive them. And, of course, 'if you build it [a service], they will come,' so these services had been delivered at capacity. The new approach starts with the individual child. If one starts with the individual child, new types of services can be envisioned and then developed to meet the needs of that child. The result is a highly individualized set of services for a particular child, aimed precisely at helping that child. The services are molded to meet the requirements of the child, rather than the

traditional pattern in which the child would have to be molded first, before treatment could begin... Once the child is included in treatment planning, it is natural to build a program for that child that is oriented toward enhancing strengths rather than driving away deficits. Once the family is included in treatment planning, it is natural to build a program that includes scaffolding a child with protective factors, such as finding employment for a father, securing family safety by finding a new residence in a less violent neighborhood, enhancing parenting skills, or finding a place in an after-school program... Yet another consequence of placing the child at the center of treatment planning is that one will readily adopt the 'no-eject, no-reject' policy that characterized the Willie M. Program. Previously, treatment programs would reject a child from participation if the child could not behave well enough to maintain order or if the child did not attend sessions regularly... By placing stringent criteria on a child before that child could be eligible to participate, treatment programs were precluding the possibility of change in the most hopeless of child cases. In contrast, the new perspective on treatment is that a child's inability to behave himself in school or her frequent tardiness and absenteeism is actually the phenomenon that needs to be addressed in treatment! The treatment provider needs to find a way to reach that child, in spite of, or even because of, the problematic behavior." Dodge, Kenneth, Kupersmidt, Janis and Reid Fontaine, Willie M.: A Legacy of Legal, Social and Policy Change on Behalf of Children. Duke University Center for Child and Family Policy

¹¹ Intensive home-based services are a well-established intervention designed to meet the girl's needs in her relative's home or foster or adoptive home and in the community where she lives. The planning and provision of intensive home-based services require an individualized process that focuses on the strengths and needs of the girl and the importance of the family in supporting her. Intensive home-based services incorporate several discrete clinical interventions, including, at a minimum, comprehensive strength-based assessment, crisis services, clinical case management, family teams, and individualized supports including clinically trained one-on-one coaches. These services must be provided in a flexible manner with sufficient duration, intensity, and frequency to address her needs and guide her caregivers. Intensive home-based services describes an individualized child-focused, family-centered approach that is offered by a range of providers and is not limited to wraparound, multisystemic therapy, or multidimensional treatment foster care programs.

¹² Massachusetts received a Robert Wood Johnson demonstration grant in the mid-1990s to develop MHSPY for children at risk of out-of-home placement or in placement ready for return to the community. MHSPY is co-funded by the Departments of Education, Mental Health, Social Services and Youth Services as well as by local school districts. MHSPY provides clinical services, including individual coaches, as well as non-clinical services and supports (all the standard Medicaid benefits and non-traditional services such as respite care for families, tutors, parent aides, transportation, and mentors). The average cost in 2001 of \$39,403 (coverage for inpatient, outpatient, medication, residential and medical services) was about one-third of what the average child living out of home in Massachusetts cost for placement alone (in excess of \$80,000 to \$100,000). MHSPY

reported reducing residential treatment days in half and foster care days from 1327 days to 317 days.

¹³ In July, 2005, at an OJJDP research and evaluation conference, Margaret A. Zahn, a principal investigator from the Girls Study Group, reported that: “Girls who are sexually assaulted and who experience early puberty are more likely to engage in physically aggressive acts. Being successful in school moderate[s] the impact of sexual assault on subsequent physical aggression.”

“Schools are often unprepared to provide the safe and nurturing environments that traumatized children need, and also are unable to engage resistant or stressed parents. Because the need for attentiveness to the social and psychological needs of children is increasingly being overlooked in the current environment of curricular accountability, the school environment may introduce additional stress rather than providing a respite and resource for children.” p. 87 in Webb, Nancy Boyd, Working with Traumatized Youth in Child Welfare.

¹⁴ See Burns, Barbara and Kimberly Hoagwood, Community Treatment for Youth. New York: Oxford University Press, 2002.

¹⁵ Wayside Youth and Family Support Network, in Framingham, Massachusetts (www.waysideyouth.org) provides a spectrum of care, including residential programs, home-based outreach services, substance abuse treatment, prevention programs, trauma intervention services, and teen parent programs. A full-time Wayside staff person is located in the DSS office and convenes family meetings which can lead to “super-intensive” (up to 20 hours/week) home-based services. Wayside Esperanza Family Based Residential Team is a short-term highly intensive blend of home based services with residential placement. Wayside Family Works offers intensive community-based programs specializing in solution focused interventions for individuals and families to increase stability and problem solving skills. Wayside’s small Family-Based Residential Program serves adolescents from DSS who previously would have been hospitalized; it is a 30-day stay in an eight-bed group home followed by 90 days of intensive home-based services at home. Wayside also designed a small Transitional Residential Service in order to keep a child in the home with the structure and daily services similar to a residential program. They indicate that many children could be kept out of psychiatric hospitals and most residential placements could be avoided by TRS which is more effective than traditional therapeutic foster homes for children whose behavior problems are likely to be associated with multiple placements.

¹⁶ For example, see Making Child Welfare Work. Washington, D.C.: Bazelon Center for Mental Health Law, 1998.