

Voice, Choice & Hope



Juvenile Justice Consensus Document

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Juvenile Justice Consensus At-A-Glance

<p>Consensus Principles</p>	<ul style="list-style-type: none"> ➤ Smaller, regionalized, secure, state-run facilities focused on education, treatment, life/social skills, employment, and transition into the community ➤ Community services must start in the out-of-home placement and be bridged when children are released into the community ➤ Expand community supports before creating new facilities ➤ Pilot community services; determine effectiveness before implementing statewide ➤ Build trust with communities by putting in the community supports first and preparing the community for the children placed there ➤ Focus on literacy ➤ Case management built on relational model
<p>Points of Consensus</p>	<p>Juvenile Justice Consensus Group Recommendations</p>
<p>Community Based Services</p>	<ul style="list-style-type: none"> ➤ Intensive in-home adolescent psychiatric services should be developed that use current IICAPS model ➤ Develop pilot in one region to determine effectiveness of the model ➤ Develop flex funds ➤ Expand Systems of Care
<p>Residential Services</p>	<ul style="list-style-type: none"> ➤ Secure Facilities -- estimated need for secure beds is 72 to 84 ➤ Smaller Facilities -- each TREC should not be larger than 24 beds ➤ Regionalized Facilities -- develop 3 to 4 state-run TRECS located near Hartford, Bridgeport and New Haven (if there is a 4th TREC, locate in Waterbury) ➤ Stronger focus on reintegration back into community
<p>Continuum of Care</p>	<ul style="list-style-type: none"> ➤ Expand the Development of Step-Down Residences ➤ Develop Therapeutic Foster Care Slots Using the MTFC Model ➤ Develop Respite Care
<p>Educational Enhancement</p>	<ul style="list-style-type: none"> ➤ Develop stronger linkages to LEAs (local school districts) ➤ Create Educational Advocates who are on-site at the school to further educational success ➤ Better access to Systems of Care

Participants (see Appendix A for listing of abbreviations)

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Governor's Charge

In response to Governor M. Jodi Rell's decision to close the Connecticut Juvenile Training School (CJTS) by 2008, the Department of Children and Families (DCF) convened a group of over 50 stakeholders to map out a proposal for secure treatment facilities, continuum of care and community based services that will need to be provided to the boys who would otherwise have resided at CJTS. The strongest area of agreement was that community based services for these boys, both while they are in secure treatment, in transition and return to their homes and communities, would need significant enhancement to result in strong, productive boys and healthy, safer communities. The group agrees that focusing earlier on re-entry or reintegration planning would result in less long-term expense, by decreasing both the financial cost of residential treatment and the human cost of recidivism.

Voice, Choice and Hope

The group agreed that children in the juvenile justice system and their families need a voice, they need choice in the type of care they will receive and they need hope in order to move forward in their reintegration back to the community. Children who are committed to DCF as delinquents or FWSNs must be seen as

individuals with specific needs and wishes. We must recognize that these children come from families and communities. We must strive to support children who are ready to thrive in communities that offer safe and welcome places for the children to return. Children must leave the juvenile justice system with the strength to use their own voices, with realistic choices for education and careers and the hope for a better future.

“The group agreed that children and families...need voice, choice and hope for a better future.”

Working Assumptions

The group discussions were based on the following working assumptions:

1. When CJTS closes in 2008, appropriate residential settings are needed for those children who would have resided at CJTS.
2. Boys as well as girls who are committed to DCF must have appropriate residential settings in the least restrictive environment while assuring public safety.
3. A wider array of community based services is needed for boys and girls committed to DCF as delinquent or FWSN.
4. Communities must be involved in the planning and design of community and residential services. All services must focus on the child's return to a community and a family. All family resources must be explored and services should be centered on the family.

Statement of Need

There has been a growing concern about the efficacy of CJTS as the site for boys committed to DCF by the courts on delinquency charges. CJTS and many other large facilities for young offenders across the U.S. have come under criticism. The need for a widely agreed upon map for the future is imperative. According to Zavlek (OJJDP, August 2005), “most youth housed in today's large, secure juvenile facilities do not require the level of security these facilities were created to provide. Furthermore, research suggests that simply “locking kids up” in such facilities are an ineffective and unnecessarily expensive approach to helping troubled youth and reducing juvenile crime.” Research continues to indicate that smaller, community based or regional facilities can provide secure confinement economically and with the best possible outcomes for the youth involved. Zavlek, conducting research throughout the nation, concluded, “For each youth who comes to the attention of the juvenile justice system, the best response is the least restrictive one that meets the needs of the youth and the community.” While the juvenile crime arrest rate has declined dramatically in the past 20 years, there has not been a concomitant decline in juvenile confinement, which has been the case in Connecticut as well.

Consensus Principles

- Before constructing new facilities, community supports must be in place in the cities from which most CJTS residents hail.

- DCF and its partners should create pilots in community service to determine whether the model piloted is effective before implementing the services statewide.
- DCF and its partners must build trust with communities by putting in the community supports first and preparing the community for the children that would be placed there in the future.
- The TRECs (Training Rehabilitation and Education Centers) should focus on education, treatment, life/social skills, employment and reintegration.
- Community services must start in the out-of-home placement and be bridged when the child is released into the community.
- There must be a focus on literacy.
- All case management work must be built on a relational model.

Points of Consensus

1. Community Based Services

The group was extremely clear that, “before a shovel is put into the ground” current community based services would be enhanced and a comprehensive community based service system would be developed for children in the juvenile justice system committed to DCF. They also agreed that Connecticut should pilot community based services in one region to determine effectiveness of the model before implementing statewide. The group agreed that, because of our

“...before a shovel is put into the ground... community services must be enhanced and...developed...”

challenges in the past, we must build trust with communities by putting in the community supports first and preparing the community for the children that would eventually be living there. We must build partnerships with a child’s home community in order to foster mutual trust. We must build effective programs to support reintegration back into the community. These services would involve strong partnerships between providers (both public and private) and families. There would be stronger service integration utilizing an interdisciplinary approach and recognizing natural supports. There would be more emphasis on building the capacity of local resources, agencies and organizations to successfully support and nurture children and families. The group strongly supported a wraparound approach to intensive in-home clinical services with strong emphasis on care coordinators and flex funds, educational advocates who would work with students transitioning back to Local Educational Agencies (LEAs) from residential treatment, access to Systems of Care and natural supports, strong mentoring services, respite care, continuity for 16-18 year olds, and case management assistance with health care, employment, housing and transportation issues. Communities must recognize that, when properly supported, these children are capable of successful reintegration. Municipalities and LEAs must assist in providing positive environments for the returning students.

2. Residential – Regionalized Secure Facilities

The group agreed there was a need for gender-specific facilities, which would focus on reintegration. After an analysis of the most current research on needs

and population forecasts, the group agreed that a total of 72-84 beds are needed for boys. Following the national model, the regionalized, smaller, secure, state-operated facilities will be known as **TRECs** (Treatment Rehabilitation and Education Centers) and will have no more than 24 beds in each of 3-4 facilities, depending on geographic need. Community and family participation are critical to the success of a facility in a particular region through community education sessions and ongoing community conversations. These will be located in the following geographic regions: Hartford, Bridgeport, New Haven and possibly Waterbury (if needed). Each TREC would house a:

- School
- Clinical Services
- Rehabilitation Services
- Secure Residence
- Recreation Areas

TREC programming (see Appendix B for a more expanded discussion of the Program Model) will be integrally connected with community based services and will consist of:

A
TREC
is a
Training,
Rehabilitation
and
Education
Center
which is
regionalized,
smaller,
secure and
has
a
focus
on
successful
reintegration.

- **EDUCATIONAL SERVICES** on-site and partnering with LEA when appropriate, including full academic classes for seven (7) hours per day and vocational education after school and resident life skills;
- **EMPLOYMENT OPPORTUNITIES**, including positive peer culture, balanced and restorative justice and recreational activities tied to pro-social skill development;
- **CLINICAL TREATMENT**, including individualized and family therapy, substance abuse and aggression replacement therapy;
- **FAMILY INVOLVEMENT**, including support, transportation and therapy for family members;
- **REINTEGRATION SERVICES**, including housing and development of natural and professional supports for pro-social successful community re-entry;
- **CASE MANAGEMENT**, built on the relational model, including an individual who continues to work with the student in school and at home after leaving the regional facility; and
- **QUALITY IMPROVEMENT**, including measurable outcomes and consumer feedback toward continual improvement.

3. Continuum of Care

While the TRECs and community based services offer a tremendous enhancement to existing services, additional levels of care need to include residential placements for children who need alternatives, such as therapeutic foster care and therapeutic group homes that offer family-style settings. Reentry or reintegration planning must recognize that children will need different levels of care once the need for secure confinement is resolved. The continuum of care

should include step-down programs for children who have families but are not ready to be reunified, therapeutic foster and group homes for children who cannot return to their families and support for families where children return home.

4. Educational Enhancements

While many (approximately 60%) of the current residents at CJTS are considered parole violators, many of them are also children who have been expelled from their local schools. Without enhancing educational supports, these children will continue to populate the juvenile justice system. The group was overwhelmingly concerned that educational linkages to LEAs, including educational advocates, who will work with students transitioning back to LEAs from residential treatment and access to Systems of Care for those with psychiatric diagnoses, are paramount to success and to a reduction in recidivism.

Girls Services

The group was also concerned about gender-specific services for girls. An independent audit by Dr. Marty Beyer, whose report was issued late for discussion in this group, recommended that no new facilities be built but to expand community supports and the continuum of care for girls. Further discussion is needed on the issue of secure beds for girls.

Costs

Current research indicates that smaller, community based facilities for housing the relatively few juvenile offenders who require a secure, structured setting is the most cost-effective. Costs for community based services vary according to the type and intensity of the service provided. Actual costs will be determined as the model is developed.

Summary

In order to develop a future with **voice, choice and hope** for the children in Connecticut's juvenile justice system who are committed to DCF and their families, the group's consensus is that the cornerstone would be the development of a pilot for community based services. Community based planning (with the involvement of DCF, community agencies, LEAs, other state agencies and families) should begin soon in each region that is chosen to house one of the TRECs. Such effective services would be far less costly than CJTS and far more successful in keeping children out of residential facilities. The smaller, regionalized TRECs would measurably impact the way in which families and providers connect with children from their particular region of the State. Programming enhancements strengthen families and children's abilities to learn new skills, acquire needed services and function more positively in their own advancement. DCF supports the Governor's leadership in implementing these recommendations and looks forward to the upcoming deliberations in the General Assembly on these timely and important matters.

Appendix A: Abbreviations

AFCAMP	African-American Parents of Children with Disabilities
BPS	Bridgeport Public Schools
CEUI	Connecticut Employees Union Independent
CCA	Center for Children’s Advocacy
CJR	Connecticut Junior Republic
CJJA	Connecticut Juvenile Justice Alliance
CJTS	Connecticut Juvenile Training School
CSEA	Connecticut State Employees Association
CSI	Community Solutions, Inc.
CSSD	Court Support Services Division
DCF	Department of Children and Families
DOC	Department of Correction
DOL	Connecticut Department of Labor
DPW	Department of Public Works
DSS	Department of Social Services
FWSN	Families With Service Needs
HPS	Hartford Public Schools
LEA	Local Educational Agency (School System)
MSJ	Mount Saint John
NPS	Norwalk Public Schools
NHPS	New Haven Public Schools
OCA	Office of the Child Advocate
OJJDP	Office of Juvenile Justice and Delinquency Prevention
OPD	Office of the Public Defender
SDE	Connecticut State Department of Education
TREC	Training Rehabilitation and Education Centers
USD II	Unified School District II
WPS	Waterbury Public Schools

Appendix B: Program Model

Programming in each TREC will be integrally connected with community based services and will consist of: 1) educational services on-site provided by USD II or in partnership with local education agencies (LEA) when appropriate, including full academic classes and vocational education after school; 2) employment opportunities through partnerships with local businesses and Department of Labor resources; 3) residential life skills, including positive peer culture, balanced and restorative justice and recreational activities tied to pro-social skill development; 4) evidence-based clinical treatment for those whose assessments point to a need, such as individualized and family therapy, substance abuse and aggression replacement therapy, motivational enhancement therapy, cognitive behavioral therapy, family functional therapy, and multidimensional family therapy; 5) family involvement, including support, transportation and therapy for family members; 6) reintegration services, including housing and development of networks for pro-social community involvement; 7) quality improvement, including measurable outcomes and consumer feedback and 8) case management., including an individual who continues to work with the student in school and at home after leaving the facility.

1. Education

- Partnering closely with the Local Education Agency (LEA) to:
 - Accurately assess each child's strengths and needs, academic standing and progress
 - Align curriculum for each child to ensure credit transfer back to LEA
 - Assist students to retrieve lost credits due to excessive absences
 - Develop Individual Education Plans (IEPs) consistent with IEPs in the school according to each child's needs, strengths and interests: special education, college prep, trades
 - Facilitate smooth transition back to the LEA
 - Gain access to alternative schools and technical schools
- Offered on-site and at the LEA when appropriate; transition to local LEA is the goal whenever possible and should be started while still in residence at the TREC. This would allow the student and the school system to benefit from the intensive support of the TREC staff and services.
- Full academic days enhanced by afternoon/evening/weekend vocational classes
- Additional academics focused on foundation building, including reading, writing and arithmetic. Literacy should be emphasized.
- Vocational programming focused on basic skill building and linked to Technical Schools, Apprenticeship and employment opportunities
- Educational planning at times that meet the needs of families

2. Resident Life Skills / Leisure Activities

- Adoption of a Positive Peer Culture model in which there is the assumption that, through training and support from staff, students will

- identify and help maintain positive and healthy relationships within the facility
- Integration of a comprehensive psycho-educational life skills program into the non-school day (evenings and weekends) based upon individual assessment
 - Focus on engaging boys in pro-social, positive behaviors and activities that promote goal attainment, self-sufficiency, health education and alternatives to previous lifestyles
 - Individual and group activities based upon children's needs and strengths
 - Collaboration with community providers on-site and in the community
 - On-site and community based diverse recreational programming, both competitive and non-competitive, that fosters positive use of leisure time, fitness and stress management
 - Incorporation of the principles of balanced and restorative justice (accountability, community safety and competency development) that promote civic responsibility and rehabilitation through active participation in community activities

3. Employment

- Develop an interest inventory in order to determine employment opportunities for each child
- On-site psycho-educational programming geared towards enhancing interest in work and job readiness
- On-site paid work and vocational instruction opportunities that teach job skills, promote a strong work ethic and connect boys to jobs
- Partnering with local businesses/merchants/community providers to:
 - Develop paid work opportunities in the community
 - Place and support boys in jobs while they are in residence and after they return home
- Partnering with the Dept. of Labor and Trades Unions to build upon the pilot Trade Mentoring Project that will establish tracks to Apprenticeship Programs
- Partnering with local Workforce Development Boards and community business partnerships.

4. Clinical Treatment

- Based on our research, over 50% of the residents will have a clinical diagnosis of mental illness or substance abuse
- Individualized treatment and re-integration planning and programming based upon a risk/needs/strength assessment
- Child and family attendance and participation in treatment and re-integration planning meetings
- Individualized, group and family therapy, substance abuse and aggression replacement therapy, motivational enhancement therapy, cognitive behavioral therapy, family functional therapy, and multidimensional family therapy and others

- On-site psychiatric, health and dental assessment, diagnosis and treatment
- Partnering with community providers to ensure continuity of care
- Substance abuse treatment using a model which is more useful for adolescents (Seven Challenges)
- Develop a program to boys diagnosed with problem sexual behaviors
- Social skill development/ moral reasoning / anger management (Aggression Replacement Therapy Training) and EQUIP
- Programs for children with incarcerated parents and for children who are parents

5. Family Involvement

- Involved in all aspects of their child's planning and programming
- Intensive effort to engage all families at the facility, home and in the community
- Identification of obstacles to active family participation including past negative experiences and planning with families
- Psycho-educational programming and support groups to assist families in their efforts to effectively parent their children
- Training for clinical staff in the implementation of Functional Family Therapy and other treatment that is deemed helpful to this population
- Exploring all extended family alternatives and mentoring for all children who do not have adequate family support
- Accommodating transportation needs for all families

6. Reintegration

- Planning for reintegration and transition start at the assessment phase
- Arrangements for alternative housing for children without family support and who don't require residential placement
- All services individually tailored to meet the needs of each unique child
- Engagement in services while still in residence is essential such as education, substance abuse, clinical treatment and vocational training
- Detailed plans defining roles and coordination of services with community providers

7. Case Management

- Prior to release from secure residential treatment, each child would get a community advocate or mentor who remains with this child throughout their continuing care
- Educational Advocate to work with child in the school system and in building community networks

8. Quality Improvement

- Measurable outcomes need to be developed for each aspect of programming
- Outcomes need to focus upon growth and achievement

- Includes child/family/staff feedback

Appendix C: Information on the Consensus Group's Structure

Background

On 8/1/05, Governor M. Jodi Rell announced her decision to close the Connecticut Juvenile Training School (CJTS) by 2008. Prior to that date, the Governor had requested the Department of Children and Families (DCF) to develop a work plan on juvenile justice reform initiatives. The work plan included plans for regionalized, smaller facilities, closer to home for the boys currently residing at CJTS. In September, at the direction of the Governor, DCF was asked to convene a group of stakeholders to develop consensus on the future of juvenile justice reforms for the State, given the working assumption that CJTS would be closing in 2008. This report is the product of those discussions. Highlights of the original DCF work plan and recommendations from the consensus group accompany this report.

Format

The format was that questions were posed at each meeting, research was presented and discussions were held, which led to consensus. When consensus was not possible, the question was posed again at the next meeting. Though there was not agreement on every issue, there was agreement on the areas described in this report.

The cornerstone of agreement was that community based services for these boys would need to be enhanced if these changes were to result in strong productive boys and healthy, safer communities. The group also agreed that focusing on transition or re-entry planning would result in less long-term expense, by decreasing both the financial cost of residential treatment and the human cost of recidivism.

Questions

The group sought to answer the following questions:

1. When CJTS closes in 2008, what should take its place for boys committed delinquent to DCF?
2. What program and model would be needed?
3. Given the needs assessment and future projections, how many secure beds are needed and where?
4. What types of residential services do we need to provide a continuum of care?
5. What types of community supports do we need?
6. What types of services do girls need?

Appendix D: Comparison of DCF JJ Reform Work Plan (8/1/05) and Juvenile Justice Consensus Group Recommendations (1/20/06)

Juvenile Justice Reforms		
Core Principles		
<ul style="list-style-type: none"> ➤ We must expand community supports before creating new facilities ➤ We should pilot community services to determine whether the model piloted is effective before we implement the services state-wide ➤ We must build trust with communities by putting in the community supports first and preparing the community for the children that would be placed there. ➤ TRECs should focus on education, treatment, life/social skills, employment, and transition into the community. ➤ Community services must start in the out-of-home placement and be bridged when they are released into the community ➤ Focus on literacy ➤ Case management built on relational model 		
Specific Reforms	DCF Work Plan (8/1/05)	Juvenile Justice Consensus Group Recommendations
Community Supports	<ul style="list-style-type: none"> ➤ Develop Intensive Home-based Substance Abuse Services and Parent Support ➤ Flexible funds to meet specialized needs not met through existing programming 	<ul style="list-style-type: none"> ➤ Intensive in-home adolescent psychiatric services should be developed that use current IICAPS model ➤ Develop pilot in one region to determine effectiveness of the model ➤ Develop flex funds ➤ Expand Systems of Care
Replacing CJTS (secure) beds	<ul style="list-style-type: none"> ➤ Estimated need for secure beds is 90 ➤ Develop 2 Treatment and Reintegration Education Centers (TRECS) to serve 36-45 children at each location. 	<ul style="list-style-type: none"> ➤ Secure Facilities -- estimated need for secure beds is 72 to 84 ➤ Smaller Facilities -- each TREC should not be larger than 24 beds ➤ Regionalized Facilities -- develop 3 to 4 state-run TRECS located near Hartford, Bridgeport and New Haven (if there is a 4th TREC, locate in Waterbury) ➤ Stronger focus on reintegration
Continuum of Care	<ul style="list-style-type: none"> ➤ Develop 3 Group Homes ➤ Develop 7 Therapeutic Foster Care Slots 	<ul style="list-style-type: none"> ➤ Expand the Development of Step-Down Residences ➤ Develop Therapeutic Foster Care Slots Using the MTFC Model ➤ Develop Respite Care
Girls Services	<ul style="list-style-type: none"> ➤ Develop a 12-bed state-operated facility for girls. ➤ Expand community supports and continuum of care for girls. 	<ul style="list-style-type: none"> ➤ Expand community supports and continuum of care for girls ➤ Further discussion is needed on issue of secure beds for girls
Educational Enhancements	<ul style="list-style-type: none"> ➤ Develop Educational Advocacy and School-based Juvenile Delinquency Prevention Services (STEP) 	<ul style="list-style-type: none"> ➤ Develop stronger linkages to LEAs (local school districts) ➤ Create Educational Advocates who are on-site at the school to further educational success ➤ Better access to Systems of Care