KidsCounsel®

a newsletter for attorneys representing children in Connecticut

Summer 2005, Vol. 5, No. 2

Table of Contents

www.kidscounsel.org

Emily J. Settlement Agreement Provides $8.5 Million for New Services for Children in the Juvenile Justice System who have Mental Health Needs

On June 5, 2005, the Center for Children's Advocacy, with the assistance of the Center of Public Representation, reached a ground-breaking new Settlement Agreement in the civil rights class action *Emily J. v. Rell.* Beginning in October 2005, children in the juvenile justice system who have mental health needs will have access to an array of new services aimed at diverting them from placement in a residential treatment facility.

Emily J. was originally brought in 1993 to challenge the conditions of confinement in the Hartford, New Haven and Bridgeport Juvenile Detention Centers. These conditions often left children with severe mental health needs uncared for and untreated. According to the New England Juvenile Defender Center, an estimated 60% of children in detention are believed to have mental health problems. In 1997, a Consent Decree resulted in significant improvements to medical and mental health care, educational opportunities, and general conditions for these children, as well as alternatives for juvenile justice youth.

Nonetheless, the Center for Children's Advocacy noted substantial noncompliance with the 1997 Consent Decree in several areas. Detention centers continued to be overcrowded, children were languishing waiting for Riverview evaluations, and delays in placement were still prevalent. The plaintiffs filed a motion for non-compliance to modify the Consent Decree, which resulted in a June 2002 Court Order requiring the Judicial Department and DCF to develop and implement a comprehensive system of screening, assessment, planning, and services for children with mental health needs who were in detention.

Most recently, the plaintiffs found continual non-compliance in the area of delivery of mental health services, and negotiated with defendants a second court-ordered Settlement Agreement that will remain in effect until October 1, 2007. This Agreement generates $8.5 million in new services and improved staff training for children with mental health needs to divert them from unnecessary confinement in detention. As a result of the Agreement, children who don't need the level of services of a residential placement will receive mental health and educational services in the community.

The following services will begin in Hartford as a pilot for year one and be expanded statewide by year two:

Planning

Defendants will create a special pre-adjudication case review protocol for children involved with DCF. The purpose is to develop treatment plans and identify options for services and placements, with the goal of reducing the number of days these children spend in detention. Prior to this Settlement Agreement, delays in placement contributed to significant overcrowding, with some children sleeping on detention center floors. With a court ordered pre-adjudication case review process, children will be directed to home-based services more quickly.

Community-based services

For the first time, the State will implement wrap-around services for juvenile justice children. Wrap-around provides home-based, behavioral health treatment services including comprehensive assessment, a clinical support team, mobile crisis, and intensive case management. DCF will provide identified community-based services/programs to supplement services already in existence. These services will include:

- Outpatient substance abuse treatment services
- Flexible funds
- Flexible funds for educational advocacy

(continued on page 2)

KidsCounsel®

Published by

Center for Children's Advocacy
University of Connecticut School of Law
65 Elizabeth Street
Hartford, CT 06105

www.kidscounsel.org
phone 860-570-5327 fax 860-570-5256
editor: bberk@kidscounsel.org

Emily J. Settlement Agreement Provides $8.5 Million in Services

(continued from page 1)

• Post Multi-Systemic Therapy support and treatment for families who have completed MST
• Therapeutic mentors
• Trauma-based services

Treatment options for those who can't return home

For the first time, multidimensional treatment foster care, based on the Oregon model, will be available for juvenile justice children as an alternative to residential treatment facility placements. In addition, clinically staffed group homes will be created for children who would otherwise be placed in residential treatment facilities.

Training

Prior to October, DCF workers, parole officers and probation officers will receive training in the wrap-around care coordination principles and practices. For children assigned a DCF child welfare social worker, that social worker will be required to work collaboratively with the child's parole or probation officer. For children not already assigned a DCF worker, the parole or probation officer will act as the case manager and the DCF social worker will be responsible for collaborating on the development of the probation treatment plan, facilitating access to appropriate DCF services and monitoring the child's progress in treatment.

Monitoring

Compliance with this Agreement will be monitored by a court appointed monitor.

Outcome Measures

By September 1, 2005 the defendants will be required to develop outcome measures for use by the providers of services. The providers' contracts will include the outcome measures. By January 1, 2006 the defendants will be required to prepare a quality assurance plan, utlizing outcome measures, to assess the efficacy of the services provided. Defendants will then use that quality assurance plan to create a report on the efficacy of the services to inform future funding decisions.

To see a full copy of the settlement agreement, go to *www.kidscounsel.org* or email Attorney Martha Stone at *mstone@law.uconn.edu*.

– *Sarah Blanton, Law Student Intern*
Center for Children's Advocacy

Systems of Care Community Collaborative: Coordination of Services for Children with Unmet Behavioral Health Needs

Unmet Behavioral Health Needs Put Children at Risk for Failure

Children with unmet behavioral health needs are often at risk for failure in school, family and community settings. They struggle with adapting their behaviors to meet socially accepted standards. Their inability to meet these standards often results in suspensions from school, dismissal from recreational programs, poor peer relationships, and strained family relationships. As an attorney representing the legal needs of children and families, circumstances or situations may arise where there is a concern that a child or youth is in need of mental health assessment and/or services. Some indicators that a child may have mental health needs as described by the National Mental Health Association [1] are:

In older children and pre-adolescents:

- substance abuse
- inability to cope with problems and daily activities
- change in sleeping and/or eating habits
- excessive complaints of physical ailments
- defiance of authority, truancy, theft, and/or vandalism
- intense fear of weight gain
- prolonged negative mood, often accompanied by poor appetite or thoughts of death
- frequent outbursts of anger

In younger children:

- changes in school performance
- poor grades despite strong efforts
- excessive worry or anxiety (i.e. refusing to go to bed or school)
- hyperactivity
- persistent nightmares
- persistent disobedience or aggression
- frequent temper tantrums

Children who are actively suicidal or homicidal should be referred to local Emergency Departments for assessment. If the child is not posing a risk to themselves or others, it is crucial to access timely and effective mental health services for your client. This involves a referral to a mental health professional for a clinical assessment. Given time constraints and the potential need for non-legal resources, it may also be prudent to access mental health case management services for your client. A major resource for these case management services is your local System of Care, also known as a Community Collaborative.

In October 2000, recognizing that this population of children were under-identified and often underserved, there was a paradigm shift in how the State of Connecticut began delivering, financing, and coordinating behavioral health services for these children. The Department of Children and Families and Department of Social Services partnered to coordinate these services for Connecticut's children. This new initiative was named Connecticut Community KidCare/ Systems of Care and later became known as Community Collaboratives. There are 27 Community Collaboratives in Connecticut. There is a listing of the various community collaboratives available on the following link: *http://www.state.ct.us/dcf/KidCare_Directory/CT_Comm.pdf*

The Systems of Care/Community Collaborative initiative is designed to improve the collaboration between state and community organizations, with the intent that the services for children with mental health needs are better coordinated. These services are provided to the child while maintaining the child in their community. Rather than send the child to a service provider whose location would be a barrier to maintaining strong family and community ties, the service providers are expected to deliver their services in the communities where the children live and attend school.

The Community Collaborative is itself a group of parents, advocates, traditional providers and nontraditional providers who meet on a monthly basis to assess the need for services in a particular community. Membership in the collaborative is free and open to anyone or any organization interested in improving the behavioral health status of children and youth. The Community Collaborative meets monthly to share resources, strategize about outreach methods so that under-identified children and youth can be brought into the system, and to identify gaps in needed services and to strategize around barriers that create a bottleneck in the delivery of timely, community based, culturally competent services.

The essential service components of each community collaborative are Emergency Mobile Psychiatric Services, Care Coordination Services and Family Advocacy. The overarching principles guiding the planning, delivery, and evaluation of all services are that children should receive individualized services in their local community, that the voices of parents/guardians are vital to all planning and decision making required, and that all services are delivered in a culturally competent manner. Services are provided in the child's home, at the parent or guardian's discretion.

Emergency Mobile Psychiatric Services

Often a child may be in immediate crisis, needing a timely assessment. The Emergency Mobile Psychiatric Program (EMPS) provides community based psychiatric assessment of children and youth in the child's home, at school, or at other community sites with the permission of the child's parent/ guardian. This component of the Community Collaborative service delivery is sometimes the initial point of entry into the array of services provided through the collaborative. The EMPS program is charged with providing assessment, brief

(continued on following page)

Systems of Care: Coordination of Services for Children with Unmet Behavioral Health Needs

(continued from previous page)

intervention, and support until the child is connected with an ongoing mental health provider. The EMPS program is designed to work seamlessly with the Care Coordination program by connecting the family with Care Coordination services for the identification of supportive services, family advocacy, systemic advocacy and other needed services.

Care Coordination Services

Care Coordinators are case managers trained in the principles of KidCare: services must be child-specific, community-based, family-driven, and culturally competent. The Care Coordinators are also trained in children's mental health issues, educational advocacy and other systemic advocacy. Care Coordinators conduct a comprehensive assessment of each child they work with, including the child's functioning in the following domains: Family, Safety/Crisis, Social/ Recreational, Psychological, Educational/Vocational, Legal, Living Situation, Medical, Cultural/Spiritual, and any other pertinent issues.

This comprehensive assessment of the child uses nationwide data of other children with behavioral health needs as a baseline. Based on the assessment of the child's functioning as compared to other children with behavioral health needs, the Care Coordinator and the parents/guardians, current and potential service providers conduct a Child Specific Team meeting where an individualized service plan is crafted to meet the needs of the child. The services included are traditional mental health services and non-traditional community services. Traditional services may included mental health counseling, mentoring programs, respite services. Non-traditional services include after school programs, recreational programs, faith-based programs, and drumming circles, among others. Care Coordinators are primarily charged with brokering services and helping to assure that identified services are delivered. With guidance from the family and other members of the Child Specific Team, the Care Coordinator also addresses the need to modify the array of services delivered.

Family Advocacy Services

Families receiving services from their local community collaborative have the option of obtaining supportive advocacy from parents of children with behavioral health needs. These parents are not only parents of children with behavioral health needs; they are also trained advocates in the areas of case management, children's mental health, and educational advocacy. Family Advocates also ensure that the direction of the case is family-driven.

Outcome Data

For Care Coordination services, functional improvement is determined by re-administering assessment tools on a periodic basis. Changes in the child's functioning are measured by the changes in the child's scores. The goal is to see a positive progression in the child's scores as the target case management objectives are met.

Customer satisfaction surveys are also requested of each parent/guardian at the conclusion of service. This information is used to assess the ability of the Emergency Mobile Psychiatric and Care Coordination staff to engage families and children. Also, there are items that ask the parent/guardian to indicate whether they believe their child's functioning has improved.

The Department of Children and Families also makes quarterly reports on the status of the Systems of Care/Community Collaboratives to the State Legislature.

These reports are available on the Department of Children and Families website: *http://www.state.ct.us/dcf/RFP/ Community_Based_Updates.htm*

Next Steps

If you are concerned about the unmet or complex behavioral health needs of any of your child clients, please contact your local Systems of Care/Community Collaborative for guidance on how to best access services for these children. Every collaborative has a toll free phone number for Emergency Mobile Psychiatric Services. Each collaborative also has a lead agency that provides access to Care Coordination services. Every family that accepts Care Coordination services is also offered the support of a Family Advocate.

The telephone access numbers for each Connecticut town or community can be found at *www.state.ct.us/dcf/ KidCare_Directory/CT_Comm.pdf*

– *Rossana L. Barnaby, LCSW, Social Work Consultant, Center for Children's Advocacy*

(Footnotes)

[1] *www.nmha.org/inforcte/factsheets/11.cfm*, accessed July 1, 2005

[2] Connecticut Community KidCare: A Plan to Reform the Delivery and Financing of Children's Behavioral Health Services, January 2001

DCF Rolls Out New Managed Service System

Managed Service System (MSS) to Coordinate Array of Behavioral Health Services Available at Local Level

In an effort to return children to their communities, and in accordance with the *Juan F.* Exit Plan, the Department of Children and Families is rolling out the Managed Service System (MSS). MSS is a consortium of DCF-funded provider agencies convened under the authority of DCF to assure that a comprehensive and coordinated array of services is available at the local level to meet the behavioral health and community support needs of children and their families.By using the MSS framework, DCF hopes to identify and meet the needs of children with significant behavioral health needs. In addition, by identifying the needs of specific children, and creating services to meet those needs, DCF can build capacity to serve other children. For example, if several children have the same identified need, such as intensive in-home psychiatric services, and there is inadequate capacity to meet this need, the MSS provider group will prioritize the need, develop alternative service plans if necessary, and work to expand service capacity to meet that need.

Enhanced Care Coordination Contractors

DCF Area Office	Enhanced Care Coordination Contractor
Bridgeport	*Child Guidance Center of Bridgeport*
Danbury	*Child Guidance Center of Waterbury*
Hartford	*Wheeler Clinic*
Manchester	*CHR*
Meriden	*Child Guidance Clinic of Central Connecticut*
Middletown	*Mid-State (Rushford)*
New Britain	*Wheeler Clinic*
New Haven	*Clifford Beers*
Norwalk-Stamford	*Child Guidance Center of Southern CT*
Norwich	*United Community Family Services*
Torrington	*Child Guidance Clinic of Waterbury*
Waterbury	*Child Guidance Clinic of Waterbury*
Willimantic	*United Community Families*

How does it work?

Representatives of all DCF-funded providers in the area attend weekly MSS meetings. At these weekly meetings, the team reviews the cases of children with significant behavioral health needs to identify which providers can provide which services to ensure that the children's needs will be met in the community. All provider representatives must have authority to make decisions on behalf of their agencies, that is, to commit their agency to provide particular services.

Children come to the attention of the MSS in one of two ways. First, each area agency has contracted for Enhanced Care Coordination. The Enhanced Care Coordinators review on a regular basis all children with significant behavioral health needs in the following settings:

• Children and youth in shelters;

• Children in SAFE homes;

• Children in DCF facilities (Riverview, High Meadows, and CCP);

• DCF involved children in community hospital emergency rooms, or who have presented to emergency rooms with behavioral health needs during the preceding week;

• Children and youth at imminent risk of residential treatment or other out of home placement;

• Children and youth scheduled to be discharged from residential treatment within 60 days;

• Children and youth at risk of disrupting from their current placement; children and youth at risk of hospitalization for psychiatric crisis; and

• Children in detention with significant mental health needs.

Second, DCF caseworkers can refer children to the MSS by completing a short form. The Enhanced Care Coordination Contractor or Area Resource Group (ARG) clinician then completes clinical evaluations for children referred to the MSS. A child-specific case conference, to include the enhanced care coordinator, the DCF caseworker, family members, caretakers, and others who know the child, is then convened. At the child-specific case conference, the team develops a community-based behavioral health service plan. The service plan is presented to the MSS at one of its weekly meetings, with specific requests for services that are based on the individual needs of the child. The members of the MSS must then determine who will meet the various needs of the child in accordance with the service plan.

(continued on following page)

DCF Rolls Out Managed Service System

(continued from previous page)

Do families participate?

Parents, guardians, providers, and other people who know the child best are invited to participate in the child-specific case conference, at which the behavioral health service plan (or plan of care) is created. The enhanced care coordinator then presents the plan to the MSS at the weekly MSS meetings. Families do not participate in weekly MSS meetings.

Who can be referred to the MSS?

The target population for the MSS is children with complex behavioral health needs who are involved in the child welfare system, who either live at home under protective supervision or are under the care of DCF. If a child with complex behavioral health needs is not receiving services sufficient to meet his or her needs, the child can be referred to the MSS. This includes children living at home who are at high risk of being placed outside of the home and children who are in residential care and can be discharged with appropriate services.

What do I do if I believe a particular child's case should be presented to the MSS?

If you believe a particular child should be presented to the MSS, you should ask the DCF caseworker to complete a referral form to refer the child to the MSS. If you are uncertain about whether the child is appropriate for referral to the MSS, you can contact the Area Resource Group Behavioral Health Clinician to discuss the case.

Is Enhanced Care Coordination different from System of Care Coordination?

While Enhanced Care Coordination under MSS is similar in concept, it provides a service that is different from that provided by the System of Care. In a nutshell, MSS focuses on those children, youth and families already involved with DCF and who are in out-of-home care or at risk of out-of-home care, while the System of Care focuses on children living in the home who have significant mental health needs.

How does the CPT process fit in?

The Central Placement Team (CPT) and the MSS are two different processes. The CPT is a mechanism for making a referral to residential, group home, and transitional living placements. Ordinarily, when a child is ready to be discharged from a mental health facility or a residential treatment center to a less restrictive placement such as a group home, the caseworker must complete a packet and send it to the CPT. This is the appropriate process if the child's needs are not complex, consultation has already taken place with an Area Resource Group Clinician or Enhanced care Coordinator, other community-based alternatives have been fully explored and the child's needs can be met in an existing placement setting. If, however, a child has complex needs or there are barriers to meeting the child's needs, the child's case should be referred to the MSS. When a child's case is referred to the MSS, it is not necessary for the caseworker to complete a CPT packet. The caseworker simply completes an MSS referral form. It is important to note that there may be instances in which the MSS will make a recommendation that requires completion of a CPT packet.

Is the process the same in every area office?

The process outlined above is the general process used throughout the state but implementation in each area office will vary. For more information about how the MSS is working in a particular area, you can contact the Mental Health Program Director in the DCF area office.

– *Christina D. Ghio, Esq., Senior Attorney, Child Abuse Project, Center for Children's Advocacy*

Thank You . . Robinson & Cole!

Through the help of some dedicated associates at Robinson & Cole, the Center for Children's Advocacy has provided immigration assistance to dozens of low-income children and youth in the Hartford area. Attorney Megan Naughton, an associate at Robinson & Cole, Hartford, CT, has been the lead attorney on this pro bono effort. She partnered with the Center's Teen Legal Advocacy Clinic to assist youth at Hartford Public High School with everything from requests for an extension of their stays in the United States, to complex abuse and neglect cases involving immigration matters.

Attorney Naughton meets with students and parents at Hartford Public High School several times throughout the school year, and also makes herself available for emergency calls. Her help has been invaluable for a population of youth who would not otherwise be able to keep up with the fast-changing world of immigration services.

Attorney Naughton is a member of the American Immigration Lawyers Association and the Labor and Employment Section of the Connecticut and American Bar Associations.

Connecticut Update: Important New State Legislation

CCA's Legislative Efforts Result in Passage of Two Major Bills

Connecticut Legislature Creates Commission on Child Protection to Improve the Quality of Legal Representation

Public Act No. 05-3, Sec. 44-47

Effective October 1, 2005 (Sec. 44, 45, 47); and July 1, 2006 (Sec. 46)

In an historic move in the waning hours of the legislature's special session, the legislature voted to create the Commission on Child Protection to administer the attorney appointment system in child protection cases. The creation of the Commission is a bold step in improving the quality of legal representation provided to parents and children in child abuse and neglect cases.

By creating the Commission on Child Protection, the law removes from the Judicial Department the responsibility for administering the attorney appointment system, thereby eliminating the conflict of interest inherent in the Judicial Department administering contracts for attorneys who appear before it.

The Commission will exist for administrative purposes under the Office of the Chief Public Defender but will operate independently. The Commission will appoint the Chief Child Protection Attorney, who will be charged with establishing a system for the appointment of attorneys in child protection matters and ensuring that it is appropriately administered.

Most importantly, the Chief Child Protection Attorney must provide initial and in-service training for attorneys providing legal services pursuant to the law and establish training, practice and caseload standards. The standards will apply to any attorney who represents children or indigent parents and must be designed to ensure (1) a high quality of legal representation and (2) proficiency in the procedural and substantive law and in relevant subject areas, including, but not limited to, family violence, child development, behavioral health, educational disabilities and cultural competence.

For full text of this Act, go to: *www.cga.ct.gov/2005/ACT/PA/2005PA-00003-R00HB-07502SS1-PA.htm*

Status Offenders Can No Longer be Incarcerated

Public Act No. 05-250

Effective October 1, 2007

For the past three years, CCA has introduced legislation regarding the incarceration of status offenders who have violated court orders. Finally, legislation passed this year prohibits any status offender from being held in a secure facility after October 1, 2007.

In Connecticut fiscal year 2003-2004, there were 4,161 Family With Service Needs (FWSN) referrals for 3,850 children.[1] Many of these youth are often victims themselves, and have significant behavioral health problems. Nevertheless, there are currently few resources to address these children's needs. As a result, many youth, particularly girls, would find themselves incarcerated in the state's detention centers only because they had not strictly followed rules relating to their behavior, and not because they had committed any juvenile justice offense.

Under current federal law, status offenders (truants and those beyond control of their parents) cannot be incarcerated because status offenses are not considered delinquent in nature.Connecticut and other states have been circumventing this law, not by incarcerating status offenders in the first instance, but charging them with a delinquent act when they violate their curfew or other rules, and then incarcerating them as a result.

Connecticut's law in this regard, until the passage of this legislation, was out of step with the national trend. For example, Florida and New York have created mandatory diversionary periods before FWSN youth can be processed through the court system. (See *Changing the Status Quo for Status Offenders: New York State's Efforts to Support Troubled Teens* – from the Vera Institute: www.vera.org/publication_pdf/253_496.pdf). Further, at least 13 states have placed a prohibition on incarcerating or placing FWSN youth violators in secure detention facilities, including Delaware, Maryland, Mississippi, New York, Pennsylvania, Massachusetts, New Mexico, Minnesota, New Hampshire, Oklahoma, Vermont, West Virginia, and Wyoming.

This Bill provides that no status offender can be processed as a delinquent or held in detention as a result of violating a court order which regulates their future conduct that was issued by the court following a FWSN adjudication. Therefore, if a child does require commitment or placement, it must be in

(continued on following page)

Connecticut Update: Important New State Legislation

(continued from previous page)

a facility that is not a juvenile detention center and must be after the court has determined that there is no less restrictive alternative appropriate to the needs of the child and the community.

The Bill now places Connecticut in consonant with those states around the country that have finally realized that the behavior of these youth is merely masking underlying academic difficulties or mental health problems. This new system also addresses the economic efficacies as well.. The average cost of detention in Connecticut is $300 per day per child. In contrast, community-based wraparound services (i.e. Wraparound Milwaukee) which would be more effective alternatives for this population are $158 per day. (See www.wraparoundmilwaukee.org). (See also, *Unlocking the Future: Detention Reform in the Juvenile Justice System, Coalition for Juvenile Justice, 2003 Annual Report*, pp.22-23, www.juvjustice.org/pulbications/2003ar.html

For the full text of the Act, go to: *www.cga.ct.gov/2005/act/Pa/2005PA-00250-R00HB-06978-PA.htm*

(Footnotes)

[1] A FWSN child is defined as one who "(A) has without just cause run away from the parental home or other properly authorized and lawful place of abode; (B) is beyond the control of parents, guardian or other custodian; (C) has engaged in indecent or immoral conduct; (D) is a truant or habitually truant or who, while in school, has been continuously and overtly defiant of school rules and regulation." Conn. Gen. Stat. § 46b-120(8).

Juvenile Justice

An Act Concerning Youthful Offender Proceedings

(Public Act No. 05-232): *Effective January 1, 2006*

The Act broadens the eligibility for youthful offender status by extending eligibility to youths with prior youthful offender convictions and youths previously afforded pretrial programs for accelerated rehabilitation. Under this Act, 16- and 17-year-olds whose cases are heard by the adult criminal court are presumed eligible for youthful offender status unless they (1) are charged with one of the eight serious felonies or (2) have been previously convicted of a felony in the regular criminal docket or previously adjudged a serious juvenile offender or serious juvenile repeat offender. Prosecuting attorneys may challenge the youth's eligibility for youthful offender status or seek a court order to transfer the defendant to the adult criminal docket. The Act sets the maximum term of imprisonment or commitment at four years regardless of the crime charged.

For full text of the Act, go to: *www.cga.ct.gov/2005/act/Pa/2005PA-00232-R00HB-05215-PA.htm*

Child Welfare

An Act Concerning Eligibility for Subsidized Guardianship

(Public Act No. 05-254) Effective October 1, 2005

The Act allows relative caregivers who have been caring for children in the care or custody of DCF to request guardianship subsidies within six months of placement, rather than the current waiting period of 12 months.

For full text of the Act, go to: *www.cga.ct.gov/2005/act/Pa/2005PA-00254-R00SB-01038-PA.htm*

An Act Concerning The Department of Children and Families and Child Abuse or Neglect Proceedings

(Public Act No. 05-207) Effective October 1, 2005

The Act requires DCF to mail a notice of recommended finding of abuse or neglect within 5 days to the accused individual and conduct an internal review within 30 days of receiving a notice of appeal. Individuals wishing to challenge the results of the internal review must request an administrative hearing within 30 days. The hearing officer must issue a written decision within 30 days after the hearing concludes. Individuals whose names were listed on the registry prior to May 5, 2000 are permitted to appeal if they have not already done so. Further, the Act requires unsubstantiated case files to be expunged five years after the completion of the DCF investigation.

Effective December 1, 2005:

The Act requires a two-step determination prior to placing an individual's name on the DCF child abuse registry. When a report of abuse or neglect has been substantiated, prior to placing an individual's name on the registry, the Commissioner must further determine that (1) an identifiable person is responsible and (2) that this person poses a risk to the health, safety, or well-being of the children. Except in cases of (1) death, (2) sexual abuse, (3) risk of serious physical or emotional abuse, (4) serious physical injury, (5) the arrest of the accused, or (6) termination of the abuser's parental rights, actual placement on the registry and disclosure of this information cannot occur until the accused individual has exhausted or waived all available administrative appeals.

For full text of the Act, go to: www.cga.ct.gov/2005/act/Pa/2005PA-00207-R00HB-05057-PA.htm

– *Johanna Francis, Law Student Intern, Center for Children's Advocacy*

Pushing Kids Out of School: What "Zero Tolerance" Means for Our Kids

Suspension, Expulsion and Arrest: A Growing Nationwide Phenomenon

Many children who would previously have been sent to the principal's office or required to remain after school are now being suspended, expelled and arrested. These children and youth are likely to be students in need of increased support, structure and services in school; instead, they are receiving less structure, an immediate result of their exclusion from school. This phenomenon is happening nationwide for a variety of reasons.

According to the US Department of Education, a "zero tolerance policy" is defined as a school or district policy that mandates predetermined consequences or punishments for specific offenses. Most districts have policies that meet this definition for incidents involving weapons, violence perpetrated upon another school community member, and drugs. Problems arise in the first two categories through policy implementation. In addition to all the stories about the children and youth who hunt and fish with their parents on the weekend and forget that they still have a skinning knife in their backpack, there are countless children and youth who are suspended and expelled for having a dull knife, less than two inches in length, *including the handle*. While schools should be allowed to ensure that students in both instances learn that responsible behavior includes remembering to remove all prohibited materials from your backpack the night before you return to school, neither scenario should warrant the expulsion of the student. However, students are expelled under these circumstances.

Similarly, while students should not fight with their peers or assault the adults in the school building, there is a level of discretion that must be exercised by school administrators to determine when a student is recommended for expulsion and/or arrested for this offense. If the term is not clearly defined, "fighting" can include a shoving match between two students, an incident where one student is overpowered by another student or students and sustains serious injuries requiring a trip to the doctor and/or emergency room, or an incident where a student assaults another with a weapon. Clearly, the shoving match is in a completely different category of offense from either of the latter two scenarios. However, the students could all be expelled and/or arrested.

Expansion of Zero Tolerance

While the principle of zero tolerance was originally applied under the limited circumstances described in the preceding section, it has gradually expanded to include minor offenses like cutting class, wandering the halls, insubordination, being late to school, etc. There is no clearly articulated rationale for this expansion. The inclusion of minor offenses expands the negative impact on students' ability to experience academic success.

Background and Research

The Federal government first sanctioned the use of zero tolerance as a disciplinary measure in primary and secondary schools when the *Guns Free Schools Act* became law in 1994. This was expanded to include students with special needs through IDEA in 1997. These laws mandated the exclusion of students who committed certain offenses for one school year, or permitted the school district to place students protected by IDEA in alternative settings, without the parent's consent, for a limited time period.

A survey completed by the Education Law Center of Newark, New Jersey, examined the positions of national organizations for key stakeholders within the education system. The survey found that the American Federation of Teachers, the National Education Association, and national associations for school administrators, school psychologists and school social workers all recognize that problems exist in the implementation of "zero tolerance" policies in schools. They all also agree that prevention and individualized approaches to discipline are most appropriate for lesser offences.

The survey also reported that school disciplinary data at both the district (Skiba et al., 1997) and national (Heaviside et al., 1998) levels reveal that those offenses that are the primary target of zero tolerance (e.g., drugs, weapons, gangs) occur relatively infrequently. The most frequent disciplinary events with which schools wrestle are minor disruptive behaviors such as tardiness, class absence, disrespect, and noncompliance.[1]

"There is as yet little evidence that the strategies typically associated with zero tolerance contribute to improved student behavior or overall school safety. Research on suspension and expulsion raise serious concerns about both the equity and effectiveness of school exclusion as an educational intervention."[2] The research that has been completed reveals that zero tolerance policies have a disproportionately negative impact on youth of color and youth who are poor. The punishment is more frequent and more severe, particularly in the area of subjective offenses like "insubordination". The data also indicates that students who drop out of school are more likely to have experienced a disciplinary exclusion from school. While the research concerning the impact of suspension and expulsion on students is clear, there is little data demonstrating that the use of suspension and/or expulsion improves school safety.

(continued on following page)

Pushing Kids Out of School: What "Zero Tolerance" Means for Our Kids

(continued from previous page)

What Can You Do?

Bringing the issue of the exclusion of students from school with the long and short term consequences this has for the community to boards of education requires a concerted and sustained effort by parents, students, and other adults who want schools to provide safe learning environments without the unnecessary exclusion of students.

Any action taken to eliminate zero tolerance policies in your local school district should highlight the following for school and municipal officials:

Such policies are not developmentally appropriate:

• They inhibit children from forming trusting bonds with adults,

• They provide troubled children with an increased level of unstructured time,

• Rather than fostering a positive attitude toward justice and discipline, zero tolerance teaches students that adults do *not* consider extenuating circumstances and, therefore, justice is arbitrary.

Such policies cause excluded students to suffer academically:

• Students fall behind in work

• Students have an increased likelihood of dropping out

• Policies increase the likelihood that students will be charged with juvenile or criminal offenses

• Students who are sixteen or older will be charged as adults for incidents as minor as fighting with another student even if no weapons are involved in the incident.

• Policies may not be uniformly applied to all students

• It is possible to have safety, low levels of disciplinary referrals, and high achievement

If you are an Attorney representing a child who is disciplined under a zero tolerance policy, it is essential that you respond quickly. If the child is receiving special education and related services, a manifestation planning and placement team meeting must occur prior to the imposition of discipline. The purpose of this meeting is to examine whether the circumstance that would otherwise lead to discipline are related to the student's disability and if so, what adjustments should be made to the student's IEP to address the issue.

If the student is a regular education student, the child should be represented by an attorney at the expulsion. The attorney should ask the parents and the student whether they know of other students who were treated less severely for the same violation. In preparation for this hearing, the attorney should review the student's entire academic and disciplinary file. A review of the file should focus upon identifying issues concerning the school's failure to comply with its policies, many of them mandated by statute, concerning the provision of services to students and parental involvement. It is essential to ensure that there are adults present who will testify about the student's good qualities. The attorney should also be prepared to enter information concerning the ineffectiveness of zero tolerance into the administrative record. This preparation includes articulating why this information is relevant to the hearing.

– *Ann-Marie DeGraffenreidt, Director, TeamChild, Center for Children's Advocacy*

(Footnotes)

[1] Survey Of Key Education Stakeholders On Zero Tolerance Student Discipline Policies, Ellen M. Boylan, Esq., and Jennifer Weiser, Esq. (2002)

[2] Zero Tolerance Zero Evidence, Skiba, Russell J. (2000), p2.

National News: Wisconsin Requires Taping of Juvenile Confessions

This is an extremely important juvenile law case. There was some effort last legislative term regarding this issue in Connecticut.

In an opinion filed on July 7, 2005, the Wisconsin Supreme Court issued a ruling requiring the recording of all juvenile confessions *(2002AP3423)*.Wisconsin, Minnesota and Alaska are the only states with this requirement.

The court held, "... we exercise our supervisory power to require that all custodial interrogation of juveniles in future cases be electronically recorded where feasible, and without exception at a place of detention."

The court clarified that audiotaping is sufficient to meet this standard, but videotaping may provide a better record of an interrogation. In her concurring decision, Chief Justice Abrahamson referenced brain research as support: "A per se rule should be adopted because juveniles do not have the decision-making capacity and understanding of adults. Emerging studies demonstrate that the area of the brain governing decision making and the weighing of risks and rewards continues to develop into the late teens and early twenties."

Medical-Legal Partnership Project Achieves Positive Results for Children's Health Outcomes

CCA's Medical-Legal Partnership Project (MLPP) is part of an important team of providers that improves children's health outcomes by ensuring that families' basic needs are met.

Mikela* is an infant. Her family is here from Ghana, and is undocumented, with no income. On a recent well-care visit to her pediatrician, Mikela's mother, Mary, informed the pediatrician that she lacked health insurance and was receiving a number of hospital-related bills stemming from her pre-natal care, Mikela's birth, and well child visits. Despite Mikela's need for on-going medical care, Mary was concerned about her mounting hospital bills. The pediatrician referred the family to the Medical Legal Partnership Project.

The MLPP attorney did an immediate intake of the family and assessed their eligibility for state cash assistance, food stamps, and health insurance. The MLPP determined that while Mikela's parents did not qualify for on-going assistance, her parents could still apply for state assistance on Mikela's behalf, since Mikela was born in the United States and thus, is a U.S. citizen. It was also determined that though Mary is an undocumented alien, she still qualified for Emergency Medicaid to cover her labor and delivery expenses.

The MLPP attorney helped the family obtain the appropriate paperwork from the Department of Social Services (DSS) and, within a couple of weeks, Mikela had cash assistance, food stamps, and health insurance in place, retroactive to her birth date. Mary was approved for Emergency Medicaid that covered her labor and delivery expenses, substantially reducing her hospital-related debt.

Stephen* is a 7 year old boy with spastic diplegia with left hip dislocation and right hip subluxation. Stephen lived at home with his mother, Gina, and older brother. Gina called the MLPP because she had concerns regarding Stephen's home nursing care. She informed the MLPP attorney that she had requested 30 hours/week of a private duty nurse and 20 hours/week of a home health aide, but the nursing agency was only providing 10 hours/week.

The MLPP attorney did an immediate intake and investigation. Upon review, it was determined that since Stephen was on Medicaid he rightfully qualified for 30 hours/week of a private duty nurse, as well as 20 hours/week of a home health aide. The MLPP attorney spoke with the managed care company responsible for Stephen's health care, as well as with the contracted nursing agency. The nursing agency initially declared that they were unable to provide the full requested hours due to a nursing shortage, After several phone-conference negotiation sessions with both the nursing agency and the managed care company, a settlement was reached that met Gina's request for additional hours, and Stephen's special healthcare needs are being properly addressed.

***** *names have been changed to protect clients' privacy*

TIPS for Lawyers

My child client has been in an out-of-state residential placement for over one year.

He wants to go to a less restrictive setting and to come back to Connecticut, but he still has some very challenging behaviors. The worker says he doesn't know of any placements that would be appropriate for my client. What can I do?

You can contact the Area Resource Group (ARG) directly to ask for their assistance in assessing the needs of the child and identifying in-state resources that can meet the needs of the child. Sometimes the ARG can develop an appropriate plan and facilitate the child's return to the community. This may or may not require that the caseworker complete a CPT packet.

If the child's needs are indeed complex, the case can be referred to the Managed Service System (MSS). The ARG or the Enhanced Care Coordinator for the MSS can complete a comprehensive evaluation of the child and hold a child-specific case conference. It is important that you, as the child's attorney, review the comprehensive evaluation and attend the child-specific case conference to ensure that the child's needs are clearly and concretely identified. The discussion at the child-specific case conference should focus on what services the child would need to successfully return to the community, rather than whether the child meets the criteria for particular placements or whether the needed services are available. The purpose of the child-specific case conference is to develop a written service plan that will be presented to the MSS.

As the attorney for the child, you should attend the MSS when your child-client's case is presented to advocate on behalf of your client. The MSS meeting should include a discussion of the services necessary for your child client to return to the community. The service providers would then be expected to "step up to the plate" and identify which providers will meet which needs.

For more information on the MSS process, see the article on page 4 of this publication.

Center for Children's Advocacy frequently receives calls from attorneys seeking advice.

If you have a question, or a tip for other attorneys who represent children, please email *cghio@kidscounsel.org.*

In this column, we'll share questions and responses that may affect other cases.

CCA Training Seminar Addresses Connecticut's Challenge to Implementation of No Child Left Behind Act

Attorney General Richard Blumenthal and Education Commissioner Betty Sternberg Address CCA Seminar on NCLB

The Center for Children's Advocacy's June 29 training seminar featured a critical analysis of the impact of the federal *No Child Left Behind Act* (NCLB) on education in Connecticut. Attorney General Richard Blumenthal addressed the legal shortcomings of the act – its unfunded mandates – as well as his office's intention to bring suit against the federal government. State Department of Education Commissioner Betty Sternberg discussed the unreasonableness of the act's various requirements, particularly its directives on testing and assessments. While both speakers recognized the well-intentioned principles behind the act, they determined NCLB ultimately fails in effectively reaching its goals, and short-changes the children it is meant to serve. This failure lies in its "one size fits all" approach to education, which provides no flexibility in addressing the educational needs of children from individual states.

Attorney General Richard Blumenthal discusses the issues regarding Connecticut's implementation of NCLB

Unfunded Mandates - The Basis for State Claim against Federal Government

Attorney General Blumenthal is currently reaching out to local school boards and educators statewide to support his office's efforts to make the federal government accountable for the act's requirements. He highlighted the following section of NCLB as providing the gravaman of Connecticut's potential claims against the federal government:

"(a) GENERAL PROVISION. Nothing in this chapter shall be construed to authorize an officer or employee of the Federal Government to mandate, direct or control a State, local educational agency, or school's curriculum, program of instruction, or allocation of State or local resources, or mandate a State or any subdivision thereof to spend any funds or incur any costs not paid for under this chapter." 20 U.S.C. §7907(a).

The language of this provision requires that states and localities *not* direct their own funding to fulfill the act's requirements. Despite this specific language, Connecticut's efforts to comply with NCLB remain grossly under-funded. In fact, according to a recent report mandated by the Connecticut state legislature, Connecticut's efforts at compliance are under-funded by more than $41 million.[1]

As a result, the Attorney General identified the following claims which he plans to bring in a lawsuit against the federal government: (1) the federal government is in gross violation of 20 U.S.C. § 7907(a) for failing to provide Connecticut with the funding necessary to ensure adequate compliance with the act at state and local levels, and, (2) the NCLB in its totality exceeds the powers of Congress and violates the basic principles of federalism by infringing upon traditional state powers to direct matters of education.

Because of the courts' general preference to refrain from considering constitutional questions when there are lesser grounds upon which an issue may be decided, Blumenthal cited the latter claim as secondary to the first. He surmised that it will not be necessary to reach the second claim, since the suit will likely focus on the allocation of funds between federal government and the state. Because of extensive research done by the state, he expressed confidence that Connecticut will prevail on these "accounting disputes."[2] Blumenthal admitted that many of NCLB's directives, especially the testing and assessment standards, require modification. He conceded that the legislature, and not the courts, however, would be the more appropriate forum to facilitate such change

NCLB's Testing/Assessment Requirements at Odds with Connecticut's Requirements

Commissioner Sternberg discussed the substantive aspects of NCLB from the practical perspective of an educator attempting to make the law a reality in her state. The heart of the problem lies in the act's "one size fits all approach" which in effect prevents states from establishing testing standards

Department of Education Commissioner Betty J. Sternberg discusses substantive educational aspects of NCLB

CCA Training Seminar Addresses Connecticut's Challenge to Implementation of No Child Left Behind

that may be more advanced than the national requirement. For example, per NCLB, Connecticut must add new Connecticut Mastery Tests (CMTs) for grades three, five and seven. In this way, NCLB effectively imposes very specific and expensive directives that provide no room for alternate means of compliance and no tangible benefit to Connecticut's children.

Commissioner Sternberg expressed frustration at the US Department of Education's recent response to Connecticut's request to consider use of alternative assessment procedures. Rather than require annual standardized testing, the Commissioner argued that NCLB should provide the opportunity for "formative assessments" which analyze students' progress by employing testing done in small pieces throughout the school year. As another option, the US Department of Education suggested a "dumbing down" of Connecticut's current testing procedures by replacing crucial writing tests with multiple choice assessments.

Important Recommendations Not Addressed by NCLB

The Commissioner outlined five specific recommendations in areas on which NCLB is silent. Rather than require inflexible testing procedures, Commissioner Sternberg proposed that the federal government adopt laws that aim to achieve the following:

1) Ensure that all three to four year-old children attend a high quality pre-school or pre-kindergarten program;

2) Address the literacy needs of the state's parents;

3) Ensure that the poorest of children are given access to high quality medical and mental health services;

4) Ensure that every child receives a high quality education taught by high quality teachers, incorporating technology as a learning tool and formative assessments to gauge academic progress; and,

5) Ensure the availability of a longer school day and school year for every child who needs this additional time.

If these objectives were adequately provided for through federal laws and were backed by federal funding, then states might be one step closer to leaving no child behind.

For more information on *No Child Left Behind* and its effect on Connecticut's children, go to *www.state.ct.us/sde/nclb/*

– *Marisa Mascolo, Law Student Intern, Center for Children's Advocacy*

(Footnotes)

[1]Connecticut State Department of Education, *Cost of Implementing the Federal No Child Behind Act in Connecticut, State Level Costs, Part I and Local Level Costs, Part II,* (2005). Go to *www.state.ct.us/sde/NCLB_Study_2_28_05.pdf*

[2] The funds the state alleges it is due are detailed extensively in the *Cost of Implementing the Federal No Child Behind Act in Connecticut, State Level Costs, Part I, and Local Level Costs, Part II,* cited above.

For a list of reference sites on NCLB, please email *bberk@kidscounsel.org*

Connecticut Supreme Court Grants Absolute Immunity to Lawyers Appointed to Represent Children in Custody Disputes

Paul Carrubba Et. Al. v. Emily J. Moskowitz (SC 17157) July 26, 2005

On July 18, 2005, the Connecticut Supreme Court issued a ruling granting absolute immunity to lawyers who are appointed to represent children in custody disputes. This decision expands last year's Appellate Court ruling that granted court-appointed lawyers qualified immunity.

The Court's ruling adopts the U.S. Supreme Court's standard in determining when a court-appointed attorney qualifies for absolute immunity. This standard includes whether liability, intimidation and harassment might deter the lawyer from performing his or her court-ordered role; whether there are sufficient procedural safeguards against misconduct by the lawyer; and, whether the lawyer is performing a function integral to the judicial process.

Truancy Court Prevention Project: First Year Update

TCPP Worked with Hartford Public Schools to Improve Attendance and Highlight Systemic Truancy Issues

The Truancy Court Prevention Project (TCPP), a joint collaboration between Hartford Public Schools, the Center for Children's Advocacy, the Connecticut Judicial Department, and state and local community service providers to combat truancy among Hartford's 9th grade students, has been working at Hartford Public High School (HPHS) over the past school year. The project began with 20 students in September 2004 and added 7 additional students in January 2005, for a total of 27. The project provided intense case management services through Catholic Charities and Youth Opportunities Hartford, as well as weekly judicial review of each student's attendance. The Project was fortunate to have a cadre of dedicated judges, including Judge Herbert Barrall, Justice Richard Palmer, and Judge Herbert Gruendel, who volunteered their time to come to HPHS and help to monitor students' attendance and academic progress.

In addition, each student in the Project received a thorough educational assessment. The TCPP partnered with Capital Region Education Council (CREC) to secure a grant from the Tow Foundation which funded a part-time educational consultant for the Project. After securing educational releases from each of the parents of TCPP youth, the educational consultant reviewed each student's entire cumulative file and made individualized recommendations for academic improvement. Although the academic deficiencies were difficult to turn around in one year's time, the Project worked collaboratively with Hartford Public Schools to not only improve individual student's attendance, but also to highlight systemic issues affecting entire groups of students. For example, the evaluator determined that after review of educational records in the Hartford school system, children with truancy problems:

• 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%).

These findings were presented to Superintendent of Schools Robert Henry in April, 2005. The Center continues to use these findings to advocate for systemic reform within Hartford Public Schools.

In looking forward to the next school year, the Center for Children's Advocacy is pleased to announce that the TCPP has been granted an Equal Justice Works Fellow who will begin in September, 2005. The Fellow will provide legal advocacy for truant youth involved in the TCPP. The Project is currently recruiting students from Quirk Middle School who have a previous history of truancy and will be entering the 9th grade at HPHS in the fall. If you know of any students you would like to refer to the Project, please call Stacey Violante Cote at (860)570-5327.

– *Stacey Violante Cote, Director, Teen Legal Advocacy Clinic, Center for Children's Advocacy*

CCA Offers Brochure Series for Teen Clients

The Center for Children's Advocacy has published a series of brochures for teen clients. Topics include: Teen Dating Violence, Child Support for Teen Mothers, Child Support for Teen Fathers, TFA (Cash Assistance), Homelessness, Financial Aid for College, Emancipation, DCF's Independent Living Program, Truancy, and Confidential Health Care.

For more information, or to order copies of the Center's brochures for teen clients, please call 860-570-5327, or go to www.kidscounsel.org/publications.

Needed Responses to Increase in Teen Dating Violence

National Survey Finds One out of Eleven High School Students Have Been Victims of Violence

What is Teen Dating Violence?

Dating violence is more than just arguing or fighting. Dating violence is a pattern of controlling behaviors that one partner uses to get power over the other, including any kind of physical violence or threat of physical violence to get control; emotional or mental abuse, such as playing mind games, making one feel crazy, or constantly criticizing or putting one down; sexual abuse, including making one do anything they don't want to, refusing to have safer sex, or making one feel bad about their sexuality.

Teen Dating Violence is on the rise. In one study, as high as 96% of high school students reported emotional and psychological abuse in their dating relationships.[1] Moreover, nearly 9% of American high school students report being physically abused by a dating partner. In Connecticut, this number jumps to 13%, higher than any other state in the nation.[2]

What are the Legal Options for Victims of Teen Dating Violence?

Most importantly, the teen should talk to his/her parent or legal guardian. If a parent or legal guardian is not available, the teen should get help from a trusted adult. The teen's parent or a trusted adult may be able to provide temporary shelter and/or arrange for shelter through local domestic violence programs. They can also assist the teen in obtaining a restraining order against their boyfriend/girlfriend.[3]

A restraining order is issued by the Family Division of the Superior Court.[4] There is no charge to file the application for a restraining order, however, most courts will require a parent to file on a teen's behalf. If the parent is not available, the teen is encouraged to work with a trusted adult who can file on their behalf as a "next friend". If they don't have a trusted adult, and they are 16 or older, the clerk's office may likely let the teen file on his/her own. If they are under 16 years old, the clerk's office can consult with a judge to determine if the teen can apply on his/her own. It is important to note that any teen 18 or older can automatically apply on their own behalf, as they have reached the age of maturity and hence are adults.

Once a teen files an application for a restraining order, the judge has three options. First, the judge can deny the request and dismiss the case. Second, the judge can grant the request, issue an ex parte temporary restraining order, and schedule a hearing (the hearing should be scheduled within 14 days). The judge's clerk will give the teen two certified copies of the judge's order, one of which, along with the original, must be provided to a sheriff, who will give notice to the defendant of the hearing date.This must be done at least five days before the hearing date. If the judge issues an ex parte temporary restraining order, there is no charge for service on the defendant.

Third, the judge can simply schedule a hearing, without an ex parte temporary restraining order. In this case, the teen would be responsible for service charges, however, the teen can always make a fee waiver request. Once at the hearing, the judge will make a final determination as to whether or not to grant a permanent restraining order. A restraining order can last up to 6 months, or longer[5] if extended by the court, and can provide many legal protections, including prohibiting the defendant from threatening, harassing, assaulting and/or molesting the teen. The restraining order can also prohibit the plaintiff from entering the teen's home and/or school.Violation of a restraining order allows police to do an immediate arrest and is a Class A misdemeanor.

What is the Difference Between a Protective Order and a Restraining Order?

It is important to note that when an abuser is arrested, the victim can also benefit from a protective order. A protective order, versus a restraining order, is issued solely by the criminal courts and thus, you must have an underlying criminal case. A protective order terminates when the court disposes of the underlying criminal case and violation of a protective order is a Class D felony. A protective order offers more protection than a restraining order because violating a protective order is a felony criminal charge.

For more information on Teen Dating Violence, please call Stacey Violante Cote at 860-570-5327 or email *sviolant@kidscounsel.org*.

– *Gladys Nieves, Esq., Medical-Legal Partnership Project*
Center for Children's Advocacy

(Footnotes)

[1] www.SafeYouth.org
[2] Connecticut Children's Medical Center, Violence Prevention Program. *Fact Sheet: Teen Dating Violence*
[3] Teens who are married, formerly married, a child of, have a child with, or if 16 and older and have lived with their abuser, or if 18 or older and are related by blood or marriage to their abuser may also file a restraining order. C.G.S.A § 46b-38a
[4] Also known as Relief from Abuse

Is Love Supposed to Hurt Me?

"Is Love Supposed to Hurt Me?" is CCA's newly published brochure on Teen Dating Violence. Please see box on page 14 to order copies of this and other brochures for teen clients.