Judicial Branch
and
Department of Children and Families

THE DETENTION DIVERSION AND RELEASE PLAN

Submitted pursuant to section 5 of P.A. 16-147

February 3, 2017

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EXECUTIVE SUMMARY

The Detention Diversion and Release Plan is submitted to the Juvenile Justice Policy and Oversight Committee (JJPOC) pursuant to section 5 of Public Act 16-147, *An Act Concerning the Recommendations of the Juvenile Justice Policy and Oversight Committee*, which requires the Judicial Branch and the Department of Children and Families to develop a joint plan for the provision of community-based services to children diverted or released from detention. The public act states that the plan shall be informed by the comprehensive behavioral health implementation plan developed pursuant to section 17a-22bb. *The Detention Diversion and Release Plan* addresses the intent of the Public Act 16-147 to limit the use of detention to only those children who present a public safety risk, are likely not to appear at court, or need to be held for another jurisdiction. This Plan describes how significant system change will be achieved through the use of behavioral health services, family interventions, training, policies, protocols, and interagency agreements. Until the impact of the new grounds for detention is fully understood, the demand on Judicial Branch and DCF resources can only be estimated. At the same time, both state agencies are anticipating significant budget cuts that will reduce current services over the next two fiscal years (2018 and 2019). By July 1, 2017, the agencies should be better positioned to comment on resources needed to meet the requirements and intent of the new law.

THE PROBLEMS TO BE ADDRESSED THROUGH THIS PLAN

There were 2,161 admissions to juvenile pre-trial detention in calendar year 2014. The Incarceration Workgroup of the Juvenile Justice Policy and Oversight Committee found that:

1. Approximately half of detention admissions result due to concerns about a child's risk to self; suitability or instability of the home; family conflict; running away and concerns for human trafficking; and technical violations, not new charges.
2. Children exhibiting problem behaviors due to mental health, substance use, traumatic stress reactions, abuse and/or neglect need streamlined access to the behavioral health and child welfare systems in order to avoid detention.
3. Children of color make up a disproportionate portion of the juvenile detention population (51% Black, 39% White, 35% Hispanic, and 10% unknown). Yet, children of color are underrepresented in the behavioral health system.

The workgroup determined, based on juvenile delinquency and other social science research literature, that detention is not an effective intervention to meet these needs, and recommended that the statutory grounds for detention be limited to a risk to public safety, ensuring that the child appears for court, and a need to hold the child for another jurisdiction. This recommendation was enacted through section 1 of Public Act 16-147. Services for children who otherwise may have been detained will be provided within existing appropriations. Access to these services will be determined based on the needs of the child, program/service eligibility criteria as established by DCF or CSSD, and bed/slot availability.

SERVICES AND STRATEGIES

1. **Community-Based Emergency Response Services (EMPS)**: EMPS (also known as mobile crisis services) is an available, but often under-utilized service, which may be used to divert children experiencing a behavioral health crisis from detention. EMPS provides assessment, crisis stabilization, short-term intervention, and linkage to long-term care. EMPS is available 24/7 and free to all children under age 18 regardless of insurance status or system involvement. Police will be educated to call 2-1-1 to access EMPS. Police departments and local EMPS providers are strongly encouraged to enter into a memorandum of agreement (MOA) to establish a working relationship. Consideration should be given for a legislative proposal to mandate MOAs between EMPS providers and local law enforcement agencies.

2. **Short-Term Family Integrated Treatment (SFIT) and Crisis Stabilization Beds**: EMPS is also the gatekeeper for the short-term family integrated treatment (SFIT) beds. SFIT provides therapeutic crisis respite/stabilization services, assessment and family intervention for up to 14 days for children meeting the level of care criteria.

3. **Staff Education**: Court and Juvenile Probation staff are being educated about the services available to children, and their families, through the Behavioral Health Partnership administered by Beacon Health Options. Behavioral health services, intensive care management, and family supports may be available to children with HUSKY insurance. In addition, Probation is being educated about support provided by the Office of the HealthCare Advocate to families seeking assistance with denials of care from commercial insurance carriers. DCF Voluntary Services may also be appropriate for some children and their families.

4. **DCF Community and Court Liaisons**: Where available, the DCF Liaisons serve a vital role by facilitating communication between the Court, Probation and the local DCF office when there are delinquency proceedings, particularly involving children involved with the child protection system. The Liaisons will assist the parties in determining available services and options, as needed.

5. **Temporary Shelter (STAR Homes)**: Short Term Assessment and Respite Homes (STAR Homes) are temporary congregate care programs that provide short-term care, assessment and a range of clinical and nursing services to children removed from their homes due to abuse, neglect or other high-risk circumstances. Available for DCF-involved children, the family is required to be involved in the assessment and treatment. The length of stay is 60 days or less.

6. **Survivor Care Services**: If the child is suspected to be a victim of human trafficking, a Careline referral should be made to initiate an investigation and services. CSSD detention and probation policies are being revised to clarify expectations and procedures for referral.

THE DETENTION DIVERSION AND RELEASE PLAN

INTRODUCTION

This report, *The Detention Diversion and Release Plan*, is submitted to the Juvenile Justice Policy and Oversight Committee (JJPOC) pursuant to section 5 of Public Act 16-147, *An Act Concerning the Recommendations of the Juvenile Justice Policy and Oversight Committee*, which requires the Judicial Branch and the Department of Children and Families to develop a joint plan for the provision of community-based services to children diverted or released from detention. The act states that,

> *Such plan shall be informed by the comprehensive behavioral health implementation plan developed pursuant to section 17a-22bb..., and shall address the needs of the child concerning (1) behavioral health, (2) intervention in the case of family violence..., and (3) identification and means of resolution of precipitating behavioral factors that may be exhibited by a child who may run away. Such services may include, but need not be limited to, assessment centers, intensive care coordination, and respite beds.*

In order to meet the needs of the child, family and the community, *The Detention Diversion and Release Plan* must address the need for safety for the child, family, and community; provide a crisis response and emergency intervention; support child and family stabilization; and provide structure and needed supervision using existing or newly developed resources. As required by the Public Act, the *Detention Diversion and Release Plan* is informed by the Children's Behavioral Health Implementation Plan which has key goals:

- All youth with behavioral health needs are identified early and have access to appropriate care; promoting equity and reducing racial and ethnic disparities;
- A full service array is available and youth and families are matched to the appropriate treatment based on their needs;
- Providers are trained and supported to provide services backed by the best available science for effectiveness;
- Service delivery is supported by robust data collection, reporting and quality improvement systems; and
- Children and families achieve the best possible outcomes, and expenditures are held at reasonable levels.

The Detention Diversion and Release Plan addresses the needs of children who are diverted or released from detention based on new and narrower grounds. Unfortunately, there is a long history of under identification of behavioral health needs resulting in children being set on a juvenile justice trajectory vs. receiving a behavioral health response. This Plan describes how significant system change will be achieved using existing or newly developed resources and strategies, including changes to statute, policy, practice and programming that are necessary to meet the mandate and intent of the law, effective January 1, 2017. Until the new grounds for detention are implemented, the impact on Judicial/CSSD and DCF resources can only be estimated. However, by July 1, 2017, the agencies should be better positioned to comment on resources that may be needed to meet the requirements and intent of the new law.

THE PURPOSE OF JUVENILE DETENTION

There were 2,161 admissions to juvenile pre-trial detention in calendar year 2014. Of those admissions, approximately 10% were children with no prior court involvement and most likely charged with a serious juvenile offense; approximately another 10% were children under some form of post-disposition supervision (i.e., Probation) who were admitted on a new criminal charge, including violation of probation; and the remaining approximately 79% were children admitted while under pre-dispositional court orders because they:

- Acquired a new criminal charge (21.5%);
- Incurred a violation of court order charge (5.6%); or
- Violated a court ordered condition (51.8%).

The Incarceration Workgroup of the Juvenile Justice Policy and Oversight Committee found that detention is often used to house children waiting to access services for behavioral health problems, to stabilize family situations, and to prevent children from running away. The workgroup determined, based on juvenile delinquency and other social science research literature, that detention is not an effective intervention to meet these needs, and recommended that the statutory grounds for detention be limited to a risk to public safety, ensuring that the child appears for court, and a need to hold the child for another jurisdiction. This recommendation was enacted (section 1 of Public Act 16-147), effective January 1, 2017, which states:

> *1(c): No child may be placed in detention unless a judge of the Superior Court determines, based on the available facts, that (A) there is probable cause to believe that the child has committed the acts alleged, (B) there is no less restrictive alternative available, and (C) there is (i) probable cause to believe that the child will pose a risk to public safety if released to the community prior to the court hearing or disposition, (ii) a need to hold the child in order to ensure the child's appearance before the court, as demonstrated by the child's previous failure to respond to the court process, or (iii) a need to hold the child for another jurisdiction. No child shall be held in any detention center unless an order to detain is issued by a judge of the Superior Court.*

Public Act 16-147, section 2, requires the use of a validated detention risk assessment instrument, referred to as the "Detention Eligibility Screen" throughout this report, to inform the Court of the child's probability of committing a public safety offense while the case is pending, and likelihood not to appear for court. In addition, the detention eligibility screen will be used by Probation as a diversion tool to determine whether a child's non-compliance with court-ordered conditions of probation or supervision indicates the child is at a high risk to commit a public safety offense, or not to appear for court based on his/her failure to respond to the court process.

Whether the child is admitted to detention or not, the child and family situation must be fully understood to determine which factors are driving the behavior in order to match the child and family to the most appropriate intervention. When the child and behaviors are examined will depend on what entity is conducting the review (DCF, private provider through insurance, or

Probation). It is important to note that Detention assesses a child's well-being only for the purpose of keeping the child safe and healthy while in custody. The information gathered by Detention medical, mental health, and counseling staff and contractors is for the management of the child while in custody. If a child needs follow up care after release, the parent/legal guardian and Probation are informed to ensure the child receives the care post discharge. The information is not intended, and cannot, be used to inform the legal proceedings (*e.g.,* need for detention, adjudication, and disposition). Probation will only be able to assess the child after the legal process has proceeded to the point when there is a signed statement of responsibility or the child has been adjudicated delinquent. Juvenile Probation may not assess or have a child evaluated until there has been a finding of delinquency, or the child and defense counsel agrees to such assessment or evaluation. If there are concerns about a child's behavioral health and there is no legal justification for Probation to be involved (a signed statement or adjudication), the child and family are best served, and served in the most timely and appropriate manner, by receiving services from behavioral health providers through insurance or DCF.

Early access to information would increase DCF's ability to appropriately plan for children needing the services of the Department. Children in the juvenile justice system are accorded the constitutional protections granted to a criminal defendant, including the right to counsel and the right against self-incrimination. Care must be taken to ensure that information sharing is done in a manner that includes the consent of defense counsel and protects the child from further legal jeopardy.

THE PROBLEMS TO BE ADDRESSED THROUGH THIS PLAN

1. Children are detained for reasons other than risk to public safety, risk of failure to appear, or the need to hold for another jurisdiction.

2. Approximately half of detention admissions result due to concerns about a child's risk to self; suitability or instability of the home; family conflict; running away and concerns for human trafficking; and technical violations.

3. Children exhibiting problem behaviors due to mental health, substance use, traumatic stress reactions, abuse and/or neglect need streamlined access to the behavioral health and child welfare systems in order to avoid detention. As of January 1st, the use of detention is limited to stricter standards for admission.

4. Children of color make up a disproportionate portion of the juvenile detention population (the population is currently 51% Black, 39% White, 35% Hispanic, and 10% unknown). At the same time,

> *The children's behavioral health system also struggles with significant racial/ethnic disparities in access to and outcomes of treatment. A recent review found that Black, Hispanic and Asian youth in the Medicaid population in Connecticut used behavioral health services at low rates relative to their proportion*

to the population. White children, by contrast, make up only 39% of the Connecticut youth Medicaid population, yet account for 45-46% of the use of behavioral health services. System reforms must address racial and ethnic disparities in behavioral health care to ensure that all children have equal access to the full array of behavioral health services and supports (Connecticut Children's Behavioral Health Plan, DCF, October 1, 2014, p. 7). It is important to note that since the issuance of the Children's Behavioral Health Plan in 2014, current outcome data indicates a decrease in disparate outcomes by race/ethnicity specific to the evidence-based treatment models.

IDENTIFIED DETENTION DIVERSION AND RELEASE POINTS AND RESPONSES

The Court's decision to detain a child will be informed by the results of the detention eligibility screen, which will determine the child's risk to public safety and risk of failure to appear. The detention eligibility screen will guide the Court's decision making but will not replace a judge's discretion. If one of the grounds for detention is found, the child may be detained if there is no less restrictive alternative available, or released with or without conditions. The Court may consider as an alternative to detention a suspended detention order with graduated sanctions. Four key points for detention diversion exist:

1. **Police Contact**

   CGS 46b-133, Section 1(c), requires that a police officer obtain a court order for the detention of a child (*Order to Detain*) should detention be warranted. The statute states that upon the arrest of a child, the Police may use their discretion to:

   a. Release the child to the custody of the child's parent(s), guardian, or some other suitable person or agency;
   b. Release the child to the child's own custody; or
   c. Seek an **order to detain** the child in a juvenile detention center.

   Effective, January 1, 2017, police only may seek an *Order to Detain* for a child when they believe that the child presents a risk to public safety; is at risk of not appearing in court; or there is a need to hold the child for another jurisdiction. It should be stressed that Communities, inclusive of Schools, Families and Police, should divert children with behavioral health problems to the behavioral health system. For children experiencing a behavioral health crisis, emergency mobile psychiatric services (EMPS) should be contacted. Police departments and local EMPS providers are strongly encouraged to establish a memorandum of agreement (MOA) for the use of these services. Public Act 13-178, *An Act Concerning the Mental, Emotional and Behavioral Health Of Youths,* mandated MOAs between school districts and their local EMPS provider, which can serve as a model MOA. Consideration should be given for a legislative proposal to mandate MOAs between EMPS providers and local law enforcement agencies. It should be noted that the MOA is an important step but must be followed by a willingness of stakeholders to utilize the service. It will be necessary to train po-

lice how to use EMPS when presented with a child and family in crisis. Just as the state uses EMPS to avoid unnecessary visits to the local hospital emergency department, EMPS should be used to stabilize the child and then, as needed, link the child and family to behavioral health services, thus, avoiding detention or out-of-home placement by DCF, which are more restrictive and costly alternatives. EMPS providers will triage cases and assess whether there is a need for immediate behavioral health intervention, such as inpatient hospitalization, short-term stabilization and respite, or community-based outpatient services. Information on police-mental health collaboration programs is available through the Bureau of Justice Assistance (BJA) at https://pmhctoolkit.bja.gov/learning . Additional information on diversion approaches for police and families is available through the Vera Institute for Justice at https://www.vera.org/publications/it-takes-a-village.

Police are mandated to report children suspected of experiencing abuse or neglect, or who are suspected to be victims of human trafficking, to the Department of Children and Families for Child Protective Services through the DCF Careline. The definitions for abuse and neglect and information on mandated reporting are available at http://www.ct.gov/dcf/cwp/view.asp?a=2639&Q=393928 and http://www.ct.gov/dcf/cwp/view.asp?a=2534&q=314388&PM=1. If a child is suspected to be a victim of human trafficking, a Careline referral should be made to initiate an investigation and services. The DCF Protocol related to Human Trafficking: *Practice Guide to Intake and Investigative Response to Human Trafficking of Children* may be accessed at http://www.ct.gov/dcf/lib/dcf/policy/pdf/Human_Trafficking_PG.pdf.

2. **Detention Admission**

Detention staff may admit a child only when presented with a judge's order. The child will be held in detention until the initial in-court detention hearing, which occurs the next business day. If the judge signing an *Order to Detain*, *Warrant* or *Take Into Custody Order* does not prohibit the release of the child prior to the in-court detention hearing, detention leadership may release the child in accordance with the results of the detention eligibility screen and policies adopted by the Court Support Services Division of the Judicial Branch.

Children presented at a Juvenile Detention Center will be administered the detention eligibility screen to determine the child's probability of posing a public safety risk. If there is no judge-ordered prohibition in releasing the child, Juvenile Detention Leadership may release those juveniles determined to be "low risk" (currently known as "1%") in accordance with policies and procedures adopted by CSSD. The child may be released to the parent/guardian or other suitable person or agency as allowed by statute. Those children determined to be "high risk" (currently known as "11%") or "medium risk" (currently known as "4%") to public safety are not eligible for release prior to the in-court detention hearing.

Different levels of care and security may be available to divert children from detention. These may include new programs and services to be developed, subject to availability of appropriations. In addition, existing programs and services may be available provided the child meets the eligibility criteria for these programs, and the availability of an open bed/slot:

- Staff secure programs to provide care, respite, and intervention as appropriate and necessary;

- Additional resources to be developed, within existing appropriations, may include, but are not limited to, multidimensional treatment foster care, increased substance use treatment bed capacity and recovery supports, and survivor care services for victims of human trafficking; and

- Additional programming may be provided at the Child, Youth and Family Support Centers (CYFSCs) as well.

If a child is committed to DCF through child protective services or juvenile justice involvement or is on an Order of Temporary Custody to DCF, he or she may be released to DCF. Children not already involved with DCF but for whom a DCF Careline referral is appropriate will be referred when there are allegations of abuse or neglect. Children who are running away will be referred to the DCF Careline if they are confirmed or suspected victims of human trafficking. In those cases, DCF will initiate its *Intake and Investigation Response to Human Trafficking of Children*.

3. **Prosecutor Request**

A prosecutor should only seek an *Order of Detention* if the child is properly charged with an offense. A prosecutor should not seek detention solely on a verbal motion outlining the reasons why detention may be warranted; a formal written motion or application to detain should be presented to the Court. (Such action is considered best practice and is under consideration for inclusion in the Connecticut Practice Book anticipated for July 1, 2017).

When a child is presented before the Court and it appears from the available facts there is probable cause to believe the child has violated a valid court order, the Court will order Juvenile Probation to administer the detention eligibility screen to determine the child's risk level. The Court may order the child to participate in nonresidential programs for intensive wraparound services, community-based residential services for short-term respite, or other services and interventions the Court deems appropriate. It is important to note, however, that beds/slots that are currently contracted solely by DCF may not be available to children on the delinquency side. With existing and anticipated budget cuts, both agencies have been forced to reduce bed/slot capacity. Shared services will only be effective if there is a corresponding influx of appropriations.

If an immediate concern exists that the child has a significant mental health or substance use problem, may run away, or is experiencing significant family conflict, and Probation cannot facilitate access to the appropriate service or intervention, EMPS or DCF may be contacted. EMPS may be called if there is need to assess an immediate behavioral health problem. DCF Careline may be contacted with allegations of abuse or neglect or a suspicion of human trafficking.

For children with a diagnosable emotional, behavioral or substance use disorder whose treatment needs cannot be met through services currently available to the parent/guardian, and who may benefit from services accessible to DCF, the child's family (or the child, if he or she is over the age of 14) can apply for DCF Voluntary Services. Applications for Voluntary Services will be assessed and acted on according to DCF's eligibility criteria, which may be found at http://www.ct.gov/dcf/cwp/view.asp?a=2639&Q=327822.

4. **Probation Request**

A probation officer must use graduated responses (incentives and interventions), including, if necessary, but not limited to intensive community-based programs, wraparound services, respite, and short-term residential programs, to motivate the child to comply with court orders and the law. If an immediate concern exists that the child has a significant mental health or substance use problem, may run away, or is experiencing significant family conflict, and Probation cannot facilitate access to the appropriate service or intervention, EMPS or DCF may be contacted. EMPS will be called if there is a need to assess an immediate behavioral health problem. DCF Careline will be contacted with allegations of abuse/neglect. DCF Voluntary Services can be applied for by the child's family. Applications for Voluntary Services will be assessed for appropriateness according to DCF's eligibility criteria.

IDENTIFIED NEEDS AND RESOURCES FOR DIVERSION AND RELEASE

The Incarceration Workgroup has identified three groups of children that may no longer meet criteria for detention, but may still need services. Services will be provided within existing appropriations. Access to these services will be determined based on the needs of the child, program/service eligibility criteria as established by DCF or CSSD, and bed/slot availability.

1. **Children with Mental Health and Substance Use Needs**

Behavioral health assessment is required to identify the acute issue that requires stabilization. Questions, such as the following, are important to ask and answer to meet the needs of the child and family: What is the behavior to be addressed (e.g., self-harm, harm of others, running away)? What is causing the behavior (e.g., trauma, family violence, abuse, neglect, substance use, parent-child conflict)? How best to stabilize, treat and support the child and family? Formal behavioral health assessment and treatment may occur in multiple community, school based, and in-home settings including, but not limited to, local hospital emergency departments, inpatient psychiatric units, psychiatric residential treatment facilities (PRTF), emergency mobile psychiatric services (EMPS), short-term family integrated treatment beds (SFIT), enhanced care clinics (ECC), intensive outpatient programs (IOP), outpatient clinics (OP), School Based Health Centers, out posted clinicians at schools, school social workers/psychologists (though resources vary depending on school system), and in-home family therapy (e.g., FFT, MDFT, MST). These resources are often accessible through a child's insurance, whether it is private or HUSKY Medicaid. Children and family in need of longer-term out-of-home care (e.g., therapeutic group home, residential treatment center) may access that level of care through a Voluntary Services application to DCF. **Available cri-**

sis intervention resources are noted below. A complete listing of behavioral health services available in Connecticut may be found in Appendix A.

a. Community-Based Emergency Response Services (EMPS: available 24/7)

Through the School-based Diversion Initiative (SBDI), EMPS has been used to divert students with behavioral health needs from arrest and court involvement. SBDI schools have reduced referrals to court by 45%. EMPS has proven to be an effective intervention for diverting children and youth from emergency department and inpatient hospitalization, as well as, arrest and court involvement. EMPS is an available, but under-utilized, intervention for police to use to divert children experiencing a behavioral health crisis from detention, as appropriate. Police will be educated to call 2-1-1 to access EMPS, which is available 24/7. EMPS providers are highly mobile (consistent statewide mobile response rates of 90% or higher) and respond rapidly to referrals (statewide median response time of 27 minutes). EMPS is free to all children under age 18 regardless of insurance status or system involvement. EMPS provides assessment, crisis stabilization, short-term intervention, and linkage to long-term care. EMPS is also the gatekeeper for the short-term family integrated treatment (SFIT) beds. SFIT provides therapeutic crisis respite/stabilization services, assessment and family intervention for up to 14 days for children meeting the level of care criteria.

b. Short-Term Family Integrated Treatment (SFIT) and Crisis Stabilization Beds

Short-Term Family Integrated Treatment (SFIT) is a short-term congregate care treatment option providing crisis stabilization and assessment with rapid reintegration and transition back home. The primary goal of the program is to stabilize the youth and family (adoptive, biological, foster, fictive kin, relative) and their extended social system; assess the family's current strengths and needs; identify and mobilize community resources; and coordinate services to ensure rapid reintegration into the home. SFIT is an alternative to psychiatric hospitalizations and admissions to higher levels of care, and diverts placement disruptions. EMPS serves a gatekeeping function for the Short-term Family Integrated Treatment (S-FIT) program for youth who are diverted from local hospital emergency departments (EDs) and inpatient hospitalization, but would benefit from a structured therapeutic respite service lasting up to 14 days.

There are two Crisis Stabilization Programs licensed in the state. These programs provide intensive, 24-hour short-term placement and intervention for youth ages 7-18 who are at immediate risk due to a deteriorating psychiatric condition or unsafe, volatile family situation. The primary goals of the program are to de-escalate the current crisis; assist the youth and family in reestablishing a safe living situation in the community; prevent placement disruption; decrease inappropriate utilization of hospital emergency departments; and involve parents, guardians and youth in the treatment planning process. Services include a multi-disciplinary assessment; psychiatric assessment if indicated; solution-focused individual, family, and group therapy; psycho-educational skill building group; substance misuse screening as indicated; and intensive case management and advocacy with a multi-systems perspective. There are two crisis stabilization programs in Connecticut: one located at Farmington on the UCONN Medical Center

Campus, a program of Wheeler Clinic, and one at Hamden, a program of the Children's Center.

c. Staff Education

Children and families can access state-operated or state-funded community services directly or through referrals from providers in the mental health system. Services are provided on a sliding scale, and the majority of service providers are affiliated with a variety of health insurance plans. Court and Juvenile Probation staff will be educated about the services available to children, and their families, through the Behavioral Health Partnership administered by Beacon Health Options. Behavioral health services, intensive care management, and family supports may be available to children with HUSKY insurance. In addition, Probation will be educated about services provided by the Office of the HealthCare Advocate to families seeking assistance with private insurance denials of care. The Office of the HealthCare Advocate has been tremendously successful in supporting consumers navigating the complicated systems of public and private insurance.

2. **Children with Child Protective Services Needs**

The DCF Community and Court Liaison (where available) can play a vital role in facilitating communication between the Court, Probation and the local DCF office when there are delinquency proceedings. All parties related to the delinquency case, including the child's attorney, must agree to allow court liaisons to be involved in case planning. If the court location has a DCF Liaison, he or she may assist in resolving issues of concern (*e.g.*, child safety, case information, notifications), and building effective working relationships between the local DCF Office and the Juvenile Court. **Available crisis intervention resources are noted below.** A listing of additional child protective/adolescent services is available in appendix B.

a. Temporary Shelter (STAR Home)

A Short Term Assessment and Respite Home (STAR Home) is a temporary congregate care program that provides short-term care, assessment and a range of clinical and nursing services to children removed from their homes due to abuse, neglect or other high-risk circumstances. The child receives assessment services, educational support, significant levels of structure and support, and care coordination related to family reunification, foster care, congregate care, or other discharge planning as appropriate. The length of stay is 60 days or less, is only for DCF-involved children, and the family is required to be involved in assessment and treatment.

b. Survivor Care Services

If the child is suspected to be a victim of human trafficking, a Careline referral should be made to initiate an investigation and services. The DCF Protocol related to Human Trafficking: *Practice Guide to Intake and Investigative Response to Human Trafficking of Children* may be accessed at:
http://www.ct.gov/dcf/lib/dcf/policy/pdf/Human_Trafficking_PG.pdf.

3. **Children with Significant Delinquency Risk Factors**

This group of children may not have significant mental health, substance use or child protective issues driving their delinquent behavior. These children may have co-occurring needs but their behavior is being driven by delinquency risk factors, not these other needs. Delinquency risk factors include family (low monitoring, high conflict), peers (law-breaking), school (low achievement, disengaged), community (lack of supports, high mobility), and individual (poor social skills, poor impulse control, anti-social values). Over fifty years of research literature indicates that the best strategies for reducing delinquency risk include restorative practices, skill building, counseling (individual and/or family; evidence-based; cognitive-behavioral), and services to address multiple delinquency factors.

a. Respite and assessment beds for juveniles with multiple technical violations

CSSD is developing a new program model of community-based, contracted short-term residential beds to meet the needs of children adjudicated delinquent and not responding to the court process by violating court orders. These children warrant a higher level of intervention than the typical graduated responses used by Juvenile Probation. A short-term residential stay (14-days) will be available to provide respite to the child and family; stabilize the child and the situation; provide assessment of the driving factors; and offer comprehensive discharge planning, including safety planning, to successfully return the child to the family and school. CSSD should be able, within available resources, to offer this new program model early in fiscal year 2018.

b. Additional programming at the Child, Youth and Family Support Centers (CYFSCs)

CSSD continually researches the availability and appropriateness of evidence-based curricula and programming to offer at the CYFSCs to meet the needs of medium-risk children on Probation. CSSD is reviewing the current complement of services available at the CYFSCs, in view of the enacted JJPOC legislation, for possible program changes in fiscal year 2018.

c. Piloting of New Community Supervision Strategies

Juvenile Probation and Juvenile Justice Social Workers are working together to pilot new community supervision strategies supported by the OJJDP Community Supervision Implementation Grant at Bridgeport, Hartford, New Haven and Waterbury; the largest feeder communities to detention. The new strategies include: 1) utilizing an empirically supported recidivism reduction framework; 2) training in effective practices in community support; 3) expanding restorative practices; and 4) establishing shared access to contracted services. These strategies are outlined in more detail below:

1. *Utilizing an empirically supported recidivism reduction framework*

In order to facilitate the adoption of a common framework, DCF and CSSD staff will conduct a self-assessment of their current practices using the *Interactive Checklist for Juvenile Justice Agency Leaders and Managers* developed by the Council of State Governments Justice Center. Through peer learning and training sessions, DCF has

begun to use the recidivism reduction framework with its Juvenile Justice Social Workers and contracted providers. CSSD will refresh its system practices so that consistent recidivism reduction approaches, will be operational within all public and contracted private agencies. The pace of the introduction and sustainability of these system enhancements will be contingent upon available resources.

2. *Enhancing community supervision through partnership and training*

Through the Community Supervision grant, Juvenile Probation and Juvenile Justice Social Workers, respectively, will partner with communities to provide not only supervision of a child, but also additional support to that child and family. A *Community Connector* organization will facilitate access to an array of concrete academic supports including tutoring, after-hours programs, summer academic and enrichment programs, credit recovery, extracurricular support and post-secondary/college support in preparation for the child's return to the community. Family engagement, family peer support and pro-social *influencers* will facilitate an individualized, intensive, and integrated community supervision process that will begin with a child and family team meeting immediately upon a child's entry into out-of-home placement, and/or placement on Probation or Parole, through aftercare.

Pending the availability of funds to support and sustain the work under the grant, training in the Effective Practices in Community Support for Influencers (EPICS-I) developed by the University of Cincinnati (UCC) will be provided. The goal of EPICS-I is to identify prosocial supports in a child's life and teach those influencers (e.g. family members, friends, coaches, and faith leaders) core skills and cognitive-behavioral approaches to help the child identify risky situations and practice skills to successfully manage these challenges. The intervention is designed to be delivered during everyday interactions between the *influencer* and child, and builds on the interventions being taught in structured treatment groups and/or during contact sessions between the youth and community supervision officers.

CSSD staff will be trained in Forensic Cognitive Behavioral Therapy; a model of interaction that uses risk assessment tools to identify criminal thinking patterns and teaches probation officers to use motivational interviewing and cognitive-behavioral techniques during supervision sessions to guide children's thinking patterns toward more prosocial behaviors. Juvenile Justice Social Work staff has begun training in motivational interviewing, the risk-needs-responsivity principle, and strength-based case planning.

3. *Expanding restorative practices*

Restorative Practices involve the use of a range of interventions to address harm that has occurred to individuals and the community, as well as practices that help to prevent harm and conflict by creating a sense of belonging, safety, and social responsibility within the community. The underlying principle of any restorative practice is the importance of relationships with individuals, families, and communities and the focus is on the harm caused to the relationship(s) and how to repair the re-

lationship(s). The State's coordinated training, coaching, and quality assurance of Restorative Justice Practices will expand to include Juvenile Probation Officers and Juvenile Justice Social Workers, Community Connector organizations in each of the four focus communities, pro-social influencers and community providers, as well as, other identified referral sources.

4. *Sharing access to contracted services*

The final component of the new community supervision strategies includes continuing to promote shared access to contracted services. Currently, DCF and CSSD fund myriad community-based programs that are designed to serve their distinct populations. DCF has reviewed its current contracts and, in many, has removed exclusionary criteria that prohibit access. The programs that are available regardless of agency affiliation include in-home services; such as, MDFT, MDFT-RAFT, MST, MST-FIT, MST-TAY, and MST-PSB; and community-based services including ACRA, EMPS, ACCESS Mental Health, Outpatient Clinics and Extended Day Treatment. CSSD will review its current contracts and vendors and develop new access criteria and procedures for high/very high risk youth. It is important to note that beds/slots that are currently contracted solely by DCF may not be available to children on the delinquency side. With existing and anticipated budget cuts, both agencies have been forced to reduce bed/slot capacity. Shared services will only be effective if there is a corresponding influx of appropriations. If the community supervision strategies are found to be effective in reducing recidivism, the necessary funding must be available to expand and sustain the practice and services needed to fully implement an effective juvenile justice system that addresses both the child's needs and protects the community.

DATA COLLECTION AND SYSTEM IMPACT MONITORING

The impact of the new, narrower grounds for detention will need to be monitored over time to determine if it contributes to the goal towards a 30% reduction in incarceration. In addition, the impact of this significant juvenile justice system reform on children, families, the courts, probation, detention, child welfare, behavioral health, the police, schools, and service providers must be understood. It is recommended that the Cross-agency Data Workgroup be charged with developing a data collection, analysis and monitoring plan to oversee the impact of the new grounds for detention; identification of gaps/volume in services for the effected population, and the associated costs to address any service or data development needs by July 1, 2017.

COMMUNICATIONS PLAN

The Judicial Branch and DCF are coordinating its efforts to release information related to this plan through various stakeholders and partners. Training related to the new grounds for deten-

tion and the detention risk screening process are available on-line at https://www.cga.ct.gov/app/tfs/20141215_Juvenile%20Justice%20Policy%20and%20Oversight%20Committee/20170120/Training%20Video.pdf

Through its relationship with the local interagency service teams (LISTs), the state agencies communicate information about system changes on a regular basis. The LISTs provide invaluable input into program planning and other agency decisions that widely impact children, their families, and the community. Notices and materials are routinely made available to inform communities (families, police, schools, providers, and others) of best practices and anticipated or recent system changes. The LISTs will continue to serve as invaluable partners in the sharing of information.

Lastly, the implementation and monitoring of the Detention Diversion and Release Plan requires ongoing collaboration and coordination with the Children's Behavioral Health Plan Implementation Advisory Board. Coordination between these plans will create more appropriate, efficient, and effective behavioral health and juvenile justice systems.

SUMMARY

The Detention Diversion and Release Plan addresses the intent of the Public Act 16-147 to limit the use of detention to only those children who present a public safety risk, are likely not to appear at court, or need to be held for another jurisdiction. This Plan describes how significant system change will be achieved through the use of behavioral health services, family interventions, and policies, protocols, and agreements. Until the new grounds for detention are fully implemented, the impact on Judicial/CSSD and DCF resources can only be estimated. At the same time, both state agencies are anticipating significant budget cuts that will reduce current services. By July 1, 2017, the agencies should be better positioned to comment on resources that may be needed to meet the requirements and intent of the new law.

APPENDIX A

AVAILABLE BEHAVIORAL HEALTH SERVICES

A. Functional Family Therapy (FFT)

Functional Family Therapy (FFT) provides home-based treatment to children and families. Services are provided by a Master's-level clinician and are typically delivered for an average of 4 months. Agencies delivering FFT are also required to provide 24-hour/7-day emergency crisis response. Functional Family Therapy Teams offer intensive clinical services and support to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to psychiatric, emotional, or behavioral difficulties. Eligibility for services does not require DCF-involvement. Referrals to FFT are typically made by the DCF Area Offices, System-of-Care Collaboratives, EMPS, and community providers. There are 645 slots available statewide.

B. Multidimensional Family Therapy (MDFT)

Multidimensional Family Therapy (MDFT) is an evidence-based intensive, in-home model that is a family-centered, comprehensive treatment program for adolescents and young adults with significant behavioral health needs and either alcohol or drug related problems, or at risk of substance use. There is a statewide capacity to serve at least 904 children and families annually.

C. Multisystemic Family Therapy (MST)

Multisystemic Therapy (MST) provides home-based treatment to children and their families. Services are provided by a Master's-level therapist typically for an average of 5 to 6 months. MST staff also provides 24-hour/7-day emergency crisis response. Multisystemic Therapy offers intensive clinical services and support to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to problems of delinquency, disruptive behavior and/or substance abuse. Eligibility for MST services does not require DCF-involvement. Referrals to MST are typically made by the DCF Area Offices, System-of-Care Collaboratives, Juvenile Justice staff, and community providers.

D. Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)

IICAPS provides home-based treatment to children, youth and families. Services are provided by a clinical team which includes a Master's-level clinician and a Bachelor's-level mental health counselor. The clinical team is supported by a clinical supervisor and a child & adolescent psychiatrist. IICAPS Services are typically delivered for an average of 6 months. IICAPS staff also provides 24-hour/7-day emergency crisis response. IICAPS offers intensive

clinical services and support to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to psychiatric, emotional, or behavioral difficulties. Eligibility for IICAPS services does not require DCF-involvement. Referrals to IICAPS are typically made by the DCF Area Offices, System-of-Care Collaboratives, inpatient psychiatric hospitals, and community providers.

E. Extended Day Treatment (EDT)

Extended Day Treatment (EDT) is a site-based behavioral health treatment and support service for children with behavioral health needs who have returned from out-of-home care or are at risk of placement due to mental health issues or emotional disturbance. For an average period of six (6) months, a comprehensive array of clinical services, supplemented with psychosocial rehabilitation activities, are provided to maintain the child at home. Approximately 1,000 children are served annually.

F. Child Guidance Clinics

This service provides a range of outpatient mental health services for children and their families. Services are designed to promote mental health and improve functioning and to decrease the prevalence and incidence of mental illness, emotional disturbance, and social dysfunction. Many clinics throughout the state have implemented evidence-based Trauma-focused Cognitive Behavioral Therapy (TF-CBT) and Modular Approach to Therapy for Children (MATCH) improving treatment outcomes. Approximately 24,000 children are served annually.

G. Care Coordination

Care coordination services are provided to children and youth who are "Seriously Emotionally Disturbed" (SED) and have complex behavioral health needs and require an intensive coordination of multiple services to meet those needs. "SED" refers to children or adolescents with a mental, behavioral, or emotional disorder, which has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. Based on the wraparound philosophy, principles and approach to care, an individualized plan of care, including the possible use of flex funds, is developed through a process that is family-driven and youth-guided. As a service, care coordination involves direct client contact by someone who has clinical knowledge but does not function as the clinician on the case. Rather, the Care Coordinator, as an architect of the service plan along with the family, uses clinical and community systems knowledge to broker and advocate for services, and coordinates and monitors the implementation of the plan. Care coordination is done by a full-time Care Coordinator through the Systems of Care/Community Collaborative. There are 1200 slots for non-system involved children statewide.

H. Intensive Care Coordination

A recommendation of the Children's Behavioral Health Plan was to build on the success of other states which created a statewide Care Management Entity (CME). In an effort to build towards a more comprehensive system of care, which includes multiple levels of care and many different types of evidence-based treatments and supports, DCF began the first stage of implementation with a focus on providing intensive care coordination to DCF-involved children. A smaller capacity of approximately 160 slots (10%) is available annually to serve juvenile justice involved and/or commercially insured children. A statewide gatekeeper has been established at Beacon Health Options to facilitate referrals.

I. Parent Support

Parent or family support includes engagement, advocacy, and peer support via individual, group, and electronic methods. FAVOR is the statewide family organization that supports families with children who have significant behavioral health issues. FAVOR employs both Family Peer Specialists and Family System Managers. Family Peer Specialists primarily support caregivers and are involved in transforming the behavioral health system to become more family-driven and family friendly. Family System Managers primary work on increasing family involvement and family voice at all levels of the behavioral health system, but also provide direct support when working with individual families. Peer support is available through the local Community Collaboratives. For children with HUSKY insurance, peer support is available through the Connecticut Behavioral Health Partnership managed by Beacon Health Options, which can be accessed by calling 1-877-55-CTBHP (1-877-552-8247) or on-line at http://www.ctbhp.com/members/members.html

J. Substance Use Treatment

As noted in the Behavioral Health Plan, "substance use issues are a growing concern among youth. Opiate and prescription drug use are identified as increasingly prevalent among the adolescent population. Participants noted that some excellent, evidence-based services exist for treating adolescent substance use. Connecticut lacks a recovery-oriented system of care for youth, although such a system does exist for adults through DMHAS. Many of the substance use services in the state are also available through the justice system, but children should not need to be arrested to access those services. A more effective approach would be to enhance access to substance use treatment for all youth who need it, thereby preventing juvenile justice and other system involvement."

Fortunately a large number of DCF funded services are available to both DCF and non-DCF involved youth. In 2016, Connecticut developed and began implementing Adolescent Screening, Brief Intervention and Referral to Treatment (A-SBIRT) drawing on the success in the adult model. As emphasized in the Children's Behavioral Health Plan, consumers

stressed the importance of early identification and treatment. A-SIBT is embedded in the Mobile Crisis Response (EMPS) and has been introduced to Youth Service Bureaus and Pediatrician Practices. In addition Connecticut has implemented Adolescent Community Reinforcement Approach-Assertive Continuing Care (ACRA-ACC), a clinic-based outpatient behavioral therapy for adolescents with a substance use diagnosis and their caregivers. When the recovery goals are achieved, ACC provides recovery support and case management in the home or community. There is statewide capacity to serve 432 children annually.

While residential treatment services exist, there is a concern that there may not be sufficient bed capacity. Residential treatment is available through insurance or Voluntary Services. The programs include Rushford Academy for males; Touchstone for females; and MDFT Residential for children adjudicated delinquent. Additional providers exist based on ability to pay and location (e.g., out of state). However, a continuum of community-based (ACRA-ACC, MET/CBT) and in-home family treatments (FFT, MDFT, MST) is available and may be more appropriate in most cases.

Unfortunately, Connecticut does not have available all the levels of care necessary to treat adolescent substance use (detox, residential, intensive outpatient, outpatient, in-home family, and recovery supports). While the state has outpatient, intensive outpatient, in-home family and residential treatment, Connecticut does not have adolescent detox services available, so children have to go to New York State. Access to medication-assisted treatment for opiate use is almost non-existent, yet is an area underdevelopment. In addition, state agencies are exploring the possibility of requiring residential and community-based providers to be trained and have available Narcan as a necessary emergency precaution.

A statewide recovery support system for children and their caregivers is lacking. DCF is the recipient of a SAMHSA planning grant, known as **Im**proving **A**ccess, **C**ontinuing **C**are and **T**reatment (IMPACCT). In partnership with Judicial/CSSD, SDE, DMHAS and others, this federal grant provides Connecticut with the resources to assess gaps in services, to conduct financial mapping, to enhance workforce development, and leads to the opportunity to apply for a SAMHSA implementation grant to expand services to youth. The focus of a possible implementation grant application has yet to be determined, but recovery supports are central to this effort.

K. Trauma Interventions

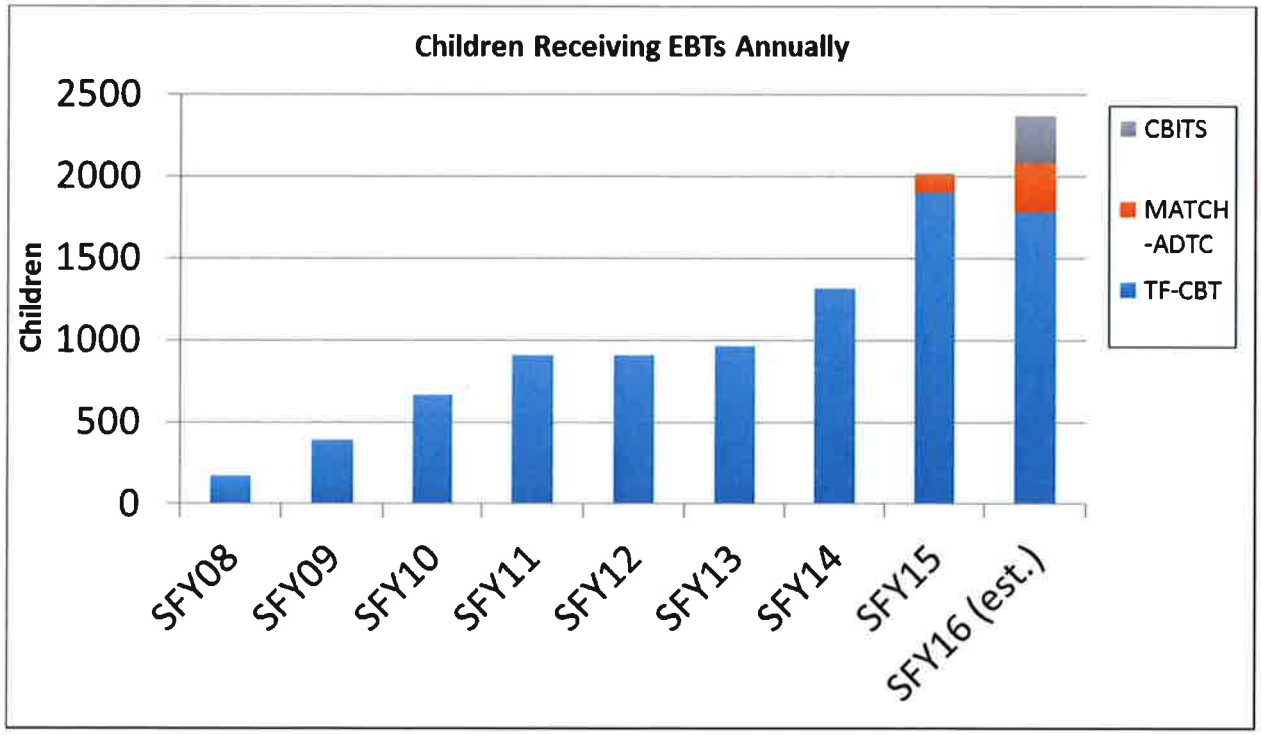
DCF has invested in several evidence based treatment models with a particular emphasis on the impact and treatment of trauma. These models include trauma-focused cognitive behavioral therapy (TF-CBT) in 34 sites; modular approach to therapy for children with anxiety, depression, trauma, and/or conduct problems (MATCH-ADTC) in 16 sites; Child and Family Traumatic Stress Intervention (CFTSI) in 7 sites; and cognitive behavioral intervention

for trauma in schools (CBITS) in approximately 20 schools. Dissemination of these treatment models has occurred in outpatient clinics and school systems.

In addition The Child Health and Development Institute (CHDI) and partners at the Consultation Center at Yale University and DCF developed a brief trauma screening measure, the Connecticut Trauma Screen, which is now being used by child welfare staff, juvenile probation officers and CYFSC staff to quickly and effectively identify children who may be suffering from exposure to trauma. See the chart below for more information about these evidence-based trauma treatment models.

Practice Model	Appropriate for	Age Range	Format
Cognitive Behavioral Intervention for Trauma in Schools **(CBITS)**	Distress caused by violence, abuse, or other trauma	7-17	Group-based; School-based
Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, and/or Conduct Problems **(MATCH)**	Anxiety, depression, behavior problems, and/or trauma	6-15	Individual; clinic-based
Trauma-Focused Cognitive Behavioral Therapy **(TF-CBT)**	Distress caused by violence, abuse, sexual abuse, or other trauma	3-17	Individual (caregiver preferred); clinic-based

The chart below demonstrates the increased utilization of evidence-based trauma treatment (EBTs) annually.



CHDI will continue to work with DCF and CSSD to strengthen the system's response to children presenting with trauma histories and reactive behaviors. The partners will continue to provide cross-training to child welfare, juvenile justice and behavioral health providers; identify and address barriers to successful engagement in trauma-focused treatment; and evaluate the role of trauma treatment in reducing recidivism.

CSSD offers TARGET in all its detention and residential programs and community-based Child, Youth and Family Support Centers (CYFSCs). TARGET is an evidence-based, psychoeducational program that educates children about trauma, triggers and trauma responses, and strategies to regulate emotions. TARGET was developed by Dr. Julian Ford at the University of Connecticut Health Center and is nationally-recognized for its effectiveness with the juvenile justice population.

L. Therapeutic Group Homes

Therapeutic group homes are designed to serve children with significant behavioral health or developmental issues through clinical treatment in the home by licensed mental health professionals. There are 161 beds available statewide.

M. Residential Treatment Centers (RTC)

Residential treatment centers are facilities that provide clinical treatment of psychiatric, behavioral and emotional disorders. The typical length of stay is four to six months. There are 195 beds statewide.

N. Psychiatric Residential Treatment Facilities (PRTF)

A psychiatric residential treatment facility (PRTF) is an inpatient program located at Solnit-North (for boys) and Solnit-South (for girls) that provides psychiatric and other therapeutic and clinically informed services to individuals under age 21, whose immediate treatment needs require a structured 24-hour inpatient residential setting that provides all required services on site while simultaneously preparing the child/adolescent and family for ongoing treatment in the community. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual, family, and group therapy, parent guidance, substance abuse education/counseling (when indicated) and other support services including on site education. The level of care is less intensive than acute inpatient hospitalization and more restrictive than residential treatment or home and community based treatment, including partial hospitalization and home based services. Youth can be admitted directly from a local hospital emergency department, as well as, step down from an acute inpatient hospital. On occasion, it may be appropriate for children to be admitted directly from the community as a diversion from acute psychiatric inpatient hospital care. The expected length of stay is between 15 and 30 days for individuals diverted from acute inpatient hospital care, and 30 and 120 days for individuals stepped down from acute inpatient hospital care, depending on clinical and dispositional needs.

O. Inpatient Hospitalization

Inpatient hospitalization provides treatment services in a licensed general or psychiatric hospital, which offers a full range of diagnostic, educational, and therapeutic services including arranging for and/or providing psychological testing when medically necessary with capability for emergency implementation of life-saving medical and psychiatric interventions. Services are provided in a physically secured setting. Child/Adolescent admission into this level of care is the result of a serious or dangerous condition that requires rapid stabilization of psychiatric symptoms. This service is generally used when 24-hour medical and nursing supervision are required to provide intensive evaluation, medication titration, symptom stabilization, and intensive brief treatment. Admission is based upon a comprehensive risk assessment and mental status exam. The first authorization is typically for up to 3 days. Subsequent authorizations are based on the individual needs of the child/adolescent with consideration to the child/adolescent's risk to self, others or disruption in permanency and consideration of the treatment plan and of the physician's recommendations.

P. Fire Setting Interventions ("Youth Set Fires")

Juvenile Fire Setting (now referred to as Youth Set Fires) is an often complex and inherently dangerous behavior that involves a diverse population of children who display a heterogeneous set of emotional, behavioral, and environmental characteristics. Successful intervention with fires setting behavior requires the ability to coordinate a multidisciplinary array of services-including mental health treatment-that addresses the often unique and complicated needs of each child or adolescent.

The Connecticut Youth Set Fire Statewide Steering Committee believes combining resources and personnel between Fire Service, Mental Health, Courts and other stakeholders will improve our ability to develop programs that can not only address the issue but withstand infrastructure changes. The steering committee, led by DCF and the State Fire Marshall Office, has developed trainings for various interested audiences, implemented the National Fire Academy Youth Set Fire training through the Connecticut State Fire Academy, developed policies and introduced legislation and pursued funding opportunities. The Steering Committee has designed and is currently implementing Pilot Programs across the state, informed by the Youth Fire Setting Prevention and Intervention curriculum developed by the National Fire Academy (NFA).

Each program is designed for the individual youth involved and the intent and motivation of the fire. Basic fire education is at times offered alone, but often the child and family require support from mental health professionals or the legal system to address the fire setting behaviors. The length of the program, interventions offered and who is involved is carefully assessed to determine the best approach.

Q. Voluntary Services

The Voluntary Services program is a DCF operated program for children and youth with serious emotional disturbances, mental illnesses and/or a substance use disorder, and the child's treatment needs cannot be met through existing services available to the parent/guardian. This program is only for families who are not involved with DCF due to abuse or neglect allegations. Current DCF regulation requires that a family with a child involved with the juvenile court on a delinquency matter must receive a waiver from the Commissioner to access Voluntary Services. DCF administration is reviewing this regulation for possible revision.

The Voluntary Services Program emphasizes a community-based approach and attempts to coordinate service delivery across multiple agencies. Parents and families are critical participants in this program and are required to participate in the planning and delivery of services for their child or youth. The Voluntary Services Program promotes positive development and reduces reliance on restrictive forms of treatment and out-of-home placement. Parents do not have to relinquish custody or guardianship under this program. The participation of parents in both treatment planning and treatment is both welcome and expected. Also, if a child is placed outside the home to address the child's behavioral health needs, the treatment plan will outline a comprehensive plan for the return home. Families can initiate an application by calling the DCF Careline at 1-800-842-2288.

APPENDIX B

CHILD PROTECTIVE/ADOLESCENT SERVICES

A. Supported Work Education and Training Program (SWETP)

SWETP group homes allow youth to live in a supervised setting with their own mini-apartments and shared kitchen spaces. Youth are employed outside of the home or are involved in schooling.

B. Community Housing Employment Enrichment Resources (CHEER)

The Department may offer CHEER and provide financial assistance to youth who were committed (uncared for, abused, and neglected) and dually committed youth as of their 18th birthday who demonstrate strong motivation and ability to pursue a post-secondary employment training and career development program. DCF offers youth in care several living options coupled with support services to assist with their gradual move towards successful adult living. Housing options include but are not limited to: individual and shared apartments, boarding arrangements and on-site living arrangements offered by employment program. Funding is based on available DCF budget appropriations and in accordance with this policy.

C. Summer Youth Employment (SYE)

Summer Youth Employment is a collaborative effort between DCF and Department of Labor (DOL) to provide gainful employment and work experience to DCF committed youth during a six week period in the summer. DCF provides funding to DOL to ensure that approximately 300 DCF committed youths (ages 14 to 18) are able to participate. In the spring of 2012 DCF and DOL began offering a year round work experience to DCF involved youth, who completed the summer employment program and wanted to continue through the school year.

D. Vocational Opportunities (Work to Learn)

The Work to Learn program is designed to insure that youth who will age out of the foster care have the skills and opportunities provided to them that will assist in a more successful transition to adulthood. Each program provides a variety of employment and educational services including; tutoring, academic assessment, job training, job shadowing and internships as well as youth business development, financial literacy, case management, clinical support, savings and asset development. These programs are available to DCF Child Welfare and Juvenile Justice adolescents from ages 14-21, and sites include Hartford, Bridgeport, New Haven, Waterbury and Norwich.