Improving Coordination between the Juvenile Justice and Behavioral Health Systems in Connecticut

The Child Health and Development Institute

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December 2015

This report was prepared by The Child Health and Development Institute of Connecticut, Inc. for the Juvenile Justice Policy and Oversight Committee

Acknowledgments

The Child Health and Development Institute of Connecticut acknowledges the contributions of many individuals and organizations who provided content or support for the development of this report. We would especially like to recognize and thank the co-chairs and members of the Juvenile Justice Policy and Oversight Committee for their leadership, guidance, and assistance throughout this process. In addition to those who participated in interviews or focus groups, we acknowledge the efforts of those listed below who provided supplementary input and additional support throughout the preparation of this document.

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Kendell Coker
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Improving Coordination between the Juvenile Justice and Behavioral Health Systems in Connecticut

I. Background and Purpose of Report

The Juvenile Justice Planning and Oversight Committee (JJPOC), under the direction of the Tow Youth Justice Institute at the University of New Haven, is leading the implementation of Public Act 14-217 (PA 14-217), one provision of which is "an assessment of the overlap between the juvenile justice system and the mental health care system for children." The Public Act also indicates that "each report submitted by the committee shall include specific recommendations to improve outcomes and a timeline by which specific tasks or outcomes must be achieved." The Tow Youth Justice Institute selected the Child Health and Development Institute (CHDI) to conduct key informant interviews and focus groups, gather and synthesize existing data, review the relevant Connecticut and national literature and extant reports, and prepare a summary with recommendations, action steps, and a timeline.

In collaboration with the Tow Institute for Youth Justice, three primary objectives were identified for assessing the overlap of behavioral health and juvenile justice systems and services: 1) describe the system-level and service-level strengths and challenges that exist in Connecticut; 2) propose action steps and desired outcomes for improving integration, and; 3) propose a timeline for enacting those action steps.

II. Methods

A. Review of Documents and Existing Data

The report includes a review of background documents and data from several Connecticut-based and national organizations (see Appendix A for a list of documents) operating in the juvenile justice and behavioral health arenas. Peer-reviewed research and reports within the "gray literature" (i.e., non-peer reviewed reports, data, and other documents developed by non-profit organizations, foundations, state and federal government entities) were included in the review. The foci of the key document and data review included:

a. The characteristics of youth who overlap (are dually involved) in the behavioral health and juvenile justice systems;
b. Strengths and gaps in current behavioral health and juvenile justice systems and services that contribute to outcomes among youth who are at-risk of, or involved with, the juvenile justice system;
c. Past and current strategies, initiatives, best practice or evidence-based interventions, and system development efforts to address the needs of these youth.

B. Interviews and Focus Groups

CHDI staff conducted semi-structured interviews and focus groups to gather information from approximately 35 individuals representing different aspects of the behavioral health and juvenile justice systems, each with unique perspectives and experiences. The participants in interviews and focus groups represented a variety of stakeholders including families, behavioral health and

juvenile justice advocates, providers, statewide and national experts, and relevant state agency personnel. Individuals were invited to participate and all interviews and nearly all focus groups were held face-to-face (one interview was conducted via telephone). Participants in interviews and focus groups included:

- The Tow Youth Justice Institute at the University of New Haven
- The Connecticut Juvenile Justice Alliance
- The Center for Children's Advocacy
- State agency representatives from the Connecticut Judicial Branch's Court Support Services Division (CSSD) and the Connecticut Department of Children and Families (DCF)
- FAVOR, Inc. (a statewide family advocacy organization for children with behavioral health needs and their families)
- African-Caribbean American Parents of Children with Disabilities, Inc. (AFCAMP)
- Connecticut Association of School Superintendents
- Representatives of behavioral health provider agencies
- Beacon Health Options, Inc.
- Connecticut Juvenile Training School
- Representatives from the Law Enforcement Committee of the JJPOC

Interview and focus group questions were semi-structured and open-ended, inviting participants to comment in four primary areas, at the system and service levels:

- **Strengths:** What is working well? What needs are being met?
- **Concerns:** What are the areas of weakness? What needs are not being met?
- **Data:** What data are available to better understand the needs and outcomes of youth with behavioral health and juvenile justice involvement?
- **Recommendations:** What suggestions do you have for improvements?

C. Analysis

A synthesis and analysis of the information collected through the two-pronged qualitative data collection process are presented in this report through the following sections:

1. **Overview and Background**: This section summarizes the national and Connecticut-specific data describing the prevalence of behavioral health concerns among youth already involved at various levels of the juvenile justice system as well as the evidence for behavioral health diagnoses or presenting problems as a risk factor for juvenile justice involvement. In addition, we reviewed national and Connecticut-specific models and examples of integration of behavioral health and juvenile justice *systems* and how they may be organized for the effective delivery of services.
2. **Results**: This section draws on the national and Connecticut-specific literature and summarizes the interview and focus group data gathered from Connecticut stakeholders, with a focus on identifying the strengths and limitations of current systems and services for addressing the needs of dually-involved youth and their families.
3. **Action Steps**: This section contains specific, actionable strategies and proposed outcomes/deliverables for improving the integration of behavioral health and juvenile justice systems and practices. An implementation timeline is provided in Appendix C.

III. Review of the Literature and Summary of Connecticut Context

A. Introduction

A summary of the literature strongly suggests significant overlap between behavioral health and juvenile justice, both in terms of the characteristics of the populations of youth served in both systems, as well as shared goals, priorities, and activities at the system level. The presence of significant overlap, at both of these levels, justifies further examination of opportunities to achieve further integration and efficiencies so that these systems work more collaboratively and that youth and who are dually involved have access to appropriate services that improve their long-term outcomes.

Although the extant research clearly indicates that youth with behavioral health concerns are at increased risk for juvenile justice involvement, this recognition has not always translated to the systems level in such a way that the behavioral health and juvenile justice systems work together in a coordinated fashion. Rather, these systems (as well as other child-serving systems) in most states and jurisdictions continue to operate quite separately from one another. This level of fragmentation in the management and delivery of services can result in high costs, missed opportunities, and poor outcomes. Although Connecticut is a national leader in juvenile justice and behavioral health reforms, there are many opportunities for further integration that are explained throughout this report.

The original charge for this report in PA 14-217 refers to assessing the overlap of juvenile justice and "mental health." In the field, the term "mental health" is often used to refer to a certain subset of conditions such as depression, anxiety, psychosis, conduct problems, and other conditions. Policy-makers and researchers have increasingly begun to use the term "behavioral health" as a broader classification that includes substance use, abuse, and dependence. As traditional mental health concerns and substance use are both relevant to this report, the term "behavioral health" will be used in order to fully recognize the importance of substance use as well as other conditions.

Below are a series of statements that can be reasonably drawn from the research literature, and that provide a context and a justification for the continued integration of behavioral health and juvenile justice systems in Connecticut.

1. The United States continues to arrest and incarcerate high numbers of youth; although in recent years, Connecticut and many other states have reduced their overall rates of arrest and incarceration.

According to the Office of Juvenile Justice and Delinquency Prevention (2010), approximately 1.6 million arrests occurred among the 70 million juveniles (individuals younger than 18) in the United States in 2010. Of those arrested, most were male (71%), between the ages of 16 and 17 (73%), and white (66%). Larceny-theft, simple assault, drug abuse violations, and disorderly conduct offenses were the identified charges for half of the total arrests. As a result of the 1.6 million annual juvenile arrests, over 600,000 youth are placed in juvenile detention centers nationally, and the average daily population of juvenile correctional facilities in the U.S. is

nearly 70,000 (Abram et al., 2004). It is important to note, however, that the total number of youth who are arrested, detained, and incarcerated has been on the decline over the last several years. Connecticut has been a national leader in this regard. From 2001 to 2010, Connecticut reduced its juvenile confinement rate by 77% and reduced its juvenile arrest rate by 32%. Juvenile arrest rates, court referrals, and detention admissions in the state continue to decline despite the inclusion of 16 and 17-year-olds into the system following Raise the Age legislation and its implementation (Mendel, 2013). In 2014, a total of 9,439 arrests occurred among youth under the age of 18 in Connecticut, most commonly for relatively minor and non-violent offenses such as disorderly conduct, breach of peace, and simple assault (Connecticut Department of Public Safety, 2014).

2. Behavioral health concerns often emerge early and are among the salient risk factors for juvenile justice involvement.

Using a nationally representative sample of youth, Kessler et al. (2005) found that about half of all lifetime mental illness emerges by age 14, suggesting that mental illness can be considered a chronic condition that begins in youth and often extends throughout one's adult years. Research on substance use demonstrates that approximately 33% of youth try alcohol by 8th grade, at least 50% of those youth have reported being drunk, and 25% of 12th graders have consumed five or more drinks in the past two weeks (NIAAA, 2011). About half of the new 2.8 million illicit drug users in 2013 were under age 18. Drug abuse violations comprised 8% of juvenile arrests in Connecticut in 2014 (CT Department of Public Safety, 2014).

Data from the National Survey of Drug Use and Health (NSDUH) shows that youth in Connecticut consistently report higher substance use rates than the national average. In the 2010-2011 survey, 16.80% of Connecticut youth aged 12-17 reported using alcohol in the past month, compared to 13.47% nationally (SAMHSA, 2011). Connecticut youth also reported higher use of marijuana and illicit drugs in the past month, and higher use of cocaine in the past year compared to national averages. Similarly, Connecticut youth reported higher rates of substance abuse and dependence than the national average (7.30% and 7.11% respectively), indicating a greater need for treatment.

The emotional and behavioral dysregulation associated with significant behavioral health conditions can place youth with these conditions at an increased risk for juvenile justice involvement.[1] In Connecticut, and throughout the country, most young people become involved in the juvenile justice system for non-violent offenses (CT Department of Public Safety, 2014). Research also indicates that behavioral health concerns are one of several factors that increase risk for juvenile justice involvement. One study, for example, found that the youth at highest risk for juvenile justice involvement included those who are older, who have externalizing behavior concerns, and who are from racial and ethnic minority backgrounds (Cauffman, Scholle, Mulvey, & Kelleher, 2005).

[1] This does not suggest that most young people with mental health conditions will ultimately become violent criminals; in fact, research indicates that individuals with mental illness are more likely to be the victims than the perpetrators of violence (Appleby et al., 2001) and the overall contribution of violence perpetrated by mentally ill individuals to overall rates of violence in American society is very small (Mulvey, 1994).

Determining the extent of overlap between youth with behavioral health needs and youth involved in the juvenile justice population is complicated by significant differences in the scientific methodology and degree of rigor used to answer these questions. Differences in the settings in which research is conducted, sampling procedures and statistical analysis are all factors that influence determinations of overlap. Grisso (2008) provides an excellent synopsis of research findings pertaining to the risk of juvenile justice involvement among *community-based* samples of youth, which include youth with and without behavioral health diagnoses or concerns. For example VanderStoep, Evans and Taub (1997) found that adolescents involved with a community mental health system were two to three times more likely to be referred to the juvenile justice system over a 9 month period than adolescents in the surrounding general population (i.e., youth who were not involved in the community mental health system). Another study (Copeland et al., 2007) sampled youth who were assessed for behavioral health conditions three times between age 9 and 16, and examined rates of arrest from age 16 to 21. The study found that for those youth who were arrested between 16 and 21 years old, 51% had been previously identified as having a behavioral health condition, whereas among youth not arrested between 16 and 21 years of age, only 33% had been previously identified as having a behavioral health condition. In reviewing the literature, Grisso (2008) concluded that although youth with behavioral health needs are more likely to come into contact with the juvenile justice system than youth without behavioral health conditions, most youth with behavioral health conditions do not engage in offenses that result in their coming into contact with the juvenile justice system. Furthermore, he noted that youth with behavioral health disorders represent only a small proportion of the total number of youth who engage in delinquent behavior.

3. Youth involved in the juvenile justice system are much more likely to have behavioral health needs than youth in the general population.

Over the last 15 to 20 years, there has been a tremendous growth in the degree to which young people are screened for behavioral health concerns upon entry to the juvenile justice system (National Center for Mental Health and Juvenile Justice, 2007). Published results of those screening efforts suggest significant prevalence of behavioral health needs within the juvenile justice population. For example, youth involved in the juvenile justice system are anywhere from three to eight times more likely to have a diagnosable mental health concern than the general population (Merikangas, et al, 2010; Shufelt and Cocozza, 2006). More than one in four youth in a juvenile justice setting are in need of *significant* behavioral health treatment and up to 60% of incarcerated youth have co-occurring mental health and substance abuse disorders. In addition, as many as 90% of the youth detained in the juvenile justice system have experienced one or more traumatic events and may be experiencing trauma-related symptoms (Arroyo, 2001; Office of Juvenile Justice and Delinquency Prevention, 2010).

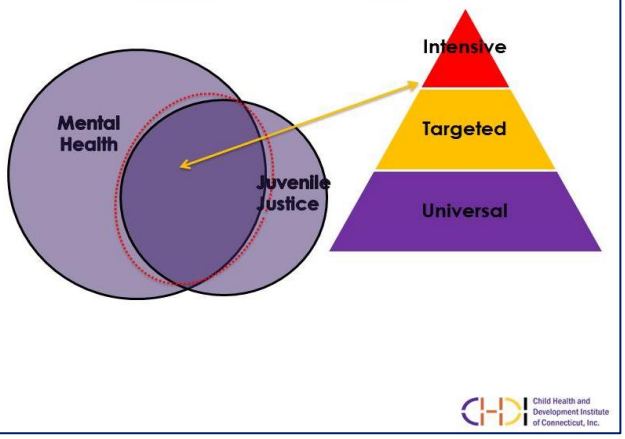
Research suggests that the following diagnoses or classifications of behavioral health conditions are most likely to result in involvement in the juvenile justice system: conduct disorders, affective disorders (e.g., depression, bipolar disorder, anxiety), substance use disorders, attention deficit/hyperactivity disorders, and developmental disabilities (e.g., Otto et al., 1992; Grisso & Underwood, 2004; Kazdin, 2000; Teplin & McClelland, 1998). The behavioral manifestations of these conditions include depressed mood, irritability, anxiety, suicidality, substance use or abuse, anger, aggression, and cognitive or neuropsychological deficits. Often it can be the

emotional or behavioral dysregulation associated with certain behavioral health conditions that place a young person at risk for juvenile justice system involvement.

Although it is important to screen for behavioral health conditions and intervene appropriately among youth who are already involved at various points in the juvenile justice system, this approach fails to recognize the importance of earlier screening, identification and treatment of behavioral health concerns before those concerns are significant enough to warrant arrest, detention, and further involvement in the juvenile justice system. Identifying and addressing risk factors for juvenile justice involvement at the earliest possible point among youth at highest risk for system contact, while they are still in normative settings (home, school, community) may be among the best strategies for improving the juvenile justice system and reducing overall levels of involvement (National Center for Mental Health and Juvenile Justice, 2007).

Figure 1 depicts the nuanced overlap between youth with behavioral health needs and youth involved in the juvenile justice system, as reflected in the research cited in points 2 and 3 of this section. Although not drawn to scale, this figure may help visually depict a few important concepts. First, the behavioral health system is larger (i.e., serves more youth overall) than the juvenile justice system. Second, most youth with behavioral health needs do not come into any contact with the juvenile justice system. Third, a relatively large proportion of youth served by the juvenile justice system do in fact exhibit co-occurring behavioral health needs.

Figure 1. Overlap of Mental Health and Juvenile Justice



Given the early emergence of behavioral health symptoms for many young people, and the increased risk that these youth will become involved in the juvenile justice system, it is important to ensure that systems are in place for early identification of youth with behavioral health concerns, and that these youth and their families can access appropriate services and supports to address their needs and ameliorate risk.

4. ***Adult decision-making and responses to challenging behaviors are often the difference between a young person receiving the behavioral health services and supports they need, or entering the juvenile justice system.***

When challenging behaviors are displayed, family members, law enforcement personnel, school personnel, and other adults often respond with discipline and punishment that tend to exclude those youth from normative settings and experiences. For example, suspensions and expulsions can be disruptive to academic engagement and success, and arrest and incarceration can severely impact normative experiences in home, school, and community settings. At times, punitive approaches that exclude youth from normative experiences may only further exacerbate the developmental challenges faced by youth with behavioral health concerns. For example, as the

number of School Resource Officers present in educational settings has increased over the last 10 to 20 years, some research indicates that adult decision-making in response to challenging behaviors in schools has resulted in more youth becoming involved in the juvenile justice system (Wolf, 2013). Although all young people should be held appropriately accountable for rule breaking and illegal behaviors, youth with significant behavioral health needs may be better served in the behavioral health system than the juvenile justice system. Adult decision-makers such as parents, teachers, and police who are in a position to observe the earliest onset of problematic behaviors can be highly influential in determining whether those needs are addressed, or whether these problems continue to escalate to the point of juvenile justice involvement.

The research literature (and the results of our interviews and focus groups) strongly supports a need to continue to focus on racial and ethnic disparities in the juvenile justice and behavioral health systems. Research shows that black youth are two times as likely as white youth to be arrested; and while they make up 16% of all public school students, black youth make up 31% of all school-based arrests. Racial and ethnic disproportionality in the juvenile justice system can have wide-ranging impacts on the development and long-term success of youth of color. For example, youth arrested in school are twice as likely not to graduate, and are four times as likely as non-arrested peers to drop out of school if processed in court (Sweeten, 2006). Experts in racial and ethnic disparities in the juvenile justice system have posited that these disparities can be related to adult decision-making processes that heavily influence whether youth are referred to behavioral health services or arrested and processed through the juvenile court system (Rovner, 2014). This suggests a number of important implications for workforce development among adults who are in positions of authority and come into frequent contact with youth.

5. ***Although juvenile justice settings should continue to screen for and treat behavioral health symptoms, juvenile justice is a less-than-ideal system for the delivery of behavioral health services. As a result, juvenile justice system partners should collaborate with other child-serving systems to ensure the delivery of effective and comprehensive services.***

Grisso and Underwood (2004) suggest that the increasing priority for juvenile justice systems to effectively identify and appropriately respond to the behavioral health needs of system-involved youth is due largely to three factors:

1. Agencies are ethically, morally, and legally obligated to meet the behavioral health needs of youth in their care;
2. Appropriate responses to behavioral health conditions often help to reduce delinquency and recidivism;
3. Early identification of factors that may contribute to immediate risk of harm through aggressive or suicidal behavior is necessary to maintain safety for all youth and staff in congregate juvenile justice facilities.

The deficiencies that often exist in the behavioral health system--particularly with respect to supporting prevention, early identification, early intervention, and the presence of an adequate community-based treatment system--have led some to conclude that the juvenile justice system may act as a *de facto* behavioral health treatment system for youth. Investigations by the U.S. Department of Justice have found that behavioral health services provided in the juvenile justice

system are often limited or inadequate (US Department of Justice, 2011). Detained youth are more likely to be victimized by other youth in these settings and to experience isolation and restraints, all of which can severely compromise normative, healthy development. The suicide rate is four times higher for youth in the juvenile justice system than the general youth population (Koppelman, 2005). These findings strongly suggest the paramount importance of establishing healthy, rehabilitative, and/or therapeutic environments that are critical to development among youth who come into contact with the juvenile justice system.

Juvenile justice facilities must continue to screen for and treat behavioral health conditions; however, the broader child-serving system has a responsibility for identification and early intervention to address the behavioral health symptoms that clearly place youth at risk for subsequent juvenile justice involvement. Comprehensive approaches are needed to ensure that child-serving systems possess that capacity (Carothers, 2004).

B. Overview of Connecticut's Juvenile Justice System

Brief Summary of Reform Efforts. For the past decade, Connecticut has been recognized nationally as a leader in juvenile justice system transformation by enacting state-level reforms in policy and practices, including some that recognize and address behavioral health and juvenile justice systems overlap (Mendel, 2013; Brown, 2015). For example, in 2007 Connecticut "raised the age" for juvenile court jurisdiction, which helped to reduce the state's juvenile justice spending by $102 million. Connecticut is one of only seven states that have passed laws to limit or prohibit the use of solitary confinement for youth in detention facilities and is one of only twelve states to introduce measures to end indiscriminate shackling. CT is also one of only three states to establish "racial impact statements" to monitor and address disproportionate minority contact in the system. Table 1 below highlights some of Connecticut's milestones and achievements in juvenile justice system reform over the last 20 years.

Table 1. CT Milestones to Address the Overlap of Behavioral Health and Juvenile Justice			
1995	Juvenile justice reform bill is enacted. Connecticut expands diversion and intervention programs for youth.		
1997	Connecticut develops a five year plan to improve behavioral health treatment and alternative programs for youth.		
2005	CT Prohibits detention of status offenders for violating probation or court orders.		
2006	First Joint Juvenile Justice Strategic Plan is published.		
2007	Family Support Centers are created to work with status offenders and their families outside the delinquency court system.	"Raise the Age" bill is passed.	Out-of-school suspension for minor misconduct becomes prohibited.
2009	Connecticut enacts racial impact rule.		
2010	Raise the Age goes into effect for 16 year olds.		
2011	Detention of Children and Disproportionate Minority Contact in the Juvenile Justice System Act is passed.		

2012	Raise the Age goes into effect for 17 year olds.	Connecticut prohibits the use of solitary confinement for youth in detention centers.
2014	Connecticut funds family violence-mediation diversion program.	The Connecticut Juvenile Justice Policy and Oversight Committee (JJPOC) is created (Public Act 14-217) to evaluate policies related to the JJ system and the expansion of juvenile jurisdiction with Raise the Age legislation.
2015	Connecticut introduces measures to end indiscriminate shackling.	The age of transfer to adult court is raised to 15.

Based on the reforms described above, Connecticut has received national recognition for the quality and progressive nature of its juvenile justice system.

In terms of its basic components, the current juvenile justice system in Connecticut is comprised of 13 juvenile courts, 3 public juvenile detention centers, private residential facilities, juvenile probation and community-based programs, and correctional facilities. The following summary, adapted from a description provided by the Office of Policy and Management, highlights some additional features of the juvenile justice system.

Goals and Principles. Goals defined in the Juvenile Justice Act of 1995 have resulted in a juvenile justice system that is intended to achieve or provide the following:

- Individualized supervision, care, and treatment through family-driven treatment planning;
- School and community-based prevention programs;
- Community-based services designed to keep youth in their homes and schools when possible;
- Uniform intake procedures, "risk and needs" assessments and treatment planning, and data-driven decision-making to inform placement in detention or residential treatment;
- Referral and access to comprehensive treatment programs addressing substance abuse, emotional and behavioral problems, sexual abuse, health needs, and education;
- A statewide network of high quality professionals to provide medical, psychiatric, psychological, and substance abuse testing and evaluation;
- Programming for anger management and nonviolent conflict resolution;
- A coordinated statewide array of services, including secure residential facilities and closely supervised nonresidential centers and programs;
- Community-centered programs involving restitution, community service, mentoring, and intensive early intervention.

State Agency Involvement. Connecticut's Judicial Branch, primarily through CSSD, manages the majority of services and supports for youth involved in the juvenile justice system, including home- and community-based programs and services, juvenile probation, and juvenile detention. DCF, through its Juvenile Services Division, oversees the delivery of all services for youth committed to DCF care for delinquency as well as juvenile parole services. In addition, DCF carries the statutory mandate for the delivery of behavioral health services to all youth, although many other public child-serving agencies pay for and manage the delivery of various behavioral health services to youth involved in their system.

Age of Jurisdiction. Currently juveniles under the age of 18 in violation of state/federal law or local/municipal ordinances in the State of Connecticut are under the jurisdiction of the Superior Court for Juvenile Matters. The age of jurisdiction was raised from 16 to 18 through legislation passed in 2007, which was fully implemented in 2008. As of the writing of this report, Gov. Dannel Malloy has publicly discussed making Connecticut the first state to increase the age of juvenile justice jurisdiction to include 19 and 20 year olds.

Connecticut's juvenile justice system also emphasizes a restorative justice approach, which is grounded in three primary principles:

- Relationship-building between those who have been harmed and those who have caused the harm;
- Accountability for repairing the harm;
- Transformation of the person who caused the harm.

A range of graduated sanctions are available in response to legislation which identified over 50 offenses as "Serious Juvenile Offenses" (SJO) in order to hold juveniles accountable for their actions. Severity of offense is just one factor in a series of decision points that determine a youth's level of involvement with the juvenile justice system. Police generally represent the first point of contact for youth entering the juvenile justice system, and they exercise wide discretion for responding to youth behaviors. Those options include releasing youth following a warning or parent conference, referring youth to community-based or diversion services (e.g., Juvenile Review Boards, youth services agencies), or making an arrest. Some arrested youth may enter one of Connecticut's two detention facilities (Hartford, Bridgeport) if they meet certain criteria. All youth in detention receive a hearing before a judge. Connecticut has thirteen Juvenile Matters Court locations across the state and cases may be handled judicially (court hearing) or non-judicially (informal processing), at the discretion of the Juvenile Probation Unit Supervisor. Detention hearings may result in the following dispositions: released with no conditions; released under probation supervision and other conditions; remanded to detention for placement in an Alternative Detention Program; or ordered to remain in detention.

Most convicted youth are placed on probation and given a supervision plan with individualized conditions, which may include: random drug testing, restitution, community service, electronic monitoring, monitored school attendance, and curfews. Probation officers also often serve as a linkage to various treatment options, which may include referral to individual or group counseling; day treatment programs with educational, recreational, life skills, substance abuse and other services; specialized services for females, sex offenders, and abused juveniles; behavioral health services; and short-term residential services.

C. Overview of Connecticut's Behavioral Health System

Connecticut's publicly funded behavioral health system is comprised of an array of services and supports that are funded and overseen by a number of child-serving agencies, led primarily by DCF, but also including: CSSD; The Department of Social Services (DSS); the Department of Mental Health and Addiction Services (DMHAS); the Department of Public Health (DPH); the State Department of Education (SDE); the Department of Developmental Services (DDS); the Department of Rehabilitation Services (DRS); and the Office of Early Childhood (OEC). Connecticut's state agencies often have their own eligibility criteria and a different "menu" of available services and supports for youth involved in their system--services that may or may not be available to youth in another system or to those with no formal system involvement. Although a number of behavioral health system improvements and reforms are underway, some families, advocates, policy makers, and other system partners describe Connecticut's children's behavioral health system as difficult to understand and navigate, fragmented, poorly coordinated, and ineffective. The Children's Behavioral Health Plan, submitted by DCF in October 2014, provides a recent summary of strengths and gaps in the children's behavioral health system as well as a detailed action plan for system integration and improvement (www.plan4children.org).

Behavioral health services may be funded by Medicaid, The Connecticut Behavioral Health Partnership (CT BHP)--a collaboration between DCF, DSS, and DMHAS--oversees the delivery of Medicaid funded behavioral health services in Connecticut. The CT BHP contracts with an Administrative Services Organization (ASO) to manage the delivery of a variety of services and supports to Medicaid members in need of behavioral health services. The ASO is currently operated by Beacon Health Options (formerly ValueOptions). In addition to Medicaid, the publicly funded children's behavioral health system is also funded by state and federal grants.

Children's behavioral health services are delivered in a variety of settings including congregate care facilities (e.g., psychiatric residential treatment, therapeutic group homes), comprehensive community-based behavioral health clinics, homes, schools, and other locations. For example, DCF funds 24 Child Guidance Clinics (representing 90+ sites) that employ psychiatrists, psychologists, social workers, and other clinicians and professionals to provide a continuum of home- and community-based services and supports for children with behavioral health needs, and their families. Many of these clinics have been designated as Enhanced Care Clinics and have access to higher Medicaid reimbursement rates in exchange for meeting various performance standards relating to access, service quality, and coordination of care. The behavioral health service system is also supported by a network of 26 System of Care (SOC) community collaboratives. DCF funds a statewide network of care coordinators who ensure children with serious emotional disturbances (SED) and their families receive individualized treatment planning and child and family teaming to coordinate their care across various systems (e.g., education, behavioral health, juvenile justice, child welfare). DPH funds a statewide network of approximately 100 School-Based Health Centers.

State-funded systems have increasingly attended to the need to identify and intervene early, for example, through the establishment of the Office of Early Childhood and also through supporting such interventions as Early Head Start/Head Start, Birth to Three, the Early Childhood Consultation Partnership, Child First and the Infant Mental Health Endorsement. Connecticut

has established and supported statewide and community-level family advocacy organizations to promote and family and youth participation and engagement in system governance, service delivery, evaluation, and improvement efforts.

The information above describes only part of the children's behavioral health system in Connecticut. Despite the extensive array of services and supports available to youth and their families, the system remains disjointed and fragmented, with services that are often inaccessible to youth in need due to a diffuse network of payers, differing categorical and financial eligibility criteria, lack of basic capacity, inadequate numbers of trained professionals, restrictions on covered services, and inconsistent standards for clinical practices. The Children's Behavioral Health Plan, submitted by DCF to the Connecticut legislature in October 2014, articulates a comprehensive set of strategies and a timeline for enhancing the organization, funding, and delivery of behavioral health services in the state (see Appendix D). Although progress has been made since then, significant work remains to be done to ensure a robust and accessible behavioral health service system that is prepared to meet the needs of all youth with behavioral health concerns.

D. Services Available to Youth with Juvenile Justice and Behavioral Health System Involvement

In Connecticut, both CSSD and DCF provide a continuum of behavioral health services to youth involved in their systems. DCF also provides many services to youth not formally involved with their department, but who may be involved in other systems. With respect to youth involved in the juvenile justice system, efforts have been made to improve access to DCF-funded services. For example, in recent years much of the contract language that excluded youth with juvenile justice involvement from DCF-funded services has been removed or greatly minimized. DCF clients, however, continue to receive priority consideration for some DCF-funded services. The table below lists services available to youth in the DCF and the CSSD systems. An "X" in the column does not necessarily indicate that these systems directly fund the service, but rather, that the service is generally available to those youth involved in each system. Appendix B provides further description of these services, including indication of whether these services are recognized as Evidence-Based Practices (EBPs).

Table 1. Services Available to Youth Involved in the Juvenile Justice System

Program or Service	CSSD	DCF
ACCESS Mental Health		X
Adolescent Community Reinforcement Approach & Assertive Continuing Care (A-CRA/ACC)	X	X
Care Coordination		X
Center for Assessment, Respite, and Enrichment (CARE)	X	
Child, Youth, and Family Support Centers (CYFSC)	X	
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)		X
Community Residential Programs	X	
Boys Therapeutic Respite and Assessment Center (TRAC)	X	
Boys Intermediate Residential Program (IR)	X	

BRAVE Community Residential Program for Boys	X	
Hybrid Girls' Community Residential Program	X	
Girls Intermediate Residential Program	X	
GRACE Community Residential Program for Girls	X	
SAGE Secure Community Residential Program for Boys	X	
SOAR Community Residential Program for Boys	X	
WSD Secure Residential Program for Girls	X	
Community Service Programs (CSP)	X	
Competency Evaluations	X	
Court Based Assessments (CBA)	X	
Detention Recreation	X	
Educational Support Services (ESS)	X	
Emergency Mobile Psychiatric Services (EMPS)	X	X
Extended Day Treatment (EDT)	X	X
Family Engagement	X	
Fostering Responsibility Education and Employment (FREE)		X
Functional Family Therapy (FFT)	X	
Girls Recognizing Their Own Worth Through Healing (GROWTH)	X	
Home Care	X	
Human Anti-trafficking Response Team (HART)	X	
Intensive In-Home Child & Adolescent Psychiatric Services (IICAPS)	X	
Juvenile Sex Offender Services (JSOS)	X	
Multisystemic Therapy (MST)	X	X
Multisystemic Therapy for Problem Sexual Behavior (MST-PSB)		X
Multisystemic Therapy for Family Integrated Transition (MST-FIT)		X
Multisystemic Therapy for Transitional Age Youth (MST-TAY)		X
Multidimensional Family Therapy (MDFT)	X	X
Multidimensional Family Therapy—Reentry and Family Treatment Program (MDFT-RAFT)		X
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	X	X
Work to Learn		X
Youth Mentoring	X	X

E. Existing Collaborations between the Judicial Branch and the Department of Children and Families

The above summary of Connecticut's juvenile justice system and behavioral health service array reveals that there are already several points of intersection, as well as several opportunities for enhanced integration. The following section summarizes the results of a series of interviews and focus groups with stakeholders in the juvenile justice and behavioral health systems in order to

explore strengths, areas for improvement, and specific recommendations for improvements in system and service development and integration.

As CSSD and DCF both play vital roles in the delivery of behavioral health and juvenile justice services, these two agencies have formalized their collaborative relationship since 2006 through a Joint Juvenile Justice Strategic Plan. The current plan (FY 2013-2016) is the second between the agencies and serves to build off of the progress made over the past decade in advancing their common vision and mission to "make Connecticut's juvenile justice system as effective as possible for children and families and all the citizens of this state." Goals of the current Joint Strategic Plan include:

- Reduced recidivism
- Increased diversion and early intervention
- Culturally appropriate and community-based care
- Reduction of racial and ethnic disparities
- Increased family engagement, and
- More effective resource sharing and decision-making.

It is important to note that there is currently not a plan for DCF and CSSD to engage in joint strategic planning past the current plan ending in 2016. Instead, the work of the Children's Behavioral Health Plan Advisory Board and the JJPOC are presumed to take on the task of ensuring ongoing system and service development and integration.

Despite this, the collaboration represented by the Joint Strategic Plan has demonstrated positive outcomes in reducing system involvement and improving services for youth. Successes noted in the 2013-2016 strategic plan include:

- 27% decrease in juvenile court intakes between 2007-2012
- 16% decrease in juvenile detention admissions between 2007-2012, even as 16 and 17 year olds were included in the system during Raise the Age implementation
- Decreased days of wait time for court-ordered hospitalization from 45 in 2001 to 9 in 2012
- 70% decrease in juvenile commitments to DCF between 1999 and 2012, and
- 4% decrease in the 24-month re-arrest rate from 2007-2012.

IV. Summary of Major Themes from Literature Review and Data Collection Results

The summary of major themes in this section of this report draws from the information above, a review of existing national and Connecticut-specific literature and reports, and data collected through key informant interviews and focus groups. Results are organized into two major thematic areas: 1) Existing System Development and Integration Efforts, and 2) Enhancement of Practices, Programs, and Services.

A. Existing System Development and Integration Efforts

A common theme across the literature and interviews and focus groups was the importance of consistent and effective collaboration across agencies that serve youth involved in the juvenile

justice system who have behavioral health needs. As identified in the United Nations guidelines (1990) for prevention of juvenile delinquency, careful collaboration between state agencies should include several key activities, including:

1) Careful analysis of the problem or needs assessment, as well as resources available;
2) Clearly defined responsibilities for each agency and key personnel;
3) Mechanisms for implementing efforts between agencies and community programs;
4) Policies and initiatives based on research and the evidence base;
5) Evaluation of the initiatives; and
6) Family and youth participation in policy and initiative development.

A review of current system efforts in Connecticut and comments from focus group and key informants highlighted prominent examples of effective coordination and communication across state child-serving agencies involved in juvenile justice and behavioral health system development and service delivery. These existing assets present an opportunity for further consolidation of system planning and development efforts to ensure a more seamless and coordinated system for at-risk and system-involved youth.

For example, the Juvenile Justice Policy and Oversight Committee (JJPOC) was established under PA 14-217 to "evaluate policies related to the juvenile justice system." The Public Act specifies membership requirements and articulates a charge for the committee that includes comprehensive cross-systems enhancements. The work of the JJPOC is guided by three primary goals for the juvenile justice system to accomplish over the next three years:

- Increase diversion by 20 percent;
- Decrease recidivism by 10 percent;
- Reduce incarceration by 30 percent.

A number of associated reports and deliverables are specified, including the current report that provides "an assessment of the overlap between the juvenile justice system and mental health care system for children." The legislation's charge presupposes that the JJPOC will incorporate input and ensure system coordination between CSSD, DCF, and other child-serving state agencies including coordination of efforts in children's behavioral health.

With respect to legislation and system development within behavioral health, Public Acts 13-178 and 15-27 have significant implications for the overlap of the behavioral health and juvenile justice systems. Public Act 13-178 charged DCF with development of a Children's Behavioral Health Plan that would provide a framework for behavioral health system development integration at the system and service delivery levels. The Plan has an explicit focus on the development of a more effective system of care to address the behavioral health needs of *all* Connecticut youth; thus, the Plan includes recommendations relating to improving access to behavioral health care based on need and regardless of system involvement, insurance type, geography, or other characteristics. PA 13-178 and the resulting Plan articulates goals and strategies relevant to effective coordination among multiple state agencies including DCF, CSSD, SDE, OEC, DMHAS, and others.

Following submission of the Plan, Public Act 15-27 established the Behavioral Health Implementation Advisory Board. The membership of this Board includes representatives of child-serving state agencies (including DCF, CSSD and others), Medicaid, commercial insurance, behavioral health providers, child advocates, families and youth, academic institutions, and other system partners. The Board currently includes three representatives that also sit on the JJPOC. As of the writing of this report, the Advisory Board has divided its work into three subcommittees:

- Fiscal Integration;
- Network of Care Integration;
- Data Integration.

Participants in the interviews and focus groups for this report noted that DCF and CSSD have developed a stronger partnership in recent years, have a joint strategic plan in place through 2016, and have made some progress in the coordination of care for youth with behavioral health and juvenile justice needs. Many participants noted, however, that additional coordination and system integration is needed. The participants strongly indicated that these systems continue to be too fragmented, resulting in significant gaps for youth and families. Others highlighted concerns that there is currently no plan to renew the Joint Strategic Plan, which may lead to diminished coordination of efforts between DCF and CSSD, despite the fact that the both the JJPOC and the Children's Behavioral Health Advisory Board are charged with system development and integration efforts that would include behavioral health and juvenile justice.

Some participants noted an unnecessary distinction between "treatment" and "service needs" between DCF and CSSD that may reflect underlying cultures or philosophies not fully aligned with respect to assessing and intervening with youth that have significant behavioral health needs. Specifically, some noted that stakeholders in the juvenile justice system refer to the "service needs" of youth and develop "service plans" that often tend toward making referrals for sub-clinical services (e.g., skill development, case management, anger management) and focus too narrowly on recidivism as the primary outcome of services. On the other hand, participants noted that stakeholders in the behavioral health system are often unaware of the criminogenic model and risk factors related to juvenile justice involvement, and that behavioral health providers develop "treatment plans" or "plans of care" that tend to over-emphasize formal clinical treatment to the neglect of youths' overall developmental needs. Participants noted that these distinctions in philosophy, language, culture and procedures can be confusing to families, especially those with dual-system involvement.

Participants also noted that there continue to be times when partners (e.g., state agency personnel, advocates, providers) in the juvenile justice and the behavioral health systems are hesitant to engage in joint meetings for the purposes of shared planning, goal-setting, and coordination of their efforts. Some suggested that this may be more characteristics at the local and regional level than at the central office/statewide level. Participants noted that at times this may hold back progress in achieving better system integration. A better understanding of the research pertaining to the overlap of behavioral health and juvenile justice risk, and the value of coordination across these systems was identified as important for ensuring better coordination and integration.

Participants also identified that the frequent shifting of youth from one system to another based on youth behaviors and other circumstances can be disruptive to youth and families and can compromise continuity of care and accountability for outcomes. To illustrate this concern, participants noted that when youth are arrested they are a "CSSD case." If committed to CJTS or Pueblo for that offense, they become a "DCF case." Upon release, they may continue to be involved in the DCF system and a "DCF case" until another arrest is made and they again become a "CSSD case." Eligibility for services, payment for services, and the service continuum available to youth differs depending on the system that happens to be overseeing their case. Better integration across systems was recommended to ensure continuity of care and accountability for outcomes regardless of one's status within either system.

In summary, participants noted that there are opportunities for better integration between juvenile justice and behavioral health system partners, for example, through better integration of the JJPOC and the Behavioral Health Plan Implementation Advisory Board. Shared meetings, planning, goal-setting, and implementation of activities was suggested. The specific tasks of this collaboration can include further de-fragmentation at the system level so that youth can access services with fewer barriers and less confusion, as well as promoting integrated treatment/service plans and coordinated service delivery that is not interrupted by changes in system status. Finally, participants highlighted the importance of breaking down siloes that drive service delivery based on fundamental practice model differences between juvenile justice and behavioral health systems.

B. Enhancements of Practices, Programs, and Services

1. Screening, Assessment, and Diagnosis for Behavioral Health Conditions

Accurate screening procedures are a critical first step in effectively addressing the behavioral health needs of youth at a population level, those at high risk of juvenile justice involvement, or those that do come in contact with the juvenile justice system. Screening involves administration of a brief validated measure by individuals with or without formal clinical or behavioral health training, with a goal of identifying mental health, substance abuse, or trauma-related needs. Screening can occur during an initial triage or intake process, with the purpose of identifying potential problems or areas of risk requiring further assessment by clinically-trained staff. For those young people that screen positively for a possible behavioral health condition, a trained and licensed behavioral health professional can then conduct a comprehensive assessment, formulate a clinical impression and diagnosis for one or more behavioral health conditions, and recommend treatment.

In 2007, the National Center for Mental Health and Juvenile Justice published a guidebook entitled *Mental Health Screening in Juvenile Justice: The Next Frontier*. This document reviewed screening practices, policies, and implementation strategies. Mental health screening protocols have been formally adopted in juvenile probation intake procedures in about half of the states in the U.S. and CT is one of twenty-four states that requires a specific tool for that purpose (Wachter, 2015). In Connecticut, the Massachusetts Youth Screening Instrument, Version 2 (MAYSI-2; Grisso & Barnum, 2001) is a 52-item self-report measure that is used to assess potential mental health and substance use problems. The MAYSI-2 is the most popular evidence-

based mental health screening tool in juvenile justice systems nationwide, and has been used in detention and probation settings (Wachter, 2015). Other commonly used measures include, but are not limited to the following:

- The Child and Adolescent Functional Assessment Scale (CAFAS)
- Global Appraisal of Individual Needs-Short Screener (GAIN-SS)
- Problem-Oriented Screening Instrument for Teenagers (POSIT)
- The Strengths and Difficulties Questionnaire (SDQ)
- The Youth Assessment & Screening Inventory (YASI) Pre-Screen
- The screening form of the Child and Adolescent Needs and Strengths (CANS)

In addition, Connecticut has been identified as one of four model states with strong protections for youth when screenings and assessments are conducted. Connecticut statute restricts utilization of mental health screening results for youth to planning and treatment efforts only, and restricts disclosure outside of the screening entity.

Screenings are also useful in identifying risk behaviors and symptoms of alcohol and illicit drug use, a common behavioral health problem among youth. Alcohol and drug use can be a contributing factor to aggressive behaviors, injuries, death, suicidality, infections and pregnancies from unplanned and/or unprotected sex, and other traumatic experiences or psychosocial problems including problems at school and problems with the legal system (Brown et al., 2008). Despite the high risk associated with youth alcohol and illicit drug use, many states and jurisdictions do not systematically and/or effectively screen for substance use. In health care settings, commonly reported barriers to screening and intervention include a lack of time and lack of confidence by medical staff to screen for and manage alcohol and drug problems (Millstein & Marcell, 2003). Youth that are exhibiting signs of alcohol and/or drug problems are unlikely to seek help from the specialty treatment system.

Since 2009, the GAIN screening tool has been used during the intake process for all DCF-funded substance abuse treatment programs in Connecticut to guide treatment planning and monitor service needs. DCF's 2012 administrative data from the GAIN indicates that 79% of youth in DCF outpatient substance abuse treatment programs met criteria for substance abuse or dependence. Problems with both alcohol and drugs were reported among 42% of youth screened, with 75% reporting marijuana as the primary problem substance.

SAMHSA established the Screening, Brief Intervention, and Referral to Treatment (SBIRT) program in 2003 to systematically screen and provide appropriate treatment to all individuals presenting in primary care settings and has been expanded to other settings over the years. Screening and brief intervention can successfully reduce risk for those with nondependent unhealthy substance use and increase referral to treatment for those in need of specialty treatment (Saitz et al., 2007; Kraemer, 2007). Both DCF and CSSD are initiating or currently underway with SBIRT initiatives, in order to increase the state's capacity to identify and address adolescent substance use needs. SBIRT has four primary components (Babor et al., 2007):

- Screening: Introduction of systematic screening in various settings such as medical facilities, schools, and the legal system, to identify the presence of substance use and

level of risk. The most widely used and recommended screening tool for use with children under the age of 21 is the CRAAFT (Knight et al, 2002).

- Brief Intervention (BI): BI refers to any time-limited effort to provide information or advice, increase motivation to avoid substance use, or teach behavior change skills that will reduce substance use and the chances of negative consequences (SAMHSA, 2011).
- Brief Treatment (BT): BT refers to the delivery of time-limited, structured (or specific) therapy by a trained clinician, and is typically delivered to those at higher risk or in the early stages of dependence (SAMHSA, 2011).
- Referral to Treatment (RT): Screening may identify individuals who already have a substance-related health condition or a suspected substance use disorder that warrants a formal diagnosis and referral to formal treatment.

Exposure to traumatic events in childhood and adolescence is also common among youth involved in the juvenile justice system and is becoming an increasingly common focus for screening among youth in the behavioral health and juvenile justice systems. Experiences such as domestic and community violence, physical and sexual abuse, neglect and maltreatment and traumatic loss are reported by between 75-93% of system-involved youth, with 84% of youth in detention reporting exposure to multiple traumas (Abram et al., 2004; National Child Traumatic Stress Network, 2009; Wilson et al., 2013). Justice-involved youth report symptoms of Post-Traumatic Stress Disorder (PTSD) at a rate that is eight times higher than youth not involved in the juvenile justice system (Abram et al., 2004; Garland et al., 2001). These prevalence rates point to the need for systematic screening for trauma-related experiences across the juvenile justice continuum (CHDI, 2015).

With support from DCF and CSSD, the Connecticut Trauma Screen (CTS; Lang, Cloud, Stover, & Connell, 2014) was recently developed as a brief screening instrument to identify child traumatic stress. It is easily administered by clinical and non-clinical staff such as child welfare workers, juvenile probation officers, primary care providers, school personnel, and others. The CTS helps identify children who may need further assessment and trauma-informed services. In 2014, six Child, Youth, and Family Support Centers (CYFSCs) in Connecticut piloted the use of the CTS among 720 youth. The results indicated that 75% of youth had experienced trauma exposure and about half of those youth had not been previously identified as having experienced trauma (CHDI, 2015). In 2016, CHDI is planning to partner with CSSD to have all juvenile probation officers implement the CTS screening tool at intake.

Participants indicated that although a number of screening and assessment instruments are currently in use in various parts of the behavioral health and juvenile justice systems, Connecticut lacks standardized and system-wide use of screening, assessment and diagnosis of mental health, trauma, and substance use problems. Given the high prevalence of behavioral health concerns among youth involved with, or at risk of involvement with the JJ system, there is a significant need to expand opportunities to screen youth for mental health, trauma, alcohol, and substance use. The failure to identify risk and ensure appropriate and early intervention can be a contributing factor to youth entering the juvenile justice system. In addition, there are many opportunities for brief intervention and treatment, and referral to ongoing treatment for youth who screen positively for these problems. Screening and early intervention can occur outside the traditional mental health and substance abuse treatment systems including settings such as

pediatric primary care, emergency departments, schools, social service agencies, and at multiple points throughout the legal/juvenile justice system.

Participants noted a need for expansion of screening and assessment efforts. Findings in this area are reviewed below.

1. **Funding and support for early screening activities in health, school, and community settings are limited.** In order to identify the emergence of health, mental health, and substance use conditions at the earliest point possible, young people should be screened periodically in routine settings such as pediatric primary care, schools, and community-based settings and programs. It is necessary, but *insufficient* to screen for these conditions for the first time upon entry to the JJ system, at which point a young person has already experienced a significant life event that may have been prevented with earlier identification and intervention.

2. **Both mental health screening and substance use screening are underutilized and too often conducted separately.** Substance use is often considered apart from depression, anxiety, psychosis, conduct problems and other mental health conditions. Professionals in the field often are not cross-trained in mental health and substance use assessment and treatment. The research suggests that both conditions are risk factors for juvenile justice involvement; therefore, both should be part of comprehensive screening and assessment protocols.

3. **Comprehensive behavioral health assessment is not adequately provided upon entry in the juvenile justice system.** Screening is a preliminary procedure to assess the likelihood of a behavioral health condition, and a comprehensive assessment is the next step after an individual screens positive for a given condition. Although screening has become more common, interview and focus group results indicated a concern regarding the adequacy of behavioral health assessment in the juvenile justice system, in part because probation officers may not be adequately trained to identify the causes or underlying factors related to behavioral problems. An inadequate assessment can lead to an inadequate or inappropriate referral and level of care. Probation officers may require better access to trained behavioral health providers that are qualified to provide comprehensive assessment to ensure that youth who screen positively progress to the stages of full assessment and treatment of these conditions.

4. **Behavioral health screening may not be routinely provided in juvenile detention centers and correctional settings.** Connecticut does not currently require screening in juvenile detention or juvenile correctional facilities. Some states without a formal requirement for screening in these deep-end settings still support screening by providing training and funding, or by employing staff within these facilities that can provide full assessments upon intake (Wachter, 2015).

2. Early Intervention, Treatment, and Diversion

Several participants noted the importance of promoting social and emotional development and preventing behavioral health problems among youth; however, participants did not mention a strong presence of such services in home, school, and community-based settings. Participants noted, and research supports, that the failure to promote social, emotional, and behavioral development for all youth can increase the rates of youth that ultimately require more intensive and costly services within the formal service delivery system. It is important to note, however, that most youth at the population level will not become involved in the juvenile justice system. Participants recommended early identification and targeted prevention activities for youth with salient risk factors for juvenile justice system involvement.

Diversion from the juvenile justice system for youth with behavioral health needs was also identified strongly for further dissemination in Connecticut. Diversion opportunities at multiple points in the juvenile justice system were strongly recommended for youth with behavioral health needs and youth at low risk for re-offense. Current best practice in juvenile justice system design indicates that community-based options that engage youth and their families in services and supports should be attempted first, before formal involvement in the juvenile justice system (Mental Health and Juvenile Justice Collaborative for Change, 2014).

Diversion can occur pre-arrest, post-arrest, and in a variety of settings. For youth with identified behavioral health needs, effective diversion from juvenile justice involvement requires adequate community-based behavioral health services as well as alternatives to incarceration. Schools provide an opportune setting for diversion initiatives. Over 15 years ago, many schools implemented "zero tolerance" policies for addressing disruptive behavior and instituted stronger punishments for problematic behavior including arrests, suspensions, and expulsions. Although zero tolerance policies initially were intended for weapons and serious threats of violence, these policies ultimately were applied to a broader range of school-based behavior problems. This has contributed to the increased number of youth entering the juvenile justice system even for relatively minor and non-violent offenses that traditionally have been managed by schools. Many students affected by these policies meet criteria for behavioral health diagnoses, disabilities and/or developmental problems. Despite the demonstrated need, school personnel often lack the training or capacity to effectively manage behavior problems which may place youth at risk for juvenile justice system involvement.

Connecticut, like many other states, has been working to address this problem; however, school-based arrest rates continue to be of concern. In the 2014-2015 school year, approximately 20% of all juvenile court referrals in Connecticut were based on school-related incidents, an increase from a rate of 10% in the 2013-2014 school year. The Connecticut School-Based Diversion Initiative (SBDI) was identified by several participants as a promising practice for ensuring students with behavioral health needs have access to behavioral health services instead of arrest, expulsion and suspension. SBDI works to reduce exclusionary discipline particularly for youth with behavioral health needs. This is achieved by increasing referrals and services by behavioral health programs such as the Emergency Mobile Psychiatric Services (EMPS). Through SBDI, schools receive: (1) training to help identify students with behavioral health needs; (2) stronger connections to effective community-based behavioral health services as an alternative to arrest,

suspension , or expulsion; and (3) revision of policies and practices to support diversion, reduce reliance on law enforcement involvement in discipline, and increase capacity and support for addressing students' behavioral health needs. To date, SBDI has served 21 schools in 10 school districts and will be significantly expanded beginning in 2016. Program evaluation results demonstrate significant reductions in student arrests, suspensions, and expulsions and increases in use of EMPS services (Bracey, Arzubi, Vanderploeg, & Franks, 2013).

In addition to diversion initiatives, several interview participants indicated that there are specific strengths in the interventions that youth receive to address behavioral health needs within the juvenile justice system in CT. Participants indicated that CSSD added Clinical Coordinators for arrested youth which has helped to facilitate access to behavioral health services. The Clinical Coordinators help streamline the process to ensure that the right youth are referred to the right behavioral health services. Several interviewees also indicated that community outpatient care (including EMPS) has helped reach a large group of youth and diverted them from juvenile justice (and emergency department) involvement.

Several individuals also highlighted improved interagency collaboration, particularly between CSSD and DCF, to meet the needs of youth who are involved in the judicial system and have behavioral health problems. It was noted that personnel from DCF and the Judicial Branch have been effective in establishing Memoranda of Agreement (MOAs) to articulate formal and informal collaborations and data sharing to support dually involved youth and to measure system and youth outcomes. Some participants focused on the efforts of leaders within these agencies in securing positive relationships with outside advocacy groups and the state legislature, while noting that increasing these efforts remains an ongoing need.

CSSD and DCF both have data collection systems in place to track outcomes and there are several examples of data analysis and reporting that have benefitted the provider network and community stakeholders in monitoring the system. Participants reported that efforts have been made to improve data integration across health and human services agencies and to promote reporting using the Results Based Accountability (RBA) framework. Nevertheless, many participants also noted the continued need for enhancement in data collection, analysis, reporting, and data sharing across behavioral health and juvenile justice systems. Participants noted that not enough staffing capacity has been dedicated to data analysis and reporting and that state agencies can be slow to respond to requests for data to monitor outcomes for youth in these systems. Participants also noted a need for common identifiers to better facilitate linking data and examining longitudinally the outcomes of youth served in the behavioral health and juvenile justice systems.

Finally, participants largely positively acknowledged CSSD and DCF for investments in evidence-based programs and best practices, and participants also recognized their efforts to provide funding to the private, non-profit sector for delivering a range of services and supports for youth.

Despite all these successes, a review of the literature and key stakeholder interviews and focus groups reveals some key gaps related to the interventions and treatments for behavioral health problems in youth at risk for or involved in the juvenile justice system.

1. **Overall access to behavioral health care is insufficient.** Increased access to behavioral health services prior to contact with the juvenile justice system was a common theme discussed in the key stakeholder interview and focus groups and was also a key theme from the Children's Behavioral Health Plan. Stakeholders described that families' best access to behavioral health treatment services may occur only after youth become involved with the juvenile justice system. Some families described the unfortunate situation in which they are advised to allow their child to be arrested so that they can access needed services only available to youth in the juvenile justice system.

2. **Specialized services for acute behavioral health problems are needed.** A concern existed among participants that some youth are detained in the juvenile justice system because there is insufficient capacity for inpatient and residential treatment to stabilize their acute behavioral health needs. Participants indicated a need to ensure that capacity for the highest levels of care meets the current need. Case management and care coordination were also highlighted as important services for youth with behavioral health needs who are involved in the juvenile justice system.

3. **Substance abuse services in CT are limited**. Several of the interview and focus group participants indicated a major gap in access to substance use assessment and treatment for youth. Community-based substance abuse treatment services for youth are available in every region of the state; however, service capacity varies by local provider and access to more specialized services is shared statewide by a smaller number of providers. Although there are several effective evidence based treatments available in the state of Connecticut, they are limited in capacity and at times only serve those on Medicaid or already involved in the state's child welfare or juvenile justice systems. Not only was access to services a problem, stakeholders indicated that assessment and identification of mental health and substance use disorders was limited. Among youth authorized for outpatient behavioral health services in the State, it has been reported that only 1.1% present with a primary substance abuse diagnosis (ValueOptions, Inc., 2014) while rates of primary substance abuse diagnoses among youth receiving Intensive Outpatient Services are significantly higher, ranging from 15 to 18 percent. Several stakeholders interviewed recommended more effective substance abuse assessment and treatment in the juvenile justice system as well as more services for youth to prevent involvement with the juvenile justice and other public child-serving systems.

4. **Integration of effective behavioral health treatment planning and practices is needed to support existing skill-based services.** A concern raised by several key stakeholders during the interviews and focus groups was that many of the programs funded and managed by CSSD are focused more on skill building and/or safety rather than improving behavioral health functioning as well as reducing risk. Participants noted that the CSSD system develops "service plans" rather than "treatment plans," which tend to focus on safety and social supports (e.g., job skills and anger management classes) versus engaging the youth in effective behavioral health treatment.

5. **Evidence based practices must balance process with outcomes.** Connecticut has been recognized nationally as a leader in delivering evidence based practices (EBPs) for behavioral health conditions. Many focus group and interview participants noted that although there is value to EBPs, they have concerns about ensuring access to these treatments given limited treatment slots and long wait lists, geographic limitations, and a "one-size-fits all" approach with many EBPs. Some participants indicated that treatment outcomes must be consistently measured and reported even for youth receiving EBPs, to ensure that youth who do not respond to these treatments have access to other service that may be more individualized and effective. One participant noted that the relational aspect of care that is central to trauma-informed clinical work, and may be effective for youth with multiple complex needs, may be compromised when referring all youth to models that are strictly based on Cognitive-Behavioral Therapy (CBT) models.

6. **Additional funding is needed to support highly qualified staff.** Several participants reported the challenge associated with continual threats to the state budget for the juvenile justice and behavioral health systems. Participants spoke of low rates of reimbursement and low salaries within the non-profit provider community serving this population, which contributes to high turnover rates, compromised continuity of care, and poor outcomes.

7. **Documented racial and ethnic disparities with respect to access and service quality.** Based on geography, income level, and Medicaid and/or insurance benefits, families have disproportionate access to treatment. Racial and ethnic disparities in the juvenile justice system are well documented nationally and in Connecticut. A series of studies conducted on Disproportionate Minority Contact (DMC) in the State's juvenile justice system indicate that Black and Hispanic youth are overrepresented (Richetelli, Hartstone, & Murphy, 2009). Racial/ethnic minority youth are often punished more harshly for the same behavior as their non-minority peers. Participants from the interviews and focus groups indicated serious concerns about these disparities and a need for increased action to address them. They also indicated that available treatments are perceived not to be sensitive to cultural differences which may contribute to disparities in outcomes among youth in behavioral health and juvenile justice systems.

8. **Cross-system Collaboration and Coordination is Needed among Schools, Juvenile Justice, and Behavioral Health Systems.** The education system is primed to address early intervention needs for youth. Schools can impact not only academic functioning, but can develop and implement policies and practices that reach a large number of youth. According to United Nations guidelines for the prevention of juvenile delinquency (United Nations, General Assembly 1990) as well as interview and focus group results, there are several ways schools can address behavioral health needs for youth to minimize risk for juvenile delinquency:
    - Increase availability of school-based behavioral health services, including substance abuse treatment, in all schools
    - Promote cultural awareness and respect for youth's own culture as well as others. This includes teaching social values of the school and community in which the child lives and learning to respect divergent cultures, views, and experiences.

- Develop youth's talents and mental and physical abilities that enhance a sense of identity and belonging to the school and local community through development and implementation of extracurricular activities in school and community that are of interest to a diverse set of students.
- Engage youth as active rather than passive participants in their education and personal development and promote peer support models.
- Facilitate readiness for the workforce including vocational training and guidance on employment and future careers.
- Provide behavioral health services and supports within schools and build capacity for connection to additional resources in the community.
- Work collaboratively with parents and families.
- Work closely with community organizations focused on youth development and emotional support.
- Ensure that students and staff are trained to screen for alcohol and drug use problems and refer for further assessment and treatment as needed.

Based on the research literature, extant reports on behavioral health and juvenile justice system development (nationally and within Connecticut), and the results of interviews and focus groups, it is clear that Connecticut has made significant progress in developing effective juvenile justice and behavioral health systems. The results suggest, however, that there remains a need for further integration of these systems and the services available to youth and their families. Moreover, other child-serving systems (child protection, education, early childhood) may also benefit from stronger integration and coordination to ensure that youth with significant needs and their families have access to a seamless and integrated system of services and supports regardless of system involvement, insurance type, geography, or other factors.

Based on these findings, action steps are offered below to better integrate the juvenile justice and behavioral health systems. These action steps are organized into two broad categories: (1) system development and integration, and (2) service delivery.

V. Action Steps

Based on the findings above, action steps are offered that may serve to better integrate the juvenile justice and behavioral health systems in the State of Connecticut. These action steps are organized into two broad categories paralleling the organization of findings in the narrative above: (1) system development and integration, and (2) service delivery. It is important to note that although some action steps can be achieved at no or minimal cost, others will require additional funding and support. Members of the JJPOC, Behavioral Health Plan Advisory Board, and other appropriate entities are encouraged to carefully consider the financial resources required to implement these action steps. A timeline for implementing these action steps is provided in Appendix C.

Area 1: Enhance system infrastructure and system integration to address the behavioral health needs of all youth, including those who are involved with, or at risk of involvement with, the juvenile justice system.

A. Enhance the children's behavioral health service delivery system and further integrate that system with juvenile justice and other child-serving systems

Action Step 1. Enhance coordination and integration of the work of the Juvenile Justice Policy and Oversight Committee (JJPOC) and the work of the Children's Behavioral Health Plan Advisory Board. Although it is important to maintain the autonomy of each entity to pursue their respective charges, further collaboration will help to enhance the development and alignment of goals, strategies, and implementation of action steps that will in turn enhance integration of the behavioral health and juvenile justice systems statewide.

1.a. Consider the following options for better coordinating the efforts of these two entities, including but not limited to: regular cross-reporting of progress and periodic joint meetings; increasing the number of shared members; or developing a shared subcommittee focused on cross-system integration.

1.b. Identify members of each entity responsible for ensuring that goals and strategies pertaining to the structure, financing, delivery, evaluation, and integration of behavioral health services are appropriately aligned across these two entities.

1.c. Ensure representation and engagement of families and youth with past or current behavioral health and juvenile justice system involvement in the governance, planning, implementation, and evaluation of behavioral health and juvenile justice system development and service delivery efforts.

1.d. Consider establishing a law and policy working group to address concerns raised among participants relating to issues of confidentiality, protection of rights, and state and federal law. This working group may be comprised of members of the JJPOC, BH Plan Advisory Board and other members, particularly those with legal and policy expertise. This group will be tasked with examining limitations and exceptions in state and federal law and policies for issues including, but not limited to the following: integrating state funds; information and data sharing; and due process and the role of screening and treatment among youth already involved in the juvenile

justice system. Upon reviewing these and other relevant issues, this group can make recommendations to facilitate cross-system integration and the implementation of action steps from this report.

Action Step 2. Provide further support for the implementation of the goals and strategies identified in the Connecticut Children's Behavioral Health Plan, specifically those relating to the integration of behavioral health and juvenile justice planning, system development, and service delivery.

2.a. Provide funding to support the planning and administrative needs of the Behavioral Health Implementation Advisory Board, such as project management, work plan development and execution, and coordination of activities with the JJPOC and other child-serving systems.
2.b. Ensure that DCF,CSSD, and the Department of Corrections (DOC) complete the detailed fiscal analysis that is currently in progress within some state agencies to examine expenditures for behavioral health services. These findings can be reported to the Children's Behavioral Health Advisory Board and the JJPOC to inform action steps to integrate funding streams and coordinate delivery of behavioral health services to youth in the behavioral health and juvenile justice systems.
2.c. To prevent system involvement at the population level, provide funding and support to promote social, emotional and behavioral development; nurturing environments for young children; and the delivery of evidence-based social and emotional skill development and universal prevention activities in home, school, and community settings.
2.d. DCF, CSSD and other child-serving systems could begin to plan jointly an expansion of the state's first Care Management Entity (CME) to include coordination of the delivery of behavioral health services to other populations of youth in need of services, beginning with the juvenile justice population.

Action Step 3. Consider legislation to ensure reinvestment of funds from reductions in deep-end juvenile justice and behavioral health placements (e.g., juvenile incarceration, residential psychiatric treatment facilities) to the community-based service system to address the needs of these youth. Consider establishing a joint behavioral health/juvenile justice finance committee, possibly as a shared committee of the JJPOC and Behavioral Health Implementation Advisory Board, to assess these cost savings and develop a plan for reinvestment in the community-based care system.

B. Expand system capacity for collecting, analyzing, and reporting data to track access, service quality, outcomes, and expenditures for youth with behavioral health needs and juvenile justice involvement.

Action Step 4. Consider legislation to facilitate the integration of data across the behavioral health and juvenile justice systems.

4.a. In the short-term (e.g., within one year), DCF and CSSD could create a shared identifier, or algorithm for creating a shared identifier, that would allow data to be more easily linked across their systems and begin to produce more robust reports examining the overlap of youth in both systems and their long-term outcomes. In the longer-term (e.g., within two years), as child-serving systems move toward better integration, all youth involved in child-serving systems could be assigned a single unique identifier to allow for tracking a variety of behavioral health, juvenile justice, and other system indicators and outcomes (e.g., maltreatment, out-of-home placements, academic achievement, physical health, employment).
4.b. In all efforts to integrate datasets, ensure that these practices and procedures are fully compliant with all relevant federal and state laws and regulations pertaining to data privacy, security and confidentiality (e.g., HIPAA, FERPA, etc.).

Action Step 5. Develop and implement a comprehensive outcome measurement plan for youth in the juvenile justice and behavioral health systems that integrates relevant indicators and outcomes.

5.a. Identify resources required to examine data across systems, either within the state agencies or through selection of an appropriate external contractor.
5.b. Develop shared indicators and outcome measures within an integrated data system that will allow for collecting, analyzing, and reporting longitudinal data on social, emotional, and behavioral functioning as well as arrests, juvenile court involvement, recidivism, and academic achievement.
5.c. Produce aggregated data reports to monitor the delivery of effective services and the achievement of positive outcomes for youth with behavioral health needs in the juvenile justice system. Disaggregate outcomes by contracted providers in the behavioral health and juvenile justice systems and engage those providers in continuous quality improvement processes to improve service delivery and outcomes.
5.d. Establish innovative reimbursement policies that create incentives for providers to deliver evidence-based care and achieve optimal outcomes.
5.e. Examine the presence of disparities related to race/ethnicity, gender, geography, socioeconomic status, and other relevant factors that are known to potentially impact access, service utilization, arrest, flow through the juvenile justice system, and outcomes.

Area 2: Develop an integrated and effective array of services and supports that identifies and addresses service needs at the earliest possible point, prevents deep-end behavioral health and juvenile system involvement, coordinates care across systems, and fully addresses the needs of system-involved youth.

A. Enhance screening and assessment in order to identify youth exhibiting risk factors for behavioral health concerns and juvenile justice involvement.

Action Step 6. Provide funding and support to enhance screening for behavioral health and juvenile justice risk factors in school and community-based settings. The purpose of expanded screening is to identify and address needs at the earliest possible point and prevent system involvement. In carrying out recommendations related to screening and treatment of youth, ensure appropriate procedures are in place to obtain informed consent and to protect the rights of youth including the due process rights of youth already involved in the juvenile justice system.

6.a. Ensure selection of common screening measures (such as the MAYSI-2 or other measures) for implementation in school and community settings, and that selected measures screen for both mental health and substance use conditions.
6.b. Ensure that youth who have risk factors for behavioral health symptoms and/or juvenile justice system involvement have access to care coordination and case management that addresses their basic material needs (e.g., housing, transportation, job training and employment).
6.c. Train probation staff, EMPS providers, school personnel, and other appropriate system partners in the Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol, and ensure consistency between current DCF- and CSSD-led SBIRT efforts in the selection of screening measures and development of protocols.
6.d. Train probation officers, EMPS providers, detention and corrections staff, and other system employees to routinely screen for suicide risk for youth at all points in the juvenile justice and behavioral health systems. Consider system-wide adoption of the Columbia Suicide Severity Rating Scale (SSRS), or a similar validated measure for assessing suicide risk.

Action Step 7. Enhance targeted screening (and full assessment as indicated) of behavioral health needs upon intake to detention, CYFSCs, and secure facilities, ensuring the full protection of youths' legal rights.

Action Step 8. Ensure that probation officers and other staff members in the juvenile justice service continuum have access to trained and licensed behavioral health clinicians to provide comprehensive biopsychosocial assessment for youth who are suspected to have more significant behavioral health concerns.

B. Enhance programs and initiatives that divert youth from the juvenile justice system.

Action Step 9. Expand efforts to reform school disciplinary policies and procedures in order to reduce school-based arrests, expulsions, and suspensions for youth involved in school-based behavioral incidents.

9.a. Determine a list of divertible behaviors and offenses that occur in school settings and train school personnel in graduated response models of disciplinary intervention to identify and divert from arrest youth exhibiting these behaviors.

9.b. Ensure sustained capacity to implement school- and district-level initiatives that reduce arrest, expulsion, and suspension; train school personnel together with SROs; screen for behavioral health needs; and refer to appropriate services and supports.
9.c. Expand the implementation of school-based restorative justice and restorative practices as a non-judicial response to school-based behavioral incidents.
9.d. Consider funding and support to increase the number of school districts with signed memoranda of agreement with their local law enforcement departments and EMPS teams.

Action Step 10. Expand the funding and capacity of Juvenile Review Boards (JRBs) to further support youth involved and at-risk of involvement with the juvenile justice system.

10.a. Expand the number of JRBs to ensure statewide coverage.
10.b. Expand the scope of JRBs to directly accept police and school referrals for youth outside of the formal juvenile justice system.
10.c. Train and resource JRB staff for the delivery of restorative justice and restorative practices in lieu of arrest and formal JJ system involvement.
10.d. Train JRB staff in how to engage parents and support families in accessing behavioral health evaluations and treatment through insurance, pediatricians, and other local providers.
10.e. Explore opportunities to expand the capacity of JRBs to deliver evidence-based services currently offered through DCF and CSSD.

C. Enhance services available to youth with behavioral health needs to ensure services can be provided outside formal involvement with the juvenile justice system.

Action Step 11. Examine and enhance existing grant funding and Medicaid reimbursement rates to expand service delivery capacity, retain highly-qualified staff, and deliver evidence-based services to a larger population of youth with needs regardless of current system involvement.

11.a. Case management. Examine possible models for reimbursing providers to deliver case management services that are critical to addressing basic needs.
11.b. Care Coordination. Ensure youth with behavioral health and juvenile justice needs have sufficient access to Care Coordination services to support the development of a single plan of care and coordination of services across systems.
11.c. EMPS and crisis respite services. Implement the planned expansion of EMPS to provide front-end diversion from the juvenile justice system and emergency departments; provide linkages to brief crisis-oriented clinical services such as S-FIT (Short-Term Family Integrated Treatment Program); and ensure youth are linked to ongoing care as needed.
11.d. Outpatient treatment. Ensure the statewide network of community-based outpatient providers has capacity to meet the current demand for services and maximize use of evidence-based practices in this setting.

11.e. Intermediate levels of care. Expand access to intermediate levels of care (e.g., Extended Day Treatment, Intensive Outpatient Programs, Partial Hospitalization Programs) for youth. This level of care provides more intensive services than outpatient treatment for youth with a higher degree of need, while allowing youth to remain in their homes, schools, and communities.

11.f. Substance use assessment and treatment. Fully implement SBIRT statewide and ensure sufficient capacity for providing evidence-based substance abuse treatment services.

11.g. Child, Youth, and Family Support Centers (CYFSC). CYFSCs provide community-based screening, referral, and brief treatment services to juvenile justice-involved youth. Consider providing financial support to CYFSCs to strengthen the clinical screening process and expand referral options within the community-based behavioral health service array, particularly for youth at lowest criminogenic risk, in order to divert them from further juvenile justice system involvement. In addition, as a relatively new program, consider providing support to CYFSCs for rigorous program evaluation to establish support for effectiveness and potential areas for expansion or improvement.

11.h. Intensive in-home services. Expand access to intensive in-home services, which can help reduce barriers to accessing care, and are appropriate for youth with behavioral health and juvenile justice needs. Treatment options include but are not limited to Multisystemic Therapy (MST), Multidimensional Family Therapy (MDFT), Functional Family Therapy (FFT), Brief Strategic Family Therapy (BSFT), and Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS).

11.i. Inpatient hospitalization and Psychiatric Residential Treatment Facilities (PRTF). Ensure that a sufficient number of inpatient and PRTF beds exist to address the need for this level of care. Risk of arrest and juvenile justice involvement increases when a youth's level of clinical acuity exceeds what can safely be provided in home- and community-based settings.

11.j. School-based mental health services. Increase the capacity of schools to deliver evidence-based, trauma-informed interventions (e.g., CBITS) and connect with community-based behavioral health providers to access a full continuum of care for youth with more acute and/or severe needs. Comprehensive approaches to expanded school mental health should include school climate improvement, family engagement, restorative practices, data and evaluation support, and workforce development.

11.k. Innovative and promising practices. Innovative models of care continue to be developed for youth with behavioral health and juvenile justice needs. Grant funds can be identified to support the implementation, evaluation, and possible scaling-up of these services.

Action Step 12. Among youth who are committed to a secure facility or served by the juvenile parole system (e.g., CTJS, Pueblo, Manson Youth Institution), implement existing report recommendations (e.g., Georgetown University, National Center for Mental Health and Juvenile Justice, Office of the Child Advocate) pertaining to the delivery of trauma-informed care, positive youth development, suicide prevention, and post-discharge transitions to community settings.

12.a. For those youth in the CT Juvenile Training School or Pueblo, ensure that transition planning is initiated at the start of their placement and that this transition planning is focused on ensuring a stable living environment with access to home- and community-based services and educational and transitional supports for those who demonstrate this level of clinical need.
12.b. If the state moves toward the closing of secure juvenile facilities, ensure sufficient time to fully scale up a network of smaller, community-based, secure therapeutic environments before such settings are closed. To inform these efforts, consider best practices currently in place in Connecticut or other identified national models, such as initiatives in Missouri, the Redeploy Illinois initiative, or the Reclaim Ohio initiative.

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Appendix A

List of Documents Reviewed

- Connecticut's Children's Behavioral Health Plan (Child Health and Development Institute, 2014)
- Juvenile Offenders and Victims: 2014 National Report (M. Sickmund & C. Puzzanchera, 2014)
- National Center for Mental Health and Juvenile Justice Reports:
    - Better Solutions for Youth with Mental Health Needs in the Juvenile Justice System (Mental Health and Juvenile Justice Collaborative for Change: A Training, Technical Assistance and Education Center and a member of the Models for Change Resource Center Partnership, 2014)
    - Blueprint for Change: Funding Mental Health Services for Youth in Contact with the Juvenile Justice System (Skowyra, K. R. & Cocozza, J. J., 2007)
    - Developing Effective Policies for Addressing the Needs of Court-Involved Youth with Co-occurring Disorders (Kinscherff, R. & Cocozza, J. J., 2014)
    - Evidence Based Practice Recommendations for Juvenile Drug Courts (Hill, H., Shufelt, J. L., & Cocozza, J. J., 2009)
    - Family Engagement and Involvement (2012)
    - Juvenile Justice Resource Series: Successfully Collaborating with the Juvenile Justice System: Benefits, Challenges and Key Strategies (Shufelt, J., Cocozza, J., & Skowyra, K., 2010)
    - New Directions for Behavioral Health Funding and Implications for Youth Involved in the Juvenile Justice System (Cuellar, A. E., 2011)
    - New Directions to Effectively Address Co-Occurring Mental Disorders: Advancing Juvenile Drug Treatment Courts: Policy and Program Briefs (Hills, H. & Keator, K. J., 2014)
    - Providing Effective Treatment for Youth with Co-Occurring Disorders (Kanary, R., Shepler, R., & Fox, M., 2014)
    - Schools Turn to Treatment, Not Punishment, for Children with Mental Health Needs (Weiss, G. & Skowyra, K., 2013)
- Family Focused Interventions to Prevent Juvenile Delinquency: A Case Where Science and Policy Can Find Common Ground (Fagan, A., 2013)
- Disproportionate Minority Contact in the Juvenile Justice System (The Sentencing Project, 2014)
- Improving Outcomes for Children in Schools: Expanded School Mental Health (Bracey, J., Arzubi, E., Vanderploeg, J., and Franks, R., 2013)
- Joint Juvenile Justice Strategic Plan FY 2013-FY 2016. (Judicial Branch and Department of Children and Families, 2013)

- Orphanages, Training Schools, Reform Schools and Now This? Recommendations to Prevent the Disproportionate Placement and Inadequate Treatment of Children with Disabilities in the Juvenile Justice System (National Disability Rights Network, 2015)
- Caring for Youth with Mental Health Needs in the Juvenile Justice System: Improving Knowledge and Skills (Meservey, F. & Skowyra, K., 2015)
- Strengthening Youth Justice Practices with Developmental Knowledge and Principles (Butts, J., 2014)

Appendix B

Description of Services Available to Youth Involved in the Juvenile Justice and Behavioral Health Systems

Program or Service	Description	CSSD	DCF	EBP
ACCESS Mental Health	Free consultation to primary care physicians and practices to assist in treating youth with behavioral health concerns under age 19, regardless of insurance.		X	
Adolescent Community Reinforcement Approach & Assertive Continuing Care (A-CRA/ACC)	Outpatient program for youth age 12-17 needing substance abuse treatment. Referrals accepted from parents, courts, hospitals, schools, primary care providers or youth themselves.	X	X	X
Care Coordination	Services provided to children and youth with "Serious Emotional Disturbance" (SED) and complex behavioral health needs across multiple services and/or systems. Priority is for youth at imminent risk of residential placement or hospitalization, or youth returning from these levels of care. Service is available to non-DCF involved youth and families with court or probation involvement, but not youth at CJTS or receiving DCF parole services.		X	
Center for Assessment, Respite, and Enrichment (CARE)	Seeks to intervene and divert girls from juvenile justice involvement through on-site stabilization, assessment, and case management in a secure facility. Average length of stay is 14 days, but may take up to 4 months.	X		
Child, Youth, and Family Support Centers (CYFSC)	Serves status offenders and delinquent youth age 11-17 with comprehensive services including evidence-based practices targeting criminogenic needs to positively change behavior and reduce recidivism. Services include assessment, case management, cognitive behavioral groups, crisis intervention, family mediation, job readiness, and service referrals.	X		
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	School-based group intervention used to reduce symptoms of PTSD and depression and psychosocial dysfunction among youth with trauma exposure.		X	X

Program or Service	Description	CSSD	DCF	EBP
Community Residential Programs	Residential programs provide on-site education, medical, mental health, and recreational services for adolescents. Generally available to youth under orders of detention and out-of-state non-delinquent runaways, at a length determined by court.	X		
Boys Therapeutic Respite and Assessment Center (TRAC)	4 week to 3 month residential placement for boys age 14-17 with respite and assessment.	X		
Boys Intermediate Residential Program (IR)	4 month residential program with MDFT designed to decrease substance abuse dependence, recidivism, and criminal activity among boys under 18.	X		
BRAVE Community Residential Program for Boys	Secure residential program for boys age 11-17.	X		
Hybrid Girls' Community Residential Program	Combination staff secure, residential program, length determined by court; and voluntary two-week residential stay with respite and assessment for girls age 11-17 on detention orders or out-of-state non-delinquent runaways.	X		
SAGE Secure Community Residential Program for Boys	Step down, secure residential program for 11-17 year old boys.	X		
SOAR Community Residential Program for Boys	Secure residential program serving boys age 11-17.	X		
WSD Secure Residential Program for Girls	Serves 11-17 year old girls.	X		
Community Service Programs (CSP)	Provides access to community service activities for juveniles referred by the court.	X		
Competency Evaluations	Provides court with competency to stand trial assessments.	X		
Court Based Assessments (CBA)	Provides court with mental health, substance abuse, and sex offender assessments for any child involved with juvenile court or probation.	X		

Program or Service	Description	CSSD	DCF	EBP
Detention Recreation	Recreational services for youth detained in a Juvenile or community-based detention facility.	X		
Educational Support Services (ESS)	Targets court-involved youth with school problems (i.e., truancy, disruptive behaviors, repeated grade failures). Special education attorneys represent parents needing support and includes assessment of educational needs and rights, and individualized advocacy.	X		
Emergency Mobile Psychiatric Services (EMPS)	Free service for all children under age 19. EMPS deploys teams of trained clinicians to homes, schools, and community-based settings to stabilize crisis situations, screen for behavioral health problems, provide follow-up and care for 45 days, and link youth and families to ongoing care as needed.	X	X	
Extended Day Treatment (EDT)	Community-based program for 5-17 year olds needing an intermediate level of care to remain in their own homes. Services include structured, intensive treatments and psycho-social interventions during non-school hours for an average of six months. Priority access is granted to children returning from out-of-home placement or who are at risk of placement due to mental health challenges.	X	X	
Family Engagement	Family engagement and empowerment support services are provided particularly in pre-trial detention to support parents in effectively engaging with the juvenile justice system and to gain self-advocacy skills.	X		
Fostering Responsibility Education and Employment (FREE)	Reentry support to youth returning from DCF commitment back to home and community. Services begin during DCF placement and extend through transition. .Services include life skills development and educational, vocational, and employment supports.		X	
Functional Family Therapy (FFT)	Intensive in-home model designed for youth returning home from out-of-home placement or psychiatric hospitalization or who are at imminent risk of placement due to behavioral health challenges.	X		X

Program or Service	Description	CSSD	DCF	EBP
Home Care	Short-term psychotropic medication management outpatient service, with an average length of two months. May be referred by juvenile probation or CYFCs.	X		
Human Anti-trafficking Response Team (HART)	DCF program to focus on and reduce commercial sexual exploitation of children and Domestic Minor Sex Trafficking (DMST). HART promotes public awareness and prevention, ongoing monitoring, and victim response.	X		
Intensive In-Home Child & Adolescent Psychiatric Services (IICAPS)	Intensive in-home model designed for youth returning home from out-of-home placement or psychiatric hospitalization or who are at imminent risk of placement due to behavioral health challenges.	X		
Juvenile Sex Offender Services (JSOS)	Provides age-appropriate, comprehensive, and multifaceted treatment to juvenile sex offenders.	X		
Multisystemic Therapy (MST)	In-home service for youth age 12-17 with conduct and/or substance abuse problems. Meets several times per week for 4-5 months.	X	X	X
Multisystemic Therapy for Problem Sexual Behavior (MST-PSB)	Designed for youth with problem sexual behaviors.		X	X
Multisystemic Therapy for Family Integrated Transition (MST-FIT)	For youth transitioning back to the community after incarceration. Combines MST with Dialectical Behavior Therapy (DBT) and Motivational Interviewing (MI).		X	
Multisystemic Therapy for Transitional Age Youth (MST-TAY)	Designed for youth age 17-20 with recent criminal involvement and concurrent mental health needs.		X	
Multidimensional Family Therapy—Reentry and Family Treatment Program (MDFT-RAFT)	In-home adaptation of MDFT for youth with substance abuse and delinquency, age 11-18, upon release of a year or longer incarceration	X	X	

Appendix C

Timeline for Implementation of Action Steps

	Action Step	6 months	12 months	18 months	24 months
Area 1: Enhance system infrastructure and system integration to address the behavioral health needs of all youth, including those who are involved with, or at risk of involvement with the juvenile justice system.					
A	**Enhance the children's behavioral health service delivery system and further integrate that system with juvenile justice and other child-serving systems.**				
A-1	Enhance coordination and integration of the work of the Juvenile Justice Policy and Oversight Committee (JJPOC) and the work of the Children's Behavioral Health Plan Advisory Board. Although it is important to maintain the autonomy of each entity to pursue their respective charges, further collaboration will help to enhance the development and alignment of goals, strategies, and implementation of action steps that will in turn enhance integration of the behavioral health and juvenile justice systems statewide.	X			
A-2	Provide further support for the implementation of the goals and strategies identified in the Connecticut Children's Behavioral Health Plan, specifically those relating to the integration of behavioral health and juvenile justice planning, system development, and service delivery.	X			
A-3	Consider legislation to ensure reinvestment of funds from reductions in deep-end juvenile justice and behavioral health placements (e.g., juvenile incarceration, residential psychiatric treatment facilities) to the community-based service system to address the needs of these youth. Consider establishing a joint behavioral health/juvenile justice finance committee, possibly as a shared committee of the JJPOC and Behavioral Health Implementation Advisory Board, to assess these cost savings and develop a plan for reinvestment in the community-based care system.		X		
B	**Expand system capacity for collecting, analyzing, and reporting data to track access, service quality, outcomes, and expenditures for youth with behavioral health needs and juvenile justice involvement.**				
B-4	Consider legislation to facilitate the integration of data across the behavioral health and juvenile justice systems.		X		
B-5	Develop and implement a comprehensive outcome measurement plan for youth in the juvenile justice and behavioral health systems that integrates relevant indicators and outcomes.				X

4 Area 2: Develop an integrated and effective array of services and supports that identifies and addresses service needs at the earliest possible point, prevents deep-end behavioral health and juvenile system involvement, coordinates care across systems, and fully addresses the needs of system-involved youth.					
A	**Enhance screening and assessment in order to identify youth exhibiting risk factors for behavioral health concerns and juvenile justice involvement.**				
A-6	Provide funding and support to enhance screening for behavioral health and juvenile justice risk factors in school and community-based settings. The purpose of expanded screening is to identify and address needs at the earliest possible point and prevent system involvement. In carrying out recommendations related to screening and treatment of youth, ensure appropriate procedures are in place to obtain informed consent and to protect the rights of youth including the due process rights of youth already involved in the juvenile justice system.			X	
A-7	Enhance targeted screening (and full assessment as indicated) of behavioral health needs upon intake to detention, CYFSCs, and secure facilities, ensuring the full protection of youths' legal rights.			X	
A-8	Ensure that probation officers and other staff members in the juvenile justice service continuum have access to trained and licensed behavioral health clinicians to provide comprehensive biopsychosocial assessment for youth who are suspected to have more significant behavioral health concerns.				X
B	**Enhance programs and initiatives that divert youth from the juvenile justice system.**				
B-9	Expand efforts to reform school disciplinary policies and procedures in order to reduce school-based arrests, expulsions, and suspensions for youth involved in school-based behavioral incidents.		X		
B-10	Expand the funding and capacity of Juvenile Review Boards (JRBs) to further support youth involved and at-risk of involvement with the juvenile justice system.		X		
C	**Enhance services available to youth with behavioral health needs to ensure services can be provided outside formal involvement with the juvenile justice system.**				
C-11	Examine and enhance existing grant funding and Medicaid reimbursement rates to expand service delivery capacity, retain highly-qualified staff, and deliver evidence-based services to a larger population of youth with needs regardless of current system involvement.				X
C-12	Among youth who are committed to a secure facility or served by the juvenile parole system (e.g., CTJS, Pueblo, Manson Youth Institution), implement existing report recommendations (e.g., Georgetown University, National Center for Mental Health and Juvenile Justice, Office of the Child Advocate) pertaining to the delivery of trauma-informed care, positive youth development, suicide prevention, and post-discharge transitions to community settings.	X			

Connecticut Children's Behavioral Health Plan

Prepared pursuant to Public Act 13-178
And Submitted to Connecticut General Assembly

October 1, 2014

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Connecticut Department of Children and Families

Prepared by: Child Health and Development Institute of Connecticut, Inc.

Funding Provided by: Department of Children and Families, Connecticut Health Foundation, Children's Fund of Connecticut, Grossman Family Foundation

Executive Summary

Overview

There are approximately 783,000 children under age 18 currently in Connecticut, constituting 23% of the state's population. Epidemiological studies using large representative samples suggest that as many as 20% of that population, or approximately 156,000 of Connecticut's children, may have behavioral health symptoms that would benefit from treatment. yet many of these children are not able to access services.[1] Families experience a number of barriers to treatment including a highly fragmented system in which access varies according to such factors as insurance status, involvement in child welfare or juvenile justice,, race and ethnicity, language, and geographic location. In addition, the array of services lacks sufficient inclusion of supports for all children and families that promote nurturing relationships and environments that foster social, emotional, and behavioral wellness. A comprehensive plan is required to guide the efforts of multiple stakeholders in developing a children's behavioral health system that builds on existing strengths and addresses the many challenges that exist.

The Connecticut Department of Children and Families (DCF) is submitting this Connecticut Children's Behavioral Health Plan in fulfillment of the requirements of Public Act 13-178, one part of the Connecticut General Assembly's response to the tragedy in Newtown in December 2012.[2] The legislation called for the development of a "comprehensive implementation plan, across agency and policy areas, for meeting the mental, emotional and behavioral health needs of all children in the state, and preventing or reducing the long-term negative impact of mental, emotional and behavioral health issues on children." This Plan provides Connecticut with a unique and timely opportunity to align policy and systems to support youth and families and to promote healthy development for all our children.

Public Act 13-178 directed DCF to include in the implementation plan the following strategies to prevent or reduce the long-term negative impact of mental, emotional and behavioral health issues on children:

A. Employing prevention-focused techniques, with an emphasis on early identification and intervention;

B. Ensuring access to developmentally-appropriate services;

C. Offering comprehensive care within a continuum of services;

D. Engaging communities, families and youths in the planning, delivery and evaluation of mental, emotional and behavioral health care services;

E. Being sensitive to diversity by reflecting awareness of race, culture, religion, language and ability;

F. Establishing results-based accountability measures to track progress towards the goals and objectives;

G. Applying data-informed quality assurance strategies to address mental, emotional and behavioral health issues in children;

H. Improving the integration of school and community-based behavioral health services;

I. Enhancing early interventions, consumer input and public information and accountability by: (i) in collaboration with the Department of Public Health, increasing family and youth engagement in medical homes; (ii) in collaboration with the Department of Social Services, increasing awareness of the 2-1-1 Infoline program; and (iii) in collaboration with each program that addresses the mental, emotional or behavioral health of children within the state, insofar as they receive public funds from the state, increasing the collection of data on the results of each program, including information on issues related to response times for treatment, provider availability and access to treatment options.

Plan development was guided by values and principles underlying recent efforts in Connecticut to create a "system of care" for youth and families facing behavioral health challenges and the Institute of Medicine framework for implementing the full array of services and supports that comprise a comprehensive system. A system of care is defined as:

> *A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.* [3]

The Institute of Medicine (IOM) framework aligns services and resources along a continuum or array that includes universal services for all children to promote optimal social and emotional development; selective services (e.g., early identification, early intervention) for children at high risk for developing a behavioral health condition; and indicated services for treating those with serious and complex disorders. The array of services and supports is used to inform the planning and implementation of a system that will meet the needs of all youth and their families.

The theory of change driving this Plan is that a children's behavioral health system based on the system of care core values and principles will result in improved health outcomes. Four core values drive the development of a system:

- **Family-driven and youth guided**, with the strengths and needs of the child and family determining the types and mix of services and supports provided;
- **Community-based**, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level;
- **Culturally and linguistically appropriate**, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.
- **Trauma informed**, with the recognition that unmitigated exposure to adverse childhood experiences including violence, physical or sexual abuse, and other traumatic events can cause serious and chronic health and behavioral health problems and is associated with increased involvement with the criminal justice and child welfare systems.

In addition, the Plan reflects the understanding that an effective system must be reorganized to include data-informed implementation, pooled funding across all payers (public and private), and

mechanisms for care coordination, with families and youth as full participants in the governance of that system.

How the Plan Was Developed

DCF contracted with the Child Health and Development Institute of Connecticut (CHDI) to facilitate an extensive input gathering process that served as the cornerstone for the preparation of the Plan. Family members, youth, Family System Managers from FAVOR, family advocates from the African Caribbean American Parents of Children with Disabilities (AFCAMP), and consultants from Yale University took lead roles in input-gathering activities, in partnership with CHDI staff. A Steering Team and a 36-member Advisory Committee oversaw the process. The core elements of the input-gathering process were:

- 26 Network of Care Community Conversations attended by 339 family members and 94 youth;
- Open forums held in six locations and attended by 232 individuals;
- Facilitated discussions on 12 specific topic areas, attended by 220 individuals;
- Website input forms submitted by over 175 individuals and groups;
- A review of background documents and data pertaining to the children's behavioral health system in Connecticut.

The process yielded the identification of seven thematic areas that will result in significant improvements to the children's behavioral health service system in Connecticut:

A. System Organization, Financing and Accountability

B. Health Promotion, Prevention and Early Identification

C. Access to a Comprehensive Array of Services and Supports

D. Pediatric Primary Care and Behavioral Health Care Integration

E. Disparities in Access to Culturally Appropriate Care

F. Family and Youth Engagement

G. Workforce

The Plan presents a set of goals and strategies for each of the areas, which are summarized below. Readers are encouraged to reference the full report for more detailed information that includes background information and summarizes the findings that inform each of the goals and strategies.

Implementation Plan: Goals and Strategies by Thematic Area

A. System Organization, Financing and Accountability

Implementing an enhanced children's behavioral health system of care will require a significant re-structuring with respect to public financing, organizational structure, integration of commercial payers, and data reporting infrastructure.

Goal A.1. Redesign the publicly financed system of behavioral health care for children to direct the allocation of existing and new resources.

A core finding from all input sources is that the children's behavioral health services are fragmented, inefficient and difficult to access for children and families. Those issues would be substantially improved by integration of public funding that brings together multiple payers and streamlines eligibility, enrollment, service arrays, documentation, and reimbursement mechanisms. Strategies in this area include the following:

1. Identify existing spending on children's behavioral health services and supports across all state agencies.
2. Determine if those existing funds can be re-aligned or used more efficiently to fund the full array of services and supports.
3. Explore mechanisms for pooling funding across all state agencies.
4. Identify a full array of services and supports that will constitute the children's behavioral health system of care.
5. Conduct a cost analysis to identify cost savings associated with implementation of the system of care approach and a focus on prevention.
6. Identify and address workforce development needs in the children's behavioral health system of care.

Goal A.2. Create a Care Management Entity to streamline access to and management of services in the publicly financed system of behavioral health care for children.

Effective access to and management of the full array of preventive and treatment services within a well-designed "system of care" can improve outcomes for children and lower costs of behavioral health services.[4] A Care Management Entity has the potential, as a model, to reduce fragmentation, integrate funding streams and service delivery, improve efficiencies and accountability, and reduce costs by disseminating information on behavioral health services, connecting families to services, and providing ongoing care coordination. This will help improve the family's experience of a culturally and linguistically appropriate system with a single point of access that helps families access information and navigate care. Efforts to improve access to information should be coordinated with the efforts underway as a result of Public Act 14-115. Strategies in this area include the following:

1. Design and implement a Care Management Entity to create an effective care coordination system based on proven Wraparound and child and family teaming models, with attention to integration across initiatives and training.
2. Develop a family support clearinghouse to increase access to information about available behavioral health services and improve supports for behavioral health system navigation.

Goal A.3. Develop a plan to address the major areas of concern regarding how commercial insurers meet children's behavioral health needs.

Given that insurance companies and self-insured employers currently cover approximately 56% of children and youth, their participation in the children's behavioral health system of care is critical. Concerns about behavioral health services for children and families with commercial insurance arose in the majority of meetings held to gather input into Plan development. Those concerns can be categorized in the following five areas: coverage for selected services; adequacy of coverage/services for selected conditions; medical necessity criteria and utilization management and review procedures; adequacy of provider networks; and perceived cost shifting to individuals and the State.

Based on the redesign of the publicly financed system, the incorporation of a Care Management Entity, and the demonstration of outcomes and cost savings, the commercial insurance sector will be incentivized to participate in the children's behavioral health system of care. Strategies include the following:

1. Conduct a detailed, data-driven analysis of each of the five issues identified in the information gathering process and recommend solutions.
2. Apply findings from the process described above to self-funded/employee-sponsored plans.

Goal A.4. Develop an agency- and program-wide integrated behavioral health data collection, management, analysis, and reporting infrastructure across an integrated public behavioral health system of care.

A core element of PA 13-178 is an emphasis on data and incorporation of results-based accountability. Implementation of the behavioral health system of care requires full attention to the development of data infrastructure for the purposes of monitoring and improving access to services, service quality, outcomes and costs. At the practice level, the collection, analysis, and reporting of data is already an element of evidence-based treatments; yet many other behavioral health services do not currently benefit from systematic data collection, analysis, reporting, standardized training and practice development and quality improvement activities. Specific strategies in this area include the following:

1. Convene a statewide Data-Driven Accountability (DDA) committee to design a process to oversee all efforts focused on data-driven accountability for access, quality, and outcomes.
2. Utilize reliable standards to guide the new data collection, management, and reporting system.
3. Assess and improve current data collection systems to serve in an integrated system across all agencies involved in providing children's behavioral health services.
4. Increase State capacity to analyze data and report the results.

B. Health Promotion, Prevention and Early Identification

Prevention of mental, emotional and behavioral health concerns for children is one of the key goals of the plan called for by PA 13-178. The law requires the inclusion of strategies that employ prevention-focused techniques, with an emphasis on early identification and intervention and access to developmentally appropriate services, which are addressed in this section.

Goal B.1. Implement evidence-based promotion and universal prevention models across all age groups and settings to meet the statewide need.

The behavioral health system should increasingly focus on promotion and universal prevention strategies to reduce or eliminate child and family risk factors, and enhance protective factors, to prevent the development of mental, emotional or behavioral disorders for children and youth of all ages. Connecticut has a wealth of expertise and programmatic efforts to train early care, education and school personnel on the promotion of social and emotional competence and how to address behavioral health concerns in school settings. However, they reach different audiences and have not been taken to scale to reach children of all (See also Strategy C.3.3. regarding professional development for school personnel in behavioral health).

The key strategy in this area is:

1. Enhance the ability of caregivers, providers and school personnel to promote healthy social and emotional development for children of all ages and develop plans to coordinate existing evidence-based efforts to take them to scale to meet the statewide need.

Goal B.2. All children will receive age appropriate periodic standardized screening for developmental and behavioral concerns as part of a comprehensive system for screening, assessment, and referral for services.

Screening and early identification are important steps toward avoiding more severe behavioral health challenges over time and deeper involvement in the behavioral health system, this is true for young

children and adolescents alike. In addition to the children's behavioral health system; parents and other child-serving systems play a critical role in this effort. Key strategies in this area include the following:

1. Expand the use of validated screening tools to assist parents and other caregivers and health, education and home visiting providers to promote social and emotional development, identify behavioral health needs and concerns, document results, and communicate findings with other relevant caregivers and providers in a child's life allowing for improved coordination of care.
2. Link all children who screen positive for developmental and behavioral concerns to further assessment and intervention using existing statewide systems to identify appropriate resources when needed.

Goal B.3. Ensure that all providers and caregivers who work with young children and youth demonstrate competency in promoting social and emotional development in the context of families, recognizing risk factors and early signs of social-emotional problems and in connecting all children to appropriate services and supports.

Providers who work with children need to have specific and developmentally appropriate competencies to assist in behavioral health promotion and prevention, and to recognize and respond to early warning signs or concerns. As those who work with young children need very specific training and have the opportunity to make the biggest difference in setting children on the right developmental trajectory, the Plan suggests beginning with this group of providers. Training for providers working with older children is covered as part of the implementation of specific interventions and through training of school personnel (Goal C.3). The following strategy is recommended:

1. Expand statewide trainings on infant mental health competencies and increase the number of providers across all relevant systems who receive Endorsement in Infant Mental Health.

Goal B.4. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and suicidal ideation.

Focus on promotion and universal prevention strategies including continued support for statewide suicide prevention activities, to reduce risk factors and promote protective factors.

C. Access to a Comprehensive Array of Services and Supports

Goal C.1. Build and adequately resource an array of behavioral health care services that has the capacity to meet child and family needs, is accessible to all, and is equally distributed across all areas of the state.

The current array of services is insufficient for meeting child and family behavioral health needs, as manifested in lack of knowledge about the service array, long waitlists for some services and high emergency department utilization. In addition, the proposed expansion of screening to identify behavioral health needs will likely increase the number of youth in need of care, and must be accompanied by an expansion of services to meet those needs. There are currently wide variations in access to and utilization of the array of services among families as the result of such factors as: past and current child welfare and juvenile justice system involvement; insurance coverage; race, ethnicity and language; and geographic location. De-linking those factors from a family's ability to access a full array of services and supports will go a long way towards meeting the behavioral health needs of all children and families. The use of evidence-based, evidence-informed practices together with innovative and customized services, is highly recommended.

The Plan recommends service expansion in the following areas:

- **Early childhood interventions** with emphasis on an array of evidence-based interventions from low to high intensity, delivered in a variety of settings;
- **Non-traditional/non-clinical services** that include community-based, faith-based, after-school, grassroots, and other supports for youth who are exhibiting, or identified as at risk for, mental health symptoms;
- **Care coordination** utilizing high-fidelity Wraparound and child and family teaming approaches;
- **Behavioral health treatment** options including: outpatient care; intensive treatment models; child and adolescent psychiatry; substance use services; and services and supports for children with autism. Crisis response services and school-based behavioral health services are also recommended for expansion, which are described in more detail below.

Specific strategies in this area include the following:

1. Establish an ongoing needs assessment protocol, across local, regional, and statewide levels.
2. Finance the expansion of the services and supports within the array that have demonstrated gaps.

Goal C.2. Expand crisis-oriented behavioral health services to address high utilization rates in emergency departments.

High utilization of EDs can be addressed through expansion of crisis-oriented services, as well as other elements of the service array. Emergency Mobile Psychiatric Services (EMPS) is a proven service that helps divert youth from entering the ED by responding to families and schools, and helps reduce ED volume by diverting youth who are in the ED from inpatient admission, and providing linkages for families to community-based care. Connections between EMPS and a statewide network of crisis stabilization beds will also help address the current crisis in ED settings. Strategies in this area include:

1. Expand EMPS by adding clinicians across the statewide provider network to meet the existing demand for services including the expected MOA's between EMPS and local school districts.
2. Enhance partnerships between EMPS clinicians and EDs to facilitate effective diversions and linkages from EDs to community-based services.
3. Explore alternative options to ED's, through short-term (e.g., 23 hour) behavioral health assessment centers and expanded crisis stabilization units.

Goal C.3. Strengthen the role of schools in addressing the behavioral needs of students.

School-based behavioral health is a key area for expansion of the behavioral health service array that can positively impact all children and should result in substantial overall cost savings through early identification and early intervention. Stakeholders across the state consistently identified schools as playing a critical role in identifying and delivering behavioral health services and supports. The input-gathering process made it clear that the primary mission of schools is to educate students; however, it was widely recognized that students are best prepared to learn when they are healthy and equipped with social, emotional, and behavioral regulation skills and competencies. The State should provide support to schools to address students' behavioral health needs.

Efforts to expand school-based behavioral health services should include co-location of community-based clinicians in schools, additional school-employed behavioral health staff with adequate numbers of behavioral health clinicians, and expansion of School Based Health Centers. All efforts to expand school-based behavioral health care must be coordinated with community-based agencies so that children and families who are identified and/or treated in schools have access to the full array of services offered at

community-based clinics, and are assured continuity of care during the summer months. Schools must also closely collaborate with EMPS, as called for in PA 13-178, and with police. School-based behavioral health efforts should pay particular attention to ensuring that youth with behavioral health needs are not disproportionately excluded from the learning environment due to behaviors that may lead to arrest, expulsion, and out-of-school suspension.

Strategies in this area include the following:

1. Develop and implement a plan to expand school-based behavioral health services.
2. Create a blended funding strategy to support expansion of school-based behavioral health services.
3. Develop and implement a behavioral health professional development curriculum for school personnel.
4. Require formal collaborations between schools and the community.

Goal C.4. Integrate and coordinate suicide prevention activities across the behavioral health service array and across multiple sectors and settings.

Improving coordination and access to a full service array of suicide prevention activities to support families with children in an acute crisis.

D. Pediatric Primary Care and Behavioral Health Care Integration

Goal D.1. Strengthen connections between pediatric primary care and behavioral health services.

Pediatric primary care provides a unique opportunity to screen for and address children's behavioral health needs from a family-based perspective. Child health providers, through the medical home model of care, are an important community-based resource for delivery of health and behavioral health services, as many youth and families access a range of services through their pediatrician. Connections among pediatricians, schools, community-based behavioral health agencies, and other settings, however, need to be strengthened. Connecticut has several initiatives and models in place for improving these connections including the State Innovation Model (SIM), Medicaid's Person Centered Medical Home, Access Mental Health, and Enhanced Care Clinics. These models can be considered when determining how best to address this goal. Strategies in this area include the following:

1. Support co-location of behavioral health providers in child health sites by ensuring public and commercial reimbursement for behavioral health services provided in primary care without requiring a definitive behavioral health diagnosis.
2. Support the development of educational programs for behavioral health clinicians interested in co-locating in pediatric practices.
3. Require child health providers to obtain Continuing Medical Education (CME) credits each year in a behavioral health topic.
4. Ensure public and private insurance reimbursement for care coordination services delivered by pediatric, behavioral health, or staff from sites working on behalf of medical homes.
5. Reform state confidentiality laws to allow for sharing of behavioral health information between health and behavioral health providers.

E. Disparities in Access to Culturally Appropriate Care

Goal E.1. Develop, implement, and sustain standards of culturally and linguistically appropriate care.

Families and other stakeholders in the children's behavioral health system identified a number of concerns regarding disparities in access to culturally and linguistically appropriate services. At the broadest level, families expressed a lack of awareness of and access to culturally and linguistically competent services and supports in the existing behavioral health care system. Families requested an expansion of the workforce and the service array to include staff that are from the same community and speak the same language as the families they serve, gender-specific interventions, and enhanced access for families in the most rural areas of the state. Culturally specific marketing, stigma/discrimination reduction, and related materials are needed, along with training provided to all behavioral health clinicians on delivering services in a manner that respects the culture (e.g., family composition, religion, customs) of each family, in accordance with Culturally and Linguistically Appropriate Services (CLAS) standards.[5] Although specific strategies are offered in this section, additional attention to disparities and cultural and linguistic competence are addressed in other sections of the report. Specific strategies in this area include the following:

1. Conduct an ongoing needs assessment at the statewide, regional, and local level to identify gaps in culturally and linguistically appropriate services.
2. Ensure that all data systems and data analysis approaches are culturally and linguistically appropriate.
3. Require that all service delivery contracts reflect principles of culturally and linguistically appropriate services.

Goal E.2. Enhance availability, access, and delivery of services and supports that are culturally and linguistically responsive to the unique needs of diverse populations.

Specific strategies in this area include the following:

1. Enhance training and supervision in cultural competency.
2. Ensure that all communication materials for service access and utilization are culturally and linguistically appropriate.
3. Provide financial resources dedicated to recruitment and retention to diversify the workforce.

F. Family and Youth Engagement

Goal F.1. Include family members of youth with behavioral health needs, youth, and family advocates in the governance and oversight of the behavioral health system.

Multiple stakeholders, including families, confirmed that a critical element in the development and implementation of a children's system of behavioral health care is the ongoing and full partnership of youth and families in the planning, delivery, and evaluation of services. At the systems-level, numerous stakeholders, including families, strongly urged that youth, family members, and family/youth advocates have "a seat at the table" in the governance and oversight of the service delivery system and that these roles be paid positions. At the service delivery level, family-advocacy as well as parent and peer support groups were highlighted as important elements of the workforce and the service array. Stakeholders highlighted the importance of opportunities for regular family and youth input and feedback into service delivery at the local and regional level. Strategies in this area include the following:

1. Increase the number of family advocates and family members who serve as paid members on statewide governance structures of the children's behavioral health system.
2. Expand the capacity of organizations providing family advocacy services at the systems and practice levels.
3. Increase the number of parents who are trained in parent leadership curricula to ensure that families develop the skills to provide meaningful and full participation in system development.
4. Provide funding to support at least annual offerings of the Community Conversations and Open Forums, and continue to sustain the infrastructure of the Plan website input mechanism to ensure ongoing feedback into system development.

G. Workforce

The topic of the workforce emerged from almost every discussion held as part of the planning process. The concept of workforce is used broadly in Connecticut with respect to children's behavioral health. It includes but is not limited to: licensed behavioral health professionals; primary care providers; direct care staff across child-serving systems; parent and family caregivers and advocates; school personnel; and emergency responders including police. It also includes youth as they engage in self-care and peer support. Concerns related to workforce included: shortages of key professionals or skills in the current workforce; lack of training capacity, including ongoing coaching, monitoring, and reinforcement in order to maintain skills; insufficient access to information for parents; and the lack of adequate knowledge among every sector of the workforce about children's behavioral health conditions and resources to address these conditions. Goals and strategies related to workforce development are reflected in 16 strategies across most of the thematic categories in the Plan. In addition, Section IV.A of the Plan calls for a workforce subcommittee of the overall governance structure for the system of care.

Implementation

In order to turn this Plan into reality, legislative action is highly recommended to fully authorize DCF and other key agencies and systems to ensure that the most urgent plan components are implemented in the short term and a detailed work plan, financing strategy and timeline are in place to implement the longer term strategies. The Plan includes a proposed timeline for implementation that focuses on the development of the infrastructure and the planning of the array of services that will comprise the System of Care.

An early task will be to design the longer-term governance structure charged with building the System of Care. The governance structure needs to have the authority to advance the ambitious agenda laid out in the plan, to develop the RBA templates to hold the initiative accountable, and a commitment to study the cost-effectiveness of service delivery types within the state. We recommend the creation of a Children's Behavioral Health Implementation Team to guarantee integrated, coordinated efforts as well as full transparency and meaningful engagement of all stakeholders, including families and youth. The Plan also recommends creation of a searchable web site with clear goals, progress benchmarks, and reporting of all actions and a Children's Behavioral Health Dashboard that will clearly report progress on a range of system and outcome measures. State level implementation will also include connection to DCF regional offices and the 26 regional System of Care Community Collaboratives, the DMHAS network of 13 Regional Action Councils and Early Childhood Community Collaboratives.

Conclusion

Children and families in Connecticut currently experience significant barriers to achieving social, emotional, and behavioral wellness and accessing quality behavioral health care. Throughout every element of the input-gathering process, it was clear that Connecticut can and should do better to meet

those needs. The process for developing the Plan yielded a comprehensive set of goals and strategies that will require a significant commitment of time and resources with the full participation of all key partners in the public and private sector and a deep commitment from state government, communities, families and youth to reach full implementation over the next five years. It is our hope that this Children's Behavioral Health Plan provides the foundation for fulfilling the vision of PA 13-178, that together we can meet the mental, emotional and behavioral health needs of all children in the state, and prevent or reduce the long-term negative impact of mental, emotional and behavioral health issues on children.

Endnotes

[1] U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

[2] Connecticut PA 13-178 State Mental Health Planning Initiative. See www.plan4children.org.

[3] Stroul, B., Blau, G., & Friedman, R. (2010). Updating the system of care concept and philosophy. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

[4] Stroul, B., Pires, S., Boyce, S., Krivelyova, A., & Walrath, C. (2014). Return on investment in systems of care for children with behavioral health challenges. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

[5] U.S. Department of Health and Human Services, Office of Minority Health (2013). *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice.* Washington, DC: U.S. Government Printing Office.