Facilitated Discussion Notes
Juvenile Justice & Mental Health
February 18, 2014

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are listed in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: info@plan4children.org.

General Notes

- Hosted by: CT Juvenile Justice Alliance
- Location: Graustein Foundation Offices, Hamden, CT
- Approximately 18 people participating in person and via teleconference

Question 1: Strengths

- Growing base of EBTs in the JJ system; trauma informed system development, MST, MDFT, other EBTs
- Implementation of EMPS, good responses, has been a helpful service
- MOAs between school districts and police
- Increasing understanding of the complexity of MH needs of children in JJ system
- Assessment procedures like the JJIE; ability to match youth to the right treatment
- Emphasis on family-oriented intervention, not treating kids separately. The use of in-home and center-based treatment settings
- Cooperation between schools and probation officers to find appropriate longer-term placements for youth
- School based Health Centers have substance abuse and mental health counselors that have been a helpful first line of defense, especially for poor youth
- Strong interest in improvement of the system; not resting on where they currently stand
- In juvenile court system and probation, access to services, including EBTs, exists for youth, especially programs operated by DCF for "cross-over youth."
- Access to respite has been beneficial to clients.
- EMPS has been helpful for clients in crisis in schools; used often in the court system.
- CT Behavioral Health Partnership has been a great way to access services for clients; has helped access services quickly
- CSSD and DCF joint strategic plan has really helped
- Advocacy of CTJJA and other partnerships is critical
- CONNECT grant to integrate systems and in response to new legislative mandates
- Groups coming together more collaboratively; sharing resources, working as system
- Family-driven and youth-informed approaches have resulted in families feeling more a part of the system.
- DCF Parole department has been a good experience (comment from parent)

- LISTS are doing a good job sharing data across systems in the community
- Assessment resources
- Promise of the "One Piece of the Puzzle" program

Question 2: Concerns

- You have to be in the JJ system to get these services
- Not everything brought to scale and available to all youth who are not in the system
- Not enough available for the "at risk" population
- LIST needs assessment reveals that mental health is a big deal in the JJ system
- LISTs also reveal that availability of substance abuse (SA) services is lacking for JJ-involved youth
    - There are some SA services for youth in JJ (MDFT was developed for that)
    - Insufficient to meet the need and not available unless you're in the system
- Once receiving services, there are time limitations that limit service effectiveness because they are needed for longer
- No-show policies, coming from Medicaid or clinics themselves, may limit needs of families with complex needs who are likely to miss appointments
- Models tend to have recommended LOS that may be too short for some individuals and families.
- Tow Foundation funded St. Vincent's Hall Brook. Clients served in IOP step down to case management; they have shown reduced recidivism over 2 years of follow-up case management
- Need better data, long-term data: Not being able to track outcomes consistently years later
- We have an insufficient continuum of care to ensure step-down services, allowing same provider to work with family after acute treatment. Need better connection to family over time.
- No, or insufficient, reimbursement for case management that occurs during a follow-up period
- Not only building the continuum of services, but developing the prosocial activities in the community after formal treatment ends. Not necessarily MH treatment per se, but they are important for maintaining positive outcomes
    - Activities that are constructive during non-school hours; that keep them connected to schools and positive peer groups, help them avoid delinquent activities
    - Gap in supportive services to maintain progress
    - Gap in helping family build on protective factors/strengths
- Lacking transportation to attend services and other non-treatment opportunities
- When reintegrated into community, some communities have disparities in support services; rivalries and geographic divisions within communities
- Older adolescents need ways to get acclimated back to community (e.g., employment services)
- Lack of information and awareness about what is available; even professionals not fully aware
- Credentials for adults providing supportive services; credentials may not always be necessary for effects; but you need to demonstrate competencies and the capacity to provide those services
- Continued siloed funding, and labeling that needs to be broken down
- Need to create capacity to divert kids from the JJ system by offering services to at-risk youth, especially to address trauma among kids in the community

- DCF, DMHAS, and OPM, federal funding sources all need to be linked funding streams
- Problems with criminalizing MH and JJ issues of girls
    - Within context of DCF opening a secure facility for youth
- Dually committed youth (child welfare and juvenile justice); where was the treatment while they were in CW to prevent JJ involvement later in youth?
- Need well-trained providers, with experience, to meet complex needs of youth in JJ and MH
    - Providers noted the extensive requirements of RFPs for providing services but not being able to pay clinicians very well. And if they are good, they are hired by the state (b/c of better pay)
- Insufficient numbers of evaluations and assessment of JJ Youth
    - Someone commented that there was less than 200 evaluations of JJ involved youth in a whole year (possibly only in one assessment program) compared to thousands of assessments in Mass.
    - Rebuttal comment that CSSD added Clinical Coordinators to ensure that assessments are being conducted when appropriate, which led to fewer assessments in certain programs, but that doesn't mean they are not getting assessed
    - Evaluations could be more focused on earlier detection, earlier intervention
- DCF's inability to use data, lacking a proper information management system
    - Judicial Branch doing a much better job and are more willing to share data and learn from it. DCF needs to "catch up" to these best practices.
- Contract management at DCF also problematic. There have been facilities that closed almost overnight, with little indication that problems in facilities were known earlier and addressed
- Inability to track youth across more than one system to look at outcomes over time
- DCF not producing data in a timely manner, mostly because they are severely understaffed. That is problematic at an $850M budget state agency, at a time where RBA is so important
    - There are solutions out there that have not gone anywhere
    - There are/have been committees/groups (JJPOC) making progress on this issue
    - Not clear consensus as to what the problem is: DCF does not have the data? DCF has the data and can't analyze it? DCF has the data and doesn't prioritize it? When legally mandated to do so, they find a way to get good data together
- Improvement in prevention services within the JJ system, to keep kids out of JJ, and to expand prevention programs that have evidence of effectiveness
- We need to support families
    - Parents feel desperate and feel alone in supporting their children
    - Address multigenerational issues
- More emphasis on diversion; SBDI mentioned as example of ensuring access to MH services
    - One participant noted, "We're OK with having kids get arrested because we know CSSD offers really good services. That is not OK."
    - There was not total agreement that CSSD services are "really good."
- Wait lists of services, quality of the services, responsiveness of providers.
- Some health insurance plans will not pay for needed services

- Ensure that the urban systems have the same resources as the wealthier, suburban systems
- Kids in Crisis Teen Talk program (Fairfield Co. program). Counselors to high schools paid to provide services (Ridgefield, New Canaan, McMahon, Norwalk, Trinity Catholic, etc.); supplemental to SBHC; one-on-one care for difficult child

Question 3: Recommendations

- Look at existing reports and recommendations and follow up on good recommendations
- Ensure that we are getting culturally responsive services
- Ensure that we have a QA/QI process in place to ensure that the state is getting what it is paying for and what is needed in the community
- Spend more money on MH and JJ continuum
    - Will ultimately save money
    - Get past the idea that we can only implement "no cost" ideas
    - Identify low-hanging fruit, but also take the opportunities to make real change
- Consider including trauma-informed services among JJ involved youth
    - Look into ARC http://www.traumacenter.org/research/ascot.php
    - CT has a number of other trauma-informed services that could be/are being adapted to JJ populations (e.g., TF-CBT)
- Ensure equal access to services regardless of insurance coverage for all kids
- Identify and expand existing services that are known to work; however, avoid one size fits all
    - EMPS; MOAs between schools and EMPS; trauma-informed services like TF-CBT
    - SBHCs
- Early identification of risk, in the community, linking youth to prevention/early treatment
    - Boston has a system that assesses at-risk youth and ensured access to services
    - Collaboration with schools to identify at-risk youth
- Access to respite to divert youth from JJ for parents who are in crisis with their youth
- Standardized approach to early identification, screening and assessment, looking at known risk factors that are associated with later MH and JJ problems
- Workforce Development
    - Retain good people to work in our system (e.g., child psychiatrists)
- Ensure continuum of care is fully represented
    - Fund prevention efforts
    - Early identification and intervention
    - Full continuum available in every community (urban and suburban)
    - Don't forget about JJ-involved youth upon reentry
    - Don't forget about deep-end kids either in efforts to fund prevention and diversion; kids who have been involved in the system have intense, complex needs (vocational supports, furthering education, clinical treatment, connection to DMHAS, etc.)
- Online directory of services to address need for information sharing and awareness
- More for SA youth who are at risk or involved in JJ system

  - Reality is that some providers are hesitant to provide SA services
- Housing, vocational services for JJ involved youth
- Case management needs to be reimbursed, in addition to treatment
- More opportunities for Positive Youth Development and other S/E development opportunities; discovering strengths and competencies; identity development
- Data Infrastructure
  - DCF needs to develop a better information management system
  - State Legislature needs to ensure that funding is available for this, even if it is not direct services, which tends to be de-emphasized during difficult economic times
  - Keep in mind that there are confidentiality concerns with data; however, there can be systems in place that allow systems to "talk" to each other w/o violating privacy
  - All state agencies involved in serving JJ youth need a better ability to report data, within and across systems, to track outcomes over time. Don't forget about SDE as an important "data sharer"
  - Consider single entity that has access to all that data
- When it comes to addressing insurance coverage barriers; make sure there are connections between Office of Healthcare Management and Child Advocate to ensure that commercial plans are paying for needed MH/SA services
  - There is good work out there in this area that needs to go from Recommendation to Actions