CLOSE TO HOME

A Report on Behavioral Health Services

for Children in Connecticut's

Juvenile Justice System

Prepared by:
Connecticut Center for Effective Practice of the
Child Health and Development Institute of Connecticut, Inc.

Funded by:
Tow Foundation, Connecticut Health Foundation,
and Children's Fund of Connecticut

February 2003

CLOSE TO HOME:

A Report on Behavioral Health Services for Children in Connecticut's Juvenile Justice System

The Connecticut Center For Effective Practice of the Child Health and Development Institute of Connecticut, Inc.

Report prepared by:

Julian Ford, Ph.D., University of Connecticut Health Center

Francis Gregory, Ph.D., Yale Child Study Center

Kathleen McKay, Ph.D., Connecticut Children's Medical Center

Janet Williams, MD, Connecticut Center For Effective Practice

---

The Connecticut Center For Effective Practice is a project under the auspices of The Child Health and Development Institute of Connecticut, developed in partnership with the Connecticut Department of Children and Families, the Judicial Court Support Services Division, the University of Connecticut Health Center, and the Yale Child Study Center, with core funding from the Connecticut Health Foundation.

The Connecticut Center For Effective Practice of the Child Health and Development Institute is grateful to the Tow Foundation for their generous support, time and funding for this project and their tireless dedication to Connecticut's children.

Thank you to the Executive Council of the Connecticut Center for Effective Practice who dedicated time and expertise to the completion of this study and report.

Jean Adnopoz
Lou Ando
Julian Ford
Cathy Foley Geib
Judith Meyers
Julie Revaz
Peter Panzarella
Karen Snyder
Robert Trestman
Joe Woolston

Janet Williams, MD, Director
Connecticut Center for Effective Practice

administrative support: Robert Walsh
editing: Rhea Hirshman
design and layout: E.K Weymouth Design

Contents

Executive Summary

Many of the children and youth in the Connecticut juvenile justice system suffer psychiatric or addictive disorders, with behavioral health problems being four to six times more prevalent among these children nationally than among children in the general population (Otto et al., 1992). A new prevalence study of youth in detention reports that, excluding conduct disorders, 60 percent of males and more than two thirds of females had one or more diagnosable mental health condition (Teplin, 2002). A recent review of the recidivism literature conducted by the Court Support Services Division's (CSSD) Center for Best Practice (Revaz, 2002) found six primary risk factors for child re-involvement with the justice system. Three of these factors — substance abuse, poor self-control, and family dysfunction — are behavioral health problems which complicate the serious legal and social impairments these children face.

Tina's story is illustrative:

Tina is a 14-year-old girl whose monolingual Cambodian mother and Italian-American step-father married after she, her mother and grandparents fled the Pol Pot regime to this country. Tina suffers from behavioral problems, intense emotional reactivity, impulsivity, and aggression, resulting from traumatic experiences in Cambodia. Tina has not developed healthy peer attachments or close family relationships. She has run away from home more than a dozen times, and has been taken to the emergency room several times following suicide attempts. Tina was arrested for shoplifting and violated probation when she was stopped while riding in the car with friends who were drinking and driving erratically. She was placed in detention after a confrontation in the court room where she became angry and physically threatening towards her mother. Tina says that she will kill herself if she is locked up because she's terrified that she'll be physically and sexually assaulted there.

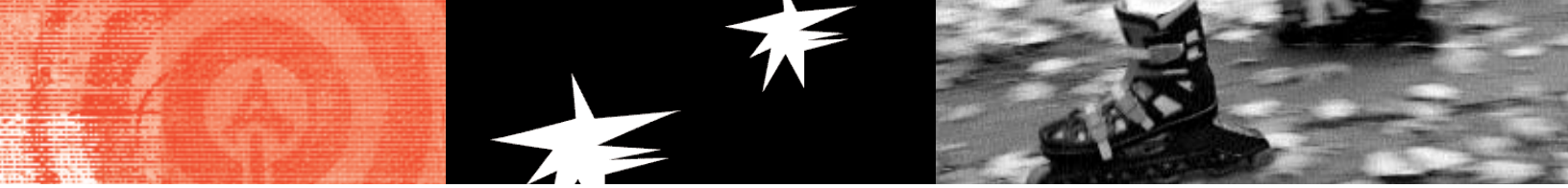
Tina is representative of many children who enter the Connecticut juvenile justice system due to behaviors driven by serious behavioral health problems. Recent developments in Connecticut highlight efforts to address these children's social, emotional, and behavioral health issues in order to improve their well-being and to protect the safety of the communities in which they live. In 2002 a federal court ruled in *Emily J. vs. John G. Rowland*, et al. that the state was out of compliance in meeting the behavioral health needs of children in juvenile detention. The Court Support Services Division of the Judicial Branch (CSSD) and the Department of Children and Families (DCF) have embarked upon a three-year court-ordered plan to provide a coordinated system of clinical risk/need assessment and multidisciplinary evaluation for arrested children who have been detained. Recently, CSSD modified its plan for outpatient substance abuse and mental health services, instituted an agency-wide automated risk assessment, and created a Center for Best Practice to better meet the changing needs. Also in 2002, the Department of Children and Families (DCF) undertook a major reorganization of services for juvenile offenders within the Bureau of Behavioral Health, Medicine, and Education to emphasize the need for treatment rather than merely confinement for delinquent children committed to DCF.

These developments take place within the context of a major reform of the children's behavioral health system through Connecticut Community KidCare. DCF has placed increased emphasis upon developing and funding services that promote the healthy functioning of at-risk or troubled children and families in their natural community settings rather than in out of home or out of state care. These reforms are also guided by the recommendations of the 2000 Governor's Blue Ribbon Commission on Mental Health, the Connecticut Mental Health Policy Council-Children's Subcommittee, which specifically addressed the needs of children in the juvenile justice system, and the legislatively created Connecticut Alcohol and Drug Policy Council.

Along with these local changes, there has been a national emphasis upon "evidence-based" treatments. These well-researched, well-documented interventions have shown success both in addressing the serious behavioral health problems of children like Tina and in offering help and support to their families. Evidence-based models, many developed using federal funds for improving substance abuse treatment, are scientifically researched interventions with an emphasis on treatment fidelity and positive outcomes. Additionally, recent comprehensive reviews of the costs and benefits of existing crime prevention and intervention programs (CT Center for Economic Analysis, 2001; Washington State Institute for Public Policy, 2001) confirm that these evidence-based community treatments are cost-saving and effective alternatives to institutionalization or incarceration.

In order to develop an informed and coordinated approach to implementing and sustaining these treatments, the Child Health and Development Institute of Connecticut (CHDI) in partnership with DCF, CSSD, the University of Connecticut Health Center, and Yale Child Study Center — established the Connecticut Center for Effective Practice (CCEP), with core funding from the Connecticut Health Foundation. The Tow Foundation contributed funding to conduct this study and prepare a report. This report's findings support the need for a comprehensive children's behavioral health system that coordinates mental health and substance abuse services for children in or at risk of entering the juvenile justice system. The report identifies a number of serious systems problems and service gaps in our current system. These include:

- The absence of systematic behavioral health screening for children entering the juvenile justice system to assist police, probation officers, and judges in making well-informed, individualized decisions and triaging children to behavioral health services.
- Provider agencies and practitioners are not adequately prepared or funded to treat behaviorally disturbed children and the families which are critical to addressing their problems.



- Insurance and state contracting mechanisms that fail to provide incentives or adequate reimbursement for using newer, more cost effective evidence-based treatments.

- The absence of effective service collaboration among education, mental health, child welfare and judicial systems – leading to the entry into the state juvenile justice system each year of hundreds of children with non-criminal behaviors such as running away or failing to attend school. Once in this system, these children receive costly services that would be better reserved for serious delinquents.

The information in this report can serve as a guide to developing policies, procedures and programs that serve more effectively the behavioral health needs of children in or at risk of entering the juvenile justice system. We begin with a description of the paths taken by children who enter that system, with particular focus on opportunities for identifying and meeting their behavioral health needs. In the past, police and probation officers have had to make decisions about services for disturbed children without the benefit of screening procedures, training in child health and development, or consultation with behavioral health professionals. We find that earlier screening and comprehensive assessments would: 1) detect problems earlier and divert more children from the juvenile justice system; 2) enable children to be better matched with appropriate treatments; 3) make more efficient use of limited court-based evaluations; and 4) assist administrators to make better choices about allocation of scarce resources.

The second section looks at research findings concerning the nature and scope of behavioral health problems faced by children in juvenile justice settings, and the best-researched, most effective practices available for those children and their families. Factors associated with higher risk of behavioral health problems include internalizing emotional problems, breakdowns in extra-familial social support systems and breakdowns in family systems. Our findings indicate that children and families benefit most when treatment focuses simultaneously on social supports, skills (or resources) and family support offered in their local communities. We highlight five distinct groups of evidence-based interventions. They range from cognitive, motivational, and skill-building methods designed to produce behavioral changes in children and parents to intensive system models that address the family, social and community context in an effort to prevent out of home placements. We find that improvements in family systems and youth development can be achieved with the behavioral, motivational and skills training approaches. However, the most significant and lasting improvements were associated with the more intensive family, social, community treatment approaches (e.g., Multisystemic Therapy and Oregon Treatment Foster Care).

The third section describes findings from a survey of Connecticut programs serving children in juvenile justice settings and also an interview with family advocates and parents of children who have behavioral health problems. We describe the resources that the programs offer and outline critical needs. Given the gaps within our current system, behavioral health providers and family advocates who were surveyed identified several important factors as being crucial to achieving successful outcomes:

- Engaging parents as full participants in their children's treatment and recovery
- Enhancing the personal well-being and psychosocial functioning of parents
- Sustaining the benefits of treatment with effective aftercare and transition services
- Psychiatric evaluation and medication treatment by a qualified child psychiatrist
- Access to vocational and recreational resources in the community
- Staffing capacity to permit counselors to do home visits and outreach to families
- Collaboration among providers and other caregivers (including education and child welfare)
- Providing services for a time period sufficient to achieve sustainable benefits
- Staffing and funding sufficient to provide fully individualized treatment planning

Providers repeatedly emphasized a desire for families and communities to be more centrally involved in rehabilitation; concern that there are too few community supports critical to positive youth development; and frustration about the lack of coordination between school and clinical services for this population.

As a result of these surveys of systems, literature, and programs, CCEP identified several areas in which changes could dramatically improve the well-being of Connecticut children, their families and communities. The report concludes with the following recommendations:

- Establish screening and assessment protocols that systematically identify children with behavioral health needs at all crucial points of entry into the juvenile justice system to accurately determine their needs and link them with effective treatments.
- Make families — not children — the clients, and full members in treatment teams.
- Establish system-wide a range of evidence-based community treatments, available to children and families based upon their specific types and levels of need.
- Mandate the delivery of core services by all behavioral health programs serving children in the juvenile justice system.
- Improve data collection and management, integrate information systems and link funding to process and outcome evaluation.
- Coordinate behavioral health care for children in and at risk for juvenile justice involvement with all other services provided through DCF's Connecticut Community KidCare and with the police, courts, schools and child welfare services.
- Examine Connecticut's current and emerging plan for behavioral health care financing to ensure effective reimbursement mechanisms and incentives to use new outcome-driven "evidence-based" treatments.
- Develop early identification and behavioral treatment interventions for families with service needs (FWSN) and youth in crisis (YIC).
- Establish gender-specific and culturally relevant behavioral health services for children within the juvenile justice system.
- Identify and take action, at all levels of the juvenile justice system, to correct disparities disproportionately affecting people of color, under-served and special populations.

Effective behavioral health interventions for children and families do exist. *Close To Home: Report on Behavioral Health Services for Children in the Juvenile Justice System* by the Connecticut Center for Effective Practice recommends several fundamental and achievable changes in Connecticut's system of behavioral health care for children in or at risk of entering the juvenile justice system.

Introduction

Shawn is a 13-year-old Caucasian boy who has been expelled from school after numerous suspensions for assaulting other students and school personnel. He has been arrested for possession of a controlled substance several times since he was 10 years old, and now is being held in a detention center on charges of robbery and possession of a firearm. Shawn says that he has no problem with anger or drugs, and that he had to participate in the robbery in order to be initiated into a gang to which several other male family members belong. He describes fighting as a way of life and a means of survival that he learned from being beaten by his mother's boyfriends and trying to protect his younger siblings. His mother, now clean and sober, is at a complete loss about how to help him.

Edgardo is a 15-year-old Latino who has multiple arrests for auto theft. He says he doesn't want to do anything except play music with the band he's formed with his friends, and that he steals cars to get money to pay for sound systems for the band. He says he plans on being a millionaire by becoming an international music star and having a Latin rap group like Vivo C. Edgardo says he can go days without sleeping or without using any drugs, but then he gets in trouble when he "crashes" and gets depressed and angry. He did very well in a residential program for boys that helped him with anger management and getting back into school, but he says he got too "stressed" being around his family and dealing with the teachers at school after he returned home and so he started skipping school and boosting cars again.

Three of the six primary risk factors for child re-involvement with the justice system were behavioral health problems: substance abuse, poor self-control, and family dysfunction.

Despite different backgrounds and experiences, these children have in common both their involvement with the juvenile justice system and behavioral health problems that put them at risk for increasingly serious and chronic criminal justice problems. Many who enter the juvenile justice system in this country each year are — or become — repeat offenders both as juveniles and as adults (Mendel, 2000). A review of the research literature on child recidivism conducted by the Court Support Services Division's (CSSD) newly created Center for Best Practice (Revaz, 2002) found six primary risk factors for child re-involvement with the justice system, three of which were behavioral health problems: substance abuse, poor self-control, and family dysfunction.

These findings highlight the need for more knowledge, both about the needs of children in the juvenile justice system and about the kinds of programs and services that now exist—or could be developed—to address these needs. In Connecticut, the disturbing convergence of criminal behavior and behavioral health problems appears to be contributing to an ongoing problem of juvenile recidivism. A recent report by the Connecticut Policy and Economic Council (CPEC; Dougherty et al., 2002) found little evidence of reduced recidivism among children in the juvenile justice system between 1994 and 1999 despite the initiation of a number of specialized rehabilitation programs during that period. Half of the children arrested in the 1999 sample committed another crime during a subsequent 18 month period, and one in three children in a broad sample of juvenile justice programs committed another crime within the next year.

The CPEC report highlighted the need for enhancing essential services that address three significant predictors of recidivism: lack of substance abuse and mental health treatment, negative peer associations, and the lack of family involvement in treatment and after care. These predictors are consistent with the risk factors identified by the CSSD Center for Best Practice. Building upon these earlier reports' findings, the present report examines specific behavioral health needs of children in the juvenile justice system, surveys the scientific literature for promising approaches and identifies effective behavioral health treatments.

The goal is to enhance the lives of children and their families involved in the juvenile justice system using a system of care that can be a national model.

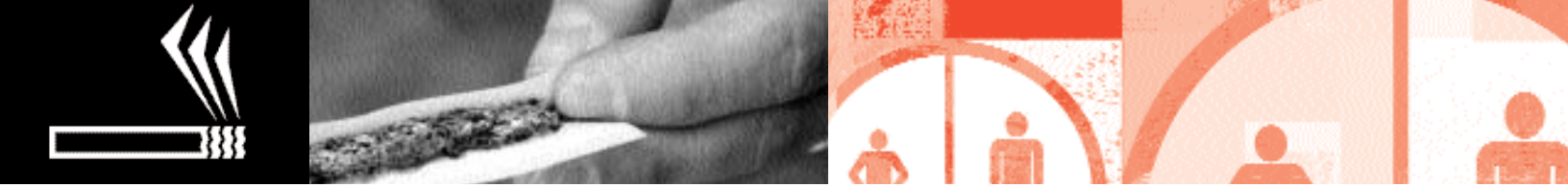
While recognizing the importance of early and effective services to alleviate behavioral health problems, the Connecticut Center For Effective Practice (CCEP) began its work with a focus on children in the juvenile justice system with behavioral health problems. This decision was based on: 1) a consensus that behavioral health problems of children in the juvenile justice system posed critical public health, safety, and economic concerns; 2) an awareness that this issue was a high priority for the state as evidenced by recommendations of the Connecticut Alcohol and Drug Policy Council, the Governor's Blue Ribbon Mental Health Report, and subsequent Connecticut Mental Health Policy Council-Children's Subcommittee Report; and 3) a strong interest in and support for evidence-based practices for this population.

This report summarizes the findings of a year-long study, conducted by CCEP with funding from the Tow Foundation, to assess Connecticut's needs and available resources for children with behavioral health problems who are in the juvenile justice system. We begin with an overview of the paths traveled by children in Connecticut's juvenile justice system and an analysis of the challenges that the overlay of behavioral health problems raises for children, families, law enforcement, correctional authorities and behavioral health providers. The second section discusses the nature and magnitude of behavioral health problems among children in the juvenile justice system, lays out definitions and standards for effective treatment approaches and then summarizes the national literature, outlining a number of effective practices. The third section describes the results of in-depth interviews with the administrations and staffs of more than twenty Connecticut behavioral health programs and a meeting with parents and administrators from several family advocacy organizations. The concluding section provides recommendations for specific steps that can improve Connecticut's current behavioral health service system for children and families involved in the juvenile justice system and serve to build a system of care that can be a national model.

Section 1.

Pathways Through the Juvenile Justice System

Gloria is a 14-year-old African-American girl living in a rural Connecticut town. She has been truant from school for three months following an extended suspension for challenging school authority and fighting with a peer. Her single mother and maternal aunt have sought help unsuccessfully — at the school guidance office, with a counselor at the town's Youth Service Bureau, and from the DCF voluntary services program. Their concern stems from Gloria's increasing use of marijuana, a petty shoplifting incident, rebelliousness toward adults, and a recent threat to hurt a teasing neighbor. Gloria's rebelliousness began at age 12 but increased drastically six months ago after her only brother was incarcerated for drug possession. She was arrested for taking her mother's car without permission and placed on probation with conditions to attend school and a hospital-based counseling center. Her mother had previously been advised to file a petition for Family With Service Needs to force Gloria to attend counseling. She reluctantly agreed to file the paperwork that was pending when Gloria was first arrested. Her mother was fearful that Gloria would hurt herself or be locked up because of her refusal to cooperate and disregard for legal consequences. Gloria had begun to stay out overnight and to say she wished she were dead, when her mother received a call from the police. Gloria was picked up and charged after acting belligerently and attacking a mall security officer when she and a group of friends were questioned. Police charged her with assault and contacted her mother, who asked that Gloria be taken to the nearest hospital emergency room to rule out drug ingestion or suicidality. The police told her mother that the town had no adolescent unit or crisis staff able to see Gloria that night.



José, a 12-year-old Latino boy, lives in a large urban city with his extended family. He attends regular-education middle school classes although he has been retained several times and cannot read or write. He has a history of cocaine exposure in-utero and treatment for lead poisoning. Both parents died after long illnesses shortly after José began school. José was hospitalized briefly at age 8 and diagnosed with Adjustment Disorder, Borderline IQ and Attention Deficit Hyperactivity Disorder (ADHD). During the school year, José was arrested several times for fighting on school property. Teachers and peers have seen José talking to himself when he's upset and his aunt has caught him sniffing glue several times. José is said to be compliant at home and spoiled by older siblings. He refuses to sleep by himself, and family members refuse to leave him at home unsupervised because of his impulsivity. José has been charged twice with Assault II for unprovoked attacks on peers in his neighborhood and placed in juvenile detention for several days. In detention he experienced frequent restraint and seclusion for fighting peers and attacking staff. Both times he was released from detention to his grandmother and adult sister and placed on probation with conditions that he return to school and agree to take medication for his well-documented hyperactivity and impulsivity. He was recently picked up for violating probation after being expelled from school for threatening a peer with a BB gun. He was placed in detention a third time and his attorney agreed to a court-based psychological evaluation. José was oppositional and uncooperative with the court evaluator who came to detention twice to interview him. The evaluator diagnosed José with Conduct Disorder and recommended that he go to the state training school for further evaluation and treatment of his aggression.

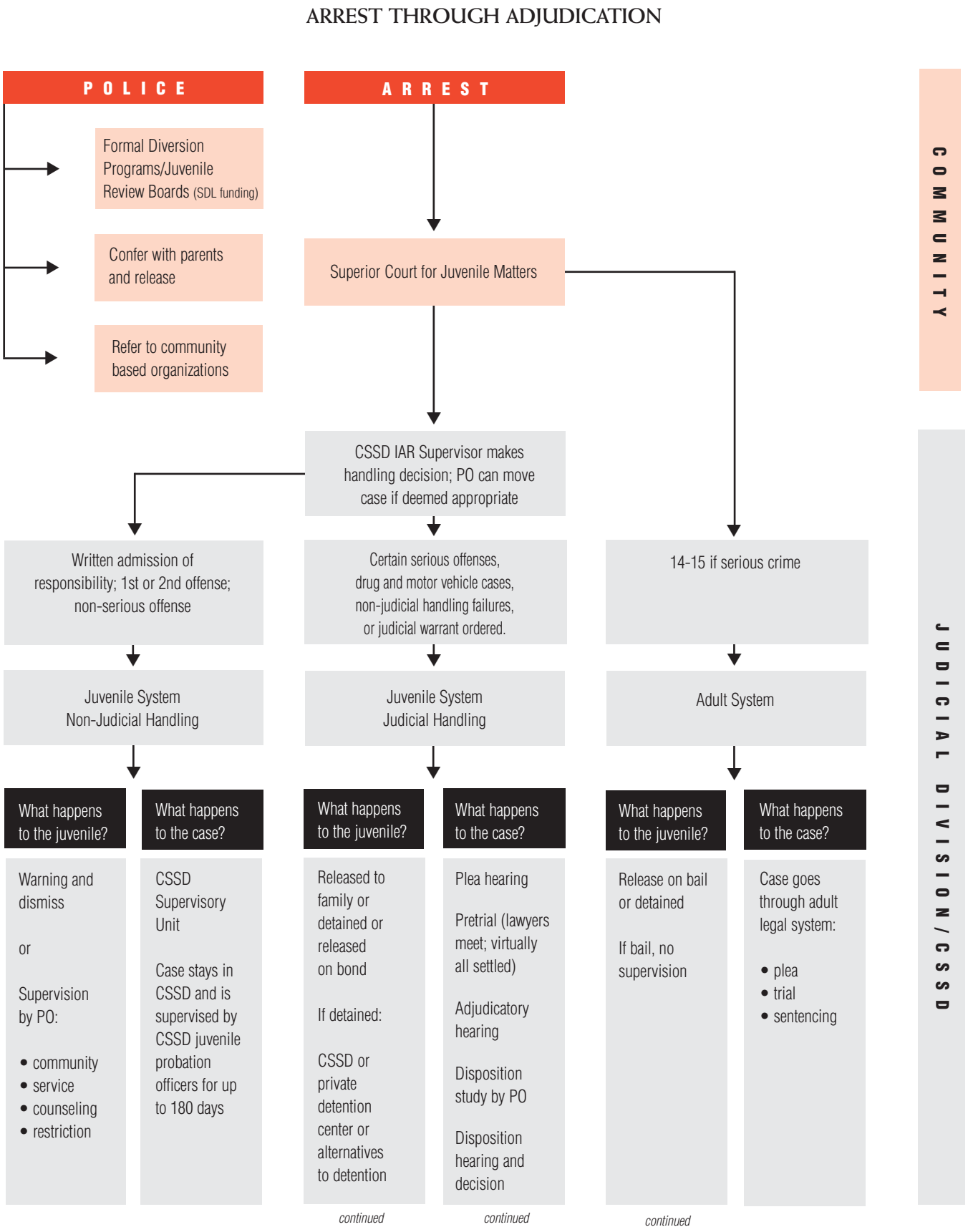
Children can take a variety of paths into and through the juvenile justice system, and many have psychological problems that place them at further risk for delinquent behavior.

Children can take a variety of paths into and through the juvenile justice system, and many who enter the system have psychological problems as illustrated by the above experiences of Gloria and José. Each turn in these paths presents legal, policy and service barriers that shape a child's future in the justice system and access to the limited resources for behavioral health assessment and treatment. Providing effective behavioral health care requires identifying these barriers and ensuring that appropriate screening, assessment or treatment options are available. Yet, the past pattern has too frequently been to make choices for children with insufficient attention to their individual behavioral health needs.

We begin on the following pages with a schematic view of the paths taken by children entering the juvenile justice system. A particular focus is on the critical points of the system where decision-makers have the burden of choosing services for children with serious behavioral health problems without having behavioral screening procedures, training in child health and development, consultation with behavioral health professionals, or effective community-based treatments. We believe that opportunities for earlier screening and comprehensive assessments would: 1) detect behavioral health problems and divert more children from the juvenile justice system; 2) enable children to be better matched with appropriate treatments; 3) make efficient use of limited court-based evaluation services; and 4) assist administrators to make more informed choices when contracting services.

Table I part A

Schematic representation of a juvenile's interaction with the juvenile justice system

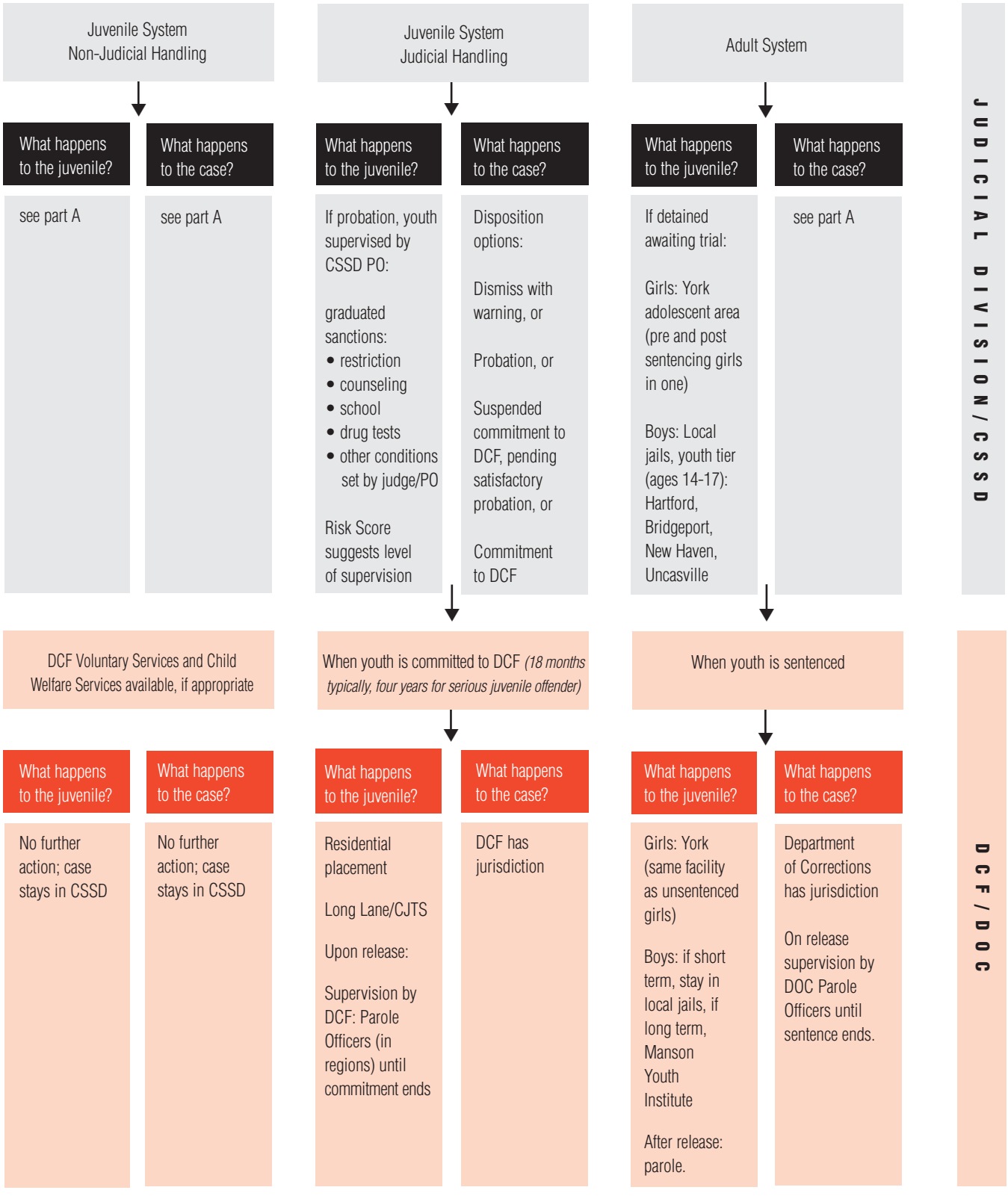


continued *continued* *continued*

Table I part B

Schematic representation of a juvenile's interaction with the juvenile justice system

ADJUDICATION THROUGH PAROLE



...police usually have the burden of making decisions about disturbed children without the benefit of screening procedures or consultation with behavioral health professionals.

A child's engagement with the juvenile justice system involves many decision-makers including the police, community agencies, the schools, the Court Support Services Division (CSSD), the courts themselves, and the Department of Children and Families (DCF). The Department of Correction (DOC, for youths handled through the criminal justice system rather than juvenile justice), and the Department of Mental Health and Addiction Services (DMHAS, which has mental health services for parolees within the adult system and for individuals aging out of DCF or CSSD) also may become involved.

Connecticut's juvenile justice system involves two government agencies, the judicial branch Court Support Services Division and the executive branch Department of Children and Families. Together, they provide a system whose purpose, as described in Connecticut state statutes is to hold juveniles accountable, protect the community, build competency and provide essential services. In Connecticut statute, a "child" is any person under 16 years of age and a "youth" is any person ages 16 or 17. The Connecticut juvenile justice system serves both children referred for delinquency offenses committed prior to their 16th birthdays and children and youth referred for status offenses prior to their 18th birthdays.

When a child like Gloria is brought to the attention of police, there are several options short of arrest. Police could refer her to a community-based organization, confer with her parents and then release her, or send her to formal diversion programs or a juvenile review board if available in the community. There are no uniform practices statewide; each community has different services and varying police department policies. If programs outside the judicial system are not adequate, or if the offense is serious, the police can arrest, bringing the child into the juvenile justice system as an alleged "delinquent." An opportunity to screen for behavioral health needs begins at the point of police involvement. The police are the point of first contact, and have substantial discretion and authority. However, police usually have the burden of making decisions without the benefit of screening procedures or consultation with behavioral health professionals.

José and Gloria were both arrested; thus their cases were sent to the Superior Court for Juvenile Matters. At the time of arrest, a child may be released to the family as happened to Gloria, detained, as happened to José, or released on bond. If the child is 14 or 15 and has committed a serious crime, the Juvenile Court may transfer the case to the adult criminal justice system. Connecticut statute requires that persons aged 16 and older be handled by the adult criminal justice system.

The decision to handle a case judicially is another point to perform a specialized behavioral health screen.

In the juvenile system, a probation supervisor in CSSD decides whether to handle the case judicially or non-judicially, based on Superior Court Practice Book rules. A first or second misdemeanor offense and some Family With Service Needs (FWSN, described below) referrals may be handled non-judicially if the child makes a written admission of responsibility and the offense is not serious. A CSSD juvenile probation officer may supervise the case for up to 180 days, but also has discretion to dismiss the case with a warning, with or without a referral to community-based services. The probation officer can require the child to perform community service, get counseling, and/or make restitution.

Judicial handling occurs for serious and violent offenses, drug and motor vehicle offenses, cases where non-judicial handling is unsuccessful and cases in which a judicial warrant is ordered. Judicial handling requires a plea hearing, a pretrial hearing where the lawyers meet and where most cases are settled, a hearing to determine adjudication (conviction in the adult criminal justice system), a dispositional study and a dispositional hearing (sentencing for adults) by the court. Possible legal outcomes include no adjudication or nolle (dismiss the case but keep open for 13 months), dismissal with a warning, adjudication with probation, adjudication with commitment to DCF, or a suspended commitment pending satisfactory probation.

CSSD has implemented a new risk/need assessment tool, Juvenile Assessment Generic (JAG), which guides the probation officer on appropriate supervision based on factors related to the child's history, background, and behavior. Currently, probation officers are expected to flag children who they believe have greater needs and refer them for a court-ordered evaluation by independent behavioral health professionals. A standardized mechanism for a behavioral health screen should be available at the point where the decision is being made about judicial handling. Such a mechanism would ensure better detection of problems and utilization of court-based assessment resources by accurately identifying those requiring more comprehensive assessment. Gloria and José would have both benefited from a screening process to identify their serious behavioral health needs and avert unnecessary confinement.

As a case is being resolved, a child may be detained in a state or privately run detention center, offered an alternative to detention program (ADP) or served through outpatient intermediate sanction programs. Research now demonstrates that children who enter detention have significant behavioral health needs compared to children in the community and are among those with the greatest mental health and substance abuse problems (Teplin, 2001; Teplin et al., 2002). As José's case illustrates, children with serious and previously unidentified behavioral health needs can end up in detention without access to intensive diagnostic and

...Connecticut does not have a standardized procedure for handling truant children nor a system for collecting aggregate data on truancy from hundreds of local education authorities.

treatment services. Recent events in Connecticut have focused attention on these children, culminating in a three-year court-ordered plan to provide a coordinated system of assessments and services for the approximately 2,000 children who are admitted to detention annually, some with serious and untreated behavioral health needs. CSSD has recently implemented a well-validated behavioral health screening tool (MAYSI - Massachusetts Youth Screening Instrument) for all children entering detention, and may implement screening at other key juvenile justice decision-making points in the future.

In 1999, the latest year for published juvenile court universal data from CSSD, about 9,000 Connecticut children, not including FWSN children, were referred to the Superior Court for Juvenile Matters on delinquency charges. More than half of those cases were handled judicially; and approximately two-thirds of those, or roughly 3,400 children, were adjudicated delinquent (comparable to an adult conviction). In that year, about 600 adjudicated children were committed to DCF for care and custody (although the total caseload approached 1,000), and approximately 100 were transferred to the adult system.

Another point of entry into the juvenile justice system is through a Family With Service Needs (FWSN) complaint or a Youth in Crisis (YIC) complaint. The Judicial Branch and the Department of Children and Families jointly administer a protocol to assist children and families who need services. Parents, guardians or school personnel may identify a child as "truant," "incorrigible," "runaway" or "defiant of school rules," enabling them to petition the courts for FWSN status. With youths ages 16-17, families or schools can petition for Youth in Crisis, a status comparable to FWSN with all of the same criteria except FWSN status includes "indecent/immoral conduct." FWSN and YIC status entitles families to a range of therapeutic services, probation supervision, and judicial review in the event that children and youth are non-compliant.

As required by statute, local education and child welfare authorities make most of the FWSN referrals for truancy, yet Connecticut does not have a standardized, state-wide procedure for handling truant children nor a system for collecting aggregate data on truancy referrals from hundreds of city and town education authorities. A standardized collaborative approach is needed among KidCare, the Department of Education and local education authorities. The state should identify all legally truant children, offer behavioral health assessment when an FWSN petition is filed, and afford community services to support the child and family and promote a return to school.

For most children, a thorough behavioral assessment is not performed until the child has been referred by their probation officer for treatment, which may be too late...

A FWSN complaint is first brought to the Superior Court for Juvenile Matters, which can elect to either handle the case judicially, or non-judicially, although there is a greater likelihood that less serious cases will be handled non-judicially. Non-judicial FWSN cases that are not handled successfully can be moved to judicial handling, a process that has been criticized as "criminalizing" non-criminal behavior such as running away or failing to attend school. Sometimes this criminalization occurs because children with unidentified behavioral health needs and their families lack appropriate supports or may be unable to cooperate with FWSN conditions imposed by the courts. Violations of those conditions can result in the generation of a delinquency petition.

The crucial decision points described above provide opportunities to identify serious behavioral health problems and thus improve decisions made for children. These points are:

- Police contacts
- Judicial handling decisions
- FWSN referrals and violations
- Detention admission

Probation officers make many important decisions about services for children under probation in the community. Probation officers receive some basic training in behavioral health issues, but their mission of supervising children with serious behavioral impairments requires sophisticated skills: crisis management, triage and service gatekeeping and astute decision-making when community treatment services are needed, but unavailable. The availability of treatment services varies widely by region, and the limited number of treatment slots requires probation officers to prioritize among the children assigned to them. For most children, a thorough multi-disciplinary behavioral assessment is not performed until the child has been referred by their probation officer for treatment, which may be too late to be most useful. A comprehensive assessment would be most useful when performed before referral to treatment, to determine whether treatment is necessary, and which treatment approaches and agencies are appropriate.

Behavioral health issues may not be seriously considered until the child is being arrested a second or third time or runs away from probation, treatment or parole.

The most serious of judicial cases are adjudicated and then committed to DCF, where the child can be placed in Connecticut or out-of-state residential facilities, or confined to Long Lane School (LLS) for girls or Connecticut Juvenile Training School (CJTS) for boys. Upon release from residential placement or training school confinement, children committed to DCF are supervised by DCF juvenile parole officers. These officers have substantial discretion in getting children to behavioral health services, yet important decisions about treatment services are made by the parole officer, without the availability of an organized system of behavioral health consultation. Referral to services often occurs based upon a parole officer's experience and judgment but without formal assessment of the child's behavioral health needs. The authority of the parole officer is limited to the duration of the child's commitment to DCF (typically an 18 month limit), and any treatment process is begun and finished according to that timing, whether or not that timing is the most beneficial for the child.

During involvement with the juvenile justice system, beginning when a police officer decides whether or not to arrest, many children never have their behavioral health needs identified or treated. Indeed, behavioral health issues may not be seriously considered until the child is being arrested a second or third time or runs away from probation, treatment or parole.

An ideal system of behavioral health care would include the following:

- Well-coordinated procedures for screening, multidisciplinary assessment, treatment planning, service referral, and quality management;
- The capacity to determine children's behavioral health needs at multiple decision points as necessary, without adverse legal repercussions such as self incrimination or loss of privacy;
- Adequate treatment capacity and an array of behavioral health services for children within the juvenile justice system. Timely screening is premised upon the ability to triage and refer children — who might otherwise be confined — to least restrictive, appropriate treatments in their communities.

When treating children with serious behavioral health problems, it is also critical that juvenile justice treatments have research and evidence documenting their effectiveness. We turn next to an overview of the scientific evidence addressing these issues.

Section 2.

Evidence-Based Approaches for Addressing the Behavioral Health Problems of Children in the Juvenile Justice System

Children and adolescents in the juvenile justice system have complex behavioral conditions — many with psychiatric, developmental and addictive disorders, as well as difficulties within their immediate families, schools and broader social environments (Sells,1998). These problems include not only externalizing °disorders — such as oppositional-defiance, hyperactivity, impulsivity, aggression, substance abuse and dependence — but also the often less visible but equally debilitating "internalizing" disorders such as depression, anxiety, posttraumatic stress, and eating disorders (Cicchetti & Toth, 1995; Dodge et al., 1995; Mullen et al., 1996; Purnell, 1999; Steiner et al., 1997l).


Behavioral health problems are four to six times more prevalent among children who are incarcerated or in diversion or probation programs than among other children (Otto et al., 1992). In a 2002 study of 1,829 children in detention, nearly two thirds of males and three quarters of females met criteria for one or more behavioral health disorders, with half of all males and females having a substance abuse disorder (Teplin et al., 2002). Behavioral health problems are generated by and contribute to difficulties in all areas of life.

Models based upon developmental and systems theory are successfully treating these social and behavioral interconnections by engaging and transforming not just the child, but the entire family and social context. Primary or secondary prevention of youth behavior problems (e.g., Compas et al., 1995; Cowen, 1998) is promising and potentially cost-effective (e.g., Conduct Disorders Prevention Research Group, 1999a, 1999b). Yet thousands of children with severe behavioral health problems "fall between the cracks" each year and end up in the juvenile justice system.

Severe behavioral problems of adolescents in this country now account for one-third to one-half of all adolescent clinic referrals. However, over the last decade juvenile justice policies have shifted from emphasizing therapeutic and rehabilitative services for juveniles to an emphasis on deterrence, punishment, retribution (National Research Council and Institute of Medicine, 2001) and the number of children in the juvenile and adult criminal justice systems has increased. Recidivism (Dougherty et al., 2002) and the prevalence of behavioral health disorders among Connecticut children have increased as well. While public safety is the stated goal of this shift of policies and resources, achieving public safety does not appear feasible if behavioral health problems are not addressed.

Recent research into behavioral health problems associated with involvement in juvenile justice has identified a myriad of risk factors (Dodge et al., 1995; Ford, 2002). Although children in the juvenile justice system most often exhibit "externalizing" problems such as aggression or defiance, these often emerge after several risk factors have created chronic emotional and social dysfunction (Loeber et al., 1993; Moffitt, 1993; Stanger et al., 1997). Factors associated with higher risk of behavioral health problems include:

- **Internalizing problems.** Anxiety, despair, depression, and traumatic stress often underlie apparently intractable callousness and the use of hostility, aggression and intimidation to solve problems and gain a sense of control.
- **Breakdowns in extra-familial social support systems.** When prosocial peer affiliations are unavailable to children or a child is rejected by peers, the result can be alienation, the adoption of deviant beliefs, and shifting loyalties from prosocial to deviant peer groups (Compas et al., 1995). The greatest risk occurs, however, if a child cannot count on a reliable and emotionally caring relationship with at least one adult (Loeber et al., 1998).

- **Breakdowns in family systems.** Parents who face socioeconomic adversity or emotional illness or who live in troubled or stressed families may have difficulty establishing and maintaining parental authority, providing effective monitoring, setting and maintaining consistent limits (such as curfews or school attendance), providing moral guidance and healthy activities, and expressing mutual affection and respect. In these situations, children are at risk for failing to develop self-esteem, a sense of security, and the skills needed for emotional self-regulation, social problem solving and interpersonal communication (e.g., Dishion et al., 1999; Taylor et al., 1999; Webster-Stratton & Hammond, 1997).

The literature is clear that a number of well-researched treatment interventions do exist, are more cost effective than confinement, and effectively reduce recidivism by working with children and families to identify and reverse dynamics that propel them toward delinquency. (Table II lists components of effective psychosocial interventions). We highlight in this report a number of these specific treatment interventions that are appealing because they have strong research support and evidence of good long-term outcomes. These interventions also emphasize treating the child at home or in the least restrictive setting, with participation of families, surrogate caregivers and community support systems.

Table II. Core components of effective interventions

Effective interventions are known to:

- address motivational issues for both youth and family;
- focus on strengths rather than solely or primarily on the elimination of "pathology";
- provide intensive contacts and round-the-clock crisis backup for a period long enough to achieve change;
- give children and their families, separately and jointly, practical skills for self-regulation;
- be tailored to the socio-cultural realities of each youth and family;
- target the full range of problems and risk or resilience factors that are relevant for the youth and family;
- promote autonomy of the youth and family in their home environments;
- ensure that the intervention as delivered is faithful to the treatment model;
- deliver services in all relevant natural environments (home, school, and community);
- afford safe, sheltered places—such as therapeutic foster care and therapeutic respite care—that reduce the stress and overload of information often experienced by children and their parents;
- coordinate services and youth/family participation with juvenile justice agents (including judges, police, probation and parole officers) to increase youth and family accountability to these agents.

Source: Huey & Henggeler, 2001.

We refer to these well-researched interventions — with demonstrated benefits for children, families, and public safety — as "evidence-based" treatments. Evidence-based treatments in health and human service delivery are scientifically researched interventions that have been studied and replicated successfully by other investigators, and are shown to result in measurable and sustained positive outcomes. Evidence-based treatments also have theories that explain why they work; procedures to evaluate outcomes; standards for conducting and evaluating staff training; procedures for maintaining the quality or "fidelity" of treatment delivery; and written manuals detailing protocols that permit clinical and research replication.

Through a review of the literature, we identified several evidence-based treatment models that are effective with children who exhibit disruptive and antisocial behaviors. We group them within five broad treatment categories: **cognitive behavioral or motivational models** (CBT/MET), **problem-solving skills training** (PSST); **parent management training** (PMT); **family therapy** (FT); **and family, school, community treatments** (FSCT). Appendix A gives brief descriptions and contact information for each evidence-based intervention. Table III describes the behavioral health risk and protective factors that each intervention model targets as primary and secondary outcomes, as well as risk factors that each approach could address.

Table III. Interventions targeting specific risk and protective factors

INTERVENTION	RISK FACTOR		PROTECTIVE FACTOR			
	internalizing problems	breakdown in social support systems	parenting & communication skills	self regulation skills	peer/school involvement	trusted adult(s)
CBT	▲	●	●	■	●	
PSST	■			■	●	●
PMT		▲	■			●
FT	▲	■	▲	▲		●
FSCT	▲	■	■	■	■	▲

■ primary focus ▲ secondary focus ● potential focus

Evidence-based treatments are scientifically researched interventions that have been studied and replicated successfully and are shown to result in measurable and sustained positive outcomes.

Five Evidence-Based Approaches To Behavioral Health Treatment

Cognitive Behavioral Therapy and Related Motivational or Behavioral Models

Cognitive-behavioral therapy (CBT), is a well-researched model for substance abuse/dependence treatment that teaches skills for productive thinking ("cognitive restructuring"), interpersonal communication, problem-solving, and relapse prevention (Myers et al., 1995). **Motivational enhancement therapy** (MET) teaches problem-solving skills to people in recovery from addiction and provides counselors with skills to engage with clients by enhancing the client's sense of empowerment and self-control (Miller, 1989). **Contingency management** (CM), is a behavior therapy intervention that institutes a system of rewards for prosocial behavior and for not behaving in disruptive or dysfunctional ways (Kaminer, 2000). CBT, MET and CM share a common theoretical emphasis upon changing the way adolescents make choices about using substances and other healthier ways of coping with problems or having their needs met. They differ in their specific underlying theories based on the relative degree of emphasis given to changing: a) beliefs that can lead to substance use (CBT); b) motivation to use or not use substances (MET); and c) the incentives or rewards for choosing to not use substances (CM).

Components of CBT, MET and CM often are used in each of the other intervention models that we will describe below, and can be used to address treatment goals other than substance abuse. For example, **Aggression replacement therapy** (ART) is a variant of CBT targeted to address aggressive youth behavior with three linked interventions in a structured curriculum: "skillstreaming (behavioral component), anger control training (emotion-targeted component), and moral reasoning training (cognitive component)" (Goldstein, Glick & Gibbs, 1998).

CBT, MET, and CM are widely used and have been extensively tested with adults in recovery from substance abuse. CBT also is a well studied evidence-based intervention for a number of anxiety disorders and depression in adults and children. CBT, MET and CM recently have been empirically evaluated with teen substance abusers (Dennis et al., 2000; Corby et al., 2001; Kaminer, 2000; Wagner et al., 1999) showing good evidence of effectiveness — although CBT or MET were not found to be as effective alone as they were when a family support intervention was included in the treatment (Dennis et al., 2000). ART showed promising results in a large single-group evaluation study with youths in a runaway shelter (Nugent et al., 1998) and in a review of the literature on cognitive skill training with offenders (Bray 2000), but the only quasi-experimental study of ART showed limited benefits (Coleman et al., 1994).

CBT has the strongest evidence base for adolescent substance abuse treatment, but MET and CM also appear promising. The ART variant of CBT is promising as a treatment for adolescent aggression.

Problem-Solving Skills Training (PSST) and Parent Management Training (PMT)

Both **problem-solving skills training** (PSST) and **parent management training** (PMT) teach children skills and support parents in helping children with "self-monitoring, prosocial goal setting, developing peer environments supportive of prosocial behavior, setting limits with friends, and problem solving and communication skills" (Dishion et al., 1999). PSST teaches the child directly. PMT changes how parents use tangible incentives to change behavior, how they model behavior, and how they interact with their children. Dishion and others evaluated the benefits of twelve 90-minute sessions of PSST or PMT or both with children aged 10 to 14 who were not in the juvenile justice or mental health systems but had numerous risk factors (e.g., estranged from parents; in emotional distress; academically disengaged; few prosocial activities; risk-taking; using substances or associating with peers who did so; living in families characterized by substance use; and/or going through stressful life events). The study found that children who received PSST, PMT, or both together demonstrated better parent-child cooperation compared to children on a waiting list to receive treatment (Dishion et al., 1999). PSST combined with PMT was associated with reduced conflict as reported by mothers; PMT was associated with reduced externalizing behavior problems as rated by teachers.

At a one-year follow-up, however, children who had received PSST or PSST and PMT showed a worsening of externalizing behavior problems as rated by teachers. Families struggling with "socioeconomic disadvantage, marital discord, parent psychopathology, [or] poor social support" have shown fewer and less durable positive outcomes after PSST or PMT than families without these characteristics (Kazdin, 1997, p. 166). These findings raise concern as to whether relatively brief skills training, even when given to both the children and the parent(s), and even when done with children not already in the juvenile justice system, is sufficient to address severe behavioral and emotional problems in children.

We know that individual and parent skills training can result in measurable improvements in cognition, behavior and parent-child cooperation for some children and families. However, more research and follow-up will be necessary to determine which children benefit most and under what conditions skill building leads to improved functional and developmental outcomes.

...more research and follow-up will be necessary to determine which children benefit most and under what conditions

Family Therapy (FT) Models

Family therapy (FT) involves several approaches that enhance communication patterns in children's family systems, as well as parenting skills and children's ability to self-regulate (Joanning et al., 1992). Family therapies focus on altering interactions between family members, improving communication patterns and fostering healthier family functioning. Family therapists view children's problem behavior as serving specific purposes within the family — for example, as an expression of conflict among several family members or of frustration and grief due to alcoholism or depression in the family. Therefore, problems are addressed with a view to improving the functioning of the family as a system as well as the functioning of individual members. Several family therapy models have been developed with very specific guidelines or manuals that therapists can follow and that researchers can use to ensure that the intervention is evaluated rigorously with adolescent substance abuse or conduct disturbances that bring children into the juvenile justice system: 1) Functional Family Therapy (FFT); 2) Multi-Dimensional Family Therapy (MDFT); and 3) Brief Strategic Family Therapy (BSFT).

In **Functional Family Therapy** (FFT) (Alexander et al., 2000), therapists use techniques associated with problem-solving skills training, parent management training, cognitive-behavioral therapy, and contingency management to give parents and children skills for resolving conflicts, promoting supportive communication and prosocial activities. FFT differs from PSST or PMT in being delivered to the parents and children together rather than separately while also working with the multiple domains and systems within which families live. Friedman (1989) reported as much as a 50% reduction in substance abuse when FFT was used with adolescents. Subsequent clinical trials of FFT with substance-abusing teens have replicated this finding and have also shown evidence of enhanced psychosocial functioning and reductions by as much as 35% in reincarceration or out-of-home placements (Alexander et al., 2000). FFT is a multisystemic prevention program with solid evidence of successfully leading families to greater self sufficiency with fewer total treatment needs and at considerably lower costs than out-of-home alternatives. To date, no controlled studies have been conducted in which children with extremely serious and violent offenses are randomly assigned to FFT and a usual alternative treatment.

The second family therapy approach, **Multi-Dimensional Family Therapy** ((MDFT) (Diamond & Liddle, 1996), is a family-based drug abuse treatment that involves sessions with adolescents and parents together, during which family interaction patterns are identified and restructured to increase trust and cooperation The focus is on helping adolescents to transform a drug-using lifestyle into a developmentally normative lifestyle, while also increasing parental knowledge, strengthening parental commitment and improving family relationships and communication patterns. In a recent multi-site trial involving 182 teens (13-18 years old) who abused marijuana and alcohol, MDFT was delivered weekly by experienced clinicians

who were monitored to ensure fidelity to the model. In a comparison with group therapy and multifamily educational groups (Liddle et al., 2001), MDFT was found to be most effective in reducing substance use and achieving sustained improvement in school/ academic performance and in observed family functioning as measured after one year.

Another multi-site study evaluated the efficacy of MDFT, CBT, and MET with six hundred 12-18 year olds meeting criteria for substance abuse or dependency and receiving outpatient treatment (Dennis et al., 2000). Most (71%) of the children and youth had been involved in the juvenile justice system, but did not currently have legal or judicial problems sufficiently severe to warrant placement in a restricted setting. The treatments were relatively brief (six to fourteen weeks), and at least 20 percent of the children sought additional treatment after the study.

Preliminary findings indicated that each treatment approach reduced substance use, and each had a distinctive outcome that was consistent with the intervention's primary focus. Furthermore, when CBT or MET were augmented by a "family support network" in the form of home visits, parent education/support meetings, and intensive case management, the results at three-month and six-month follow-ups for children with the most severe initial problems were superior to the outcomes for CBT or MET alone. In short, reducing behavioral health problems and increasing resiliency will require improving extrafamilial support networks, the intrafamilial support system, and the skills and assets of children and parents (Benson, 1997).

Brief Strategic Family Therapy (BSFT) is a problem-focused family therapy, developed, tested, and well replicated with minority families. It focuses on eliminating substance abuse risk factors through focused interventions that improve problematic family relationships and on building family strengthening strategies that address family leadership, alliances, behavioral control, and parental responsibilities. It was developed at the Center for Family Studies in Miami and used extensively with inner city children and families of color. A recent randomized trial (Coatsworth et al., 2001) with inner city families whose children had a variety of behavior problems and varying degrees of juvenile justice involvement showed that BSFT was superior to usual community care services in engaging (81% vs. 61%) and retaining (71% vs. 42%) children and families — including the most troubled. In a 2000 study, BSFT was more successful than group counseling for Latina adolescents with conduct disturbance. Half of the BSFT participants made substantial improvement compared to 5 percent of youth in group therapy, and BSFT participants were three times as likely to reduce their aggression (Szapocznik, & Williams 2000).

...reducing behavioral health problems and increasing resiliency will require improving extrafamilial support networks, intrafamilial supports and skills.

Family, School, Community Treatment (FSCT) Models

Children who cannot be maintained safely in their families because of dangerous or disruptive behaviors traditionally have been placed in residential group care in the social welfare, mental health, or juvenile justice systems. There has been little evidence, however, that such placements are successful (Kazdin, 1997; Lipsey, 1995). FSCT interventions have been designed as the most intensive intervention alternatives available to keep in their own environments those children who would otherwise require out of home placement. FSCT interventions coordinate the child's and family's involvement with school and community networks in order to empower the parents and engage the child in prosocial relationships and activities. Several FSCT interventions have shown promise, but only two models have consistently shown positive outcomes in scientific studies: (see below) Multisystemic Therapy (MST) and Oregon Treatment Foster Care (OTFC).

FSCT interventions such as diversion programs (Davidson et al., 1987), family preservation (Heneghan et al., 1996), and vocationally oriented psychotherapy (Shore & Massimo, 1979) are all alternatives to residential group care that have shown promise in single studies. There is however, limited "evidence" in favor of these models — no written protocols, comparative studies or successful replications to validate their superiority to residential group care or to other "treatments as usual." Wrap-around treatment such as the well-established Wraparound Milwaukee program is designed to coordinate intensive long-term care involving parents and children as full partners in all aspects of treatment. The system of care wraps individual treatment services around the child and family as needed. However, the specific content of services provided relies completely on the social and mental health services already available in communities; thus all wrap-around initiatives do not get equal results (Ellsworth, in press). In 2000, Wraparound Milwaukee reported successful recidivism reduction at one year follow-up with a population of 600 children where 69 percent were delinquent offenders and 72 percent were diagnosed with conduct disorder or oppositional defiant disorder (Seybold 2000). While promising, the model has been only partially described in manual form and preliminarily validated with high-risk adolescents in one controlled study and one quasi-experimental study (Burns et al., 2000).

Multisystemic Therapy (MST) (Henggeler, 1999) involves up to six months of individualized, community-based contact by a therapist, supported by a round-the-clock back-up team. MST addresses all relevant environments — home, school, and peer group — by "empowering parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising adolescents" (Borduin et al., 1995, p. 571). MST has been found to be superior to individual therapy in reducing recidivism and crime severity over a four-year follow-up, and equally effective for children of both genders, for both younger and older adolescents, and for individuals from all socioeconomic and ethnocultural backgrounds

(Henggeler, 1999). A recent study with violent and chronic juvenile offenders showed that MST, as compared with usual juvenile probation services, resulted in reduced psychiatric symptoms, in 50 percent fewer out-of-home placements, and in recidivism lowered by 26 percent (Henggeler et al., 1998). A study with substance-abusing delinquents found that, compared with the usual community services, MST reduced drug use, days in out-of-home placement, and recidivism. Follow-up results after more than a year indicated that the sustained benefits offset the additional cost of MST (Huey & Henggeler, 2001).

MST also has been shown to produce greater caregiver satisfaction, fewer externalizing problems, improved family functioning, more consistent school attendance, 75 percent fewer days of hospitalization, and 50 percent fewer out-of-home placements than psychiatric hospitalization (Henggeler, 1999; Henggeler et al., 1999). Hospitalization, however, was more effective in enhancing children's self-esteem. In general, better provider adherence to MST protocols was associated with the most positive results (Huey & Henggeler, 2001). A recent four year outcome study of Canadian youth randomly assigned to MST and usual services reported no statistically significant treatment effect in the MST group when aggregated across several sites (Cunningham, 2002). The MST groups did considerably better in some sites compared to others and overall showed better outcomes in half of the indicators. This reinforces the importance of having solid research and evaluation capability to study local implementation efforts, treatment fidelity and outcomes.

Oregon Treatment Foster Care (OTFC) (Chamberlain & Mihalic, 1998; Chamberlain & Reid, 1991, 1998), provides training and ongoing support to enable foster parents to maintain a structured therapeutic environment for teaching skills, setting limits, modeling communication and problem-solving strategies, encouraging school attendance, and providing individualized emotional support. Thus, OTFC incorporates components of CBT, MET, CM, PMT, and PSST in a comprehensive approach to educating, supporting, and teaching behavior management skills to foster parents.

Several studies suggest that therapeutic foster care is associated with positive psychosocial outcomes (Curtis, Alexander, & Lunghofer, 2001) including three controlled trials that specifically evaluated Oregon Treatment Foster Care. One study found that 9- to 17-year-olds were better able to avoid recidivism following discharge from a psychiatric hospital when they had been given Oregon Treatment Foster Care than when they had been placed in residential group care (Chamberlain & Reid, 1991). A second study found that, when compared with boys randomly assigned to residential group care, boys placed in OTFC had less than half as many arrests, days incarcerated, days running away from placement, and episodes of delinquency in the following year and at a two-year follow-up (Chamberlain & Reid, 1998). A third study reported that boys in OTFC had fewer arrests, engaged in less drug use and unprotected sex, and had better vocational outcomes (Fisher & Chamberlain, 2001).

No behavioral health intervention is 100 percent effective. Therefore, the focus should be on developing a spectrum of carefully targeted assessments and matched interventions.

Evidence-based Approaches: Summary and Concerns

Taken together, these findings suggest that children and families benefit most when treatment focuses attention on social supports, skills (or resources) and family support offered in the home environment. Interventions focused directly on troubled adolescents who are in, or at risk for involvement in, the juvenile justice system appear beneficial in reducing substance abuse and interpersonal problems, but less so when the family is not systematically included using a family support component. While improvements in family systems and youth development were achieved with the use of problem-solving skills training, parent management training, and structurally oriented family therapy, the most significant and lasting improvements for seriously delinquent children facing out of home placements were associated with the more intensive family, social, community treatment approaches (e.g., Multisystemic Therapy and Oregon Treatment Foster Care). However, family, social and community therapy (FSCT) interventions are expensive: they require low caseloads, assertive community-based services, frequent contacts, and round-the-clock coverage. FSCT interventions also do not systematically teach children and parents individual self-management and relational skills. No behavioral health intervention is 100 percent effective with all children and families. Therefore, the focus should be on developing a spectrum of carefully targeted assessments and matched interventions addressing each of several levels of clinical risk, strengths and needs.

Although the models highlighted are effective in many respects, none adequately addresses three key areas of concern. First, with the partial exception of one MST study (Henggeler et al., 1999), the need for psychiatric, neuropsychological, and pharmacological treatment are not mentioned. There is literature that stresses the importance of assessing delinquent children for their higher risks of psychomotor seizure, lead poisoning, intrauterine drug exposure, Tourette's syndrome, attentional problems, mental retardation and pervasive developmental disorders (Lewis et al., 1994). The developmental and functional impairments caused by these conditions can be devastating and are equally as important to address as the behaviorally oriented interventions that emphasize skill development, education, and family strengthening. The Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) program is an approach to intervention with children who show severe emotional disturbance (as a follow-up or alternative to hospitalization) which includes psychiatric professionals as members of the primary in-home treatment team (Woolston et al., 1998). IICAPS has been adopted by DCF and CSSD in Connecticut as a model for delivery of intensive in-home psychiatric service to children up to age 18. Unlike the approaches described above, IICAPS does not yet have an evidence base supporting its methods. However, it has developed a manual, standardized training, and a system for data collection that will support rigorous research and replication. Currently, it is the only known, well-described approach for the intensive in-home psychiatric treatment of severely impaired children and youth.

Second, while gender-specific, cultural and developmental (life stage) issues receive relatively little attention, they may substantially affect an intervention's effectiveness. Preliminary findings with MST services in Connecticut indicate that engagement is more difficult and outcomes are less impressive for Latina youth compared to boys or girls of other backgrounds. Most research to date on interventions for children with behavioral health problems in the juvenile justice system has focused on boys. Concerns that disproportionately affect girls entering the juvenile justice system include depression, prostitution, sexual abuse, neglect and abuse, pregnancy and parenting responsibilities. While boys are affected by these issues, biological, psychological and social factors make those effects both different and less common. In addition, girls and boys have different types of peer group conflicts and norms.

Connecticut has several promising girl-centered programs and there is a growing body of evidence that similar gender-specific approaches are more successful with girls (Greene, et al., 1998). It is critical that gender-specific approaches and practices based on normative female development be rapidly incorporated into the developing evidence base, as girls comprise an increasing percentage of court-involved children and youth (in Connecticut, girls are currently 34% of all court-involved youth — a figure 9% higher than national rates) (Lyons & Spath, 2002). On the other hand, older adolescent males of color may be entering residential group care with disproportionate frequency (Curtis et al., 2001), potentially as a result of deeply ingrained systemic biases that result in over reliance on confinement and punishment with these boys (Greater Bridgeport Juvenile Justice Task Force, 2002). Even the most effective interventions require adaptation to reach diverse children and families. Brief Strategic Family Therapy is particularly promising, with evidence of success in non-white substance-abusing populations (Robbins and Szapocznik, 2000). A community-building approach may also enhance outcomes for children and families from varied ethnocultural, racial, and linguistic backgrounds, while building social skills and promoting self-advocacy (Sampson et al., 1997).

Third, while children in the juvenile justice system are likely to have been exposed to abuse and violence (Erwin et al., 2000; Ford, 2002; Steiner et al., 1997), none of the evidence-based models explicitly address the cognitive, biological, psychosocial, or spiritual effects of trauma. Although neither trauma nor traumatic stress inevitably lead to law-breaking, children who have been victimized in home, school or institutional settings often exhibit emotional reactivity, impulsivity and aggression that place them at risk for juvenile delinquency. Assessment of these consequences of trauma is essential to inform effective treatment strategies and to prevent further traumatization. New interventions must address repercussions of children's traumatic experiences such as poor self-regulation and troubled relationships (Ford, 2002; Glodich & Allen, 1998; Saltzman et al., 2001).

Section 3.

A Survey of Connecticut's Intensive Community-Based Behavioral Health Services for Children in the Juvenile Justice System

No single database or infrastructure currently exists to monitor, coordinate or evaluate behavioral health services provided to children in Connecticut's juvenile justice system. Therefore, the CCEP study team decided that the best approach to developing a preliminary understanding of the relevant behavioral health services would be to interview the programs providing these services. A list was obtained from CSSD and DCF of all agencies with whom they contract that have the capacity of providing intensive (3 times/week) nonresidential behavioral health services to children involved in the legal system. A member of the research team conducted a ninety-minute semi-structured interview with agency staff about intensive, community-based program(s) provided by that agency for children with behavioral health problems and juvenile justice involvement (see Appendix B for the survey methodology and Appendix C for the interview protocol).

The agencies were located across Connecticut, with the highest concentration in the Hartford area (see Appendix D for names, dates, staff members and locations of agencies interviewed). Agencies on the CSSD list were of two types, "Outpatient Mental Health and Substance Abuse Treatment" (OPSAMH), and "Juvenile Supervision and Reporting Center" (JSRC). OPSAMH programs provide screening and treatment focused on behavioral health problems, while the six JSRC programs serve 135 children, providing services that, while not directly treating behavioral health disorders, address relevant problems such as anger and stress management, peer group relationships, school attendance, and prosocial work and recreational activities. Agencies on the DCF list provide a range of behavioral health screening, assessment, and treatment services, including Multisystemic Therapy (MST).

Children served by the programs represented a variety of ethnocultural backgrounds (although most were African-American or Caucasian), primarily from low-income families (i.e., on Medicaid, receiving public assistance, or working poor). The children also had a range of severity of juvenile justice involvement, from mild (e.g., FWSN, truancy, substance abuse, minor theft or assaults) to severe (e.g., aggravated assault, armed robbery, possession with intent to sell narcotics). Both boys and girls were served by all programs, with several programs serving mostly boys and a few serving more girls than boys. Some programs had relatively few children with problems severe enough to warrant a formal psychiatric diagnosis, but more than half of the programs estimated that at least 75% of the children they served had clinically significant behavioral health problems, including conduct disorder or oppositional defiant disorder, attention deficit hyperactivity disorder (ADHD), depression, or posttraumatic stress disorder (PTSD). By contrast only three programs reported that fewer than half of the children they served received psychotropic medication. Substance abuse was common but far from universal (primarily marijuana and alcohol), with more than one third of the programs estimating that at least 75% of the children they served had substance use disorders.

Once a child is enrolled, all but three JSRC programs conduct an intake evaluation, although the depth and range of the intakes varies greatly from one program to another. Three programs that do not conduct formal intakes rely instead on thorough clinical evaluations procured by the probation department. While specific components of the evaluations performed by programs varied, most consisted of a clinical interview and record review that assesses the child's presenting problem and psychiatric history, family dynamics, educational history, and socioeconomic demographics. Evaluations usually included interviews with both children and their parent(s), although some programs reported that parents were not always available.

Virtually all programs identified the child as the patient, yet most reported that in practice they attempted to treat the child in the context of the family system...

Virtually all programs identified the child as the patient, yet most reported that in practice they attempted to treat the child in the context of the family system, to involve the family in developing either a "service plan" (JSRC) or treatment plan (OPSAMH; DCF) and to reassess the plan biweekly or monthly.

All JSRC services and most services provided by OPSAMH and DCF sites require the child's attendance at the program (as often as 5-7 days per week in JSRC programs, but generally 3-4 times per week), with the major exception that MST services are almost exclusively provided by staff going to the home and school. In JSRC programs, males and females receive separate services. In other programs services tend to be provided in co-ed groups, although most offered at least one gender-specific group. Other than MST, the treatment models cited most frequently were cognitive behavioral therapy or family therapy or both.

Most programs reported having mechanisms in place to evaluate their services, but most did not collect data to measure either process (e.g., quality; fidelity to treatment model) or outcome (e.g., recidivism; change in target problems). Examples of evaluation mechanisms included agency utilization reviews, parent/child satisfaction questionnaires, and counting the number of completers vs. dropouts. MST programs were the exception, with process and outcome data formally collected and evaluated for ongoing quality assurance purposes at all MST sites.

Most (65%) of the programs had waiting lists for services, typically one to four weeks. A few (20%) reported that they are not permitted to exclude those for whom the program is not clinically appropriate and are required to accept all youth. Length of stay for most programs varied from six to twenty-four weeks, with 15 percent of programs reporting longer stays.

Some programs referred few children for follow-up services upon discharge, but half the programs referred more than 75 percent for further services. Programs decided when it was time for discharge in three ways: 1) a child achieves service goals; 2) a child completes a designated treatment curriculum; 3) a child completes parole or probation. Most programs reported that relatively few children dropped out before completing the program — usually only if rearrested or placed in detention or residential treatment due to probation violations. Several providers noted that ongoing consultation with referral sources, particularly probation officers, had reduced the number of inappropriate referrals and hence of dropouts.

Most programs had both full-time and part-time staff. Clinicians held a master's degree in social work, marriage and family therapy, or a comparable field. Case managers typically held a bachelor's degree. Program directors and clinical supervisors almost without exception had a master's degree or a doctorate. Few programs reported having a consulting psychiatrist. Staff training was provided in all programs, although typically not in a specific treatment approach and not on an ongoing basis aimed at supporting clinical skills (e.g., clinical consultation groups or case conferences).

The providers exhibited a high degree of commitment and dedication to the children in their programs and seemed collectively to have amassed a wealth of knowledge and experience. Table IV summarizes the factors that providers identified as important to successful outcomes.

Table IV. Factors identified by providers as contributing to successful outcomes

- Engaging parents as full participants in their children's treatment and recovery
- Enhancing the personal well-being and psychosocial functioning of parents
- Sustaining the benefits of treatment with effective aftercare and transition services
- Psychiatric evaluation and medication treatment by a qualified child psychiatrist
- Access to vocational and recreational resources in the community
- Staffing capacity to permit counselors to do home visits and outreach to families
- Collaboration among providers and other caregivers (including schools)
- Providing services for a time period sufficient to achieve sustainable benefits
- Staffing and funding sufficient to provide fully individualized treatment planning

When probation officers and judges or court staff were active partners in the referral and treatment process, providers felt more confident about being able to...help the child.

The most consistently cited determinant of successful outcomes was parental involvement in the child's treatment and ability to provide supervision and motivation. Sometimes this involvement depends upon parents' ability to cope with poverty, psychosocial stressors, relational conflicts, and their own psychiatric or addiction issues. To the extent that the child could form an attachment at home, the providers believed that the child could form an attachment with treatment staff and prosocial relationships with other children. Children who did not have secure attachments with parents (whether biological, step, foster, or surrogate) were viewed as likely not to engage, to drop out, or to perpetuate deviant peer relationships.

Providers also consistently viewed probation officers and juvenile court officers or judges as playing a critical role (often as surrogate or co-parent) in the lives of children in the juvenile justice system. When probation officers and judges or court staff were active partners in the referral and treatment process, providers felt more confident about being able to engage and help the child. On the other hand, when juvenile justice personnel (or the program itself) communicate the view that treatment amounts to "serving time" the outcomes were viewed by providers as much less likely to be positive.

Several providers stressed the importance of community recreation and vocational resources and commented upon their scarcity. Some felt that recreational and community-based activities should be better tailored to the needs and interests of children in their program. Some also identified a need for additional staff to transition children into community-based and pre-vocational activities. Concern was expressed about transitions to home from residential placement or detention. Some providers felt that more in-home services should be available while the child resides in and transitions from placement to prepare both children and families for reunification. Providers frequently identified a lack of available community-based outpatient aftercare as a threat to the sustainability of gains made by children in their programs. They noted particularly the lack of child psychiatrists who can and will treat children on Medicaid.

Fiscal concerns were often raised. Even in relatively well-funded programs such as MST, providers expressed concern about the long-term sustainability of funding for intensive low-caseload services necessary to help children change and frustration that comprehensive behavioral health services for children in justice programs are not fully eligible for reimbursement under Medicaid. Beyond increasing staffing to enable the enrollment of more children needing services, the providers viewed enhanced funding as providing opportunities for: more ongoing collaboration with juvenile justice personnel; longer treatment stays to allow for more sustained changes; more gender-specific programming; and increasing parental involvement and support (e.g., by providing transportation to bring parents on site, increasing the number and types of family activities, or adding outreach staff able to visit families at home). In their focus on the need for transportation, increased parental involvement and improved transition planning/aftercare, these providers echoed the conclusions of other recent studies (Dougherty, Sieve, & Thomalla, 2002).

In addition to interviewing service providers, the CCEP team held a meeting to solicit input from parent and staff representatives from several Connecticut family advocacy organizations. Their feedback echoed that of the providers and included additional suggestions to:

- Increase emphasis upon prevention by improving mechanisms for screening, assessment, early parental education and family supports prior to formal juvenile justice involvement;
- Expand mental health resources in the local school systems and improve their coordination with the continuum of care;
- Allocate resources away from confinement, enabling families and communities to play a central role in implementing strategies for juvenile delinquency prevention and rehabilitation;
- Provide sufficient funding for pro-social recreational, vocational and mentoring supports critical to positive youth development;
- Provide sufficient community treatment services within the Connecticut Community KidCare system to avoid inevitable competition between the needs of delinquent and non-delinquent children.

Section 4.

Conclusion and Recommendations

As a result of this review of the juvenile justice system and the clinical research literature, and survey of family advocates and relevant program providers, CCEP identified several areas in which substantive change will improve the well-being of children and families, protect public safety and save money for the state and taxpayers.

Significant disparities are evident when we compare the current system described by providers with the literature about effective practices. Although programs, providers, and advocates have goals that are consistent with the findings of scientific research on treating delinquency, they typically do not have access to the materials, training, or funding required to implement evidence-based practices.While providers identify parental and family involvement as crucial to successful behavioral health treatment, and view treatment as best provided in a home or community setting, the majority of Connecticut providers treat the child alone as the primary client and do so primarily in a clinic or program setting.

In Connecticut, programs serving children in the juvenile justice system did not — until the very recent introduction of MST — have any tools for determining if providers are actually delivering clinically-successful and cost-effective treatments or conducting the treatments according to recommended or standard practice guidelines. Until recently, few resources in Connecticut have been dedicated to training, supervision or skill development in evidence-based models of treatment for delinquent and at-risk children. Moreover, there are no standard recommended or required methods for monitoring children's clinical outcomes, nor are providers required to formally assess child and family functioning, develop treatment plans or conduct outcome evaluation. Thus providers must rely upon their own initiative to gain and update (as new approaches are developed) the skills and knowledge required to provide effective treatment services.

Currently, CSSD has implemented a standardized risk and needs assessment that is administered to judicially-handled children by trained probation officers. However, there is no standardized process for juvenile probation or DCF parole officers to screen and assess the problems, strengths or treatment needs of non-judicially handled, FWSN or DCF committed children — a prerequisite for referring these children to appropriate community interventions and program providers. Program lengths of stay are frequently determined by sentencing guidelines rather than by treatment needs and few programs offer services well informed by gender, cultural or trauma-specific treatment approaches. Even the most powerful evidence-based intervention is unlikely to be successful unless matched to children's individualized treatment needs and delivered with sensitivity to the roles of gender, ethnicity, and trauma history.

The severely-limited capacity and frequent gridlock within the children's behavioral health service system is another hurdle for children in the juvenile justice system. The wait for most programs is not days but instead weeks or months. There are not enough child psychologists or psychiatrists serving on or consulting to treatment teams, and few community-based options for vocational and recreational pro-social experiences exist. All of these factors leave worrisome gaps between the evidence of what is required to achieve good outcomes and the current resources available to support anything more than minimal services.

The wait for most programs is not days but instead weeks or months.

What can be done? CCEP identifies several areas in which changes could dramatically improve the well-being of Connecticut children, their families and communities. The next steps we propose for rapid implementation include:

- Establish screening and assessment protocols that systematically identify children with behavioral health needs at all crucial points of entry into the juvenile justice system to accurately determine their needs and link them with effective treatments.

  Children should be screened upon entry and at all critical decision points. Screening enables decision-makers to identify children needing further assessment to determine their mental health and substance abuse needs, the most effective services, and a specific service plan including outreach and community resources.

- Make families — not children — the clients, and full members in treatment teams.

  Services that identify the family as the focus achieve the best long-term outcomes. A family-centered system is best for service delivery, but requires resources, incentives and systematic treatment approaches that providers can use to work collaboratively with each family and with family advocates.

- Establish system-wide a range of evidence-based community treatments, available to children and families based upon their specific types and levels of need.

  DCF and CSSD should collaboratively develop a plan for state-wide implementation, support and evaluation of evidence-based treatments as integral components of juvenile justice provider contracts. These effective treatments should be available to children in all regions of the state. State agencies can take advantage of economies of scale by jointly establishing training, clinical supervision, research and important quality assurance mechanisms.

- Mandate the delivery of core services by all behavioral health programs serving children in the juvenile justice system.

  Several core services should be offered by all behavioral health providers who have DCF or CSSD contracts to serve children in the juvenile justice system. Providers should have choices as to how to implement these core services in order to best fit their program and their clients. Effective core services consider the child within a larger community system, build skills and competencies for the caregiver and child, strengthen family and community linkages, and encourage prosocial peer involvement.

- Improve data collection and management, integrate information systems and link funding to process and outcome evaluation.

  A data tracking system is needed that enables agencies to collect and track essential information about treatment effectiveness across juvenile justice and behavioral health delivery settings. DCF and CSSD should work together with evaluation specialists, providers and families to develop adequately staffed and equipped system databases and agency-specific mechanisms to support the monitoring of service quality, model fidelity and child and family outcomes.

- Behavioral health care for children in and at risk for juvenile justice involvement must be coordinated with other services.

  Behavioral health services for children involved with or headed toward the juvenile justice system must be readily available and accessible, through Connecticut Community KidCare collaboratives to families, police, the courts, schools, and child welfare staff. KidCare should offer adequate capacity and variety of evidence-based treatments and other services, (home-based crisis stabilization and family assessment, therapeutic respite and foster care, medication and psychiatric management), that provide community stabilization and diversion from detention and other costly juvenile justice services.

- Examine Connecticut's current and emerging plan for behavioral health care financing to ensure effective reimbursement mechanisms and incentives to use new outcome-driven "evidence-based" treatments.

  Currently in Connecticut, neither Medicaid nor private insurers fully reimburse the types of intensive, cost effective treatments emphasized in this report — home-based, 24 hours/7days/week, family-oriented alternatives to out-of-home placement and institutionalized care. Connecticut's efforts to reform behavioral health care financing should include careful consideration of procedural changes that would make all types of evidence based treatments eligible for federal reimbursement under Medicaid.

Connecticut's citizens and policy makers have a responsibility to create reform and wise allocation of resources....

- Develop early identification and behavioral treatment interventions for families with service needs (FWSN) and youth in crisis (YIC).

  Juveniles who are chronically truant, suspended, or expelled from schools often are referred to courts as families with service needs (FWSN) or youth in crisis (YIC). These children are at higher risk for mental health, substance abuse, educational, legal and family problems. Connecticut Community KidCare and school districts should collaborate to establish effective services that increase the likelihood of school success, strengthen families, and reduce legal involvement and emotional disability.

- Establish gender-specific and culturally relevant behavioral health services for children within the juvenile justice system.

  Children in juvenile justice settings often have histories of experiencing racism, stigma, community and family violence, abandonment, and — especially for girls — sexual trauma. Behavioral health services for children must be capable of mediating the impact of these stressors and also serving the unique needs of girls, children of color, and children from families in which English is not the first language.

- Identify and take action, at all levels of the juvenile justice system, to correct disparities disproportionately affecting people of color, underserved and special populations.

  Connecticut must remedy the disproportionate entry and confinement of minority children in the juvenile justice system. Also the failure to properly assess and serve the treatment needs of the under-served populations (e.g., Asian-Americans, recent immigrants from Eastern Europe, sexual minorities) must be examined and corrected with appropriate linguistic and culturally-sensitive services.

These essential changes are achievable in Connecticut's system of behavioral health care for children in or at risk of entering the juvenile justice system. Effective interventions do exist. Given the current fiscal reality, Connecticut's citizens and policy makers have a responsibility to create system reform through resource planning and investment in services identified as cost effective, scientifically proven to reduce juvenile crime, and able to improve the lives of children and families.

Appendix A: Evidence-based treatment model descriptions

A. Aggression Replacement Training (ART)

Aggression Replacement Training is a violence prevention program that has been in operation for over ten years both in the U.S. and abroad. The ART curriculum uses a three-pronged approach to replace aggressive behavior with socially acceptable responses. *Skillstreaming* teaches interpersonal skills for dealing with anger-provoking events. *Anger control training* teaches self-control strategies. *Moral reasoning training* promotes socio-moral reasoning through social decision-making meetings, a feature distinguishing ART from other violence prevention programs.

Training on each of the three components runs concurrently for an hour a day, and lasts approximately ten weeks. Depending on the setting, ART may be conducted as a pull-out or integrated program. Parent involvement ranges from mandatory participation (separate parent training packages are available) to daily homework-based contact. ART has been implemented in a variety of settings including an alternative school, a community agency, a neighborhood center, a residential school, and a school district.

Contact:

http://www.sharingsuccess.org/code/eptw/profiles/86.html

Arnold Goldstein, Ph.D.
Center for Research on Aggression
Syracuse University
805 South Crouse Avenue
Syracuse, NY 13244

Tel: (315) 443-9641 Fax: (315) 443-5732

B. Brief Strategic Family Therapy (BFST)

Brief Strategic Family Therapy was developed at the Spanish Family Guidance Center in the Center for Family Studies, University of Miami, where it has been conducted since 1975. The Center for Family Studies is the nation's oldest and most prominent center for development and testing of minority family therapy interventions for prevention and treatment of adolescent substance abuse and related behavior problems. It is also the nation's leading trainer of research-proven, family therapy for Hispanic families.

BSFT is an effective, problem-focused, and practical approach to the elimination of substance abuse risk factors. It successfully reduces problem behaviors in young people 6 to 17 years old, and strengthens their families. BSFT provides families with tools to decrease individual and family risk factors through focused interventions and skill building strategies. It targets conduct problems, associations with anti-social peers, early substance use, and problematic family relations.

The program fosters parental leadership, appropriate parental involvement, mutual support among parenting figures, family communication, problem solving, clear rules and consequences, nurturing, and shared responsibility for family problems. In addition, BFST provides specialized outreach strategies to bring families into therapy.

Contact:

http://www.strengtheningfamilies.org/html/programs_1999/09_BSFT.html

José Szapocznik, Ph.D.
(Contact) Carleen Robinson-Batista
1425 NW 10th Avenue, Third Floor
Miami, Florida 33136

Tel: (305) 243-2226 Fax: (305) 243-5577

C. Functional Family Therapy (FFT)

Functional Family Therapy is so named to identify the primary focus of intervention (the family) and reflect an understanding that positive and negative behaviors both influence and are influenced by multiple relational systems (i.e., are functional). FFT is a multisystemic prevention program, meaning that it focuses on the multiple systems within which adolescents and their families live. FFT is also multisystemic and multilevel: if focuses on the treatment system, family and individual functioning, and the therapist as major components.

FFT works first to develop family members' inner strengths, providing the family with a platform for change and future functioning that extends beyond direct support by the therapist and other social systems. Thus the FFT philosophy leads to greater self sufficiency, fewer total treatment needs and considerably lower costs.

FFT targets youth between the ages of 11 and 18 from a variety of ethnic and cultural groups. It also provides treatment to the younger siblings of referred adolescents. FFT is a short-term intervention, including, on average, 8 to 12 sessions for mild cases and up to 30 hours of direct service (e.g., clinical sessions, telephone calls, and meetings involving community resources) for more difficult cases. In most cases, sessions are spread over a three-month period. Regardless of the target population, FFT emphasizes the importance of respecting all family members on their own terms (i.e., as they experience the intervention process).

Contact:

http://www.fftinc.com/

Doug Kopp dkfft@msn.com

D. Motivational Enhancement Therapy (MET)

Motivational Enhancement Therapy (MET) seeks to evoke from clients their own motivation for change and to consolidate a personal decision and plan for change. The approach is largely client centered, although planned and directed.

As applied to drug abuse, MET seeks to alter the harmful use of drugs. Because clients set their own goals, no absolute goal is imposed through MET, although counselors may advise specific goals such as complete abstention. A broader range of life goals may be explored as well.

MET is based on principles of cognitive and social psychology. The counselor seeks to develop a discrepancy in the client's perceptions between current behavior and significant personal goals. Consistent with Bem's self-perception theory, emphasis is placed on eliciting from clients self-motivational statements of desire for and commitment to change. The working assumption is that intrinsic motivation is a necessary and often sufficient factor in instigating change.

This therapy views relapse and recovery as a spectrum, and although most commonly used to treat addictions, can also be applied to changing undesired behavior such as medication noncompliance or overeating. Note that these stages are more cyclical than linear: it is more the rule than the exception that the patient will move backwards as well as forwards.

Contact:

http://www.motivationalinterview.org/clinical/

Chris Wagner, Ph.D., and Wayne Conners, M.Ed.
Mid-Atlantic Addiction Technology Transfer Center
A CSAT Project mid-attc@mindspring.com

http://www.mid-attc.org

E. Multidimensional Family Therapy (MDFT)

Multidimensional Family Therapy, an outpatient family-based treatment, is used with teen substance abusers — and those at risk for substance abuse — and their families. It has been applied in several geographically distinct settings with a range of populations, targeting ethnically diverse adolescents (White, African-American, and Hispanic).

Targeted outcomes in MDFT include reducing the impact of negative factors as well as promoting protective processes in as many areas of the teen's life as possible. Objectives for the adolescent include transformation of a drug using lifestyle into a developmentally normative lifestyle and improved functioning in several developmental domains, including positive peer relations, healthy identity formation, bonding to school and other pro social institutions, and autonomy within the parent-adolescent relationship. For the parent(s), intermediate objectives include: increasing parental commitment and preventing parental abdication; improved relationship and communication between parent and adolescent; and increased knowledge about parenting practices (e.g., limit-setting, monitoring, appropriate autonomy granting).

The format of MDFT has been modified to suit the needs of different clinical populations. A full course of MDFT ranges between 16 and 25 sessions over four to six months. Sessions may occur multiple times during the week in a variety of contexts including in-home, in-clinic, or by phone. The MDFT approach is organized according to five assessment and intervention modules: 1) interventions with the adolescent; 2) interventions with the parent; 3) interventions to change the parent-adolescent interaction; 4) interventions with other family member; and 5) interventions with systems external to the family.

Contact:

http://www.strengtheningfamilies.org/html/programs_1999/10_MDFT.html

Dr. Howard A. Liddle
Center for Treatment Research on Adolescent Drug Abuse
Dept. of Psychiatry and Behavioral Sciences
University of Miami School of Medicine
Dominion Tower 1108; 1400 N.W. 10th Avenue; M-711
Miami, FL 33136

Tel: (305) 243-6434 Fax: (305) 243-3651
hliddle@med.miami.edu

F. Multisystemic Therapy (MST)

Multisystemic Therapy is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. The multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems.

MST targets chronic, violent, or substance abusing juvenile offenders at high risk of out-of-home placement and their families. The major goal of MST is to empower parents to independently address the difficulties that arise in raising teenagers and to empower youth to cope with family, peer, school, and neighborhood problems. Within a context of support and skill building, the therapist places developmentally appropriate demands on the adolescent and family for responsible behavior. Intervention strategies are integrated into a social ecological context and include strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavior therapies.

MST is provided using a home-based model. This model helps to overcome barriers to service access, increases family retention in treatment, allows for the provision of intensive services (i.e., therapists have low caseloads), and enhances the maintenance of treatment gains. The usual duration of MST treatment is approximately four months.

Contact:

http://www.mstservices.com/

Dr. Scott W. Henggeler
Family Services Research Center
Department of Psychiatry and Behavioral Sciences
Medical University of South Carolina
171 Ashley Avenue
Charleston, SC 29425-0742

Tel: (843) 876.1800 Fax: (843) 876.1808

G. Oregon Treatment Foster Care (OTFC)

Oregon Treatment Foster Care, originally called Multidimensional Treatment Foster Care, targets teenagers with histories of chronic and severe criminal behavior who are at risk of incarceration. It is a cost effective alternative to group or residential treatment, incarceration, and hospitalization for adolescents with chronic antisocial behavior, emotional disturbance and delinquency. Community families are recruited, trained, and closely supervised to provide OTFC-placed adolescents with treatment and intensive supervision at home and in school. It also emphasizes positive reinforcement for appropriate behavior; a relationship with a mentoring adult; and separation from delinquent peers.

OTFC includes several content areas: training for community families; services to the youth's family; and coordination and community liaison. Training emphasizes behavior management methods to provide youth with a structured and therapeutic living environment. After completing a pre-service training and placement of the youth, OTFC parents attend a weekly group meeting where ongoing supervision is provided. OTFC parents also receive daily check-in telephone calls from staff.

Services include family therapy for the youth's biological (or adoptive) family, with the ultimate goal of returning the youth back to the home. The parents are taught to use the structured system that is being used in the OTFC home. Closely supervised home visits are conducted throughout the youth's placement in OTFC and parents are encouraged to have frequent contact with the OTFC case manager to get progress reports. Contact is also maintained between the OTFC case manger and the youth's parole/probation officer, teachers, work supervisors and other involved adults.

Contact:

pattic@oslc.org

Patricia Chamberlain, PH.D.
Clinical Director, Oregon Social Learning Center
160 E 4th Street
Eugene, OR 97401

Tel: (541) 485-2711 Fax: (541) 485-7087
Website: www.oslc.org

Appendix B: Survey methodology

The Department of Children and Families (DCF) and the Court Support Services Division (CSSD) were asked to submit a list of agencies with contracts to provide intensive non-residential services to children matching the study criteria. Agencies providing a representative sample of available services were selected for participation in this survey. All agencies were initially contacted by telephone by a member of the interview team to explain the project and solicit participation. Of the initial group of agencies provided, nine indicated that they no longer conducted programs that fit the study criteria (eight DCF programs and one CSSD program). The interview team was unable to schedule two of the agencies despite repeated telephone contact. In cases where an agency indicated that it maintained more than one program that fit the study criteria, these multiple programs were interviewed. The final group of interviews comprised thirty programs.

Interviews were conducted between January, 2002 and June, 2002 by doctoral level psychologists working at Yale Child Study Center, using a semi-structured protocol designed for this purpose (see Appendix C). Most interviews were conducted in person; a few were conducted by telephone. Interviews lasted an average of 90 minutes. In some cases follow-up calls were made. Data were entered into a statistical database by a member of the interview team, and analyses were conducted to provide descriptive statistics on appropriate variables.

Appendix D maps the programs and lists those surveyed by date and category, and identifies the staff members interviewed by job function.

Appendix C: Interview protocol

Connecticut Center for Effective Practice
Survey of Clinical Services

Name of agency/program:
Agency/program personnel interviewed (name and position):
Interviewer(s):
Date:
Brief program description:

CLIENTS:

1) By whom are these children referred to you? What is the referral process? Is the referral process different for youth involved with the juvenile justice (JJ) system?
2) Do referrals come through your parent agency or directly to the program?
3) Is there a waiting list for these services? How long is the typical wait?
4) Does your program turn down referrals? If yes, what percentage? For what reasons?
5) Is your program or parent agency able to provide alternate services or referrals to children and families not able to participate in this program?
6) How many children and families are served by this program? Currently? In the past year? How many of these are JJ-involved?
7) In what towns do the children and families in this program live? JJ? Non-JJ?
8) What is the gender/socioeconomic/racial breakdown of these children and families? JJ? Non-JJ?
9) Does the program intake include a formal evaluation? If yes, what does this evaluation include? By whom is it done? Whom (e.g., child, parents, family, other systems) does this evaluation assess? Where does it occur?
10) Who is perceived to be the primary client of this program? Child? Family? Other
11) What types of court involvement do JJ-involved children in this program have (e.g., FWSN, truancy, drug offenses, robbery, assault)?
12) What percentage of the children in this program have a substance abuse history? JJ? Non-JJ?
13) What percentage of the children in this program have a formal psychiatric diagnosis? What is the range of these diagnoses? Are certain diagnoses more prevalent among these children? Please describe for both JJ and non-JJ children.
14) What percentage of the children in this program take prescribed psychiatric medication? Are these medications prescribed by your program staff or outside providers? Please describe for both JJ and non-JJ children.
15) With what type of children and families does this program work particularly well?
16) With what type of children and families does this program not work particularly well?

CLINICAL CONTACT:

17) What is the nature of the clinical contact (e.g., home-based; intensive on-site; etc.) in this program?
18) What is the frequency of service delivery in this program?
19) What is the length of service in this program? Average? Range?

20) Is there a "typical" course of treatment? If so, please describe it.

21) Is the course of treatment influenced by particular theoretical paradigms or treatment models? If so, what are these?

22) Is there a manual for this treatment?

23) Does your parent agency have an overall philosophy or treatment approach which influences the delivery of services in your program? If yes, please describe.

24) Do children in this program have a formal treatment plan? If yes, by whom is it developed? Does the child participate? Does the family participate? Others?

25) Are there written explicit goals, objectives, and planned interventions? If yes, where are these written? By whom are these read?

26) Are treatment plans formally reassessed on a periodic basis? If yes, by whom? What is the mechanism for this? What is the frequency?

27) What percentage of cases involve collaboration with other mental health programs within your agency, or with other mental health agencies? Please describe this collaboration. Are there differences between JJ and non-JJ children?

28) What percentage of cases involve collaboration with schools? Please describe this collaboration. Are there differences between JJ and non-JJ children?

29) What percentage of cases involve collaboration with other community resources, e.g., churches, police, etc.? Please describe this collaboration. Are there differences between JJ and non-JJ children?

30) How are decisions regarding termination reached? Are there differences between JJ and non-JJ children?

31) What percentage of cases are terminated prematurely due to noncompliance and similar reasons? Are there typical reasons for this occurring? Are there differences between JJ and non-JJ children?

32) What percentage of children and families are referred for other clinical services as part of a termination/discharge plan? What type of services are usually required? Are there differences between JJ and non-JJ children?

33) Are there mechanisms in place to evaluate the services provided by this program? What are these mechanisms?

34) Are data available regarding service effectiveness/clinical outcomes? If yes, what are they? How are they used? By whom?

35) Is there contact with the referral source regarding treatment compliance and outcome? Are there differences between JJ and non-JJ children?

STAFF:

36) What is staffing of this program? What is the professional background/training of staff members?

37) Are these staff members assigned only to this program?

38) What training is provided to staff to prepare them for working in this program?

39) What supervision is provided to staff? Frequency? By whom? What is the professional background/training of the supervisor(s) in this program?

40) What program-wide and agency-wide staff development opportunities exist (including clinical team, case conference, etc.)?

PROGRAM FINANCIAL RESOURCES:

41) How are the services provided by this program funded? Are there differences between JJ and non-JJ children?

42) How many children and families are ineligible for services due to lack of funding? Are there differences between JJ and non-JJ children?

43) Are there specific additional services you would provide if funding were not an issue?

POST-INTERVIEW GENERAL IMPRESSIONS:

Appendix D: Interview agencies, dates and staff members (by position) interviewed

Multisystemic Therapy Programs:

AGENCY	STAFF INTERVIEWED	DATE
Community Solutions, Hartford	MST Supervisor, Area Director, Program Director, Director of Youth Services, MST Clinician	1/15/02
Hartford Behavioral Health, Hartford	MST Supervisor, MST Clinician, Director	1/11/02
North American Family Institute, Hartford	MST Supervisor, Clinical Director, Regional Director	2/8/02
Wheeler Clinic, Plainville	MST Supervisor, Associate Director	2/15/02

Juvenile Supervision and Reporting Center Programs:

AGENCY	STAFF INTERVIEWED	DATE
JSRC, Bridgeport	Program Coordinator	5/31/02
JSRC, Hartford	Supervising Program Director	1/15/02
JSRC, New Haven	Program Coordinator	5/28/02
JSRC, Norwalk	Program Director	6/2/02
JSRC, Waterbury	Program Administrator	5/30/02
JSRC, Willimantic	Program Director	5/31/02

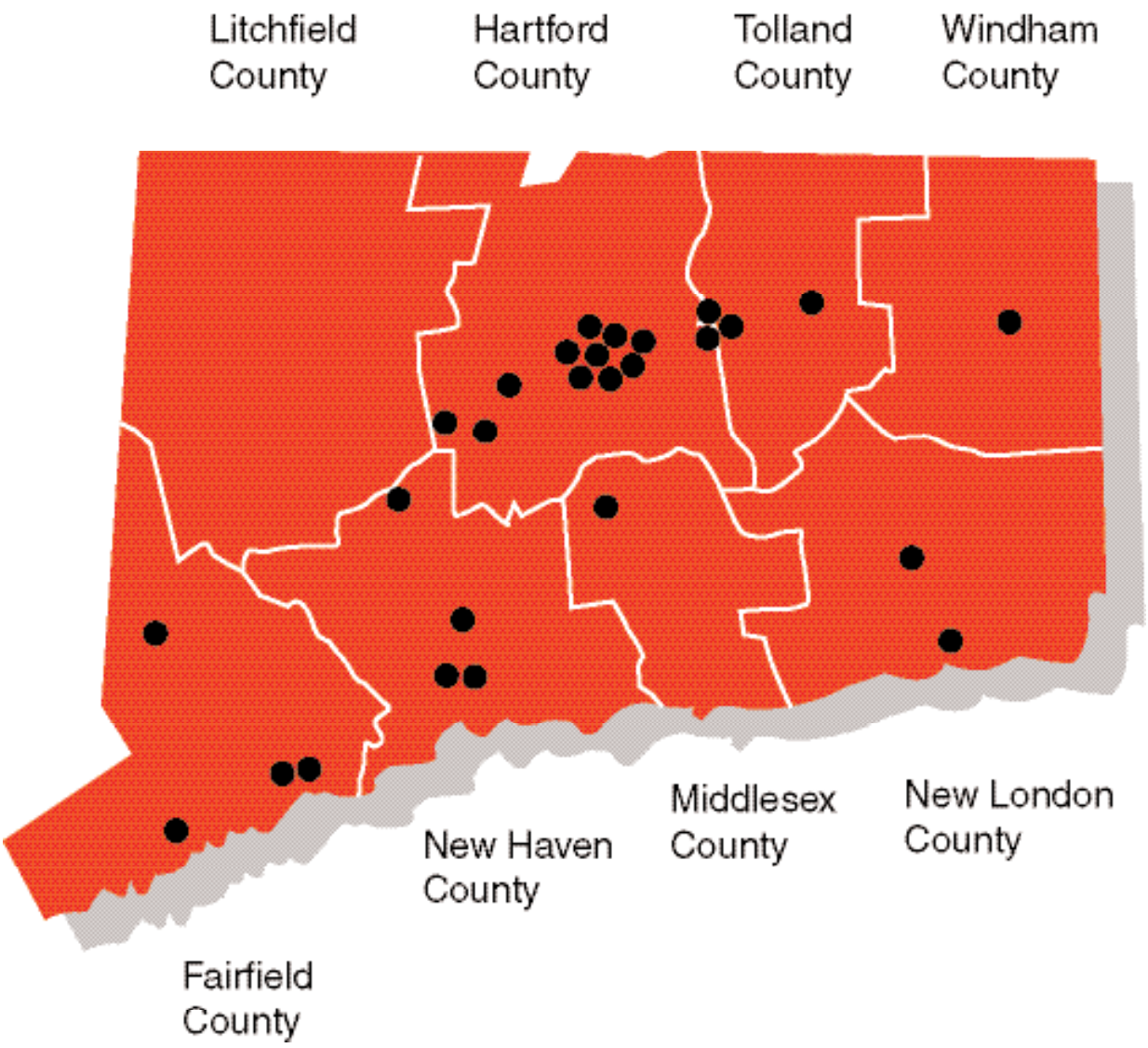
CSSD outpatient mental health and substance abuse programs:

AGENCY	STAFF INTERVIEWED	DATE
Southwest Region		
Child Guidance of Greater Bridgeport, Bridgeport	Director, Program Coordinator	4/12/02
Connecticut Renaissance, Norwalk	Director, Clinician	4/9/02
South Central Region		
New Haven Family Alliance, New Haven	Project Manager, Executive Director	3/22/02
Eastern Region		
Natchaug Hospital, Mansfield Center	Program Director	6/5/02
Natchaug Hospital, Uncasville	Clinical Director	4/5/02
North Central Region		
Wheeler Clinic, Plainville	Program Coordinator, Associate Director	2/15/02
Village for Families and Children, Hartford	Program Director	5/31/02
Northwest Region		
Family and Children's Aid, Danbury	Clinical Director, Clinician	5/9/02
Catholic Family Services, Waterbury	Program Director, Clinician	3/15/02

DCF mental health/substance abuse treatment programs:

AGENCY	STAFF INTERVIEWED	DATE
Southwest Region		
Family Services Woodfield, Bridgeport	Clinician, Vice President, Program Services	3/15/02
South Central Region		
Rushford Center, Middletown	Clinical Case Manager	3/20/02
Clifford Beers, New Haven	Clinician	3/13/02
The Children's Center, Hamden	Clinician	3/27/02
Eastern Region		
St. Francis Behavioral Health, Groton	Primary Therapist	5/31/02
North Central Region		
Catholic Family Services, Hartford	Director of Youth Services, Clinician	4/5/02
Community Child Guidance, Manchester	Director, Child & Adolescent Services	5/31/02
Community Mental Health Affiliates, Bristol	Assistant Director, Child & Adolescent Services	5/28/02
Manchester Memorial Hospital, Manchester	Director, Child & Adolescent Services	6/11/02
Northwest Region		
Wheeler Clinic, Plainville	Associate Director, Program Coordinator	2/15/02

Intensive non-residential behavioral health programs



Appendix E: Glossary of terms and acronyms

List of Acronyms

ADHD	Attention Deficit Hyperactivity Disorder
ART	Aggression Replacement Training
BSFT	Brief Strategic Family Therapy
CBT	Cognitive Behavioral Therapy
CCEP	Connecticut Center for Effective Practice
CHDI	Child Health and Development Institute
CJTS	Connecticut Juvenile Training School
CPEC	Connecticut Policy and Economic Council
CSSD	Court Support Services Division
DCF	Department of Children and Families
FT	Family Therapies
FFT	Functional Family Therapy
FWSN	Families With Service Needs
JSRC	Juvenile Supervision Reporting Center
MDFT	Multidimensional Family Therapy
MET	Motivational Enhancement Therapy
MST	Multisystemic Therapy
OPSAMH	Outpatient Programs for Mental Health
OTFC	Oregon Treatment Foster Care
PTSD	Post Traumatic Stress Disorder
PSST	Problem-solving Skills Training
PMT	Parent Management Training
SAMHSA	Substance Abuse and Mental Health Services Administration
SCT	School and Community Treatments
YIC	Youth in Crisis

Glossary of terms

Adjudication: A finding by the court indicating that a child is guilty of committing an offense(s) alleged in a petition. Similar to a "conviction" in adult criminal court.

Alternative to detention: A privately-run facility contracted by the CSSD to provide an environment made secure by staff. This type of facility is for children from detention who are assessed to be appropriate for this less restrictive environment. ADPs offer both intensive day reporting and residential programming.

DCF commitment: Placement of a child / youth in the custody (for delinquent and FWSN children) or guardianship (for neglected, dependent or uncared for children / youth) of the Department of Children and Families by an order of the court.

Delinquent: A child who is found to have violated any federal or state law, municipal or local ordinance (other than one regulating behavior of a child in a FWSN), or order of the Superior Court.

Detention: State-operated or state-designated facility to provide the temporary care for a child who is alleged to be delinquent and who requires a physically-restricted secure environment.

Dismissal: A judge's decision to end the court proceedings.

Dismissal without prejudice: A judge's decision to end a case but allowing for the complainant or prosecutor to renew the case later. In contrast, dismissal "with prejudice" prevents the complainant or prosecutor from bringing the same claim or action again.

Disposition: Orders of the court following adjudication that assign the most appropriate type of care and treatment for a child / youth (similar to sentencing in criminal court).

Diversionary programs: Community-based programs that allow convicted criminal offenders who are eligible to remain out of prison.

Evidence-based treatments: Theoretically-based, scientifically researched interventions that have clear evaluation procedures, have been replicated successfully, and are shown to result in measurable and sustained positive outcomes.

Externalizing disorders: Behavioral health disturbances characterized by the manifestation of physically demonstrated symptoms such as hyperactivity, impulsiveness, or fighting.

Extra-familial supports: Activities, resources, or people, outside of one's immediate family, that are available to provide help and support.

Family with service needs: A family which includes a child who a) runs away without just cause; b) is beyond the control of his/her parents or guardian; c) has engaged in indecent or immoral conduct; and/or d) is truant, habitually truant or continuously and overtly defiant of school rules and regulations.

Felony: Offense for which a person may be sentenced to a term of imprisonment in excess of one year.

Gender-specific: (female focus) A program that adheres to the principles of effective programming for girls as delineated by the Office of Juvenile Justice and Delinquency Prevention (see Guiding Principles for Promising Female Programming, OJJDP, 1998). Founded in research about female development, the program design emphasizes relational and strength-based approaches delivered within female-only environments.

Internalizing disorder: Behavioral health disturbances characterized by the manifestation of non-physically demonstrated symptoms such as fear, anxiety, or depression.

Judicial handling: Cases, handled by a judge, where a person is not willing to admit responsibility, or which require issuing of a judicial order. A delinquency petition is filed with the court stating the allegations and the state's attorney becomes involved.

Misdemeanor: A broad category of offenses for which a person may be sentenced to a term of imprisonment of not more than one year.

Nolle: A decision by the State's Advocate that a pending case may not be prosecuted. A case which has been "nolled" may be reopened within 13 months; if it is not reopened by then it is automatically dismissed.

Non-judicial handling: Minor delinquent or FWSN cases handled in an informal manner by a probation officer when the child admits responsibility. The probation officer can dismiss the case, place the child in a program with supervision or treatment for up to six months, or recommend a court hearing before a judge.

Parole: Placement of an adjudicated and committed delinquent under the supervision of a DCF- employed parole officer following a period of residential treatment or incarceration.

Probation: Placement of an adjudicated delinquent under the supervision of a CSSD-employed probation officer and the rules set forth by the Court.

Recidivism: Relapse into a previous condition of [criminal] behavior. Usually refers to re-arrest and adjudication.

Residential treatment programs: Programs that provide extensive behavioral, psychiatric or alcohol treatment while the individual is attending school and living in residence at the program.

Supervision: A status used in FWSN or delinquency cases, similar to probation, where it is understood that the court can take further action if a child or guardian does not follow court recommended plans.

Treatment plan: A written plan of service containing problem formulations and recommended treatment interventions that have measurable outcomes.

Truancy: Four unexcused absences from school in any single month or ten unexcused absences in any school year as defined by Connecticut statute.

Wraparound: Interventions delivered to children in their communities and characterized by individualized plans that are driven by need and use strength-based and family-focused interventions.

Youth in crisis: Youth between the ages of 16 and 17 who have within the last two years a) run away from home without just cause; b) are beyond the control of parents / guardian / custodian; or c) truant from school.

References

Alexander, J., Barton, C., Pugh, C., Parsons, B., Sexton, T., Barton, C., Bonomo, J., Gordon, D., Grotpeter, J., Hansson, K., Harrison, R., Mears, S., Mihalic, S., Ostrom, N., Schulman, S., & Waldron, H. (2000). *Blueprints for violence prevention: Functional family therapy.* Boulder: Center for the Study and Prevention of Violence, University of Colorado.

Benson, P. L. (1997). *All kids are our kids: What communities must do to raise caring and responsible children and adolescents*. San Francisco: Jossey-Bass.

Borduin, C. M., Mann, B. J., Cone, L.T., Henggeler, S. W., Fucci, B.R., Blaske, D. M., & Williams, R.A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting & Clinical Psychology*. 63, 569-578.

Bray, C., (2000) *Cognitive Behavioral Curricula in Correctional Settings: A Review of the Literature*, Minneapolis: University of Minnesota Press.

Burns, B., Schoenwald, S., Burchard, J., Faw, L., & Santos, A. (2000). Comprehensive community-based interventions for youth with severe emotional disorders: Multisystemic therapy and the wraparound process. *Journal of Child and Family Studies*, 9, 283-314.

Chamberlain, P., & Mihalic, S. (1998). *Blueprints for violence prevention: Multidimensional treatment foster care.* Boulder: Center for the Study and Prevention of Violence, University of Colorado.

Chamberlain, P., & Reid, J. B. (1991). Using a specialized foster care community treatment model for children and adolescents leaving the state mental hospital. *Journal of Community Psychology*, 19, 266-276.

Chamberlain, P., & Reid, J. B. (1998) Comparison of two community alternatives to incarceration for chronic juvenile offenders. *Journal of Consulting and Clinical Psychology*, 66, 4

Cicchetti, D.L., & Toth, S.L. (1995). Developmental psychopathology and disorders of affect. In D. Cicchetti & D.J. Cohen (Eds.), *Developmental psychopathology: Risk, disorder, and adaptation*, Vol. 2 (pp. 369-420). New York: Wiley.

Coatsworth, J. D., Santisteban, D., McBride, C., & Szapocznik, J. (2001). Brief strategic family therapy versus community control: Engagement, retention, and an exploration of the moderating role of adolescent symptom severity. *Family Process*, 40, 313-332.

Coleman, M., Pfeiffer, S., & Oakland, T. (1994). Aggression replacement training with behaviorally disordered adolescents. *Behavioral Disorders*,18, 54-66.
Compas, B.E., Hinden, B.R., & Gerhardt, C.A. (1995). Adolescent development: Pathways and processes of risk and resilience. *Annual Review of Psychology*, 46, 265-293.

Conduct Problems Prevention Research Group. (1999a). Initial impact of the Fast Track Prevention Trial for Conduct Problems: I. The high-risk sample. *Journal of Consulting & Clinical Psychology*, 67, 631-647.

Conduct Problems Prevention Research Group. (1999b). Initial impact of the Fast Track Prevention Trial for Conduct Problems: II. Classroom effects. *Journal of Consulting & Clinical Psychology*, 67, 648-657.

Carstensen, F. V., (2001). *A Dynamic Economic Impact Analysis of Alternatives to Incarceration in Connecticut.* Connecticut Center for Economic Analysis, University of Connecticut.

Corby, E., Roll, J., Ledgerwood, D., & Schuster, C. (2001). Contingency management interventions for treating the substance abuse of adolescents: A feasibility study. *Experimental & Clinical Psychopharmacology*, 8, 371-376.

Cowen, E. (1998). Changing concepts of prevention in mental health. *Journal of Mental Health*, 7, 451-461.

Curtis, P., Alexander, G., & Lunghofer, L. (2001). A literature review comparing the outcomes of residential group care and therapeutic foster care. *Child and Adolescent Social Work Journal*, 18, 377-392.

Cunningham, Alison (2002) *One Step Forward: Lessons Learned from a randomized study of MST in Canada*, Center for Children and Families in the Justice System.

Davidson, W., Redner, R., Blakely, C., Mitchell, C., & Emshoff, J. (1987). Diversion of juvenile offenders. *Journal of Consulting & Clinical Psychology*, 55, 68-75.

Dennis, M., & the CYT Executive Committee, Steering Committee, and Staff. (2000). *The Cannabis Youth Treatment (CYT) Experiment: Preliminary findings.* Washington, DC: SAMHSA.

Diamond, G., & Liddle, H. (1996). Resolving a therapeutic impasse between parents and adolescents in multidimensional family therapy. *Journal of Consulting & Clinical Psychology*. 64, 481-488.

Dishion, T.J., Capaldi, D.M., & Yoerger, K. (1999). Middle childhood antecedents to progressions in male adolescent substance use: An ecological analysis of risk and protection. *Journal of Adolescent Research*, 14(2), 175-205.

Dishion, T.J., McCord, J., & Poulin, F. (1999). When interventions harms: Peer groups and problem behavior. *American Psychologist*, 54, 755-764.

Dodge, K., Pettit, G., Bates, J., & Valente, E. (1995). Social information-processing patterns partially mediate the effect of early physical abuse on later conduct problems. *Journal of Abnormal Psychology*, 104, 632-643.

Dougherty, V., Sieve, M., & Thomalla, T. (2002). *State of Connecticut juvenile justice programs: Recidivism outcome evaluation.* Hartford: Connecticut Policy and Economic Council.

Ellsworth, L. *Better Aftercare for Delinquent Youth:* A Report prepared for the Eckerd Family Foundation, in press

Erwin, B., Newman, E., McMackin, R., Morrissey, C., & Kaloupek, D. (2000). PTSD, malevolent environment, and criminality among criminally involved male adolescents. *Criminal Justice & Behavior*, 27, 196-215.

Fisher, P., & Chamberlain, P. (2001). Multidimensional treatment foster care. *Journal of Emotional and Behavioral Disorders*, 8, 155-169.

Ford, J. D. (2002). Traumatic victimization in childhood and persistent problems with oppositional-defiance. *Journal of Trauma, Maltreatment, and Aggression*, 6, 23-58.

Friedman, A. (1989). Family therapy vs. parent groups: Effects on adolescent drug abusers. *American Journal of Family Therapy*, 17 (4), 335-347.

Glodich, A., & Allen, J. (1998). Adolescents exposed to violence and abuse: A review of the group therapy literature with an emphasis on preventing trauma reenactment. *Journal of Child and Adolescent Group Therapy*, 8, 135-154.

Goldstein, A., Glick, B., & Gibbs, J. (1998). *Aggression Replacement Training: A comprehensive intervention for aggressive youth* (Rev. Ed.). Champaign, IL: Research Press.

Greater Bridgeport Juvenile Task Force. (2002). *Bridgeport juvenile justice report: Who are the children in the juvenile justice system?* Bridgeport, CT: RYASAP.

Greene, Peters & Associates. (1998). *Guiding Principles for Promising Female Programming: An Inventory of Best Practices.* Report. Washington DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Heneghan, A. M., Horwitz, S. M., & Leventhal, J. M. (1996). Evaluating intensive family preservation programs: A methodological review. *Pediatrics*, 97, 535-542.

Henggeler, S. W. (1999). Multisystemic therapy. *Child Psychology & Psychiatry Review*, 4, 2-10.

Henggeler, S. W., Mihalic, S. F., Rone, L., Thomas, C., & Timmons-Mitchell, J. (1998). *Blueprints for violence prevention: Multisystemic therapy*. Boulder: Center for the Study and Prevention of Violence, University of Colorado.

Henggeler, S. W., Rowland, M., Randall, J., Ward, D., Pickrel, S., Cunningham, P., Miller, S., Edwards, J., Zealerg, J., Hand, L., & Santos, A. (1999). Home-based multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 1331-1339.

Huey, S., Jr., & Henggeler, S. (2001). Effective community-based interventions for antisocial and delinquent adolescents. In J. Hughes & A. La Greca (Eds.), *Handbook of psychological services for children and adolescents* (pp. 301-322). New York: Oxford University Press.

Joanning, H., Quinn, W., Thomas, F. & Mullen, R. (1992). Treating adolescent drug abuse: A comparison of family systems therapy, group therapy, and family drug education. *Journal of Marital and Family Therapy*, 18, 345-356.

Kaminer, Y. (2000). Contingency management reinforcement procedures for adolescent substance abuse. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39, 1324-1326.

Kazdin, A.E. (1997) Practitioner Review: Psychosocial Treatments for Conduct Disorder in Childen, *Child Psychology & Psychiatry Review*, Feb: 38(2)161-175.

Lewis, D.O., Yeager, C. A., Lovely, R., Stein, A., Cobham-Portorreal, C. S., (1994) A clinical follow-up of delinquent males: ignored vulnerabilities, unmet needs, and the perpetuation of violence. *Journal of American Academy of Child & Adolescent Psychiatry*, 33, 518-528

Liddle, H., Dakof, G., Parker, K., Diamond, G., Barrett, K., & Tejeda, M. (2001). Multidimensional family therapy for adolescent drug abuse: Results of a randomized clinical trial. *American Journal of Drug & Alcohol Abuse*, 27, 651-688.

Lipsey, M. (1995). What do we learn from 400 research studies on the effectiveness of treatment with juvenile delinquents? In J. McGuire (Ed.), *What works: Reducing reoffending* (pp. 63-78). New York: John Wiley.

Loeber, R., Farrington, D.P., Stouthamer-Loeber, M., & Van Kammen, W.B. (1998). Multiple risk factors for multiproblem boys: Co-occurrence of delinquency, substance use, attention deficit, conduct problems, physical aggression, covert behavior, depressed mood, and shy/withdrawn behavior. In R. Jessor (Ed.), *New perspectives on adolescent risk behavior* (pp. 90-149). New York: Cambridge University Press.

Loeber, R., Wung, P., Keenan, K., Giroux, B., Stouthamer-Loeber, M., Van Kammen, W., & Maughan, B. (1993). Developmental pathways in disruptive child behavior. *Development and Psychopathology*, 5, 103-133.

Lyons, E., Spath, R., (2002) *Court Involved Girls in Connecticut.* A Report prepared for the Court Support Services Division, State of Connecticut Judicial Branch.

Mendel, Richard (2000) *Less Hype, More Help Reducing Juvenile Crime, What Works — and What Doesn't*, American Youth Policy Forum

Miller, W. R., & Hester, R. K., (1989). Treatment of alcohol problems: Toward an informed eclecticism. In R. K. Hester & W. R. Miller (Eds.) *Handbook of alcoholism treatment approaches: Effective alternatives.* New York: Pergamon

Moffitt, T. E. (1993). Adolescence-limited and life-course-persistent antisocial behavior: A developmental taxonomy. *Psychological Review*, 100, 674-701.

Mullen, P., Martin, J., Anderson, J., Romans, S., & Herbison, G. P. (1996). The long-term impact of the physical, emotional, and sexual abuse of children: A community study. *Child Abuse and Neglect*, 20, 7-21.

Myers, M., Brown, S., & Mott, M. (1995). Preadolescent conduct disorder predicts relapse and progressive addiction for adolescent alcohol and drug abusers. *Alcoholism: Clinical and Experimental Research*, 19(6), 1528-1536.

National Research Council and Institute of Medicine (2001). *Juvenile crime, juvenile justice. Panel on Juvenile Crime: Prevention, Treatment, and Control.* J. McCord, C. S. Widom, and N. A. Crowell (Eds.). *Committee on Law and Justice and Board on Children, Youth, and Families*. Washington, DC: National Academy Press.

Nugent, W., Bruley, C., & Allen, P. (1998). The effects of aggression replacement training on antisocial behavior in a runaway shelter. *Research on Social Work Practice*, 8, 637-656.

Otto, R., Grenstein, J., Johnson, M., & Friedman, R. (1992). Prevalence of mental disorders among youth in the juvenile justice system. In J. Cocozza (Ed.), *Responding to the mental health needs of youth in the juvenile justice system* (pp. 7-48). Seattle, WA: National Coalition for the Mentally Ill in the Criminal Justice System.

Purnell, L.A. (1999). Youth violence and post-traumatic stress disorder: Assessment, implications, and promising school-based strategies. In C. W. Branch (Ed.), *Adolescent gangs: Old issues, new approaches* (pp. 115-127). Philadelphia: Brunner/Mazel.

Revaz, Julie (2002) Report of the Center for Best Practice, Court Support Services Division, State of Connecticut Judicial Branch

Robbins, M.S., Szapocznik, J. (2000). Brief Strategic Family Therapy. *Family Strengthening Series Bulletin*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Saltzman, W., Pynoos, R., Layne, C., Steinberg, A., & Aisenberg, E. (2001). Trauma- and grief-focused intervention for adolescents exposed to community violence: Results of a school-based screening and group treatment protocol. *Group Dynamics*, 5, 291-303.

Sampson, R. J., Raudenbush, S. W., & Earls, F. (1997). Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science*, 277, 918-924.

Sells, S. P., (1998) A family based model for adolescents, In *Treating the Tough Adolescent*, Guilford Press.

Seybold, E., (2002) *WrapAround Milwalkee*. A Report, Milwalkee Community Health Division, Child and Adolescent Services Branch.

Shore, M., & Massimo, J. (1979). Fifteen years after treatment: A follow-up study of comprehensive vocationally-oriented psychotherapy. *American Journal of Orthopsychiatry*, 49, 240-245.

Stanger, C., Achenbach, T.M., Verhulst, F.C. (1997). Accelerated longitudinal comparisons of aggressive versus delinquent syndromes. *Development & Psychopathology*, 9(1), 43-58.

Steiner, H., Garcia, I., & Matthews, Z. (1997). Posttraumatic stress disorder in incarcerated juvenile delinquents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 357-365

Szapocnik, J. & Williams, R.A (2000) Brief Strategic Family Therapy: Twenty-five Years of Interplay Among Theory Research and Practice In Adolescent Behavior Problems and Drug Abuse," *Clinical Child and Family Psychology Review* Jun3(2): 111-134.

Taylor, T., Schmidt, F., Pepler, D., & Hodgins, D. (1999). A comparison of eclectic treatment with Webster-Stratton's Parents and Children Series in a children's mental health center. *Behavior Therapy*, 29, 221-240.

Teplin, Linda A. (2001) Assessing Alcohol, Drug and Mental Disorders in Juvenile Detainees, *OJJDP Fact Sheet*

Teplin, L. A., Abrahms, K. M., McClelland, G. M., Dulcan, M. K., Mericle, A. A., (2002) Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry* 59: 1133-1143.

Wagner, E., Brown, S., Monti, P., Myers, M., & Waldron, H. (1999). Innovations in adolescent substance abuse intervention. *Alcoholism: Clinical and Experimental Research*, 23, 236-249.

Washington State Institute for Public Policy. (2001). The comparative costs and benefits of programs to reduce crime, Report. Version 4.0

Webster-Stratton, C., & Hammond, M. (1997). Treating children with early-onset conduct problems. *Journal of Consulting & Clinical Psychology*, 65, 93-109.

Woolston J., Berkowitz, S., Schaefer, M., & Adnopoz, J. (1998). Intensive, integrated, in-home psychiatric services: The catalyst to enhancing outpatient intervention. *Child & Adolescent Psychiatric Clinics of North America*. 7, 615-633

The Connecticut Center For Effective Practice of
the Child Health and Development Institute of Connecticut, Inc.

270 Farmington Avenue, Suite 325
Farmington, Connecticut 06032

phone 860.679.1519
fax 860.679.1521
www.chdi.org