State of Connecticut
Judicial Branch
Court Support Services Division

REGIONS Juvenile Justice Process and Outcome Evaluation

Final Process and Outcome Evaluation Report

November 10, 2023

DSG
Development Services Group, Inc.

ACKNOWLEDGMENTS

Contents

Appendix A. Process Evaluation Methodology

Appendix B. Sources of Information for Each Metric

Appendix C. Detailed Information about Metric 25. Determine if There is a Discernible Pattern of Clinical and Behavioral Needs for Children Recommended for Placement Versus Those not Recommended for Placement

Appendix D. Outcome Evaluation Methodology

Appendix E. Acronyms and Initialisms

Chapter 1. Introduction

Background and Purpose of This Report

This report is a requirement of Contract No. 041929 to conduct a Juvenile Justice Process and Outcome Evaluation for the State of Connecticut's Judicial Branch Court Support Services Division (JBCSSD) on its **R**e-**E**ntry, **G**oal-oriented, **I**ndividualized, **O**pportunity to **N**urture **S**uccess (REGIONS) program. JBCSSD awarded the contract to Development Services Group, Inc. (DSG), on Nov. 11, 2020. Upon award, DSG produced a workplan that JBCSSD approved. DSG then began carrying out the workplan. DSG submitted a draft interim process evaluation report on October 15, 2021. After incorporating JBCSSD's written feedback, DSG submitted the final interim process evaluation report on Nov. 15, 2021. JBCSSD and DSG met on January 13, 2022, to discuss the interim report. The interim report summarized the work to date and presented preliminary findings and recommendations. On July 10, 2023, we submitted the draft final process and outcome evaluation report. We presented our findings and recommendations to JBCSSD leadership on Aug. 31, 2023, and to the Juvenile Justice Policy and Oversight Committee on Sept. 18, 2023. This final report incorporates feedback JBCSSD provided after reviewing the draft report.

To accomplish the assessment and prepare the report, DSG used a mixed-methods approach, combining qualitative and quantitative data collection, analysis, and interpretation, and the expert judgment of our highly experienced team. The process evaluation—in Chapters 2, 3, and 4—describes DSG's completed assessment of the implementation fidelity of the three REGIONS model components (evaluation, residential treatment, and community supervision) and how well each component aligns with best practices. There is a section for each of the 81 metrics JBCSSD created for assessment, in which we describe how we evaluated the metric, discuss the findings, and present recommendations. The outcome evaluation—in Chapter 5—uses inferential statistics to compare outcomes for REGIONS youths with a matched group of youths on probation.

Design Overview

Taking a multi-informant, mixed-methods approach, DSG conducted a process evaluation and outcome evaluation of the post-adjudicatory juvenile justice process established to implement Public Act 18–31, *An Act Concerning the Recommendations of the Juvenile Justice Policy and Oversight Committee and Concerning the Transfer of Juvenile Services from the Department of Children and Families to the Court Support Services Division of the Judicial Branch.* For the process evaluation, we conducted interviews and focus groups with a variety of stakeholders and decision-makers, including the following: clinical coordinators; judges; attorneys (public defenders, prosecutors, and post-conviction attorneys); probation officers; JBCSSD administrators; residential program staff, managers, and reintegration mentors; parent/guardians; and juveniles in Connecticut's REGIONS secure and staff-secure programs; along with other stakeholders related to re-entry such as education liaisons and staff from community-based programs. We also observed treatment groups in five REGIONS residential programs. Additionally, we reviewed Court Clinic service memos, other juvenile files, and data from the Contractor Data Collection System (CDCS) database.

The process evaluation covers implementation from Jan. 1, 2019, through May 31, 2023, which reflects 4 and a half years of REGIONS implementation. The process evaluation assesses the implementation of each of the three model components (evaluation, residential treatment, and community supervision). We examine the degree to which each component is being implemented in accordance with its specified design and with best practices. The process evaluation considers 81 metrics that were specified in the original request for proposals (RFP). The data and records reviewed for this final process evaluation address the period spanning Jan. 1, 2019, through Sept. 30, 2022. We conducted interviews from March 2021 through May 31, 2023.

1

The outcome evaluation examines several recidivism measures. These analyses used coarsened exact matching (CEM) to compare REGIONS youths with similar youths who were placed on probation supervision during the same period of observation but did not attend REGIONS.

Methodology

To gather information for the process evaluation, DSG reviewed audit reports and JBCSSD policies and procedures, analyzed data in state databases, reviewed juvenile files, conducted in-person and remote interviews and focus groups, observed treatment groups, and conversed with other REGIONS staff. JBCSSD led several meetings with DSG researchers to explain the REGIONS approach and the various datasets (e.g., records from the Case Management Information System [CMIS], records from the Contractor Data Collection System [CDCS], electronic health records related to the metrics). DSG also met regularly with JBCSSD administrators and leadership.

Site Visits. DSG staff and consultants conducted site visits to three courthouses and seven REGIONS residential treatment programs in 2021, 2022, and 2023. During these site visits, we obtained information through interviews, focus groups, and observations. We also conducted follow-up site visits to some of the residential treatment programs to observe additional treatment groups.

Interviews and Focus Groups. The final report reflects the input, opinions, and perspectives of about 200 individuals involved in the new post-adjudicatory juvenile justice process. Through in-person and remote interviews and focus groups, we were able to discuss Court Clinic, residential treatment, re-entry, and probation metrics with the following justice process decision-makers, staff, and stakeholders: 17 Court Clinic staff (clinical coordinators and Court Clinic auditors), 49 Court staff and attorneys (probation officers, attorneys, judges), 75 REGIONS treatment program staff (juvenile detention officers/youth mentors, reintegration mentors, clinical staff, superintendents, directors, supervisors, managers, rehabilitation therapists, teachers, continuous quality improvement (CQI) consultants, social workers), 10 JBCSSD central office administrators, 17 REGIONS youths, 7 parents/guardians, and 12 community-based service providers. Also, DSG engaged in several ad hoc discussions with stakeholders (outside of these scheduled interviews) to obtain feedback.

Observations. From July 2021 through July 2022, DSG residential treatment experts observed Dialectical Behavior Therapy (DBT) groups at each of the seven residential programs. In four of the programs (Bridgeport, Hartford Secure, Hartford Staff-Secure, and Hamden), groups were observed twice—once in July 2021 and again in July 2022.

Analysis of State Datasets. The CDCS data that DSG analyzed represented all intakes to REGIONS from Jan. 1, 2019, through Dec. 31, 2021. Data were available for 354 REGIONS stays, which represented 193 youths (i.e., multiple youths had multiple REGIONS stays). Data from CMIS included 269 cases with service memo order dates from Jan. 1, 2019, through March 16, 2023.

File Review. DSG reviewed all service memos completed between Jan. 1, 2019, and May 31, 2022. We also reviewed files for a sample of 40 youths, which included the Prospective Risk Evaluation for Delinquency in Connecticut (PrediCT), initial Integrated Treatment Plan (ITP), Short-Term Assessment for Risk and Treatability: Adolescent Version (START:AV), and probation case plan. To select the 40 files, random stratified samples were drawn from all youths in the CDCS data we received. Also, we reviewed all discharge summaries for youths leaving a REGIONS residential program in 2022.

Finally, DSG staff reviewed several other documents, including Court Clinic audit reports, JBCSSD Policy and Procedures documents, a Performance-based Standards (PbS) Youth Reentry Survey, and findings from a JBCSSD–conducted focus group of REGIONS youths aimed at obtaining feedback from

youths on barriers to re-entry, their needs and experiences, and gaps in services.

Appendix A provides a more detailed description of the process evaluation methodology. Appendix B includes a table showing the data sources used to assess each metric. The outcome evaluation methodology is in Appendix D. Finally, a list of acronyms and initialisms can be found in Appendix E.

Chapter 2. Court Clinic

This process evaluation covers four Court Clinic areas: a) effectiveness of the clinical coordinator role, b) effectiveness of the current continuous quality improvement (CQI) process, c) effectiveness of the forensic formulation model, and d) utility of Court Clinic data.

A. Effectiveness of the Clinical Coordinator Role

According to JBCSSD Policy and Procedure 6.103 (Clinical and Educational Services, Referral Process for Forensic Clinical Assessment [Judicial]), a clinical coordinator is a licensed mental health professional with specialized forensic training in providing consultation to the Superior Court for Juvenile Matters on issues related to delinquency and behavior/mental health. Clinical coordinators must address referral questions received from the Superior Court for Juvenile Matters.

Clinical coordinators are employed by JBCSSD and cover all 11 Superior Court for Juvenile Matters locations. According to the RFP:

> The goal of the Court Clinic is to provide the Court with timely, relevant, and accurate clinical and forensic information to assist the judge in dispositional planning. Clinical Coordinators are responsible for responding to referral questions generated by the Superior Court for Juvenile Matters and act as an independent and neutral party in accordance with their profession's ethical standards when responding to those questions. The Clinical Coordinators may recommend further evaluation to assess for intellectual functioning, educational achievement, and specialized needs (e.g., developmental disability, problem sexual behavior), if necessary, to answer the referral questions. Clinical Coordinators provide consultation on a range of behavioral/mental health issues with the underlying goal of reducing recidivism.

This process evaluation assesses the effectiveness of the clinical coordinator role through six metrics:
- Metric 1. Availability to assist Court personnel
- Metric 2. Availability to the Court for emergent concerns
- Metric 3. Timeliness of interview scheduling
- Metric 4. Timeliness of report completion
- Metric 5. Consumer satisfaction with the service memorandum
- Metric 6. Value added to the juvenile justice process

1. Availability To Assist Court Personnel

JBCSSD Policy and Procedure 6.116 (Clinical and Educational Services, Service Memorandum for Residential Placement) requires that the clinical coordinator provide the Court with a service memorandum for residential placement in response to an order and a completed referral packet. The service memo is a requirement for REGIONS placement. Additionally, JBCSSD Policy and Procedure 6.103 states that the clinical coordinator will assist in refining referral questions and will communicate with Court parties (primarily by email) to ensure transparency and mutual understanding.

DSG asked Court stakeholders, clinical coordinators, and auditors several questions during interviews and focus groups about this metric. Most of these interviews occurred during the summer of 2021. This metric's assessment overlaps with that of other metrics in the Effectiveness of the Clinical Coordinator Role subcomponent, such as Metric 2, Metric 5, and Metric 6. It is difficult to separate these metrics from one another because they are so closely related. However, slightly different information is presented in the discussion of each metric.

Clinical Coordinator, Judge, Attorney, and Probation Officer Perspectives. We asked judges, attorneys, and probation officers about the clinical coordinators' ability to assist them and other Court personnel. They overwhelmingly responded that the clinical coordinators were helpful to the Court in

making decisions about the youths. Interviewees used phrases such as "exceedingly helpful," "overwhelmingly useful," and "always readily available to us." Some interviewees mentioned specifically that they appreciated the clinical coordinators' science-based approach. The overall consensus was that their expertise was valuable.

One judge said: "They are of great assistance. Judges can look at a file, and we can say we think a child needs A, B, or C, but we're not clinical…Having someone with that expertise is valuable." Another judge said: "Often when kids come in, you know that there is something there that isn't operating the way it's supposed to, but you don't know why. It's great to have those evaluations to help to point you in the right direction." Several judges mentioned that they will not decide about REGIONS placement without the service memo and that they receive the service memo before a Court date for disposition. One judge said:

> With the process that is designed, we can't go forward with any kind of placement if we don't have an assessment of what that child needs, and rightly so. The way the system is designed with all these changes, all of this is based on a child's needs and appropriate treatment. If they are in REGIONS, what are the goals for that child? Have those goals been met? And if they have been met, can they go to a step-down facility? If we don't have a mental health person or someone with a social work degree, then we cannot go forward with this new system of treatment.

Another judge indicated:

> We have a process in place [so we can] be unbiased and look at these kids holistically, not just take their charge and be reactive with that and ultimately lock them up. We can really tell the story about this kid, about how these behaviors came about…their risk and their needs, and really offer a solid opinion around whether or not they need residential. And if they do, what's the appropriate security?

This positive sentiment was generally expressed by all but was conveyed more strongly by judges and defense attorneys than by probation officers and prosecutors. The latter two groups sometimes felt that they knew the same information as the clinical coordinators but that the clinical coordinators' opinions were given more weight in judicial decision-making.

The probation officers also acknowledged that the roles and purposes of the different stakeholders were different. When discussing the clinical coordinator role, one probation officer said:

> As part of our role, we look at the offense. They are making clinical decisions. Sometimes it's hard for me to look past the charge when their assessment says low-level of security, when the charge is a serious charge. We're all figuring this out together.

Another probation officer shared:

> Initially when this whole change happened, the probation officers felt like our discretion was taken away. I completely understand why it's a clinical decision compared to way back when. In the past, decisions may have been too subjective. But now the decision is not really in the probation officer's purview. Sometimes that is difficult for us because many probation officers feel they have that expertise. But I do understand the importance of the SAVRY [Structured Assessment of Violence in Youth] and doing it clinically. But it's very different from how we used to do this.

Some interviewees, especially the clinical coordinators and probation officers, commented on the importance of the clinical coordinators building relationships with Court personnel. They often commented that having a clinical coordinator assigned to a specific Court works much better than having the clinical coordinators assigned to Courts based on cases and availability.

5

According to both the clinical coordinators and the probation officers, when they lacked a strong working relationship, the probation officers sometimes felt they were treated merely as information gatherers for the clinical coordinators. Several probation officers commented that, when clinical coordinators are assigned cases in Courts other than their "home Court," it has been more difficult to establish the kinds of meaningful professional relationships needed to support effective communication and collaboration between clinical coordinators and probation staff. One probation officer said about the clinical coordinators: "They are just reformulating what we're already doing."

One clinical coordinator made this observation:

> As a unit, we forget that we're still very young. We're not really as embedded in the Court culture system as we think that we might be, and where we are placed in a position to make decisions, that means that we've taken away the decision-making power from someone else. And that can be very [disempowering], I think, to some probation officers, when someone else is coming into a case that they've been working on for maybe years, maybe decades, if it's intergenerational.

Some clinical coordinators mentioned that their communication with probation officers, defense attorneys, and prosecutors varies in terms of collaboration, routines, and effectiveness based on the Court to which they are assigned.

Another theme expressed by interviewees was that they sometimes missed having a more general mental health assessment of the youths, although they valued the forensic focus of the clinical coordinator's work. This sentiment came mostly from probation officers but also from a few of the clinical coordinators. One probation officer shared:

> Looking at only the risk factors for arrest and court involvement is important. But I miss the general psychological assessment we used to get. With the CCs, they don't really take a deep dive into that because they aren't asked to do that. But I miss having the full picture. I do think using CC's role is helpful because it removes some of the bias. Before that, we all used to decide differently. Now with the same tools it's more structured and consistent. It eliminates some of the bias. But I would like more information.

Summary. The interviewees overwhelmingly agreed that the clinical coordinators were available to assist Court personnel. Their role seems to be especially helpful to the judges and defense attorneys, who appreciated the clinical perspective and science-based approach. The consensus was that the clinical coordinators' expertise was valuable for judicial decision-making.

One challenge to the process of court coordinators assisting Court personnel was a concern about defining roles, input, and influence on Court decision-making (especially to distinguish between probation officers and clinical coordinators); and about determining who is supposed to do what. In at least some Courts, it seems that all parties, and especially probation staff, would benefit from a stronger understanding of the clinical coordinator's role, the information the clinical coordinator needs and why, and how the clinical coordinator offers opinions related to REGIONS. The importance of building relationships between the clinical

The interviewees overwhelmingly agreed that the clinical coordinators were available to assist court personnel. Their role seems to be especially helpful to the judges and defense attorneys, who appreciated the clinical perspective and science-based approach. The consensus was that the clinical coordinators' expertise was valuable for judicial decision-making.

coordinators and other staff involved in the disposition was a consistent theme. There was a consensus that the process worked more smoothly and effectively when clinical coordinators had routine contact with other participants in the disposition process, especially with probation officers. Administrative flexibility and cost-savings may be the benefits of using clinical coordinators for cases in Courts where those clinical coordinators are not routinely assigned or for short-term management of caseloads in Courts where different clinical coordinators usually are sited. These benefits, however, come at the cost of not building the interprofessional relationships that are important facilitators of the REGIONS evaluation and disposition process and of related, more informal consultations. Another topic to be addressed is identifying other ways decision-makers can get the "overall mental health" information they sometimes want. Alternatively, if this information is unimportant, more education on why it is unnecessary would be helpful.

2. Availability to the Court for Emergent Concerns

In some juvenile Court Clinics in other states, court clinicians provide same-day evaluations for civil commitments or respond to persons in crisis in the courthouse. We assessed the availability of clinical coordinators for emergent concerns by analyzing information gathered through key stakeholder interviews.

Clinical Coordinator, Judge, Attorney, and Probation Officer Perspectives. Some interviewees from the Court pointed out that the clinical coordinators are available to address some types of emergent concerns, especially when a good relationship exists between the clinical coordinator and the Court. Interviewees mostly mentioned in-house clinical consultation resources for informal conversations with probation officers and defense attorneys. Clinical coordinators made comments such as the following:

> I find that there's a lot of utility in a mental health person being on the ground, feet on the ground, because even yesterday, I had probation officers cycling through my office regularly to ask about kids that they're working with to get clarification, to ask questions—this sort of stuff.

> So, I find a lot of utility in the conversation and consultation that happens outside of our evaluations. Not just the reports that we produce as a final product for a judge and parties to review when they're making that final decision.

> The public defender will call me and say: "Hey, I'm thinking about asking for a clinical for this kid. I'm not quite sure. Can I just talk about it with you for a little bit first?"

Although most clinical coordinators described the additional consultation roles as a helpful contribution, some felt that these roles should be better documented in their job description. One clinical coordinator said: "Unfortunately for us, there's no credit that we're gaining because there's no way that we are documenting, or at least CMIS doesn't allow for us to document, that we've had this elongated conversation, that we've sort of helped to guide a probation officer in a particular direction."

Summary. Being available for emergent concerns such as same-day evaluations or assisting a youth with a behavioral or mental health crisis does not appear to be a key role for the clinical coordinators. The system in Connecticut is not designed to have clinical coordinators serve in that capacity, because other means are in place to perform crisis evaluations or crisis-response functions. Connecticut has devised methods that do not require Court involvement to address the immediate needs of youths in a behavioral and/or mental health crisis. As a result, the kinds of same-day civil commitment or crisis evaluations with which juvenile court clinicians are tasked with in other states are not required in Connecticut. However, clinical coordinators can be an important resource to the Court for other emergent concerns by providing information, engaging in conversations, and offering assistance outside their role of completing the service memo. These conversations and consultations help build relationships between clinical coordinators and Court stakeholders that facilitate the Court process and

7

should be supported.

3. Timeliness of Interview Scheduling

JBCSSD Policy and Procedure 6.103 (Clinical and Educational Services, Referral Process for Forensic Clinical Assessment [Judicial]) requires that the clinical coordinator schedule an interview for a forensic clinical assessment with the juvenile and his or her parent/guardian within 2 business days from the time the Court orders the forensic evaluation and the Court Clinic receives a complete referral packet from the Court. Concurrently, this policy requires that the clinical coordinator notify the Court parties (i.e., the juvenile probation officers, the State's Attorney, and the defense or pre-conviction attorney) by email of the scheduled date and time of the juvenile's interview.

The referral packet, according to JBCSSD Policy and Procedure 6.103 (Clinical and Educational Services, Referral Process for Forensic Clinical Assessment [Judicial]), is prepared by the juvenile probation officer and includes a copy of the youth's statement of responsibility or formal adjudication on all charges, the probation risk assessment (i.e., the PrediCT), the juvenile's offense history and all police reports, the pre-dispositional study, and any other pertinent information (such as interviews, school records, special education evaluations/records, and behavioral/mental health records).

Dataset. Sixty-one cases in the CMIS dataset included "interview scheduled date," which refers to the date the youth interview was scheduled, and the date the service memo was ordered by the Court. Sixty-one cases also included the date the Court Clinic received the referral packet from the Court, and 60 included the date the referral was assigned to a clinical coordinator. The first interview date entered into CMIS was Jan. 3, 2022, and the last date included in the analysis of this metric was March 21, 2023.

- **Time between Court-ordered evaluation and youth interview scheduling.** The average number of business days from the time the Court ordered the evaluation to the time the youth interview was scheduled was 5.9, the median was 5, and the number of days ranged from 0 to 19.

- **Time between complete referral packet receipt and youth interview scheduling.** The average number of business days from the time the Court Clinic received a complete referral packet to the time the youth interview was scheduled was 2.0, the median was 1, and the number of days ranged from 0 to 16. In 67 percent of the cases (41 of the 61 cases), the clinical coordinator scheduled an interview for a forensic clinical assessment with the juvenile within 2 business days from the time the Court ordered the evaluation and the Court Clinic received a complete referral packet.

- **Time between assignment to clinical coordinator and youth interview scheduling.** The average number of business days from the date the referral was assigned to the date the youth interview was scheduled was 1.5, the median was 1, and the number of days ranged from 0 to 16.

Summary. JBCSSD Policy and Procedure 6.103 (Clinical and Educational Services, Referral Process for Forensic Clinical Assessment [Judicial]) requires that the clinical coordinator schedule an interview for a forensic clinical assessment with the juvenile and his or her parent/guardian within 2 business days from the time the Court orders the evaluation and the Court Clinic receives a complete referral packet. According to data entered into CMIS for cases with Court order dates between April 18, 2023, and March 16, 2023, this 2-day goal was achieved in about two thirds of the cases.

4. Timeliness of Report Completion

JBCSSD Policy and Procedure 6.116 (Clinical and Educational Services, Service Memorandum for Residential Placement) states:

> A Service Memorandum must be completed and disseminated to Court parties (such as Juvenile Probation Officers, the State's Attorney, and Defense or Pre-Conviction Attorney) within 15 business days from the time the Court order and referral packet was received (or earlier if ordered by the judge). If these sections cannot be completed, then the Clinical Coordinator must still complete the Reason for Referral/Identifying Information section and provide a justification regarding why the Service Memorandum is incomplete, and what is necessary to provide an opinion and complete report. The incomplete Service Memorandum should be distributed to the Court parties within ten (10) business-days from the time the Court order and referral packet was received.

The steps to complete the service memo generally are as follows:

Figure 2.1. Steps To Complete Service Memo

Youth is adjudicated delinquent. → Judge orders Court Clinic to complete REGIONS evaluation and service memo. → Court Clinic receives referral packet from Court.

Clinical coordinator is assigned. → Clinical coordinator interviews youth, interviews parent/guardian, reviews collateral information, and writes service memo. → Clinical coordinator submits service memo to Court.

Judge reviews service memo, reviews other information, and makes decision regarding disposition of youth (secure REGIONS placement, staff-secure REGIONS placement, another option).

To assess this metric, we examined data from CMIS, extracted information directly from service memos, and obtained input from stakeholders through interviews and focus groups.

Dataset. In the CMIS database, there were 265 cases with information included under "Report Submission Date/Activity Closed," which is the date that the service memo was submitted to the Court. The dates ranged from Jan. 22, 2019, through March 1, 2023. CMIS calculated the number of business days to complete the service memos in two ways: 1) before March 2020, it was calculated from the date of the Court order to the date of service memo completion; and 2) after March 2020, it was calculated from the date the service memo was assigned to the date of service memo completion.

The CMIS data included the date the Court order was received to complete the service memo (269

cases), the date the referral was received (24 cases)[1], the date the referral packet was received by the Court Clinic (260 cases), the date the referral was assigned to a clinical coordinator (202 cases), and the date the service memo was completed (265 cases).

- **Time between Court Clinic receipt of referral packet and completion of service memo.** JBCSSD Policy and Procedure 6.116 requires that the service memo be completed within 15 business days from the time the Court Clinic received the Court order and referral packet. Since the referral packet is always received after the Court order, measuring the number of days between receipt of the referral packet and completion of the service memo is the most accurate way to assess whether practice is following policy. There were 253 cases with both the date of referral packet receipt and the date of service memo completion. The average number of business days was 16.4, the median was 15, and the range was 0 to 43. There does not appear to be much of a change in the average number of days by year (see Figure 2.2). In 61.3 percent of the cases (155 of the 253 service memos), the service memo was completed within 15 days of the time the Court Clinic received the Court order and referral packet.

To ascertain how the various steps contribute to the time required to complete a service memo, we examined several other dates (see Figure 2.2).

- **Time between Court order and completion of service memo.** The average number of business days between the time the Court ordered the service memo and the time the service memo was completed was 21.5, the median was 19, and the range was 0 to 51.

- **Time between Court order and Court Clinic receipt of referral packet.** There were 255 cases with both the date of the Court order and the date that the Court Clinic received the referral packet. The average number of business days between these two steps was 5.8, the median was 4, and the range was 0 to 43. The average number of business days between the Court order and the Court Clinic's receipt of the referral packet appears to be improving over time. It has decreased steadily from 8.3 business days in 2019 to fewer than 4 business days in 2022 and 2023.

- **Time between Court Clinic receipt of referral packet and assignment of clinical coordinator.** There were 196 cases with both the date of referral packet receipt and the date of clinical coordinator assignment. In 23 of the cases, the date of clinical coordinator assignment was before the date of referral packet receipt, and these cases were omitted from analysis. In 121 of the cases, the two dates were the same. The average number of days from receipt of the referral packet to assignment of the clinical coordinator was 0.67, and the range was 0 to 18.

Although the average number of business days to complete the service memo does not appear to have changed much, as measured to assess compliance with JBCSSD Policy and Procedure 6.116, there have been improvements in some of the steps, including the number of business days between the Court order and the Court Clinic's receipt of the referral packet.

---

[1] In 7 of the 24 cases, the referral date was the same as the date the referral packet was received. We did not use the data on these 7 cases in any analysis.

Figure 2.2. Timeliness of Steps To Complete Service Memo, 2019–2023

Average Number of Business Days to Complete Various Steps of Service Memo Process
2019-2023
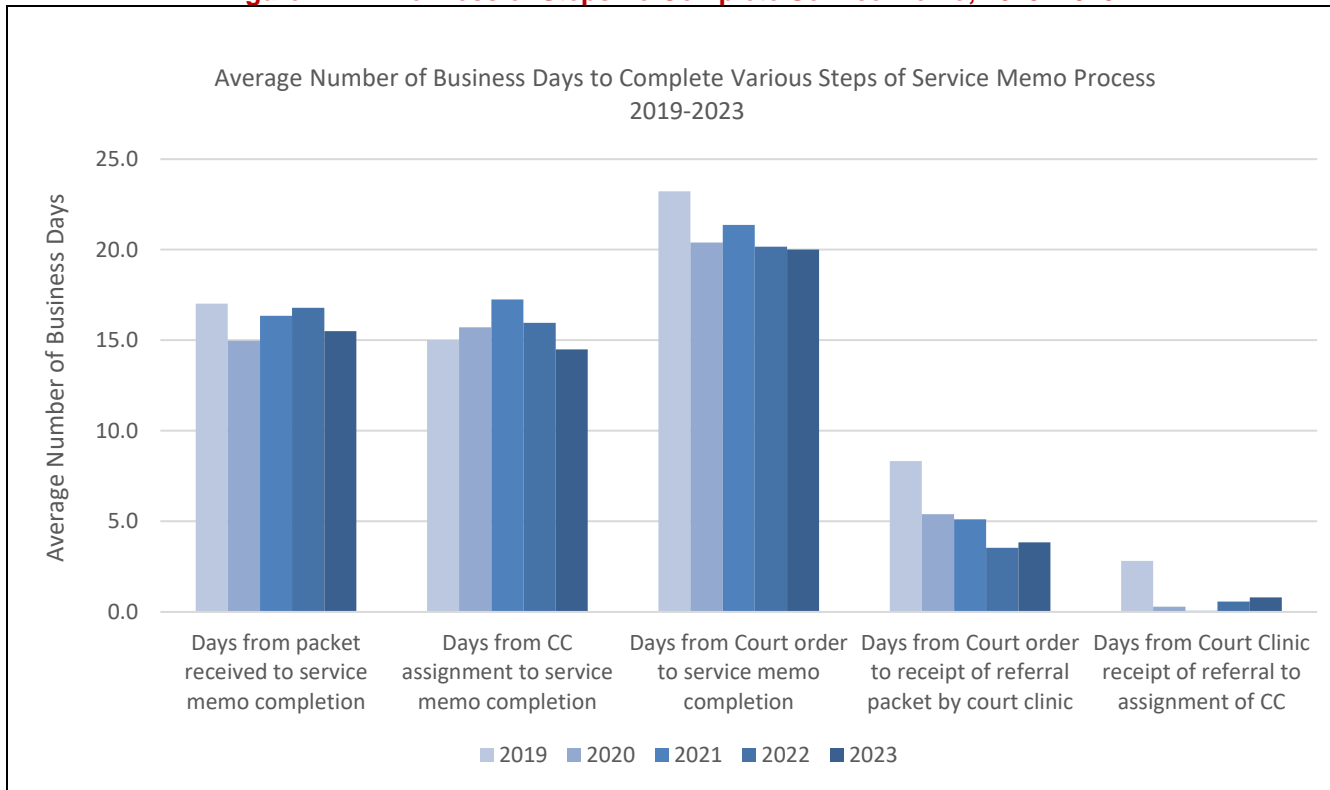
Data source: CMIS. *N* = 269. CC = clinic coordinator.

Analysis of Service Memo Dates. For the interim process evaluation report, DSG researchers extracted dates from 116 service memos completed from Jan. 1, 2019, through May 31, 2021. We examined the timeliness of report completion in several ways, including alignment with JBCSSD Policy and Procedure 6.103 and timeliness in general. For this final process evaluation report, we were able to examine CMIS data to assess much of this metric. However, some of the data in the service memos are not yet included in CMIS. Thus, we extracted the following information directly from the 223 service memos completed from Jan. 1, 2019, through Sept. 8, 2022.

- **Time between Court-ordered evaluation and youth interview.** There were 215 service memos that had both the date of the Court-ordered evaluation and the date the youth was interviewed.[2] The average number of business days between the Court order date and the youth interview date was 10.0, the median was 8, and the range was 1 to 37. The number of business days between the ordering of the evaluation and the youth's interview appears to be decreasing: In 2019 the average was 12.2 days; in 2020, 12.1 days; in 2021, 7.7 days; and in 2022, 7.5 days (See Figure 2.3).

- **Time between Court-ordered evaluation and parent interview.** There were 207 service memos that had both the date the Court ordered the evaluation and the date the parent/guardian was interviewed.[3] The average number of business days from the date of the Court order to the date of the parent/guardian interview was 13.1, the median was 11, and the range was 1 to 42. The number of business days between the ordering of the evaluation and the parent/guardian's

---

[2] One service memo was completed before the Court order as part of a related assessment, and the others were missing either the interview date or the Court order date.
[3] The other service memos were missing either the interview date or the Court order date.

interview appears to be decreasing: In 2019 the average was 17.2 days; in 2020, 15.0 days; in 2021, 10.4 days; and in 2022, 9.1 days (see Figure 2.3).

To understand how long youths wait for the service memo to be completed, we also measured business days from adjudication to service memo completion. Both adjudication dates and service memo completion dates were included in 159 of the service memos. According to these service memos, youths waited an average of 25.9 business days between adjudication and service memo completion, and the range was 3 to 110 days (see Table 2.1). The median number of business days was 22 (indicating that half of the youths waited fewer than 22 days and the other half waited more than 22 days).

Figure 2.3. Time To Complete Youth and Parent Interviews for Service Memos, 2019–2022
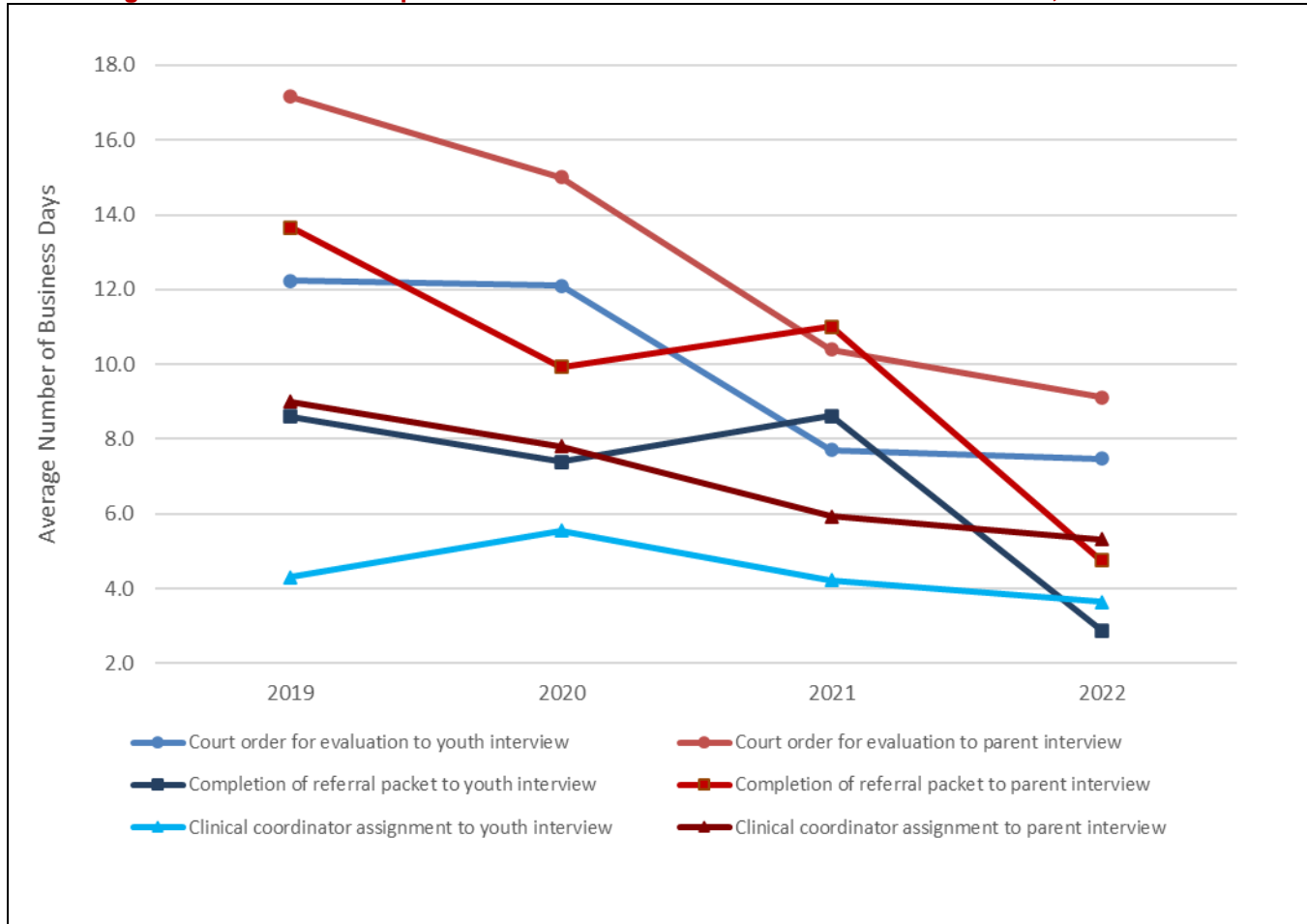
Data source: Court Clinic service memos. *N* = 223.

Court Perspective. The judges and attorneys we interviewed commented that the time to complete the service memos generally was acceptable. Some mentioned that the evaluations were backlogged for a time shortly after the Connecticut Juvenile Training School was closed and that this delay was inconvenient. However, most judges and attorneys felt that the service memos were completed more rapidly as the initial cases cleared, and that the current timing works for them and their Courts. They also said that if the clinical coordinator needs more time, granting an extension generally is not a problem.

When the service memos are delayed, interviewees mentioned that the delay most often was due to waiting for records from schools. Clinical coordinators also felt that they were completing their reports

within a workable amount of time and that when extra time was needed, their request for an extension generally was accommodated. For example, one clinical coordinator said:

> I think we're also comfortable saying to the Court, we're going to need a little extra time on this one. There are special circumstances here. And they haven't had a problem...we can just ask [Clinical Coordinator Supervisor] Tracy [Duran] in this case...she offered, if I wanted it, and I took her up on it, but we could request it at any time.

Of course, some interviewees also felt that it would be helpful if the process moved faster, to reduce the delay in determining services for the youths and in facilitating access to those services, but most acknowledged that it takes some time to gather the information and present it properly.

Table 2.1. Time Between Court Order for Evaluation, Completion of Referral Packet, Clinical Coordinator Assignment, and Interviews

	Average Number of Business Days				
Task	**2019**	**2020**	**2021**	**2022**	**Sample Size (of Service Memos)**
Court order for evaluation to youth interview	12.2	12.1	7.7	7.5	215
Court order for evaluation to parent interview	17.2	15.0	10.4	9.1	207
Completion of referral packet to youth interview	8.6	7.4	8.6	2.9	46
Completion of referral packet to parent interview	13.7	9.9	11.0	4.8	44
Clinical coordinator assignment to youth interview	4.3	5.6	4.2	3.6	142
Clinical coordinator assignment to parent interview	9.0	7.8	5.9	5.3	137

Summary. JBCSSD Policy and Procedure 6.116 requires that the service memo be completed within 15 business days from the time the Court order and referral packet were received. According to data entered into CMIS in 2019, 2020, 2021, 2022, and 2023, the average number of business days to complete the service memo was 16.4, the median was 15, and the range was 0 to 43. In 61.3 percent of the cases (155 of the 253 service memos), the service memos were completed within 15 days of the time the Court order and referral packet were received. Although this measure has not changed much since the start of REGIONS, several other timeliness indicators have improved, including the number of days to interview parents and youths and the number of days between the Court order and receipt of the referral packet by the Court Clinic.

Most youths undergoing an evaluation in anticipation of service memos being filed with the Court remain in secure detention while awaiting the completion of this memo (typically after waiting in detention before adjudication). The purpose of juvenile detention is to ensure that youths appear for Court hearings and to protect the community during the pendency of Court proceedings until adjudication and disposition. Treatment is not the purpose of detention, and the time spent there is not ideal for positive behavior change. There are several reasons youths may stay in detention longer than expected, including delays in completing the pre-dispositional study or the service memo, the youth's behavior, or delays in other legal processes. Researchers and juvenile justice advocates generally agree that time in secure detention should be as short as possible (DSG, 2019b; Holman and Ziedenburg, 2006; National

Research Council, 2013).

Having a 15-day target for service memo completion is one way to prevent youths from remaining in detention for prolonged periods. However, at least at times, the 15-day target results in clinical coordinators completing service memos without the benefit of relevant information (usually school records), or in the evaluation being prolonged while clinical coordinators wait for records or other information. Consideration should be given to whether "record release" policies and protocols might be established, at least with the school districts of the youths who are most frequently referred for REGIONS evaluations. Such policies and procedures could minimize delays and reduce the pressure to complete the evaluations without important education information. Currently, any memo that is late is already on the program manager's radar, and a process for tracking these data is in place. According to JBCSSD Policy and Procedure 8.600 (Judicial Residential Services REGIONS Secure Treatment Program), juveniles who are expected to have to wait for admission for more than 7 days on a pre-trial unit will begin the REGIONS Engagement Program (stage 1 of treatment). However, a REGIONS unit is generally a better environment for youths than detention for any amount of time.

5. Consumer Satisfaction With the Service Memorandum
The clinical coordinator's service memo provides the Court with the following information: 1) forensic clinical assessment, 2) assessment for the potential risk of harm to others, and 3) assessment of the need for staff-secure or secure residential treatment. At a minimum, the service memo should include the following sections: 1) reason for referral/identifying information, 2) consent and limits of confidentiality (forensic notification), 3) collateral information, 4) relevant historical information, 5) current clinical functioning/behavioral observations, and 6) findings and recommendations, including prognosis (JBCSSD Policy and Procedure 6.116 [Clinical and Educational Services Service Memorandum for Residential Placement]). We assessed this metric by analyzing interview responses from court decision-makers and stakeholders.

Clinical Coordinator Perspective. We discussed the service memos in focus groups with 15 clinical coordinators in summer of 2021. Most of them expressed a desire for consistency and transparency in the development of the service memo and its recommendations. They intend their communications with Court stakeholders (such as judges, attorneys, and probation officers) to be clear, open, and readily understandable, both during conversations and in the service memo. One clinical coordinator said: "I think the biggest expectations are that we show consistency with our reports and the recommendations, we're completing them in a timely manner, and we communicate with them and try to be as transparent as possible."

> **One clinical coordinator said: "I think the biggest expectations are that we show consistency with our reports and the recommendations, we're completing them in a timely manner, and we communicate with them and try to be as transparent as possible."**

Court Perspective. However, among many of the Court stakeholders, there seems to be some lack of understanding about how recommendations are developed through use of the forensic formulation model. One judge made this observation:

> You have these different risk assessment tools given us. You have the SAVRY, PrediCT, and other standardized tools. If it fits in column A, you check the box, and you add it all up and get a score, which is supposed to tell you something. My question is more about what that tool looks like. We only get the outcome. Sometimes you wonder what the contents are of that particular risk assessment tool and whether it's a good tool. Sometimes it doesn't seem right. Sometimes you question it.

14

Similarly, one probation officer said: "Introducing POs to the SAVRY would be helpful. If we had a better understanding of the tool being used, it would be an easier pill to swallow when it disagrees with our professional discretion."

Another challenge that surfaced in the assessment of Metric 1 was the extent to which the clinical coordinator considers the probation officer's experience with the youth and the youth's community when developing the service memo. Some probation officers shared that their opinion seemed not to matter, unless documentation existed to back it up: "Instead of having conversations with us, if it's not in the paper collateral, it won't be a part of the report. Some have lots of previous documentation. But when they don't, and we have that information, they won't ask us." This issue is discussed at greater length in Metric 22.

Also, some interviewees felt that judges were too reliant on the clinical coordinator's service memo. One probation officer said:

> I think the Court often places too much emphasis on the clinical consultant's recommendation. I mean, you have a person who, especially during Covid, has never met the client in person. She spent a couple of hours with him interacting the way we are interacting right now. Had never met his parent, had never been to his house and took a lot of information.

One attorney said: "In practice they [the judges] are very accepting of the service memo recommendations. They are deferential to the service memo. It's determinable." Ultimately, however, the placement decision is up to the judge. Most interviewees agreed that the clinical coordinator and the service memo may properly inform judicial decision-making but that the final determination should rest with the judge rather than the clinical coordinator and the service memo. There were differences in perspective regarding whether the service memo properly weighs (and whether it *should* properly weigh) community or youth safety concerns, and most interviewees strongly believed that the service memo should not be the sole driver of judicial decision-making in these cases.

Finally, two opposing complaints emerged regarding the service memo recommendations. On the one hand, some Court stakeholders complained that the clinical coordinators were recommending services and interventions that did not exist or were difficult to access. On the other hand, some stakeholders felt that clinical coordinators only recommended either a secure or staff-secure REGIONS treatment program (although clinical coordinators also have the option of recommending community-based services). One interviewee offered this explanation:

> I think a few years back, we used to get those types of recommendations and we didn't have those places. They were stating that the kids should go to a place that had X, Y, and Z. And we're like, okay, but where? These programs don't exist, or we don't have access to the programs. And then there was a shift where now they only recommend the programs that we have, although we're told they can recommend anything. It's been a very long time since I've seen a recommendation that we don't have access to it. It seems like the only recommendations they're making are the programs that we have, which is good for the PO, because it's an easy referral. But then I question if it's also the best recommendation for the kid treatment-wise, or is it just because that's what they have, have available to them? They're trying to fit in where it goes. 'Cause it's almost like every report I read says every kid needs DBT [Dialectical Behavior Therapy].

Residential Treatment Staff Perspective. We asked 15 residential treatment staff who were routinely given access to the service memo for the youths in their care some questions about their levels of satisfaction with the report. Personnel who received access included the licensed mental health clinicians and mental health staff, juvenile detention officers, program managers, classification and program officers, and others. All 15 staff members felt that the service memo was easy to understand: 20 percent said it was "somewhat easy" and 80 percent said it was "very easy" to understand. None

said the service memo was not understandable.

Thirteen residential treatment staff answered the question, "How helpful is the Court Clinic Service Memorandum to you when working with the youths in your care (with 1 indicating "not at all helpful" and 10 being "very helpful")?" All respondents rated the service memo as a 7 or higher (23 percent of respondents gave the service memo a rating of 7; 54 percent chose a rating of 8; 8 percent chose a rating of 9; and 23 percent chose a rating of 10), which resulted in an average rating of 8.3 (see Figure 2.4).

Figure 2.4. Residential Treatment Staff Perspectives on Helpfulness of Service Memo

How easy is the Court Clinic Service Memorandum information to understand?
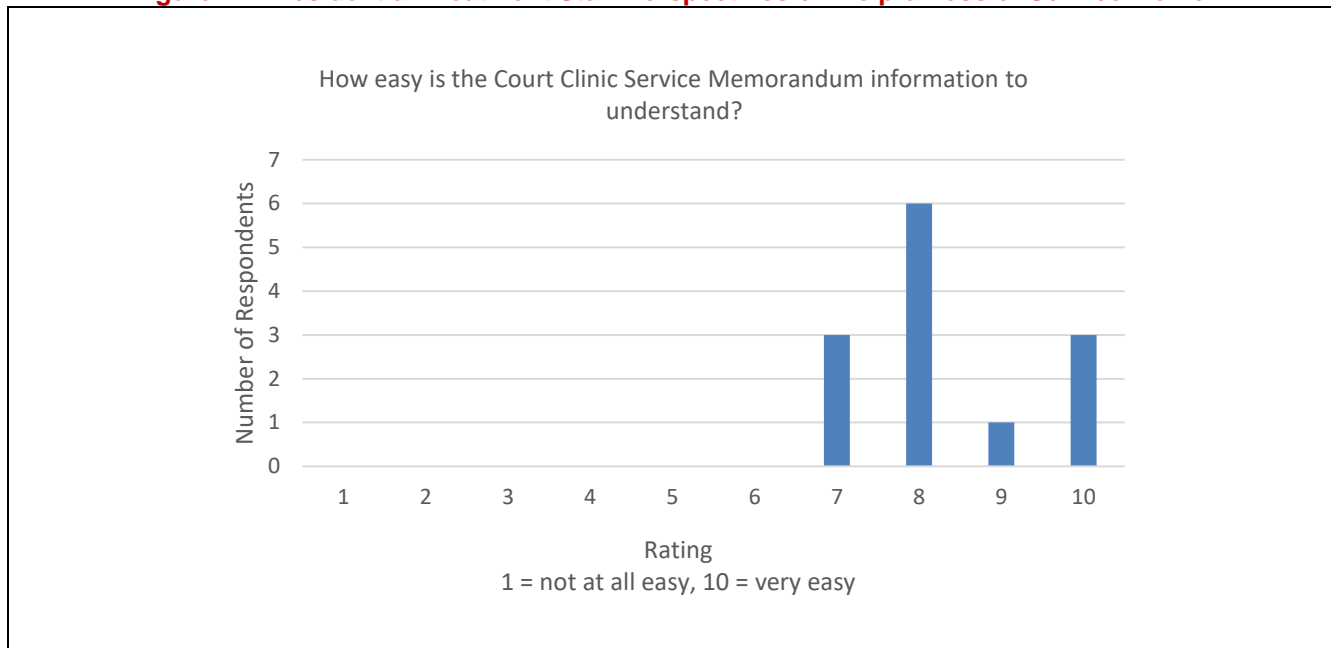
Data source: Residential treatment staff interviews. *N* = 13.

Summary. Most interviewees felt that the service memo was a helpful addition to the juvenile justice process and that the memos were easy to understand. Although clinical coordinators attempt to make the service memo process transparent, our interviews indicate that it may be helpful to plan additional opportunities for Court staff and attorneys to better understand this process. These opportunities can strengthen buy-in; enhance relationships between Court stakeholders, decision-makers, and clinical coordinators; and improve the overall process. Currently, clinical coordinators conduct training about the Juvenile Court Clinic to incoming juvenile probation officers. After the interviews were conducted, the training was updated to include documents for probation officers, such as "Forensic Clinical Assessment Checklist" and "REGIONS Consult Collateral Checklist," which may help increase understanding of the service memo process.

Also, after many of these interviews were conducted, the service memo was updated to include a summary of the results of the Risk-Sophistication-Treatment Inventory Treatment Amenability Scale (RSTI[TA]). This tool is used for structuring and guiding the evaluator's estimate of the likelihood that the youth's characteristics will support successful juvenile justice interventions. In the service memo, it is used to measure treatment amenability (which is one of the five factors in the forensic formulation model; see Metric 14 and Metric 18). Incorporating the results of the RSTI's Treatment Amenability scale has increased the service memo's usefulness for decision-makers.

6. Value Added to the Juvenile Justice Process

Three previous metrics (Metric 1, Metric 2, and Metric 5) describe the value added by the clinical coordinator role in Juvenile Court. Interviewees indicated that they value the clinical coordinator's neutral, evidence-based approach and recommendations. In addition to points made in previous sections, some interviewees mentioned the influence that the clinical coordinator's opinion has on families. One attorney said:

> If they were to recommend a staff-secure or locked facility, a lot of times we find our clients, or their parents, aren't ready to accept that. But if we can say that the clinical coordinator says it, they accept it more...They accept their fate when it's not a punishment. It's a place to meet clinical needs. They seem to accept the CC's opinion.

A clinical coordinator shared this observation:

> I think what's really cool about our job is that we get to tell the story that might not have otherwise been told. That we can shift the perspective hopefully—not in every case but in some cases—on how people look at these kids. And that to me makes this job awesome in that respect. Because who else would be able to do that for them? It may never happen, and it's not happened for so many. And we get to do that.

And a probation officer made a similar comment:

> When our CCs get a case, they look at the kids individually. They are accurate in their assessment [although] they don't know the kids well. They know about them by reading about them on paper, but they are spot on. If we see the kid over and over again, then we may recommend higher levels of placement because we know them more over time. When the CCs recommend REGIONS, it's because they've exhausted the other less restrictive options.

However, not all Court staff felt as strongly about the value of the clinical coordinator's role. Some staff were more concerned about what they perceived as undue weight given by judges to the service memo and to the clinical coordinator's influence in the overall decision-making process. Others believed that the clinical coordinator's analysis did not add anything to the process. One probation officer said: "I think in some ways we could function without them. At some point, we know who should be removed from the community so it's probably unnecessary to get their opinion." This perspective should be addressed directly because it can make REGIONS decision-making more difficult by interfering with the development of the trust and collaboration that facilitate the decision-making process. Additional attention to transparency, information about the components of the evaluation process, acknowledgement of community safety concerns, and a focus on increasing understanding of expectations among the clinical coordinators and judicial decision-makers and stakeholders will make the clinical coordinator's role even more valuable.

Some interviewees also mentioned that having clinical coordinators employed by JBCSSD helps to prevent unnecessary outside evaluations. They explained that the assessments used to be conducted by a psychiatrist who was a JBCSSD contractor. Like many providers, the psychiatrist charged for missed appointments, which also drove up costs. Additionally, interviewees felt that sometimes youths were "over-evaluated," and that the clinical coordinator's gatekeeper role was helpful.

Most clinical coordinators felt that their role would add still more value if at least one more supervisor were available to them, particularly for consultations during the evaluation and the service-memo writing process (before the service memo is filed with the Court). The clinical coordinators understood the demands on their current supervisor's time and greatly appreciated her contributions but felt that they did not have sufficient access to her for timely consultations. One clinical coordinator said: "It really helps if there's a person or people that you can process your cases with. It's not always there. We just don't have that structure right now. It's to the harm of our unit."

17

Summary. The clinical coordinator role clearly adds value to the juvenile justice process. In addition to the findings and recommendations mentioned above related to the effectiveness of the clinical coordinator role (e.g., DSG recommends that judges, probation staff, and attorneys receive training on the components of the forensic formulation model), the interim process evaluation report (submitted in November 2021) concluded that the clinical coordinators would benefit from increased supervision and dedicated supervisory staff who would be available for real-time case consultation during the evaluation and service-memo writing process (before the service memo is filed with the Court). The clinical coordinators view Ms. Tracy Duran, Clinical Coordinator Supervisor, as an exemplary supervisor and highly value her supervision. Given her other responsibilities, however, Ms. Duran did not have enough time to provide the needed amount of supervision to all the clinical coordinators. Since then, JBCSSD has hired additional supervisors to work with clinical coordinators. This quick response to DSG's recommendations was an important step in strengthening a Court Clinic process that was already quite strong, especially as compared with other jurisdictions in the United States.

B. Effectiveness of the Current CQI Process

Continuous Quality Improvement (CQI) is a process that can help juvenile justice and other youth service organizations demonstrate accountability. Through CQI, organizations use their own data to continually improve services with the goal of achieving the best possible outcomes for youths. Regularly assessing an organization's performance is necessary to understand how current conditions are impacting the quality of services and outcomes (Daly et al., 2018; Dedel, 2014; Loeffler–Cobia, Deal, and Rackow, 2012; O'Brien and Watson, 2002).

The scope of service in the JBCSSD CQI RFP provides information about the responsibilities of the Court Clinic CQI contractors, who are part of a comprehensive system of quality assurance to ensure that Court-ordered evaluations meet standards of professional best practices and usefulness. The CQI contractors' responsibilities include the following:[4]

a) Consulting on the research and development of standards related to the provision of child and adolescent evaluation services in the juvenile justice and child protection systems
b) Conducting a blind review of Court-ordered evaluations
c) Developing, maintaining, and/or enhancing the JBCSSD structured audit tool for each specific evaluation type and providing results of quality assurance (QA) reviews after each QA session
d) Writing the final summary report of the reviewed evaluation and services provided, to be submitted by the end of the fiscal year to JBCSSD
e) Consulting on the development of an ongoing feedback and data analysis mechanism
f) Providing ongoing consultation to the authors of the evaluation in support of enhancing professional development and evaluation practices
g) Providing consultation on complex cases at JBCSSD's request to authors of the evaluation
h) Meeting regularly with the JBCSSD administrator of Clinical, Educational, and Juvenile Residential Services to monitor and review contract issues, evaluation performance, and professional relationships with others
i) Demonstrating knowledge of all appropriate validated instruments that are normed for the client's age and related to specific evaluation types
j) Being familiar with and adhering to the Specialty Guidelines for Forensic Psychologists and ethical standards for one's profession
k) Working collaboratively with other CQI team members to provide consultation and to advance best practice standards
l) Performing other related duties and tasks as required by the JBCSSD administrator

---

[4]Not all of these responsibilities pertain to the CQI contractors' work with clinical coordinators assessing REGIONS youths.

This process evaluation examines the effectiveness of the current CQI process through seven metrics:

- Metric 7. Suitability of the audit tool
- Metric 8. Number of reports reviewed
- Metric 9. Number of training hours
- Metric 10. Number of case consultations with forensic experts
- Metric 11. Adherence to the requirement that quality assurance report reviews occur at the designated intervals for all clinical coordinators
- Metric 12. Frequency and modification of practices based on feedback provided to the clinical coordinators
- Metric 13. Number and types of trainings generated through the CQI process

7. Suitability of the Audit Tool

The most recent Clinical Coordinator Service Memo Audit Instrument includes 115 items in six main categories. The categories are: 1) Reason for Referral/Identifying Information, 2) Consent and Limits of Confidentiality (Forensic Notification), 3) Collateral Information, 4) Relevant Information, 5) Mental Status/Current Clinical Functioning, and 6) Findings and Recommendations. Each of the items is rated as present (2 points), partially present (1 point), missing (0 points), or not applicable (NA).

To examine the audit tool's suitability, we compared the tool with the requirements in JBCSSD Policy and Procedure 6.116 (Clinical and Educational Services, Service Memorandum for Residential Placement); reviewed completed audit forms; interviewed Court Clinic auditors; and held focus groups with clinical coordinators.

Comparing Audit Tool With Policy. Our review of how the audit tool aligns with the requirements of JBCSSD Policy and Procedure 6.116 identified some slight differences between the policy requirements and the information the audit tool addresses. However, no information appeared to be missing from the audit tool. Generally, the differences related to the inclusion of more information in the audit tool than policy requires. For example, the audit form contains "E. Alleged Offenses," which assesses the extent to which information on the alleged offense(s) was provided under "I. Reason for Referral/Identifying Information," section, but this item is not required by the policy. Also, the audit form includes "D. RSTI(TA)" under V. Mental Status/Current Clinical Functioning, but addressing the results of the Risk-Sophistication-Treatment Inventory's Treatment Amenability scale was not required in the service memo when the policies were created. Some information is in a different section on the audit form when compared with the policy. For example, in the policy, under "Relevant Historical Information," the clinical coordinator is supposed to include "history of court involvement, history of probation and response to probation, current legal situation, and summary of the most recent Probation Risk Assessment results" as part of the legal information (in the Legal section). In the audit form, "history of probation" and "history of technical violations of probation" are included under "Intervention History and Intervention Response" (instead of "Legal"). At the time the draft findings and recommendations were developed, JBCSSD was in the process of updating policies to reflect the audit tool. The tool is a dynamic document that is often reviewed and revised; it is used internally by the clinical coordinators and the CQI team.

Analyzing Audit Tool Updates. We also identified differences between the audit form used before 2021 and the form used in 2021–2022. Some of the changes were structural, to make the tool easier to use. For example, a space was added in each section for the subsection ratings and the overall section score. To make the service memos easier to track, spaces were added for two dates (date of service memo and date of audit), whereas the previous version only had one space for a date, and it was unclear which date should be entered. In DSG's interim process evaluation report, it was recommended that the audit form include both the date of the service memo and the date of the audit form. Providing

spaces for both dates was a helpful addition. Also, the new form includes a space for the youth's first name and the first letter of their last name. The tool features several new subsections and sections. Three examples: "D. RSTI(TA)" under V. Mental Status/Current Clinical Functioning, which is a subsection on the results of the RSTI's Treatment Amenability (TA) scale; "Overall Feedback on Data Sections," where auditors can highlight positive aspects of the data sections and suggest improvements; and "Clinical Coordinator Service Memo Audit Instrument (REGIONS) Scoring," which lists the audit scores for each of the form's six sections) [see Table 2.2 and Figure 2.5]. Adding items to assess inclusion of the results of the RSTI(TA) was a logical change, given that a new section on the RSTI(TA) was included in the service memo.

Table 2.2. Comparison Between 2019–2021 Audit Tool and 2021–2022 Audit Tool

Audit Tool Category	Changes From the 2019–2021 Tool to the 2021–2022 Tool
Introduction Information	• The format was updated to make it easier to read. • A space was added for the youth's first name and the first letter of their last name. • Spaces were added for the date of the service memo and the date of the audit (the 2019–2021 audit form included one space marked "date," and did not specify what that referred to).
I. Reason for Referral/Identifying Information	• "D. Date of clinical coordinator assignment" was added.
II. Consent and Limits of Confidentiality (Forensic Notification)	• "A. Date of interview(s)" was changed to "A. Date & length (time spent) of interview(s)." • "H. Collateral Contacts/Provider acknowledgment of forensic warning" was added.
III. Collateral Information	• "E. Steps taken to access missing resources are identified" was added. • "F. Quality of the data available for the evaluation is described" was added. • "G. Quality of the opinions based on the data are described" was added.
IV. Relevant Information	• "a. Prior Interventions linked to domains (A-I)" was added under "J. Intervention History and Intervention Response."
V. Mental Status/ Current Clinical Functioning	• "D. RSTI(TA)" was added, with four parts: a) Notification/description of the RSTI(TA), b) Summarize each RSTI(TA) cluster, c) Order RSTI(TA) clusters to best support overall results, and d) Identify RSTI(TA) items within each cluster to best support overall results within that cluster.
VI. Findings and Recommendations	• "g. Data across five factors integrated to support placement" was added under "B. Placement Opinion (bulleted)." • "F. Prognosis (Linked to Placement Opinion)" was change to "Prognosis."
Other Changes	• A space was added in each section to summarize the subsection ratings and the overall score achieved for that section. • A section was added for "Overall Feedback on Data Sections" before VI. Findings and Recommendations. • A section was added at the end of the tool for "Clinical Coordinator Service Memo Audit Instrument Scoring Summary."

Clinical Coordinator Perspective. In summer of 2021, we asked clinical coordinators several questions during the focus groups to guide our discussion about the audit tool's suitability. The questions varied slightly based on the flow of the conversation but included the following: "Do you feel that the audit tool is auditing the right items?" "How well is the tool auditing them?" "Is the audit tool getting at everything you think it should be asking?" "Does the rating system seem fair?" "How helpful is the feedback from the audit tool for your work?" "What works best in the audit tool?" and "What should be improved with the audit tool?"

The clinical coordinators generally indicated that the auditors were helpful. However, many clinical coordinators felt that the audit tool and the auditing process had not been as helpful as originally hoped. Five primary themes emerged in our interviews about the audit tool's suitability, which were presented in the interim process evaluation report: 1) The audit tool can be helpful during the writing of the service

memo; 2) the audit reports are sometimes scant in detail; 3) the audit reports are often completed and returned after considerable time has passed; 4) the audit tool is updated frequently; and 5) some clinical coordinators felt that some measures in the audit tool were too difficult to achieve, given their other responsibilities. However, this negative feedback does not mean the clinical coordinators found the CQI process to be without value. Many clinical coordinators commented that being able to work with the auditors while they were developing their service memos was extremely helpful, especially when the clinical coordinators lack years of experience. This assistance from the auditors occurs during the case consultations, which are described in Metric 10. Also, the clinical coordinator interviews were completed during 2021, and their opinions may have changed since then, especially regarding delays in receiving audits and feedback (which has improved since the 2021 interviews).

Figure 2.5. Comparing Audit Instruments Used in 2019–2021 and 2021–2022

2021–2022 Service Memo Audit Instrument (Initial Identifying Information and Section I)

Clinical Coordinator Service Memo Audit Instrument (REGIONS)

Clinical Coordinator/Court: █████████████   Youth First Name & Last Initial: ████████████

Date of Report: 1/12/2022   Reviewer Initials: ████   Date of Audit: 4/9/2022

Rating: 2 = Present 1 = Partial   0 = Missing   N/A = Not applicable

I: Reason for Referral/Identifying Information   11 / 12   92 %
  A. Basic demographics of the youth   1
  B. Originating Court   2
  C. Date of court order   2
  D. Date of Clinical Coordinator Assignment   2
  E. Reason/justification for court order and/or referral question(s)   2
  F. Alleged offenses   2

2019–2021 Service Memo Audit Instrument (Initial Identifying Information and Section I)

Clinical Coordinator Service Memo Audit Instrument (REGIONS)

Reviewer Initials: ████   Date: 4/23/19 Clinical Coordinator/Court: ████████████████

Rating: 2 = Present 1 = Partial   0 = Missing   N/A = Not applicable

                                                                    RATING

I: Reason for Referral/Identifying Information
  A. Basic demographics of the youth   2
  B. Originating Court   2
  C. Date of court order   2
  D. Reason/justification for court order and/or referral question(s)   2
  E. Alleged offenses   2

Summary. The current version of the audit tool aligns well with the service memo requirements in JBCSSD Policy and Procedure 6.116. However, according to the interviews conducted in 2021, the audit tool process is complicated by four factors: 1) delays in getting reports audited; 2) scant feedback (although this has improved); 3) the audit report items being a work in progress and being updated often; and 4) the tool not accounting for balancing the Court's requirements, the clinical coordinators' needs, and the child's best interests. It is possible that these factors have all improved since the 2021 interviews. For example, as of March 2022, CMIS is documenting the dates that audits are assigned to the CQI team as well as the dates the CQI team returns the completed audit forms to the clinical coordinators. The audit tool is a dynamic document that is often reviewed and revised to improve its usefulness.

8. Number of Reports Reviewed
To assess this metric, we reviewed the two audit summary reports as well as each of the individual audit reports completed for service memos submitted between Jan. 1, 2019, and June 15, 2022.

File Review. From Jan. 1, 2019, to May 31, 2021, the clinical coordinators completed 137 service memos for REGIONS-eligible youths. Eleven—or about 8 percent—of these memos were audited. The audited memos were completed between April 23, 2019, and June 24, 2020. Ten of the 11 audits were conducted by the same auditor. No CQI contract was in place for 10 months during 2019–20. The new CQI contract became effective March 2020, and the audits began again in October 2020. From June 1, 2021, to June 15, 2022, the clinical coordinators completed 79 service memos for REGIONS-eligible youth. Nineteen (about 25 percent) of these memos were audited. The audits were conducted between Nov. 21, 2021, and Sept. 29, 2022, by three auditors, who each reviewed three, seven, or nine service memos.

Summary. Between January 2019 and May 2021, about 8 percent of 137 service memos were audited, and 10 of the 11 memos were audited by the same auditor. In the interim process evaluation report (submitted Nov. 15, 2021), DSG wrote:

> There was a 10-month hiatus owing to the absence of a CQI contract, and audit reviews resumed in October 2020. As a result: a) the current audit review process has reviewed an insufficient number of service memos to draw conclusions; b) the audit process has been too erratic, and the items used for audit review too frequently revised to draw conclusions; and c) confidence in the conclusions drawn is limited by the fact that they are essentially from a single source (given that all reviews except one were conducted by the same auditor). As a CQI measure, the current audit process a) cannot be confidently relied upon, and b) does not currently provide timely feedback of the sort that would be most helpful to the clinical coordinators. However, the current process can be adapted to provide helpful real-time consultation on complex cases and identify current training needs.

However, from Nov. 21, 2021, through Sept. 29, 2022, the auditors audited 25 percent of the 79 service memos completed from June 1, 2021, to June 15, 2022. There has been improvement in the percent of service memos audited and also in the number of auditors conducting the reviews (the most recent audits were completed by three auditors who each reviewed at least three service memos). Given the auditors' other responsibilities and priorities, the 25 percent audit level is acceptable.

9. Number of Training Hours (Pre-service and In-service)
Information to assess this metric came from interviews with Court Clinic leadership and managers as well as a review of the pre-service training list.

Pre-service Training. Most of the pre-service training for clinical coordinators occurs within 3 months of hiring. It consists of 173.75 hours of training, which is either instructor led (by several different trainers) or web based. The training includes an 8–hour new employee orientation and several modules

about general workplace topics, such as a 1-hour welcome to JBCSSD, a 1–hour overview of the training academy, 1.5 hours to learn about Occupational Safety and Health Administration (OSHA) standards, 2.5 hours of sexual harassment awareness training, and a 2.5–hour introduction to the use of JBCSSD computer equipment and forms, as well as training on computer security (1.5 hours), workplace violence awareness (1 hour), situational awareness (4 hours), the Learning Management System (LMS) [1 hour], active shooter awareness and preparedness (45 minutes), the Employee Assistance Program (1 hour), phishing awareness (30 minutes), and emergency and security review (30 minutes).

Juvenile justice training modules include an introduction to juvenile justice (3 hours), juvenile legal issues (3 hours), risk reduction frameworks (3.5 hours), courtroom demeanor (2 hours), Prison Rape Elimination Act (1 hour), mandated reporter training (1 hour), and essentials of justice (45 minutes).

Trainings designed specifically for the clinical coordinators include a 1.5–hour overview of the clinical coordinator's role and responsibilities; 3 hours on juvenile forensic mental health assessment; 12 hours on the forensic formulation model, which is used in report writing and to assess juveniles; 21 hours on conducting specialized evaluations for the courts (with a focus on risk factors, ethics, maintaining objectivity, and concise report writing); 2 hours to discuss clinical coordinator staff meetings; 2 hours on competency/restoration guidelines; and 2 hours to review the audit tool, interview guide, and service memo template. Clinical coordinators also need to examine reports that other individuals prepare, as part of the collateral information required to complete the service memo. Thus, the coordinators receive training on the PrediCT (3 hours), which is delivered by probation officers, and the Massachusetts Adolescent and Youth Screening Instrument (MAYSI) [3 hours]. The training also includes 14 hours on cultural competency, 3 hours on diversity in the workplace, 6 hours on LGBTQIA+ issues, 6 hours on the role of race in juvenile justice processing, 4 hours on human trafficking awareness, 45 minutes dedicated to the Americans with Disabilities Act, and 1.5 hours on Limited English Proficiency (LEP).

Pre-service training includes more than 30 hours scheduled for clinical coordinators to visit each of the 11 courts; learn procedures, cultural functions, and day-to-day functions of each of these courts; and shadow current clinical coordinators for hands-on training. The pre-training schedule also includes tours of Solnit (Connecticut's state-administered psychiatric facility), and residential programs such as the Therapeutic Respite and Assessment Center (TRAC), Helping Adolescent Males in Learning Their Options Now (HAMILTON), Adolescent Male Intermediate Residential (AMIR), and Adolescent Female Intermediate Residential (AFIR). In other training modules, clinical coordinators learn about the following: the roles of juvenile probation officers, juvenile detention officers (JDOs), and classification and program officers (CPOs) [3.5 hours]; the contracted services (3 hours); the role of the Clinical, Educational, and Juvenile Residential Services Unit (2 hours); and Connecticut's education law and advocacy efforts (6 hours). They also visit a detention center, which is where the JDO and CPO sessions occur.

In addition to completing these training hours, newly hired clinical coordinators meet with the Court Clinic supervisors twice per week, and sometimes more. One of the interviewees commented: "This is a more labor-intensive process than someone unfamiliar with this work may expect."

In-service Training. Clinical coordinators receive three categories of in-service training. These hours are tracked in the Learning Management System (LMS) that JBCSSD uses to register and maintain training records. First, clinical coordinators are required to earn 15 hours of continuing education units (CEUs) each year to maintain their respective clinical licenses. Most clinical coordinators are Licensed Clinical Social Workers (LCSWs) but they can have other licenses as well, such as Marriage and Family Therapist (LMFT) or Licensed Professional Counselor (LPC). To meet this 15-hour requirement, clinical coordinators generally need to supplement the training offered by the Judicial Branch with training from

other sources.

Second, clinical coordinators must complete 40 hours of in-service training throughout the year (the 15 hours of CEUs to maintain their clinical licenses can count toward this requirement). As part of the clinical coordinators' performance appraisals, JBCSSD program managers 1) document that the clinical coordinators have completed the 15 hours of CEUs needed to maintain their license, 2) obtain a copy of the license, and 3) access the LMS to verify that the clinical coordinators have completed their 40–hour in-service training requirement. Clinical coordinators can meet the 40–hour requirement through opportunities offered within or outside the Judicial Branch.

Third, there are mandatory trainings that result from the CQI process. These trainings may occur if the CQI team finds common themes during audits that need to be addressed. Examples: a SAVRY booster training and training on using the RSTI, which were specific needs identified in the past year or so. Earlier in REGIONS implementation, the CQI process generated a training on concise report writing that is now part of the pre-service training.

Summary. When the pre-service and in-service trainings are viewed together as a training process, the training is comprehensive, substantive, and well-aligned with the role of the Court clinicians. The training robustly equips clinical coordinators with the information and skills they need to operate effectively and ethically in a forensic context.

10. Number of Case Consultations With Forensic Experts
This metric was assessed by gathering and analyzing information through interviews.

Clinical Coordinator Perspective. Interviews with clinical coordinators, auditors[5], and Court Clinic administrators indicate that there are fewer case consultations than there are audits. In 2022, the year before this report was due, only two case consultations occurred. Both were high-profile cases. The dates of the case consultations started being entered into CMIS in 2022.

Most clinical coordinators—especially the newer ones—felt that the case consultations were extremely helpful. They liked the interactive nature of the case consultations and the fact that it happens in "real time," so what they learn during the consultation process can be incorporated in the reports before the reports are submitted to the Court. Several clinical coordinators mentioned benefiting from the expertise of the more experienced auditors.

Access to case consultations is not always possible, however. One clinical coordinator said: "I would like to have more conversation and consultation with the auditors...Now, we're submitting the report, we get the audit back, we see their notes, but that consultation—that conversation isn't there."

Summary. Clinical coordinators value the opportunity to have conversations with the forensic expert and felt that the case consultations were an important learning tool. The background, experience, and demeanor of the main auditor are assets to the REGIONS program. It may be beneficial to make consultations with forensic experts more accessible, especially for the newer clinical coordinators. DSG did not have the records needed to count the number of case consultations.

---

[5] Some of the forensic experts also served as auditors.

11. Adherence to the Requirement That Quality Assurance Report Reviews Occur at the Designated Intervals for All Clinical Coordinators

CQI contractors are required to conduct audits quarterly, as stated in the CQI contract and in accordance with overarching quality assurance procedures that align with JBCSSD Policy and Procedure 1.8 (Court Support Services Division Administration, Policy and Procedures Field Audits) and 8.504 (Continuous Quality Improvement Program).

Review of Audit Forms. DSG reviewed the audit reports for the 11 audits that occurred from Jan. 1, 2019, through May 31, 2021, but most of the audit reports did not include the two dates we needed; thus, we were unable to examine adherence to the requirement that the reviews occur quarterly. However, we were able to assess this metric with the service memos completed between June 1, 2021, and Sept. 15, 2022. Nineteen audits occurred during this time, as follows: November 2021 (1 audit), December 2021 (3 audits), April 2022 (7 audits), August 2022 (3 audits), and September 2022 (5 audits). Three auditors completed the audit forms, each reviewing three to nine service memos prepared by a total of 15 clinical coordinators. These auditors reviewed 19 service memos completed in 2021 and 2022, as follows: July 2021 (1 service memo), October 2021 (3 service memos), January 2022 (2 service memos), February 2022 (5 service memos), April 2022 (1 service memo), June 2022 (6 service memos), and July 2022 (1 service memo). Eleven of the audits were for service memos completed in the New Haven Court, 3 in the Bridgeport Court, 2 in the New Britain Court, and 1 in the Hartford Court. The Court was not identified in two of the audits. The 19 audits occurred an average of 49 business days after the service memo was completed. The median number of business days was 47 (meaning that half of the audits occurred sooner than 47 days after service memo completion and half occurred more than 47 days after service memo completion), and the range was 27 to 92.

Summary. The most recent 19 audits occurred during a 10–month period. Four were completed in November and December 2021, seven in April 2022, and eight in August and September 2022. The number of audits was not more consistent from quarter to quarter because the sample of reports to audit is drawn from all service memos (not only the REGIONS service memos). The reports are identified randomly, and the REGIONS service memos as well as the service memos for youths not being considered for REGIONS are in the same "pot" from which service memos are randomly selected for auditing. JBCSSD should set a standard for how many audits should be conducted each quarter, and the standard should be defined as a percentage of service memos completed rather than as an absolute number of service memos. We suggest a review of no fewer than 25–30 percent of submitted service memos. JBCSSD should consider creating the random sample to be audited exclusively from the REGIONS service memos to ensure that a sufficient number of REGIONS service memos are audited.

12. Frequency and Modification of Practice Based on Feedback Provided to the Clinical Coordinators

To assess this metric, DSG staff interviewed clinical coordinators, auditors, and Court Clinic supervisors. We asked about the feedback clinical coordinators receive from both auditors and supervisors.

Court Clinic Stakeholder Perspective. Most interviewees shared that the clinical coordinators appreciated the feedback and that they incorporated it into their final service memos, when it was provided in a timely manner. From our first interviews in 2021 to our final interviews in 2023, the rate of positive comments increased. This change was due to increased access to feedback from supervisors, which, in turn, was a result of additional supervisors being hired.

During our initial interviews, many of the interviewees felt that they needed more feedback than was available. As mentioned in other sections, they felt that the problem of not receiving enough timely

feedback was caused by not having a sufficient number of supervisors. One of the clinical coordinators said:

> We need more than one supervisor; we need at least two. You can make an argument for three, but at least two. In other departments, they wouldn't allow this. It's crazy that we have a 1:14 ratio. Our reports are not reviewed very often. No matter how long I do this or how long we've been doing this (and I feel like I'm pretty good), it is helpful to get feedback. There are cases I get stuck with all the time, or you think you have the right thinking in a situation but it's good to make sure. It really helps if there's a person or people that you can process your cases with. It's not always there. We just don't have that structure right now. It harms our unit.

However, clinical coordinators appreciated the feedback when it was timely. One of the clinical coordinators said:

> I enjoyed the feedback. Any change made was a necessary change. More times than not, you mean something as a writer, but the reviewer isn't understanding it the way you explained it, so it's nice to have another set of eyes. It's really important to get feedback from a supervisor. This makes the reports better. Sometimes they even ask questions like, "why did you recommend MST instead of another program," and then I can explain better in the report why I recommended what I recommended.

The auditors also felt that the feedback they provided was well received. One of the auditors said:

> I'm sure I might be a little prickly at times if someone were reviewing my evaluations and giving me feedback. But they're not. I have to say initially, maybe before meeting us, they may have had a negative attitude. But as far as I can see, they're very open to the kind of feedback we give about how to do things better. I think it's because the stakes are high; there's some very serious cases that are evaluated. As a team, they seem to work very efficiently together, even with everything that's been going on over the last year.

According to the last few interviews, which were conducted after initial supervisors were hired, access to feedback appears to have improved. By the time this process evaluation was completed in 2023, the number of supervisors had increased from one to three. One of the supervisors said:

> When I receive a report, I use track changes and add, "Why didn't you choose this?" or "Can you explain more?" Or if they don't have the data to support their recommendation, I say, "Add more here" or "Tell me why you chose this or didn't choose this."

The three Court Clinic supervisors agreed that the distribution of work was much improved. However, they also shared that after feedback is given to a clinical coordinator, "There is an understanding that they will accept the changes and address the questions. We don't check it after that." They felt that a second check would be too much, but they do follow up, "if it seems like there is a lot to change or to think about."

Summary. Information gathered through interviews with auditors, clinical coordinators, and Court Clinic supervisors indicates that clinical coordinators value the feedback they receive from auditors and supervisors and that they use this feedback to modify their reports. Over the past 3 years, access and timeliness of feedback has improved, which is a positive change that will substantially benefit the Court Clinic.

13. Number and Types of Trainings Generated Through the CQI Process

To assess this metric, we gathered and analyzed information through interviews with clinical coordinators, auditors, and Court Clinic supervisors.

Court Clinic Stakeholder Perspective. In interviews and focus groups, the auditors and clinical coordinators mentioned several trainings that were generated through the CQI process, including trainings on concise report writing, assessing social attitudes, assessing parenting and supervision, and understanding trauma and coping strategies, as well as a SAVRY booster. One of the auditors said:

> At one point, we thought the CCs were spending too much time and using too much space in the reports talking about average risk stuff (versus high-risk stuff) when discussing the SAVRY results. So, we did some retraining with them about how to write that up. That just happens to be one of the more recent, specific examples of how a training is generated through the process. There was a dialog between the three of us [auditors], and we kind of said: "Hey, I don't like the section of the report; it feels like the important stuff gets lost." Or, someone would say: "You know, the important factors are not here." So that was a dialog between the three auditors. Then we talked about it with Tracy [Duran]. Then, the process continued, and we talked to the CCs about how they could do that a little bit differently. That is the retraining piece. And then, we look at the audit tool and how it reflects that expectation. We make changes to the audit tool, if necessary.

Another auditor said: "Instead of just dinging them on the issues, we get back and help [the clinical coordinators] do a better job."

Also, when new clinical coordinators are hired, CQI providers offer consultations on REGIONS assessments, including service memos. Clinical coordinators and auditors felt that the trainings were relevant and helpful. One interviewee said: "All of our trainings that are generated through the CQI process are dynamic and based on any themes or needs of improvement that may have been highlighted following the CQI review process."

Summary. The number and types of trainings generated through the CQI process appear to be sufficient for meeting the needs of clinical coordinators and the Court Clinic. JBCSSD Central Office Administrators should pay attention to the process through which these trainings are generated to ensure the bureaucratic oversight does not become burdensome and hinder learning.

C. Effectiveness of Forensic Formulation Model

Forensic formulation is the process or product of gathering and integrating diverse information to develop a concise account of the etiology, nature, and course (with and without interventions) of the problems affecting a person's mental health and/or functional difficulties (such as conduct that may result in arrest). The purpose of the formulation is to guide integrated treatment planning and other decision-making such as risk management or collateral services (e.g., social services such as housing or other supports addressing social determinants of delinquent misconduct and recidivism).

Forensic formulation is a core competency in mental health practice, including forensic mental health. Although a consensus exists about what constitutes best practices in forensic assessment, the complexities of individual cases seen in a forensic context have precluded a consensus on any specific process or on what must be included in all forensic assessments. These complexities are due, at least in part, to the many legal contexts in which forensic assessments occur and the need to tailor forensic assessments to each context. There is, however, a best practices approach in juvenile forensic assessments that includes 1) evaluations incorporating multiple sources of information; 2) reliance on evidence-based tools for risk assessment and management; 3) reliance on a science-based developmental framework; and 4) consideration of evidence-based treatment of behavioral health disorders and interventions to reduce recidivism risk and foster access to, and engagement with,

positive youth development assets.

This process evaluation examines the effectiveness of the forensic formulation model through 13 metrics:

- Metric 14. Utility and validity of the forensic formulation model
- Metric 15. Extent to which the factors identified as relevant in the forensic formulation model design are effective in answering referral questions
- Metric 16. Frequency of objections, expressed concerns, and/or modifications to referral questions
- Metric 17. Extent to which the necessary data is available to inform the decision-making process and is reflected in the final recommendations provided in the service memo
- Metric 18. Rate of reference in the placement opinion to the five factors for or against probation with residential placement
- Metric 19. Extent to which protective factors are considered in recommendations for treatment
- Metric 20. Balance and/or integration between addressing risk reduction needs and clinical needs
- Metric 21. Extent to which trauma, culture, and gender are sufficiently identified and addressed in the recommendations
- Metric 22. Extent to which collateral information is integrated into the formulation
- Metric 23. Occurrences and frequency of placement opinions citing a history of violence, future violence risk, AWOL risk, prior treatment response, and current treatment amenability for or against a probation with placement recommendation
- Metric 24. Occurrences and frequency of noting strengths and an explanation of how to leverage strengths in the report toward behavior change)
- Metric 25. Determine if there is a discernible pattern of clinical and behavioral needs for youth recommended for placement (secure versus staff-secure) versus those not recommended for placement
- Metric 26. Extent to which the PrediCT, Service Memorandum, and the REGIONS Integrated Treatment Plan match in identifying the critical static and dynamic risk, protective, and resilience factors in cases

14. Utility and Validity of the Forensic Formulation Model

The REGIONS forensic formulation model focuses on violence as the functional problem behavior. As stated in JBCSSD Policy and Procedure 6.116 (Clinical and Educational Services, Service Memorandum for Residential Placement), the service memo requires a description of critical vulnerabilities and risk factors (consistent with the Structured Assessment of Violence Risk in Youth [SAVRY]) and a description of how and why these vulnerabilities and risk factors lead to problem behaviors.

The service memo includes a forensic clinical assessment, a violence risk assessment, and the weighing of five factors to determine security level: 1) history of violence, 2) public safety risk/future violence, 3) history of unauthorized absences/AWOL risk, 4) past treatment response/history of poor compliance or no progress made in least restrictive settings/interventions, and 5) treatment amenability. The methodology for this assessment was developed with the assistance of JBCSSD-contracted forensic psychologists.

Summary. The forensic formulation model is both useful and valid. The REGIONS forensic formulation model is consistent with best-practice approaches to the assessment of youths before courts for alleged or adjudicated delinquent misconduct. The model uses a widely accepted, research-based assessment of juvenile violence risk (the SAVRY [Vincent, Chapman, and Cook, 2011]) and five evidence-based factors to support structured professional judgement regarding security levels. The REGIONS

assessment model also reflects a research-informed assessment of the following elements: a) exposures to adversities and evidence of traumatic reactions to these exposures; b) peer relationships and family dynamics; c) history of misconduct and responses to prior interventions, including failures of probation or other supervision and/or history of responses to attempted behavioral health and other interventions; d) assessment of strengths and evidence-based protective factors; and e) treatment amenability.[6]

15. Extent to Which the Factors Identified as Relevant in the Forensic Formulation Model Design Are Effective in Answering the Referral Questions

The factors identified as relevant in the forensic formulation model are evidence based and supported by a robust body of literature. Although there is some variability among clinical coordinators regarding what information is collected and how it is reported in the service memo format, the Court clinicians are largely consistent in collecting and reporting information from multiple sources relevant to the forensic formulation model. We identified several training opportunities, including the following: a) distinguishing between "strengths" and "protective factors" and more clearly linking both to issues of recidivism risk, level of placement security, and intervention/treatment planning; b) considering intervention-matching (e.g., matching a youth's needs to interventions such as individual treatment, DBT treatment, or evidence-based family treatment); and c) evidence-based interventions specifically addressing criminogenic attitudes, values, and beliefs such as adapted Functional Family Therapy and/or Moral Reconation Therapy.

Summary. Overall, available information indicates that the factors embedded in the forensic formulation model are effective in answering the referral questions pertaining to a) the recommended level of security/supervision, and b) behavioral health treatment and other interventions likely to reduce recidivism risk.

16. Frequency of Objections, Expressed Concerns, and/or Modifications to Referral Questions

To assess this metric, DSG gathered and analyzed information through interviews with key stakeholders.

Probation Officer, Judge, and Attorney Perspective. We asked several interviewees about the frequency of objections, expressed concerns, and modifications to the referral questions. Most did not have much to say about this metric. Interviewees expressed concern about a few situations in which they did not understand how the recommendations were formulated. These instances occurred more often when clinical coordinators recommended a staff-secure placement, but Court stakeholders felt the youth might be better off in a secure placement. Usually, the clinical coordinator was able to explain the formulation to clear up any misunderstanding.

Some interviewees also expressed concern about the classification of gun charges. A few of the probation officers, judges, and attorneys felt that gun charges were not being addressed sufficiently in the forensic formulation model. When asked, "How often do you agree with the recommendations in the service memo?" one interviewee responded: "Most of the time I agree. When I don't, it's because of the questions in the risk assessment tool. For example, having a gun but not shooting it isn't considered high risk in the tool. I disagree with this." Another interviewee said:

> At one point there was a kid in a car with a pistol, but because the gun wasn't fired, there's no substantial risk of violence in that tool. We didn't agree with that. Ever since that was pointed out, there seems to be more [attention paid to] looking at that like a different kind of factor. Some of these tools are useful, but we need more in the equation than the tool.

---

[6] The RSTI(TA) was added to the service memo during the REGIONS process and outcome evaluation.

Summary. There do not appear to be many objections, expressed concerns, or modifications to the REGIONS referral questions. When objections or concerns are raised, it seems as though clinical coordinators are able to satisfactorily explain the reasoning and formulation. However, several Court stakeholders indicated that they were dissatisfied with the classification of certain gun charges. This issue should be addressed by providing more information to probation officers and other Court stakeholders regarding why gun possession charges are not reflected in the SAVRY as a violence risk, and greater transparency and education about how gun possession charges factor into the clinical coordinator's risk assessment determinations in individual cases. REGIONS administrators should consider how to weigh gun possession and other factors not specifically included in the SAVRY in the overall assessment of risk. In October 2022, Court Clinic administrators conducted training specifically for judges and then for individual courts related to this issue. Probation officers, attorneys, and judges were all in attendance. The training is a positive step in addressing these issues.

17. Extent to Which the Necessary Data Are Available To Inform the Decision-Making Process and Is Reflected in the Final Recommendations Provided in the Service Memorandum

Information is ordinarily available and sufficient to support the REGIONS evaluation and service memo, as discussed in detail under other metrics (for example, see Metric 22). At times, however, obstacles hinder obtaining important collateral information such as prior treatment program records and school records. In these situations, decision-makers must choose between timely completion of the service memo or waiting a little longer until all collateral information is accessed. A memorandum of understanding (MOU) and a release of information (ROI) form with parent/guardian signatures are still required to obtain information. Sometimes, what is identified in an existing MOU does not include the clinical documents that the clinical coordinators need, which can also cause delays.

Summary. As reported by clinical coordinators, judges, and probation officers, the necessary data are sufficiently available to inform the REGIONS decision-making process. In the higher-volume Courts, the Court may wish to consider developing MOUs with established behavioral health providers and school districts to prioritize Court requests for records (for more information on collateral information integrated into the formulation, see Metric 22). Steps have already been taken through State of Connecticut Public Act 18–31 to improve access to educational records in the residential programs. The Act requires that each public school district with an enrollment of at least 6,000 students designate a juvenile justice liaison/re-entry coordinator to facilitate student transitions between public schools and the Connecticut juvenile justice system, including the timely transfer of records of justice system-involved students to and from juvenile justice agencies and facilities. However, it is unclear whether there is a similar arrangement for Courts.

18. Rate of Reference in the Placement Opinion to the Five Factors for or Against Probation With Residential Placement

The five factors are as follows: 1) history of violence, 2) risk for future violence, 3) past treatment compliance or no progress made in least restrictive settings/interventions, 4) current amenability to treatment, and 5) AWOL risk/history of absence/absconding. Assessment of these five factors is weighed, along with a forensic clinical assessment and a violence risk assessment, to determine the security level (i.e., secure or staff-secure program) for youths sentenced to a period of probation with residential placement (PWP). DSG assessed this metric using file review.

Review of Service Memos. DSG staff reviewed each of the 223 service memos for youths with new adjudications for PWP, completed between Jan. 1, 2019, and Sept. 30, 2022. Four researchers reviewed and extracted information from each of the memos, indicating whether they addressed any of the five factors. We found that every service memo addressed history of violence, risk of future violence, and current amenability to treatment in the placement opinion. One service memo was missing the AWOL risk. Another was missing past treatment compliance, but the clinical coordinator explained in

30

the recommendations section that the youth had not yet participated in any intensive, home-based interventions that could target his primary risk factors.

Summary. The service memos consistently include references to the five factors, which are used to determine the level of security of each youth's placement.

19. Extent to Which Protective Factors Are Considered in Recommendations for Treatment

Protective factors are characteristics or conditions of the child, family, and/or broader social environment that reduce the likelihood of a) exposures to adversity, or b) negative child and youth development behaviors and outcomes (including delinquency and adult offending) if the child is exposed to adversity. Protective factors may reduce the influence of risk factors related to delinquent and violent behavior, and they sometimes are thought of as "buffers" that lessen the negative effects of adversity on child outcomes (Vanderbilt–Adriance and Shaw 2008; DSG, 2015).

Protective factors, like risk factors, typically are organized in the following domains:
- Individual (e.g., biological and psychological dispositions, attitudes, values, knowledge, skills)
- Family (e.g., function, management, bonding)
- Peer (e.g., norms, activities, attachment)
- School (e.g., bonding, climate, policy, performance)
- Community (e.g., bonding, norms, resources, awareness/mobilization)

Protective factor measures have been developed for juvenile justice populations to assess the likelihood that a young person will follow the most common developmental trajectory among delinquent children and youths—desistance from delinquent/criminal misconduct with maturation and greater life experience as they complete adolescence and enter their early 20s (Barnes–Lee, 2020). The SAVRY is an example of a tool that assesses research-based protective factors among youths where violence is also a potential concern.

JBCSSD Policy and Procedure 6.116 (Clinical and Educational Services, Service Memorandum for Residential Placement) requires that the service memo for residential placement include a subsection on strengths in the findings and recommendations section, specifically "relevant strengths/protective factors, and how and why strengths/protective factors can be leveraged to reduce problem behavior." Notably, strengths and protective factors are different.

> **Difference Between Strengths and Protective Factors**
> Although all protective factors can be considered strengths, not all strengths are considered protective factors because research has not linked them to reductions in delinquency and other negative outcomes (or increases in positive outcomes). Some of the service memos noted this difference. For example, one memo stated: "[Child] does not have any SAVRY protective factors present; however, he does have many strengths that can be leveraged in treatment that will be discussed later in this assessment." Because the policies and audit tools combine strengths and protective factors, both are discussed in this section. More information on strengths is summarized in Metric 24.

The service memo incorporates findings from the SAVRY, including six protective factors that may buffer a youth's risk for violence and guide intervention strategies to reduce general and violent offending recidivism risk. Each protective factor is rated as present or absent in the SAVRY. The service memo contains a narrative section in which clinical coordinators indicate whether each of the six protective factors is present and describe how the factor's presence manifests for the specific youth. The six protective factors are as follows:

1. Prosocial involvement
2. Strong social support

3. Strong attachment and bonds
4. Positive attitude toward intervention and authority
5. Strong commitment to school
6. Resilient personality traits

Rating Strengths and Protective Factors in the Audit Tool. DSG reviewed two audit reports, each covering a 1-year period of CQI audits (Kruh, Kemp, and Palmisano, 2021; Kruh, Kemp, and Palmisano, 2022). The Clinical Coordinator Service Memo Audit Instrument contains three items, which are included in the Findings and Recommendations section of the service memo, related to protective factors:

1. Relevant strengths/protective factors (in the Strengths subsection of the Findings and Recommendations)
2. How and why strengths/protective factors can be leveraged to reduce problem behavior (in the Recommendations subsection of the Findings and Recommendations)
3. Interventions and services appropriately leverage strengths/protective factors (in the Recommendations subsection of the Findings and Recommendations)

Auditors rate how well the clinical coordinators addressed these items in their service memos. Each item is rated as present (i.e., addressed by the clinical coordinator) [2 points], partially present (1 point, missing (0 points), or not applicable (N/A). Evaluation strengths are identified when the average score for an item across evaluations was equal to or greater than 1.8; evaluation weaknesses are identified when the average score for an item across evaluations was equal to or lower than 1.0. In the 2020–2021 audit report, the auditors concluded that identifying relevant strengths/protective factors was a strength. In the 2021–2022 audit report, auditors concluded that two of the items were strengths: 1) identification of how and why strengths/protective factors can be leveraged to reduce problem behavior, and 2) the way that clinical coordinators explained how to leverage strengths/protective factors (see Figure 2.6).

Figure 2.6. Extent to Which Clinical Coordinators Met the Strengths/Protective Factors Requirements of the Service Memo, According to 2019–2021 and 2021–2022 Audit Reports
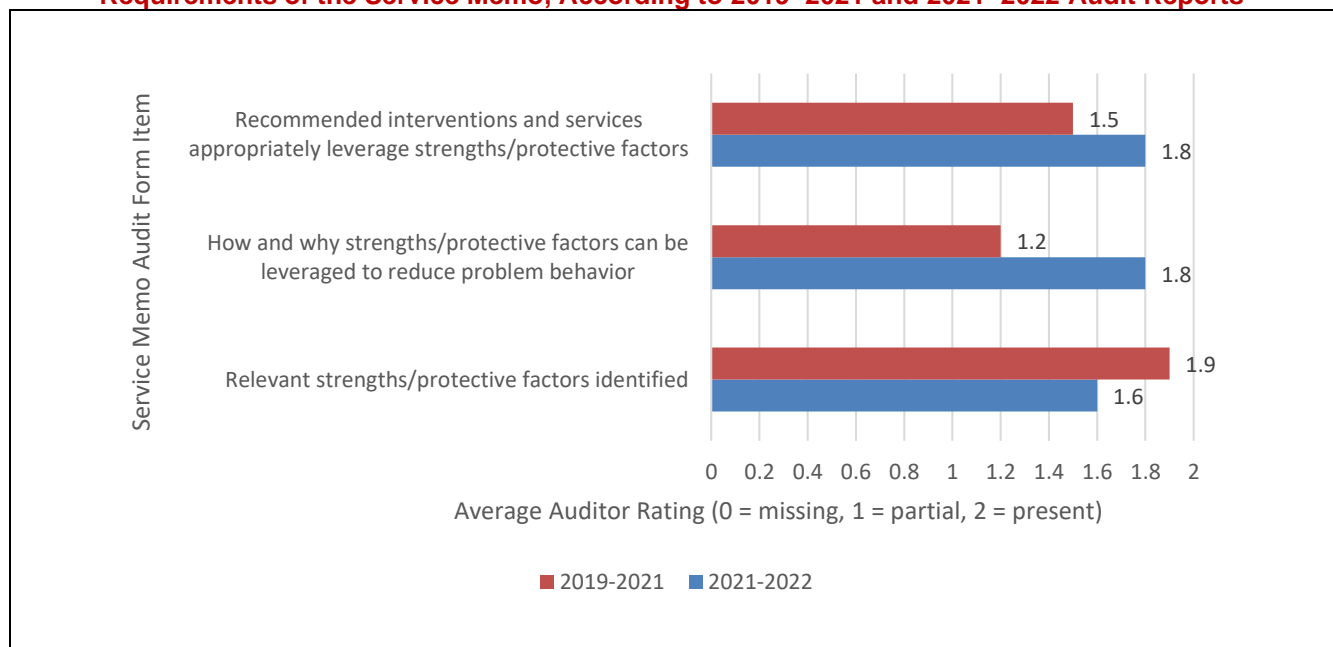
Data source: Service memo audit reports.

Audit reports generally provided relevant, actionable, and helpful suggestions for improving the service memo by addressing the leveraging of strengths/protective factors to reduce problem behaviors. In the 2020–2021 report, auditors offered perspectives and suggestions in five of the six audits reviewed, although most focused on "strengths" rather than "protective factors" specifically. Their comments included the following:

- The evaluator identified two strengths: an openness to intervention and feeling close to family. However, the manner in which these strengths can be leveraged in treatment was not discussed.
- When discussing his positive relationship with his mother you might discuss how, through family-level services, she could be a prosocial influence, such as helping him to enhance his commitment to academic/occupational success.
- Remember to discuss why the strengths are relevant to efforts to reduce risk. For example, because the youth is "smart," he may be more likely to benefit from efforts to develop his insight into his problems. His motivation to gain the skills for employment might provide a hook for investment in skill-building.
- The way her leisure interests could be capitalized upon in treatment was discussed, but ways her relationship with her mother and her history of academic success was not. Be sure to discuss how strengths can be used, which helps the reader to make the links with the treatments that are proposed.
- The Strengths section is the place where we also want to make explicit how the strengths can be leveraged. His abilities to engage conversationally, to develop insight, and to succeed academically all speak to his ability to benefit from talk therapy, for example. It may seem obvious to us as clinicians but may not be obvious to the legal professionals reading the report.
- Good strengths and protective factors were identified but remember to discuss how they can decrease his risk. For example, while it may seem obvious to us, it should be made clear to the reader that his interest in employment is a strength because employment is a better way to structure his time than associating with negative peers and reduces the relevance of poor supervision by his mother.

In the 19 audit reports completed between November 2021 and September 2022, only 3 included comments on protective factors specifically, as follows:

- … the protective items may have been rated with more leniency than was warranted and without careful adherence to the item criteria in the manual. For example, his positive relationship with his 1-year-old nephew was cited as support for a "present" rating on Strong Attachment and Bonds even though that item is specific to prosocial adults. It is important to remember that protective factors are rated as "present" only when the youth is an exemplar of that trait – when they would be considered an "A+" on that item. The lower number of risk factors and potential protective factors, as well as the nature of the risk factors, support a sense that risk management is feasible.
- There are also some contradictions in the protective factors. For example, positive attitude toward intervention and authority is present despite prior text noting that he did not comply with a number of Court-ordered sanctions and also took police on a high-speed chase. Regarding strong bonds, school supports are listed though it was noted throughout the report that he does not attend school. It may be that his mother may be a strong bond but there lacked sufficient detail in the report [to] indicate that providers or school should be considered under this category.
- Don't forget the key issue of reporting here the protective factors identified on the SAVRY (Strong Attachment & Bonds; Strong Social Support), as these are empirically supported strengths.

Review of Service Memos. DSG sampled and reviewed 112 of the 230 service memos, completed from Jan. 1, 2019, through Sept. 15, 2022, to assess the extent to which protective factors were considered in recommendations for treatment. Clinical coordinators listed at least one protective factor in 54 percent of this sample of service memos (61 of 112), and 46 percent of the service memos indicated that the youth had no protective factors (see Figure 2.7).

Figure 2.7. REGIONS Youth Protective Factors

SAVRY Protective Factors Listed in Service Memos, 2019–2022

- No protective factors listed: 46%
- Resilient personality traits: 10%
- Strong commitment to school: 8%
- Positive attitude toward intervention and authority: 13%
- Strong attachment and bonds: 46%
- Strong social support: 29%
- Prosocial involvement: 4%
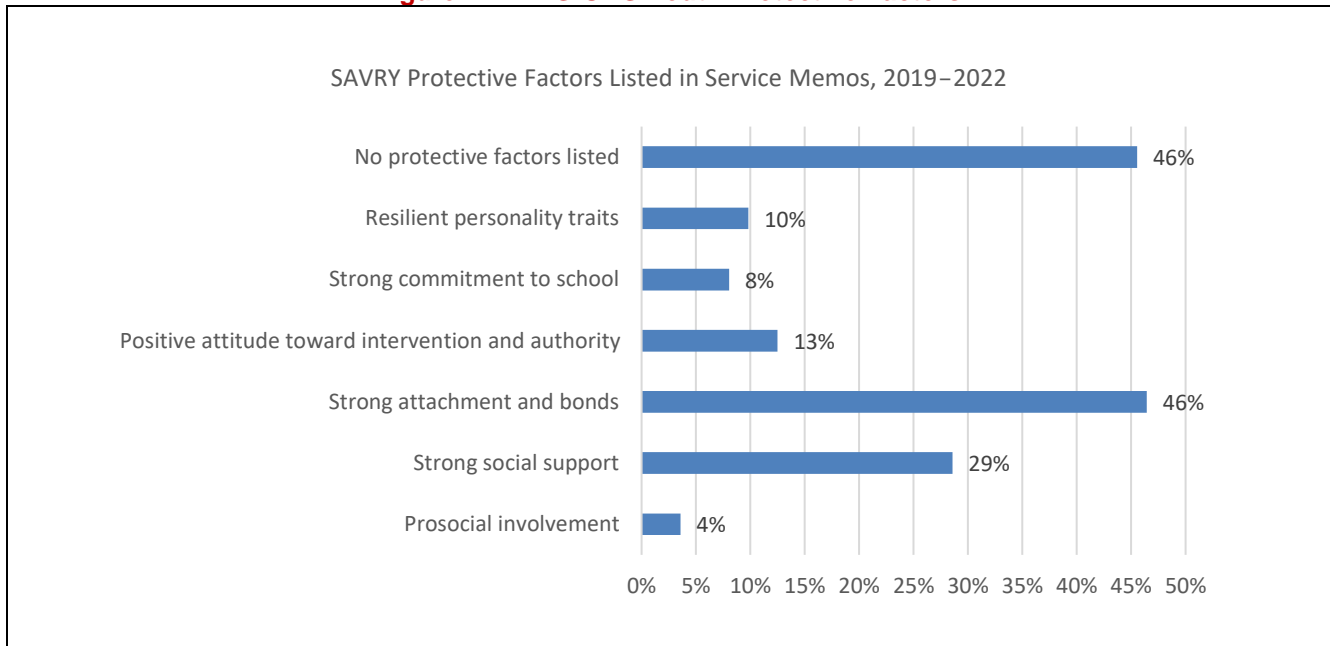
Data source: Service memos. *N* = 112.

Although 46 percent of the service memos indicated that the youth had no protective factors, all at least mentioned that protective factors were measured. Some merely stated that no protective factors were present (e.g., "In the Protective Factors domain this writer rated [the child as] having no specific protective factors"). Others provided a bit more detail. One report noted: "In the Protective Factors domain this writer rated [the child] as having no specific protective factors. While [the child] does have an attachment and bond with his parents, their relationship alone does not appear to be a strong enough motivator to mitigate against the likelihood of future violent behavior and/or domestic-related matters." Others provided even more detail.

The most common protective factor identified by clinical coordinators was strong attachment and bonds, generally with their mother, grandmother, or other family members (46 percent of the service memos), followed by strong social support (29 percent), positive attitudes toward intervention and authority (13 percent), resilient personality traits (10 percent), and strong commitment to school (8 percent). The least commonly identified protective factor was prosocial involvement (4 percent of the service memos).

Protective factors were identified more often in the service memos recommending a non-REGIONS placement or services than in service memos recommending a secure or staff-secure REGIONS placement (see Figure 2.8). Forty-six percent of the service memos recommending a REGIONS placement identified at least one protective factor, compared with 84 percent of service memos that did not recommend a REGIONS placement.

Figure 2.8. Identification of Protective Factors in Service Memos Recommending REGIONS Compared With Service Memos Not Recommending REGIONS
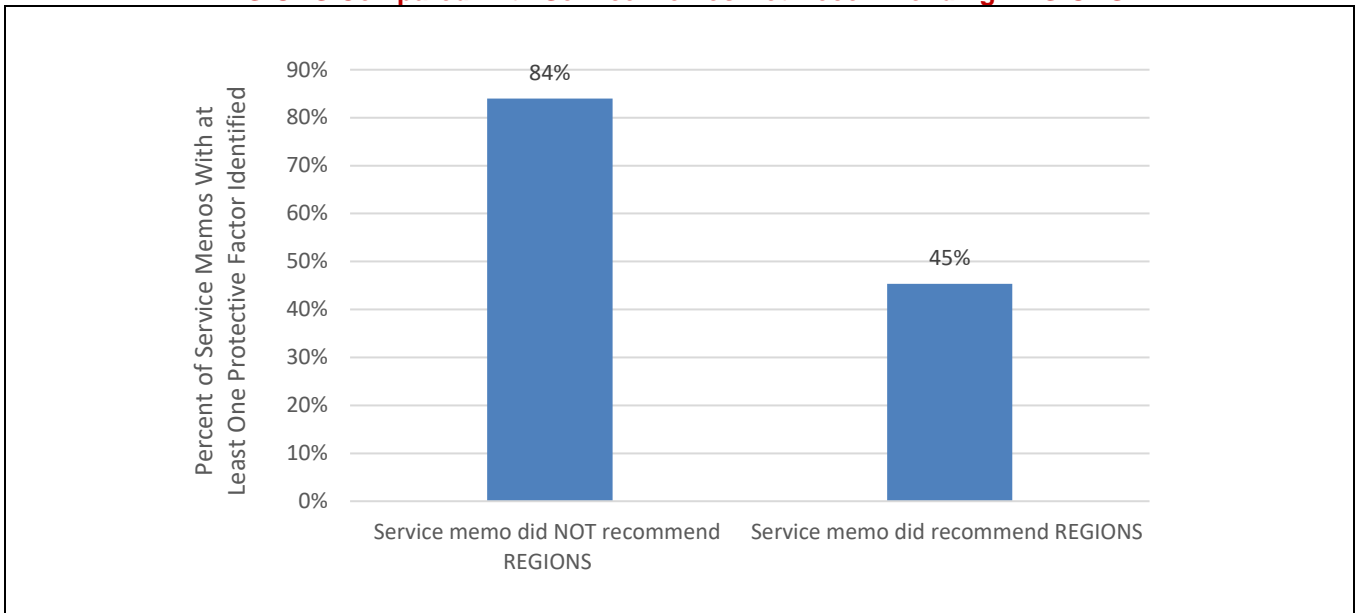
Data source: Service memos. *N* = 112 service memos.

Many service memos also considered protective factors in the recommendations for treatment and other interventions, generally by recommending that the family be involved in treatment (when strong family attachments and bonds or strong social support from family were chosen as protective factors). Of the 61 service memos that identified at least one protective factor, 40 (66 percent) considered the protective factor(s) in the recommendations for treatment. Consideration of protective factors in treatment recommendations has improved over time. In the service memos completed between October 2018 and May 2021 where protective factors were identified, 49 percent considered the protective factor(s) in the recommendations for treatment, whereas 91 percent of the service memos completed between June 2021 and August 22 that identified protective factors considered these protective factors in the recommendations for treatment (See Figure 2.9).

Also, when clinical coordinators concluded the child had no protective factors, they often indicated the child had strengths that could be leveraged to reduce problem behaviors.

Summary. Protective factors were mentioned in each of the service memos DSG reviewed. This fact is important, because it shows that the clinical coordinators pay attention to the role of protective factors, even if there are no protective factors present. In the 112 service memos completed between 2019 and mid-2022 that were reviewed to examine this metric, 54 percent identified at least one protective factor, while 46 percent identified no protective factors. Of the 61 service memos that identified at least one protective factor, two thirds considered the protective factor(s) in the recommendations for treatment. Consideration of protective factors in treatment recommendations has improved substantially over time. In the most recent service memos reviewed, 91 percent of the service memos that identified protective factors clearly considered them in the recommendations for treatment (see Figure 2.9).

In addition, it appears that the identified protective factors may contribute to decision-making. In the service memo placement opinion, clinical coordinators generally recommend either a REGIONS secure residential placement, a REGIONs staff-secure residential placement, or a non-REGIONS option (which may include staying at home with community-based services or receiving a residential placement unrelated to REGIONS, such as Intermediate Residential Placement [AMIR]). Youths without any identified protective factors were more likely to be recommended for a REGIONS placement than youths

35

with at least one protective factor (see Figure 2.8).

In the interim process evaluation report, DSG suggested that clinical coordinators may benefit from more training in considering protective factors when making treatment recommendations. For example, training in *developmentally positive relationships* and *youth development assets* (see https://www.search-institute.org/developmental-relationships/developmental-relationships-framework/) would strengthen clinical coordinators' ability to incorporate appropriate recommendations in the service memos concerning engagement strategies and access to services. We also recommended training for clinical coordinators on *differentiating between protective factors and strengths.* Much progress has been made since the interim process evaluation report. However, it may be helpful to keep these training topics in mind, especially for new clinical coordinators. Also, the audit forms should separate strengths from protective factors to ensure clinical coordinators incorporate this information correctly.

Figure 2.9. Extent to Which Protective Factors Are Considered in Treatment
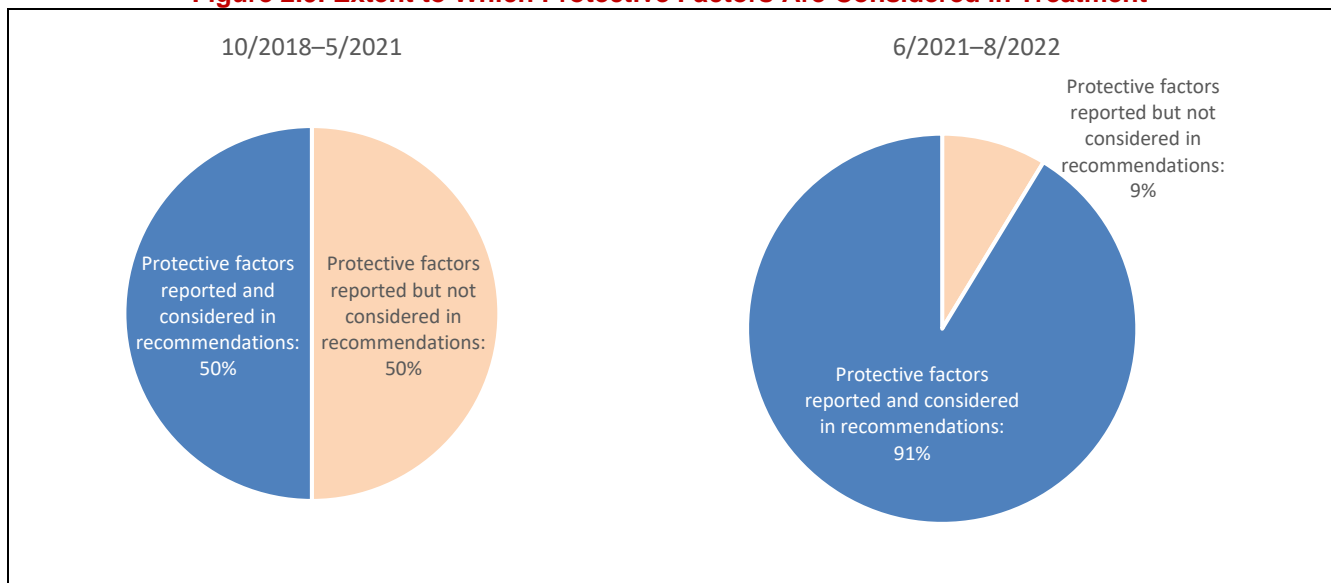
Data source: Service memo audit reports. *N* = 112 service memos.

20. Balance and/or Integration Between Addressing Risk Reduction Needs and Clinical Needs

Across the United States, juvenile courts have two important responsibilities: 1) promoting the positive development of youths who commit offenses, and 2) preventing future offending to ensure community safety (Mulvey and Iselin, 2008). Balancing these two demands requires court decision-makers to make difficult decisions about amenability to treatment and risk of reoffending (Mulvey and Iselin, 2008; National Research Council, 2013). Many jurisdictions use risk assessment instruments to guide these decisions (Viljoen et al., 2019). In Connecticut, Court decision-makers use tools such as SAVRY and PrediCT. We assessed this metric by analyzing information from interviews with court decision-makers and stakeholders.

Court Perspective. During interviews with judges, attorneys, and probation officers, we asked questions related to achieving the appropriate balance between addressing risk reduction and meeting clinical needs. Most interviewees felt that there was a good balance between these two needs. However, a couple of concerns emerged that should be considered.

First, prosecutors, judges, and probation officers expressed frustration that gun possession was not

36

considered a "violent" offense in the forensic formulation (as discussed in Metric 16). Also, some probation officers and prosecutors felt that the judges weighed the opinions of the clinical coordinators and their clinical needs more than community safety needs. One interviewee said:

> The CCs look only at things from a clinical perspective. Because they're clinicians and they have a big report, the CC recommendation holds more weight than the probation officer's opinion. We're looking at safety, and they're looking at the clinical side. Once it rises to the level of a REGIONS consult, we're to the point where we are extremely concerned about safety of community and for the kid. If we're requesting secure, it's not for nothing; it's because he's already done three probation placements.

Clinical Coordinator and Auditor Perspectives. When we discussed this topic with the clinical coordinators and auditors, the discussion focused more on the difference between the clinical coordinators' role currently, which includes addressing criminogenic needs, and their role in the past, which emphasized addressing other mental health needs. For example, one clinical coordinator made the following observation:

> When we were hired, we were to be the in-house mental health consultants to the Court…They wanted someone in-house who could do reports more immediately. And for many years, we really focused on the mental health needs of the children in our reports…At some point our reports started becoming more forensic in nature where we're taking the legal problems that were leading them into the Court much more in account.

Some clinical coordinators felt that focusing on forensic needs and having to write the placement opinion recommending either a secure or staff-secure facility were difficult tasks given their backgrounds and training, which concentrated more on addressing the youth's mental health in general. However, most interviewees felt that they were willing and able to make these recommendations, especially after the training, case consultations, and feedback they had received.

Summary. The Court Clinic appears to be doing a good job of gathering and presenting a range of relevant information to the judge for decision-making. Adding the RSTI(TA) assessment to the service memo enhances this information. However, across the Court system, there continues to be some disagreement or discomfort concerning how best to explicitly factor in public safety. A good example of this disagreement is the controversy about how to weight a gun charge. This controversy is driven partly by the nature of the tools clinical coordinators rely on, and partly by the pragmatic recognition that an adolescent armed with a handgun clearly represents a safety issue. In many ways, this debate illustrates the nature of the work: some professionals are more risk tolerant, and some are more risk averse, usually owing to differences in personality, training, and role in the Court system. In most cases, a full picture of the youth's risk reduction and clinical needs comes before the Court through the information the clinical coordinators and probation officers provide.

21. Extent to Which Trauma, Culture, and Gender Are Sufficiently Identified and Addressed in the Recommendations

Trauma, gender, and culture are regarded as responsivity characteristics in the correctional literature (Bonta and Andrews, 2007; Fritzon et al., 2021; Latessa, Listwan, and Koetzle, 2015; Taxman, 2014). These three concepts are inconsistently correlated with recidivism and therefore are considered non-criminogenic. Although trauma, gender, and culture are viewed as non-criminogenic factors, they are important issues that can interfere with the impact of treatment. For example, if high-risk youths have experienced trauma and only trauma is addressed, the youths are likely to recidivate because the criminogenic needs were not targeted for change. However, if trauma is ignored and only criminogenic needs are addressed, the youths still may re-offend because the effects of the trauma prevented them from receiving the full benefit of treatment (e.g., the youth may not participate in group treatment because they are experiencing trauma symptoms). To ensure that REGIONS interventions achieve

their full impact, programs should assess youths for responsivity issues related to trauma, culture, and gender and determine how these issues should be addressed.

We asked Court stakeholders and decision-makers, clinical coordinators, Court Clinic auditors, and residential treatment staff members for their perspective on the extent to which trauma, culture, and gender are identified and addressed in the service memo recommendations. One clinical coordinator commented that the main purpose of the service memos is to identify and propose how to address the risk factors, which do not necessarily include trauma, culture, and gender. This interviewee said:

> We're focusing on the risk factors. The impact of trauma is often a responsivity factor. Whatever symptoms they may incur from the trauma. It was a lot of focus nowadays on gender and different gender roles. Right now we're being told or asked to focus on what's really playing a role in the youth ending up in our system. And if that gender role is not playing a strong role, then we're not really focused on that very much. You're not going to see too much of that in our reports.

Interviewees felt that trauma was addressed well, especially given the relatively short amount of time a clinical coordinator spends meeting with the youth. Although culture was harder to define, they also felt that this element generally was addressed well. Gender was discussed less, and few negative comments were made in the service memos about how gender is addressed, aside from observations regarding the limited placements for girls. More information on these three topics (trauma, culture, and gender) is provided below.

21a. Extent to Which Trauma Is Sufficiently Identified and Addressed in the Recommendations
Court Clinic Auditor Perspective. The audit tool scores three factors related to traumatic event exposure and trauma reactions and how well they were presented in the "Relevant Information" section of the service memo. The three factors are: 1) history of physical abuse, sexual abuse, and/or neglect; 2) history of other traumatic events; and 3) history of trauma-related reaction. DSG reviewed two audit reports covering 2 years of audits. The first report summarized the audits of 11 service memos completed between Jan. 1, 2019, and May 31, 2021, and the second report summarized the audits of 14 service memos completed between June 1, 2021, and May 31, 2022. The audit review tool rates key elements of the service memo on a scale of 2 (adequate), 1 (partially adequate) or 0 (missing). Evaluation strengths were identified when the average score for an item was equal to or greater than 1.8. Evaluation weaknesses were identified when the average score for an item was equal to or lower than 1.0 (Kruh, Kemp, and Palmisano, 2021; Kruh, Kemp, and Palmisano, 2022).

For each of the three audit factors related to traumatic event exposure and trauma reactions, there was an observed improvement over time (see Figure 2.10). At the same time, the bulk of the comments were similar for both years. In both reports, the auditors indicated that the service memos addressed traumatic event exposure fairly consistently. However, the auditors expressed concern that although certain traumatic events were addressed in some sections of the service memo (e.g., bullying in the "School Section" or traumatic death of friends in the "Social Section"), there was a failure to follow up specifically on certain situations with elevated likelihood for trauma in the "Relevant Information" section (e.g., specifically asking about neglect if a caregiver has a substance abuse problem; specifically asking about exposure to witnessing violence when there is a history of family violence). Both reports included the following finding and recommendation:

> The youth's experiences of consequent traumatic reactions as sequelae were fairly consistently addressed. Given the high prevalence of trauma and trauma reactions in justice-involved youth and best practices in trauma-sensitive assessment, it is essential that consideration be given to the trauma reactions experienced in response to each traumatic event, to the extent that the information allows.

Also, in the summary conclusions of the report covering June 1, 2021–May 31, 2022, the auditors wrote:

Clinical coordinators were not always clear that all potentially traumatic experiences should be reported in the "Trauma History and Trauma Responses" section. Certain traumatic experiences tended to be reported in other sections, such as exposure to domestic violence being reported in the "Family History" section and bullying victimization being reported in the "Social History" section. These issues were discussed with the clinical coordinators at a feedback meeting earlier in the year and it was agreed that all potential traumas will be discussed in the Trauma section. It is also important to, as best as is possible given the frequency of polyvictimization with many youth, that the full array of trauma responses are asked about in reference to each trauma. In this way the full impact of trauma in the life of the youth can be effectively communicated to the Court.

Residential Treatment Staff Perspective. We asked 20 residential treatment staff members who noted that they routinely had access to the Court Clinic service memos to rate how well they thought trauma was identified and addressed in the service memo recommendations, on a scale of 1 to 10, with 1 indicating not sufficient at all and 10 being completely sufficient. The scores ranged from 5 to 10, the average score was 7.9, and the median score was 8, indicating that residential treatment staff felt that the service memos sufficiently identified and addressed trauma in the recommendations. Although some interviewees acknowledged that it was difficult to identify trauma in the service memo because the clinical coordinators only meet once or twice with the youths, most felt it was sufficiently addressed. One interviewee said: "Kids don't reveal a lot of trauma until they start [to] build alliances and reveal info while doing their work." Another interviewee said: "I believe they have a Trauma section in the service memos. So, it's pretty easy to find and get that information from there."

Figure 2.10. Service Memo Audit Scores Related to Trauma
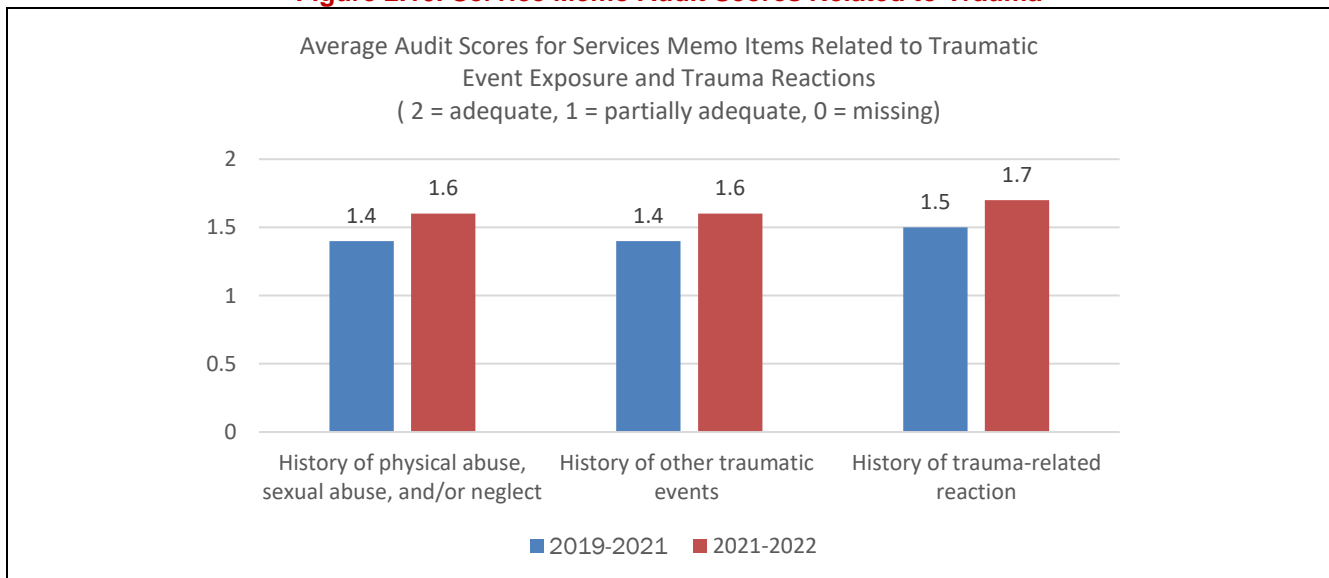
Average Audit Scores for Services Memo Items Related to Traumatic Event Exposure and Trauma Reactions
(2 = adequate, 1 = partially adequate, 0 = missing)

Data sources: Service memo audit reports; Kruh, Kemp, and Palmisano, 2021; Kruh, Kemp, and Palmisano, 2022. *N* = 25.

Review of Service Memos. For the interim process evaluation report, DSG reviewed a sample of service memos completed before May 31, 2021, and found the following: Clinical coordinators consistently reported and considered histories of exposures to adversities, although it was less apparent from the service memos whether or how these adversities resulted in posttraumatic disorders (e.g., PTSD) or maladaptive efforts to overcome trauma. This lack of information may be due to one or more of the following factors: 1) youths may be reluctant to identify post-adversity trauma symptoms or adaptations during interviews with clinical coordinators; 2) youths may lack insight at the time of the REGIONS evaluation into the ways they have been affected by exposure to adversities; and/or 3) Court clinicians may benefit from further training in how best to identify features that fall short of a PTSD

diagnosis but are consistent with a developmental trauma disorder.

21b. Extent to Which Culture Is Sufficiently Identified and Addressed in the Recommendations

Clinical Coordinator and Court Clinic Auditor Perspectives. Some clinical coordinators and auditors felt that the cultural element could be "more robust" and that more guidance should be provided on the kind of cultural information to include.

Court Perspective. Many interviewees felt that culture was sufficiently addressed in the service memo recommendations, but they often were unable to explain how or provide examples. The examples that were given related to parent discipline styles, family background, countries of origin, and cultural expectations.

Residential Treatment Staff Perspective. Most interviewees from residential programs did not have much to say about this metric. Thirteen residential treatment staff ranked (on a scale from 1 to 10) how well they felt culture was incorporated into the service memo recommendations. The scores ranged from 2 to 10, the average score was 6.9, and the median score was 7. Staff members who offered comments in addition to numeric ratings mentioned that ethnicity, race, and religion usually are noted and that sometimes family culture information (e.g., youth disciplined by belt) is included. Other interviewees said that the level of detail varies depending on the clinical coordinator writing the service memo.

21c. Extent to Which Gender Is Sufficiently Identified and Addressed in the Recommendations

Court Perspective. During interviews and focus groups, the topic of addressing gender in the service memo was not discussed a great deal. The only point made several times was that resources for girls were limited in the REGIONS programs. Journey House, Natchaug Hospital Limited-Secure REGIONS Treatment Program, is the only residential program for girls, and if a girl is not a good fit for that program, no other options are available. However, many comments about Journey House were quite positive.

Residential Treatment Perspective. Nine residential treatment staff rated (on a scale from 1 to 10) how well they felt gender was incorporated into the service memo recommendations. The scores ranged from 6 to 10, the average score was 8.2, and the median score was 7. However, given that most interviewees did not answer this question, the results are not necessarily meaningful. Most comments about gender related to serving transgender youths or not having multiple placement options for girls.

Summary. This metric examined the extent to which trauma, culture, and gender are sufficiently identified and addressed in service memo recommendations. Although trauma is included in the audit form, gender and culture are not. If identifying and addressing gender and culture is to be a focus of the service memo, clinical coordinators would benefit from more clarity and training on how they are expected to treat these two topics in the service memo. If addressing gender and culture is a priority of the Court Clinic, these two topics should also be included in the audit form.

22. Extent to Which Collateral Information Is Integrated Into the Formulation

JBCSSD Policy and Procedure 6.103 (Clinical and Educational Services, Referral Process for Forensic Clinical Assessment [Judicial]) states that the clinical coordinator reviews collateral information provided by Court parties and will determine if additional information is necessary. Also, JBCSSD Policy and Procedure 6.116 (Clinical and Educational Services Service Memorandum for Residential Placement) states that the Collateral Information section of the service memo should include a list of all the reviewed information, the specific type of information reviewed, the name(s) of the source(s), and the dates the information was requested and obtained. In addition, the clinical coordinator should note any missing information.

Court Perspective. Two main points about collateral information came up during the interviews with clinical coordinators and probation officers. First, interviewees felt that the collateral information most likely to delay the service memo process (or be omitted from the service memo) was related to education. Many agreed that obtaining records from schools in a timely fashion is often challenging and that some schools commonly do not respond at all to requests for education records (including special education records).

Second, there appeared to be some tension in particular Courts as to "whose job it is" to obtain the collateral information. A probation officer said:

> I think one of the things that some of us would probably like to see is the clinical coordinators to do more of the groundwork. I think that a lot of it is relied on probation to get records and get all this information and including school reports. I think we'd like to see that to be more comprehensive. There's reports sometimes that we get that there's no school contacted. And I think that in order to get a real comprehensive evaluation, you have to reach out to all the systems that are involved for any kid. And it's not typical of them to not contact the schools or just say that probation didn't give us the record…Everything on probation, probation has kind of felt like everything is kind of always dumped on us for as far as responsibilities go.

Another complaint from the probation officers was that the clinical coordinators did not view them as providers of legitimate information (this issue was also described briefly in [Metric 5](#)). When the clinical coordinators wanted information from existing but inaccessible documents, they would omit the information from the service memo, even if the information was well known and verifiable through probation officers or other sources. One probation officer said: "We do the best we can for the CCs to get everything they need. But if we can't get everything on paper, we can give them that information ourselves, but they often don't want to use that." The clinical coordinators' unwillingness to accept information from the probation officers (unless it is included in an official report) appears to exacerbate the probation officers' perception that their professional opinions are less valued now that the service memo is a part of the decision-making process.

Service Memo Audits. Auditors audited 11 service memos between Jan. 1, 2019, and May 31, 2021, and 14 service memos between June 1, 2021, and May 31, 2022. During both time periods, auditors measured whether four items related to collateral information were sufficiently addressed: 1) collateral sources are listed; 2) records are specified by type, name of source, and date; 3) interview contacts are specified by date and methods; and 4) missing resources are identified. During the 2022 audit, three additional items were added, for a total of seven items: 5) steps taken to access missing resources are identified, 6) quality of the data available of the evaluation is described, and 7) quality of the opinions based on the data is described.

In their reports, the auditors identified strengths as items with average scores equal to or greater than 1.8 and weaknesses as items with average scores equal to or lower than 1.0 (Kruh, Kemp, and Palmisano, 2021; Kruh, Kemp, and Palmisano, 2022). Each item related to collateral information was rated as a strength in the more recent report, and three of the four items in the earlier report were identified as strengths (see Figure 2.11). None of the items related to collateral information was identified as a weakness in either audit report. In the 2021–2022 audit report, there were perfect scores for listing collateral sources, identifying steps taken to access missing resources, and describing the quality of the data available for the evaluation. Identifying missing resources was the item that improved the most in the 2021–2022 report compared with the 2019–2021 report. Describing the quality of opinions based on the data was the item with the lowest rating. Overall, the auditors' findings and recommendations related to the documentation of collateral information were positive (see Table 2.3).

**Figure 2.11. Extent to Which Clinical Coordinators Met the Collateral Information
Requirement of the Service Memo, According to Audit Reports**
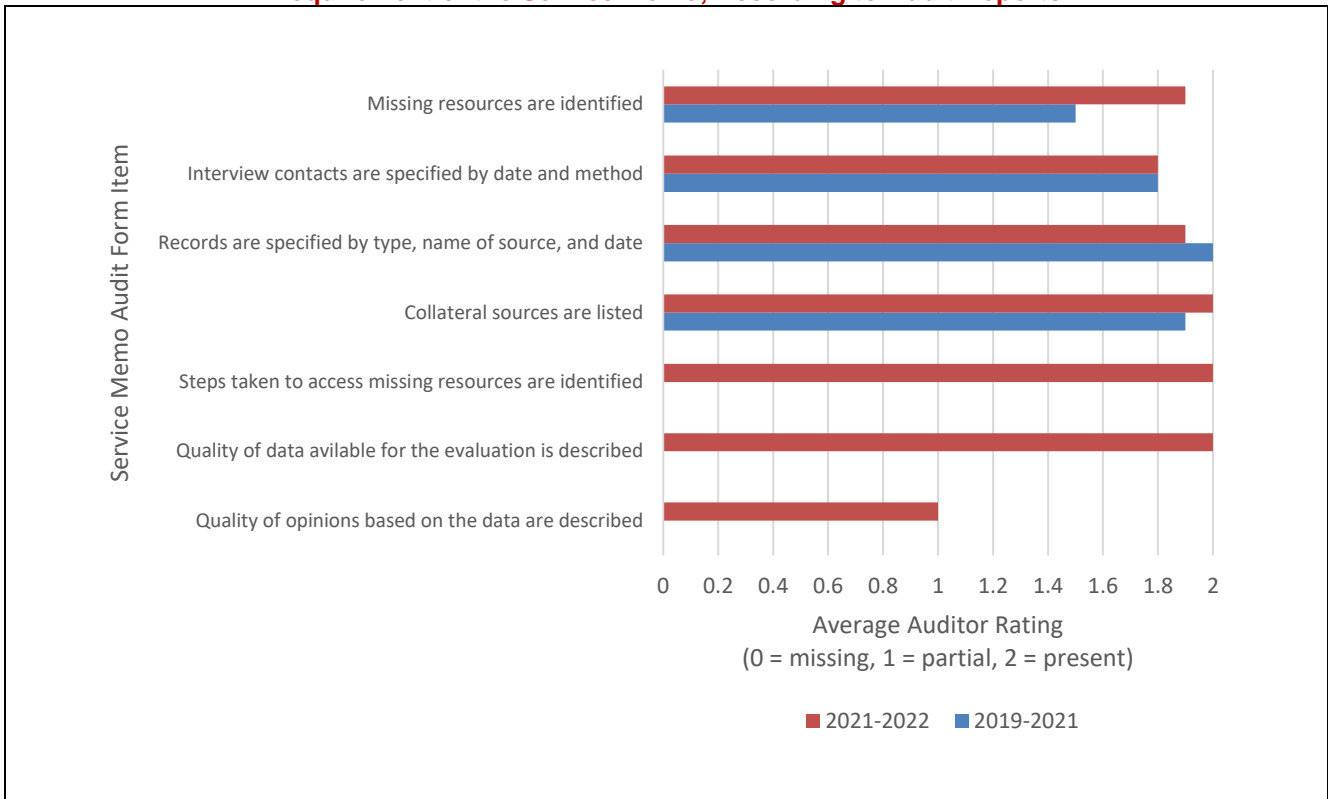
Data sources: Service memo audit reports; Kruh, Kemp, and Palmisano, 2021; Kruh, Kemp, and Palmisano, 2022. *N* = 25.

Analysis of Service Memos. DSG sampled half of the service memos (119 of the 241) to extract information related to collateral information.[7] Of the 119 reviewed service memos, 72 (61 percent) indicated that collateral information was missing, 34 (29 percent) stated that no collateral information was missing, and 13 (11 percent) did not mention whether anything was missing. None of the reviewed service memos had a blank Collateral Information section. As shown in Figure 2.12, treatment discharge summaries were the collateral information most frequently missing from service memos, followed by school records and DCF-related records. Most service memos with any collateral information had multiple categories of missing information.

One of the service memos, which was missing three pieces of collateral information (police reports, treatment summaries, and school records) stated:

> [The youth] has a significant history of therapeutic intervention dating back to 2008; collateral information from treatment providers was not available for review at the time of the assessment, resulting in missing data, hindering the ability to corroborate responses provided by all parties. There were also several police reports which were not available for review at the time of the evaluation; the information obtained outside of the provided reports were obtained through other collateral sources such as the pre-adjudicatory forensic clinical assessment. However, this writer is confident in identifying risk factors and vulnerabilities surrounding his involvement with the Court and its relation to future recidivism.

---

[7] We entered each of the service memo's file names into a database and chose every other one for the sample.

Table 2.3. Auditor Findings and Recommendations Related to Collateral Information in Service Memos

2019–2021	2021–2022
• "The listing of collateral sources was typically comprehensive and included all documents and sources that were reviewed for evaluation and report purposes. Records were consistently identified for name of source, date, and type." • "Interview contacts were typically specified by date and method. The method of collateral interviewing, especially of caregivers, at times needed further clarification (e.g., in-person; by phone; by teleconferencing)." • "Missing information sources were typically identified within the reports."	• "Necessary elements of documenting the collateral information used in the evaluation were consistently documented." • "Last year, collateral sources failed to appear in the list of collateral sources with some frequency, but that was not true this year. This reflects an improvement in practice." • "The last three items reflect several new requirements that were added this year. These were all addressed with consistency. The rapid adjustment to these new requirements is commendable."

The service memos that did not indicate whether collateral information was missing were all completed in 2019 and 2020. It was unclear from those service memos whether the clinical coordinator received all the requested information. The service memos completed in 2021 and 2022 all included two new sections about the status of collateral information:1) a section on "additional sources of information that were pursued for this evaluation but could not be accessed," which contained either a list of missing information or a brief statement indicating that no additional information was requested; and 2) a section on "steps taken to access the missing information." Below is an example of the new sections, taken from one of the service memos.

> **Additional sources of information that were pursued for this evaluation but could not be accessed included the following:** DCF family involvement records. Past hospitalization discharge summaries, current school records.

> **The steps taken to access this information included:** Sending/submitting Release of Information forms recent Hospitalization discharge Summaries (Solnit–South, Natchaug Hospital), recent school records (Brooklyn School System).

These additions to the service memo template make it easier to understand whether collateral information is missing.

Additionally, a new section was added to the service memo to describe the quality of the data informing the evaluation/opinion. Clinical coordinators provided varying levels of detail in these sections, either stating that the level of quality was reliable or describing the degree to which missing collateral information or potentially unreliable collateral information may affect the evaluation/opinion. Below are three examples.

> While the missing documents would have been helpful, this assessment is believed valid without them. It is believed that the information these historical documents might have provided would not have substantially impacted the recommendations.

> It was observed in both parent and youth interviews that the parties were open in providing information in regard to past and present matters. The child minimized his behavioral, mental health and legal history. The parent and the child presented as poor historians and were not corroborated by the collateral provided. The quality of data informing this evaluation and level of confidence in the opinions provided is assessed to be as reliable and adequate as can be provided at this time.

The child and her mother were both rather guarded and were not forthcoming in their interviews. They both minimized the child's negative behaviors and provided some responses that did not match their previous reports or differed from the report of others. As a result, this assessment relied heavily on collateral information. The quality and scope of all the considered information together is believed sufficient for valid assessment for the Court's purpose.

Figure 2.12. Service Memos With Missing Collateral Information
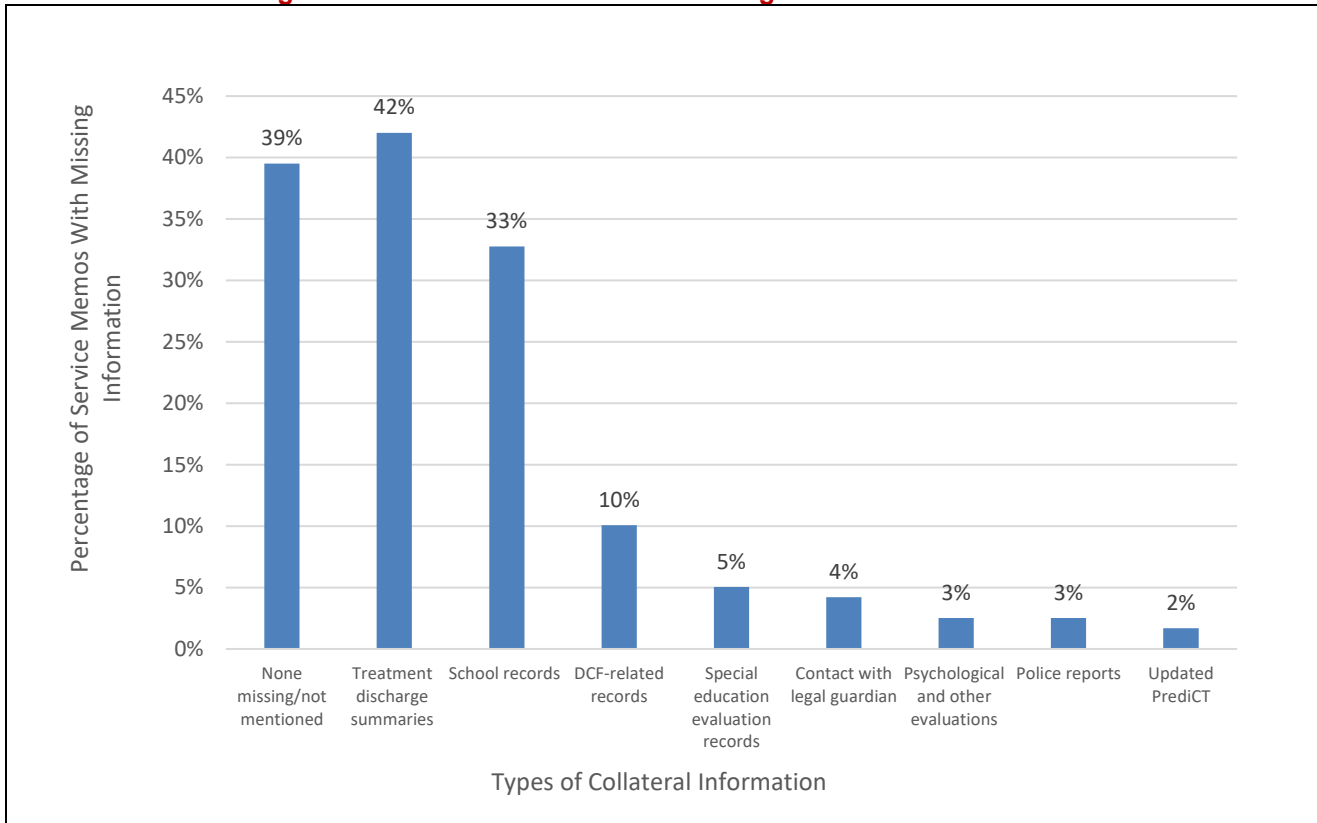
Data source: Service memo audit reports. *N* = 119.

Summary. There have been many improvements since the start of REGIONS in how the service memo captures and describes collateral information, including missing collateral information. The service memo audit process suggests that there has been improvement in identifying missing sources. Also, the usefulness of the service memo has been strengthened by the addition of three new sections for information related to collateral information: 1) additional sources of information that were pursued for this evaluation but could not be accessed; 2) steps taken to access this information; and 3) quality of the data informing the evaluation/opinions.

However, during interviews, there was a sense that the process of obtaining collateral information was unclear to some of the probation officers. This lack of clarity about who is responsible for obtaining missing collateral information has created tension in some Courts. Also, although the Court Clinic administrators shared that juvenile probation case notes are used as collateral information, interviewees disagreed about whether the clinical coordinators should accept information from the probation officers as credible when it is not documented in official records. Generally, it is a characteristic feature of forensic practice to develop comprehensive evaluation reports based on multiple sources. Probation officers are among the most common sources in juvenile forensic evaluations. Collaterals such as attorneys, probation officers, school staff, and others frequently offer information combined with their

44

own opinions about what that information means. Collateral information may come in the form of written documents but also may include trustworthy oral reports. Information that is relevant to the clinical coordinators' assessments, such as observations and background, may be very useful to the Court clinicians, although collaterals' opinions may not be particularly helpful.

Clinical coordinators conduct training sessions about the Juvenile Court Clinic for incoming juvenile probation officer classes/new hires. One of the session topics relates to partnerships between clinical coordinators and probation officers regarding collateral information. As this evaluation was being conducted, the training was updated to include documents for probation officers called "Forensic Clinical Assessment Checklist" and "Regions Consult Collateral Checklist," which explain the specific documentation required and additional collateral to further support the court-ordered assessment (e.g., individual education plans; behavioral, psychological, cognitive/intelligence, and other evaluations; intake/discharges summaries, treatment plans/updates, risk assessments; records from the Department of Children and Families). These approaches likely have resolved much of the lack of clarity in collecting collateral information mentioned by interviewees and discussed above.

23. Occurrences and Frequency of Placement Opinions Citing a History of Violence, Future Violence Risk, AWOL Risk, Prior Treatment Response, and Current Treatment Amenability for or Against a Probation With Placement Recommendation

To assess this metric, DSG staff reviewed service memos completed between January 1, 2019, and September 30, 2022. As discussed under Metric 18, DSG research staff reviewed each of the 223 service memos for youths with new adjudications for probation with placement (PWP).[8] The service memos consistently include references to the five factors, which are used to determine a youth's placement's level of security. The five factors are: 1) history of violence, 2) risk of violence, 3) AWOL risk, 4) prior treatment, and 5) current amenability to treatment. The newer service memos also provided more specificity about how and why each category was a risk and specifically how it affected the placement determination for the juvenile.

File Review. To assess Metric 23, four researchers reviewed and extracted information from each of the 223 service memos completed between January 1, 2019, and September 30, 2022. For each of the service memos, researchers indicated whether each of the five factors was used to support a disposition of PWP, was not used to support PWP (i.e., against probation with placement), or whether the information was unclear.

We received the service memos in two batches. The first batch included reports completed between January 1, 2019, and June 15, 2021. The second batch was completed between June 16, 2021, and September 30, 2022. There was an improvement in the level of detail provided from the first batch to the second batch. The service memos in the second batch were more likely to include an overall rating of "low," "moderate," or "high" when describing the risk related to each of the five factors. In comparison, the 2019-2020 service memos were not as detailed. They included some information in each category but not as much specific reasoning for how the risk ratings affected placement for the juveniles. This made that data more subjective and so more challenging to consistently analyze and compare all the service memos for placement.

---

[8] We excluded three service memos because they were either follow-up reports or reports for youths who had not been adjudicated yet.

Figure 2.13. Percentage of Placement Opinions Citing Each of the Five Factors for or Against Probation With Placement: All Service Memos, Jan. 1, 2019–Sept. 3, 2022
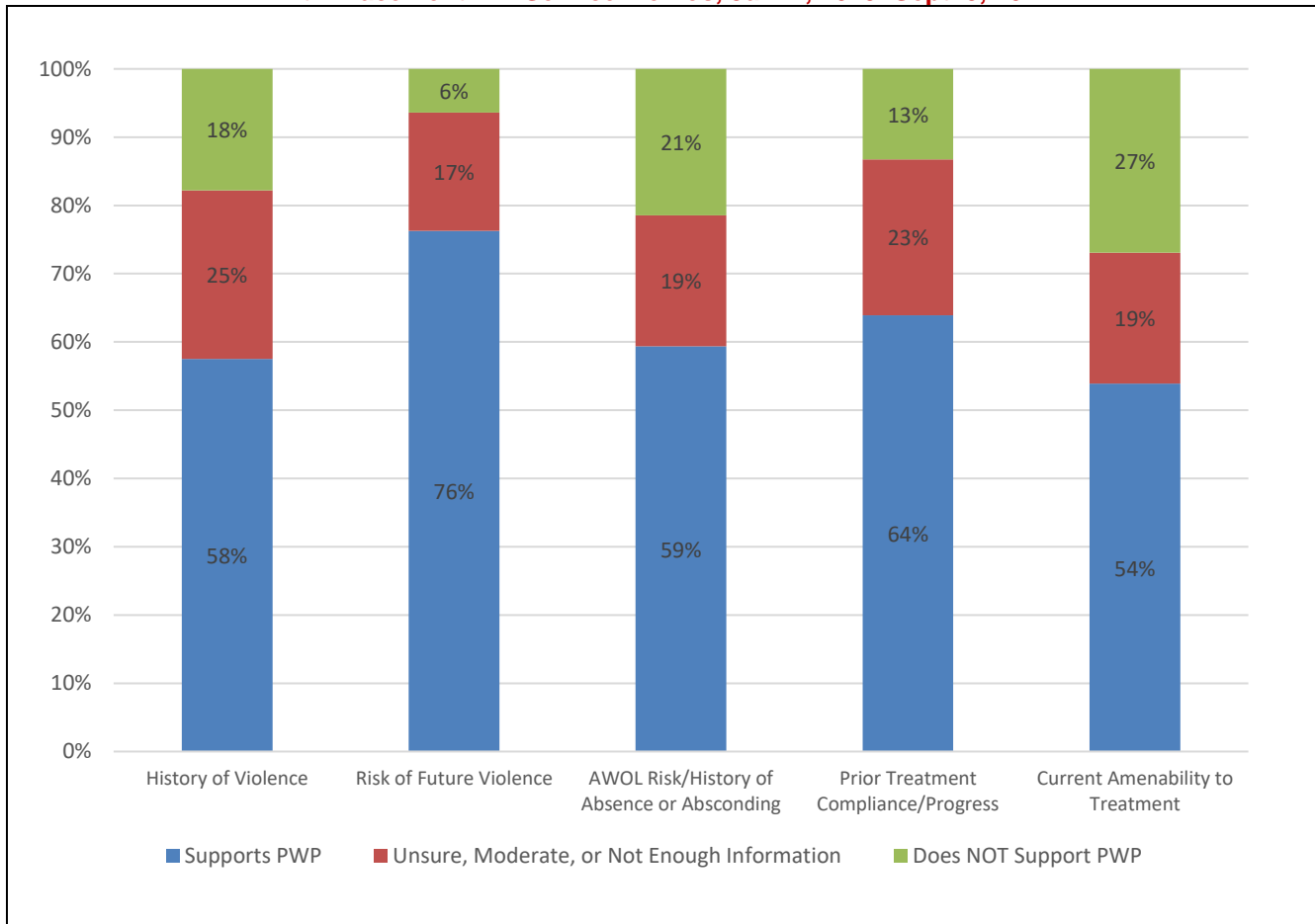
Data source: Service memo audit reports. *N* = 223.

Among all of the service memos (which include those recommending secure placement, those recommending staff-secure placement, and those recommending a non-REGIONS placement), risk of future violence was the factor that was most likely to be cited as a factor for recommendation of PWP (in 76 percent of the cases) [see Figure 2.13]. Current amenability to treatment was the least likely to be cited as a factor for recommendation of PWP. Among the youth recommended for secure placement, each of the factors was identified as a factor for probation with placement three quarters of the time or more. For example, in 85 percent of the service memos completed for youth who were recommended for PWP, AWOL risk was identified as a factor justifying this recommendation (compared to 59 percent in the overall sample).

Youths who were recommended for secure REGIONS placement, staff-secure REGIONS placement, and non-REGIONS placement (community-based services or residential programs) differed in the number of factors that were cited supporting PWP. The youths recommended for REGIONS secure placement had an average of 4.2 factors cited supporting PWP. Youths recommended for REGIONS staff-secure placement had an average of 2.4 factors cited supporting PWP. Youths who were not recommended for PWP had an average of 1.4 factors cited.

Summary. The five factors that are assessed to determine whether a youth is appropriate for probation with placement are: 1) history of violence, 2) risk of future violence, 3) AWOL risk, 4) prior treatment compliance/progress, and 5) current amenability to treatment in the placement opinion. Each of the five

factors was used to justify a recommendation for probation with placement at least half of the time in the service memos that were completed from January 1, 2019, through September 30, 2022. The factor most cited for PWP was risk of future violence, and the factor least frequently cited as a reason for PWP was current amenability to treatment. Finally, there was an improvement in the level of detail provided related to the five factors in the service memos over time.

24. Occurrences and Frequency of Noting Strengths and an Explanation of How To Leverage Strengths in the Report Toward Behavior Change

As mentioned above, JBCSSD Policy and Procedure 6.116 (Clinical and Educational Services, Service Memorandum for Residential Placement) requires that the service memo include a subsection on strengths in the Findings and Recommendations section, specifically covering "relevant strengths/protective factors" and "how and why strengths/protective factors can be leveraged to reduce problem behavior."[9] In this section, we present findings from our review of the service memos as well as findings from the auditors related to the occurrences and frequency of noting strengths and explaining how to leverage strengths toward behavior change. Assessment of protective factors and assessment of strengths and protective factors taken together are described in Metric 19.

File Review. DSG sampled 113 service memos completed between October 2019 and August 2022, to extract information about the youths' strengths. This sample represents about half of the REGIONS service memos completed during that time. In each of the 113 service memos, DSG rated the occurrences and frequency of noting strengths and whether a specific explanation was provided of how to leverage strengths in the report toward behavior change (see Table 2.4). Suggestions for how to leverage the noted strengths were included in the Recommendations section of the service memo or in the Strengths subsection.

Table 2.4. Identification of Strengths in Service Memos

Level of Identifying and Leveraging Strengths	No. of Service Memos	%
0. Does not indicate any strengths in the service memo	0	0%
1. Notes strengths but provides no ideas for how to leverage them	18	16%
2. Notes strengths and vaguely alludes to how they may be helpful for behavior change	36	32%
3. Notes strengths and specific ways to leverage them for behavior change, including specific strategies	59	52%
Total	**113**	**100%**

Every reviewed service memo included at least some information about the youth's strengths, and 84 percent mentioned how these strengths could be leveraged toward behavior change. Among the 16 percent of service memos that did not provide ideas for how to leverage identified strengths, one reason may be that it can be difficult to provide reasonable ideas for leveraging certain strengths (e.g., "Youth is likeable." "Youth is kind, sensitive, and empathetic."). However, in other service memos, strengths were identified that could clearly be used to leverage behavior change (e.g., "Multiple interests are reported, including volleyball, skateboarding, and drawing. These activities can be leveraged to build rapport and engage her in treatment."), but no explanation was given for how these strengths could be leveraged.

---

[9] These two requirements are from the audit form.

Figure 2.14. Identification of Strengths in Service Memos: Changes Over Time
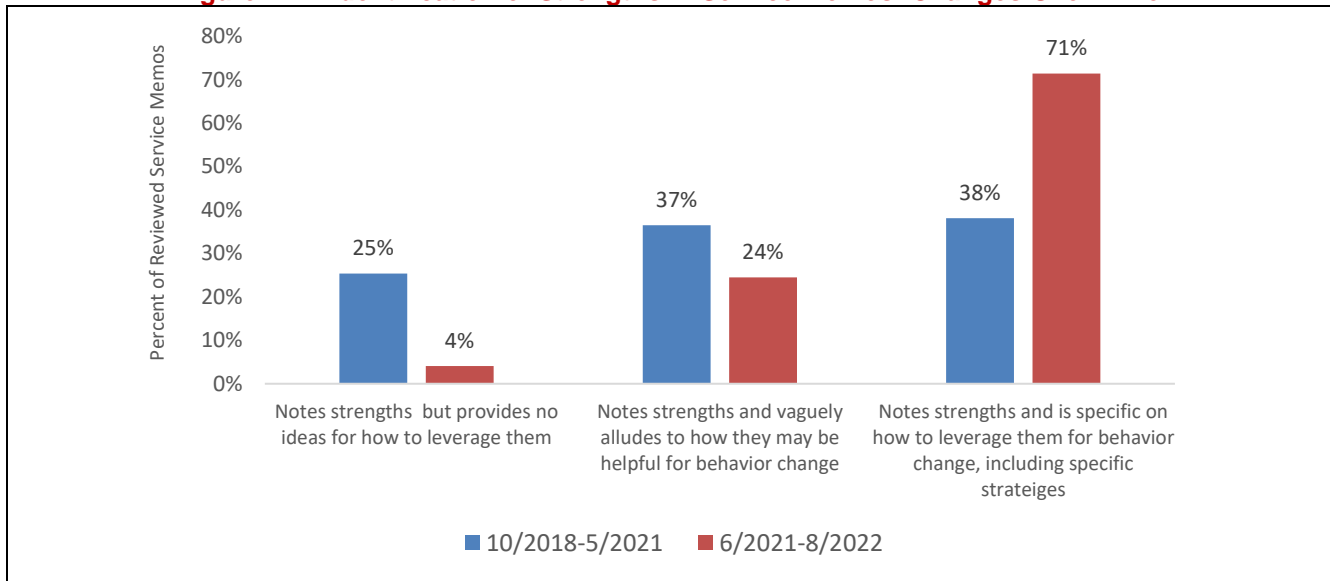
Data source: Service memo audit reports. *N* = 113.

There was improvement over time in how well the service memo explained how to leverage noted strengths (see Figure 2.14). Among the service memos completed in May 2021 and earlier, 38 percent noted strengths and included specific ways of leveraging them for behavior change. Among the service memos completed between June 2021 and August 2022, 71 percent successfully incorporated this information.

Auditor Perspective. DSG reviewed two audit reports: one report covering 2020–2021 (Kruh, Kemp, and Palmisano, 2021) and one covering 2021–2022 (Kruh, Kemp, and Palmisano, 2022). The audit reports provided relevant, actionable, and helpful suggestions for improving answers to the question of how the strengths/protective factors can be leveraged to reduce problem behavior and why this leveraging will benefit the youth. DSG agrees with the conclusion made in *Clinical Coordinator REGIONS Evaluation Reports: Continuous Quality Improvement Audits Final Report—2020–2021* (Kruh, Kemp, and Palmisano, 2021), which stated:

> Reports sometimes fail to make explicit when strengths can be capitalized through a given intervention. For example, if a youth has a love for art which is identified as a strength and a recommendation includes increased involvement in prosocial activities, the recommendation should specify that art activities could be a particularly effective type of intervention.

Like DSG, the auditors found that the service memos did a better job at considering strengths in recommendations for treatment in the newer service memos, compared with the ones completed before May 2021. In the audit report covering 2021–2022, the auditors rated "How and why strengths/protective factors can be leveraged to reduce problem behavior" as 1.8 out of 2.0, compared with the 2020–2021 audits, which were rated 1.2 out of 2.0. The auditors wrote:

> The reports fairly consistently identify key strengths exhibited by the youth that can be leveraged in the services they receive.

> Importantly, the relevance of how each strength can be leveraged to the overall risk/needs assessment was explained consistently.

Summary. Every one of the service memos we reviewed included at least one strength. And over time, service memos improved in their explanations of how to leverage strengths toward behavior change. This improvement is to be commended. We agree with the recommendation made in the 2020–2021 audit report that a sentence drawing attention to leveraging strengths be included before the Recommendations section. The auditors recommended adding a statement such as the following: "The following strengths of the youth will be leveraged in the recommendations below: _____." *On July 27, 2023, this boilerplate language was added to REGIONS service memo templates.* Also, we recommend exploring whether it would make sense to separate the review of strengths and the review of protective factors throughout the audit tool.

25. Determine if There Is a Discernible Pattern of Clinical and Behavioral Needs for Children Recommended for Placement Versus Those Not Recommended for Placement

To assess this metric, we reviewed and extracted information from service memos and used both descriptive and inferential statistics.[10] The outcome we analyzed was the Court Clinic's recommendation. That recommendation may differ from the ultimate placement, which is decided by the Juvenile Court judge.

File Review and Inferential Statistical Analysis. DSG researchers reviewed and extracted information from 230 service memos of youths interviewed from late 2018 through December 2022. These interviews were conducted by 17 clinical coordinators from 11 Courts. Descriptive statistics (means, standard deviations, proportions) on demographic variables, SAVRY future risk of violence, SAVRY protective factors, and PrediCT risk domains were obtained for the sample as a whole and separately for youth recommended for placement and those who were not recommended for placement. Two-sample *t*-tests with equal variances were conducted to determine whether there were statistically significant differences between the two groups. We used logistic regression analyses to assess the impact of 1) risk assessments, 2) protective factors, and 3) PrediCT risk domains on the odds of being recommended for REGIONS. To account for covariates, we also included offense type and demographic measures in the analyses. Listwise deletion resulted in the removal of 31 to 42 percent of cases (or 72 to 98 observations) due to missingness of key variables.

The two most consistent predictors of a REGIONS placement recommendation were: 1) PrediCT classification and 2) crime against another person. Demographic characteristics, the SAVRY violence risk assessment rating, protective factors, and specific PrediCT domains had very little to no impact on the odds of being recommended for REGIONS. The lack of significance of demographic characteristics indicated that placement was fairly determined in terms of gender, age, and race/ethnicity.

We found that children recommended for placement presented with a discernable pattern of clinical and behavioral needs compared with those not recommended for placement. Children recommended for placement were more likely to score Tier IV or V on the PrediCT classification and more likely to have committed a crime against another person. However, one limitation of the logistic regression analyses is the possibility of bias due to missing data on key variables, so these findings should be considered preliminary. (For more information on these analyses, see Appendix C.)

Summary. Because research has consistently demonstrated support for the risk principle (see, for example, Lipsey, 1999a; Lowenkamp and Latessa, 2004; Lowenkamp, Latessa, and Smith, 2006), REGIONS should ensure that youths admitted to a REGIONS residential program are high to moderate risk on the PrediCT or SAVRY. Although the SAVRY is a valid tool, it focuses on violence, whereas the

---

[10] Inferential statistics is a branch of statistics that allows us to make inferences about population data based on sample data. Descriptive statistics is a different branch of statistics that enables us to summarize the features of the data set. Most of the quantitative analyses, charts, and tables in this process evaluation report use descriptive statistics. However, for Metric 25, we used inferential statistics, which helped us draw conclusions about the population.

PrediCT focuses on general criminality. If REGIONS is targeting those at high risk for future violence, the admit decision should be based on the SAVRY results. If the REGIONS program wishes to target those at high risk of reoffending in any form, the admit decision should be based on the PrediCT results.

Overall, analysis of Metric 25 demonstrated that youths recommended for REGIONS might benefit from programs and services addressing the clinical and behavioral needs that distinguish them from youths not recommended for REGIONS, such as those that are used to develop the PrediCT classification. The SAVRY risk assessment and protective factors were expected to play a significant role in the placement recommendation. DSG recommends that REGIONS continues to actively incorporate SAVRY results regarding risk for future violence and general delinquency in decision-making about placement recommendations.

Finally, although clinical and behavioral needs were considered in ratings provided by the SAVRY risk of future violence and general delinquency risk assessment, assessing the individual impact of these needs may provide a more nuanced understanding of the differences between youths recommended for placement and those who are not. Gaining this deeper understanding is essential for those seeking to identify the services that would benefit youths in either condition.

26. Extent to Which the PrediCT, Service Memorandum and the REGIONS Integrated Treatment Plan Match in Identifying the Critical Static and Dynamic Risk, Protective, and Resilience Factors

To assess this metric, DSG extracted data from youth files and analyzed the extent to which the assessments match one another in identifying risk, protective, and resilience factors. Files were from a sample of 40 youths who were selected using random stratified sampling (for more information on our approach, see Appendix A). We examined items from the PrediCT, SAVRY, START:AV, and the initial ITP.

The PrediCT is JBCSSD's risk assessment tool. Completed by the probation officer when the youth becomes Court involved, the PrediCT consists of 44 items indicating criminal risk classification, risk for recidivism, treatment guidelines, and prognosis. The SAVRY is completed by the clinical coordinator after a judge decides the youth should be considered for REGIONS; it assesses the youth's risk for future violence and identifies the areas of need interventions should target to manage that risk. The START:AV is completed by the clinician at the residential program within 5 days of admission and establishes an individual's level of risk for adverse outcomes such as violence or victimization. We coded the START:AV since it was used to inform other parts of the ITP, and we coded any narrative from the ITP related to each of the different risk and protective factor categories.

File Review. We examined the files for a sample of about 40 REGIONS adolescents, coding each individual's service memo, PrediCT tool, START:AV risk assessment guide, and first REGIONS ITP to assess the extent to which they match with respect to identifying the critical static and dynamic risk, protective, and resilience factors. DSG developed a tool in Microsoft Excel to extract data systematically from the youth files. Items in each assessment were categorized into broad domains (e.g., Disruptive Behavior Factors, Antisocial Attitudes and Beliefs, Substance Use Problems, Anger Management, Antisocial Associates/Peers). Although not all the assessments contain items that fit in every domain, all assessed similar areas. For example, Anger Management issues are assessed by the PrediCT and the SAVRY and are mentioned in the ITP for many youths. Table 2.5 organizes the items in each assessment under the appropriate broad domain. Some items are included in multiple domains, as appropriate.

Figure 2.15 and Figure 2.16 present the number of high, medium, and low matches among the assessments for each vulnerability or risk factor (Figure 2.15) and each strength or protective factor (Figure 2.16).

Table 2.5. Items Assessing Each Risk, Protective, and Resilience Factor

Vulnerabilities, Risk Factors, Strengths, Protective Factors, and Resilience Factors	PrediCT	Service Memo (SAVRY)	START:AV*
Disruptive Behavior Factors, Oppositional, Impulsive	Impulsiveness Excitement Seeking Dishonesty Defiance towards Rules and Authority Inadequate Coping Skills	Risk Taking/Impulsivity Stress and Poor Coping	Vulnerabilities: Impulse Control Conduct Rule Adherence Coping
Anger Management	Externalizing Anger Problems Anger and Vengeance Conflicts with Teachers and School Staff Conflicts with Peers Family Conflict History of Aggression and Violence	Anger Management Problems Early Initiation of Violence History of Violence	
Delinquent/Antisocial Associates or Peer Relationships	Presence of Prosocial Close Friends Conflicts with Peers Presence of Antisocial Close Friends Influence of Antisocial Peers Socially Motivated Antisocial Behavior Obstacles to Developing Prosocial Close Friends	Peer Delinquency Peer Rejection	Vulnerabilities: Relationships – Peers Social Support – Peers Peers
Antisocial Attitudes and Beliefs	Callousness – Empathy Callousness – Remorse	Negative Attitudes About Crime and Violence Low Empathy/Remorse Support	Vulnerabilities: Attitudes Plans
Substance Use Problems	Alcohol Marijuana Other Drugs Physical Effects of AOD Use and Interference with Functioning AOD as a Cause of Illegal Behavior	Substance Use Difficulties	Risk of Substance Abuse as an Adverse Outcome Substance Use Vulnerability
Family Dysfunction, Problematic Parenting and Family Relationships	Parent/Caregiver Problems Problems with Siblings or Other Family Members in the Home Insufficient Parent Supervision/Monitoring Insufficient Parent Authority/Control Parent/Caregiver Disruption	Parental/Caregiver Criminality Poor Parental Management Early Caregiver Disruption Exposure to Violence in the Home	Vulnerabilities: Relationships – Caregivers/Adults Parenting Parental Functioning

	Family Conflict		
Education and Employment Difficulties	Interest and Perceived Value in Education Academic Achievement School Attendance and Unexcused Absences Suspensions and Expulsions Extracurricular School-Based Activities Conflicts with Teachers and School Staff	Low Interest/Commitment to School Poor School Achievement	School and Work Vulnerability Risk of Unauthorized Absence as an Adverse Outcome
Lack of Personal/Social Support		Lack of Personal/Social Support	Social Support – Adults Vulnerability
Individual Strengths		Resilient Personality Traits Positive Attitude Toward Intervention and Authority	Strengths: Rule Adherence Conduct Coping Impulse Control Mental/Cognitive State Emotional State Attitudes Insight Plans
Family Strengths		Strong Social Support from Family Strong Attachments and Bonds with Family	Strengths: Relationships – Caregivers/Adults Parenting Parental Functioning
Peer Strengths	Presence of Prosocial Close Friends	Prosocial Involvement Strong Social Support from Peers Strong Attachments and Bonds with Peers	Strengths: Relationships – Peers Social Support – Peers Peers

* Items on the START:AV are listed as strengths or vulnerabilities.

DISRUPTIVE BEHAVIOR. This category is assessed by five items in the PrediCT: impulsiveness, excitement seeking, dishonesty, defiance towards rules and authority, and inadequate coping skills. It is assessed by two items in the SAVRY: risk taking/impulsivity and stress and poor coping. It also is assessed by four vulnerabilities in the START:AV: impulse control, conduct, rule adherence, and coping. A total of 37 records had disruptive behavior ratings from at least two assessments. Of these, 23 (62.2 percent) were coded as high matches, 11 (29.7 percent) were coded as medium matches, and 3 (8.1 percent) were coded as low matches. Of the three records with a low match of risk for disruptive behavior, the PrediCT tended to have lower ratings than the other assessments, particularly with regard to coping and impulsivity.

ANGER MANAGEMENT. This category is assessed by six items in the PrediCT and three items in the SAVRY. The items in the PrediCT are externalizing anger problems, anger and vengeance, conflicts with teachers and school staff, conflicts with peers, family conflict, and history of aggression and violence. The items in the SAVRY are anger management problems, early initiation of violence, and history of violence. This risk factor had one of the lowest percentages of high matches among the

assessments. Of the 37 records coded, only slightly more than half had high matches (20 records or 54.1 percent); 9 (24.3 percent) had medium matches; and 3 (8.1 percent) had low matches. Five records (13.5 percent) did not have enough information for us to make a determination. The three records with low matches indicated very low risk for anger management problems according to the PrediCT but very high risk according to the SAVRY. For example, one youth's SAVRY ratings indicated high risk for anger management problems and having a history of violence. In contrast, this youth was rated using the PrediCT as having low risk in terms of conflicts with peers and history of aggression and violence, and no risk on all other items in this category. Another youth's ITP identified physical and verbal aggression toward others and a history of physical violence as risk factors, but the youth was rated by the PrediCT as having low risk for externalizing anger problems and conflicts with family and peers, and no risk on the remaining items.

DELINQUENT/ANTISOCIAL ASSOCIATES OR PEER RELATIONSHIPS. This category is assessed by six items in the PrediCT: presence of prosocial friends, conflicts with peers, presence of antisocial close friends, influence of antisocial peers, socially motivated antisocial behavior, and obstacles to developing prosocial close friends. It is assessed by two items in the SAVRY: peer delinquency and peer rejection. The START:AV includes three items regarding delinquent or antisocial peers: vulnerability with respect to peer relationships, peer social support, and a negative peer network. A total of 37 records had ratings on delinquent or antisocial peers from at least two assessments. This risk area had the highest percentage of high matches of all of the risk and protective factors. Of the 37 records coded, 32 (86.5 percent) were coded as high matches, 4 (10.8 percent) were coded as medium matches, and there were no low matches. One file (2.7 percent) did not have enough information for us to make a determination.

ANTISOCIAL ATTITUDES AND BELIEFS. This category is assessed by two items from each of the three assessment tools. The items in the PrediCT are callousness–empathy and callousness–remorse. The items in the SAVRY are negative attitudes about crime and violence and low empathy/remorse support. The items in the START:AV are vulnerabilities with regard to attitudes and plans. Of 36 records coded, 24 (64.9 percent) had high matches in this risk factor among the assessments, 11 (29.7 percent) had medium matches, and 1 (2.7 percent) had a low match. One record (2.7 percent) did not include enough information to make a determination. The youth with a low match among the assessment tools was rated as high risk for negative attitudes by the SAVRY but low risk for negative attitudes by the START:AV.

SUBSTANCE USE PROBLEMS. This category is assessed in the PrediCT by five items: alcohol use, marijuana use, other drug use, physical effects of AOD use and interference with functioning, and AOD as a cause of illegal behavior. The SAVRY includes a rating for substance use difficulties. The START:AV includes two items for substance use problems: vulnerabilities regarding substance use and risk of substance abuse as an adverse outcome. A total of 37 records had ratings on substance use problems from at least two assessments. Of these, 26 (70.3 percent) were coded as high matches, 7 (18.9 percent) were coded as medium matches, and 3 (8.1 percent) were coded as low matches. One file (2.7 percent) did not have enough information for us to make a determination. There were no discernible patterns for the three records rated as low matches. Two records indicated a high risk for marijuana use according to the PrediCT but a low to moderate risk according to the SAVRY and START:AV. The third record with a low match indicated that there was no risk for substance use problems according to the PrediCT and SAVRY but a high risk according to the START:AV.

Figure 2.15. Level of Matching Among Tools Assessing Each Risk Factor and Vulnerability
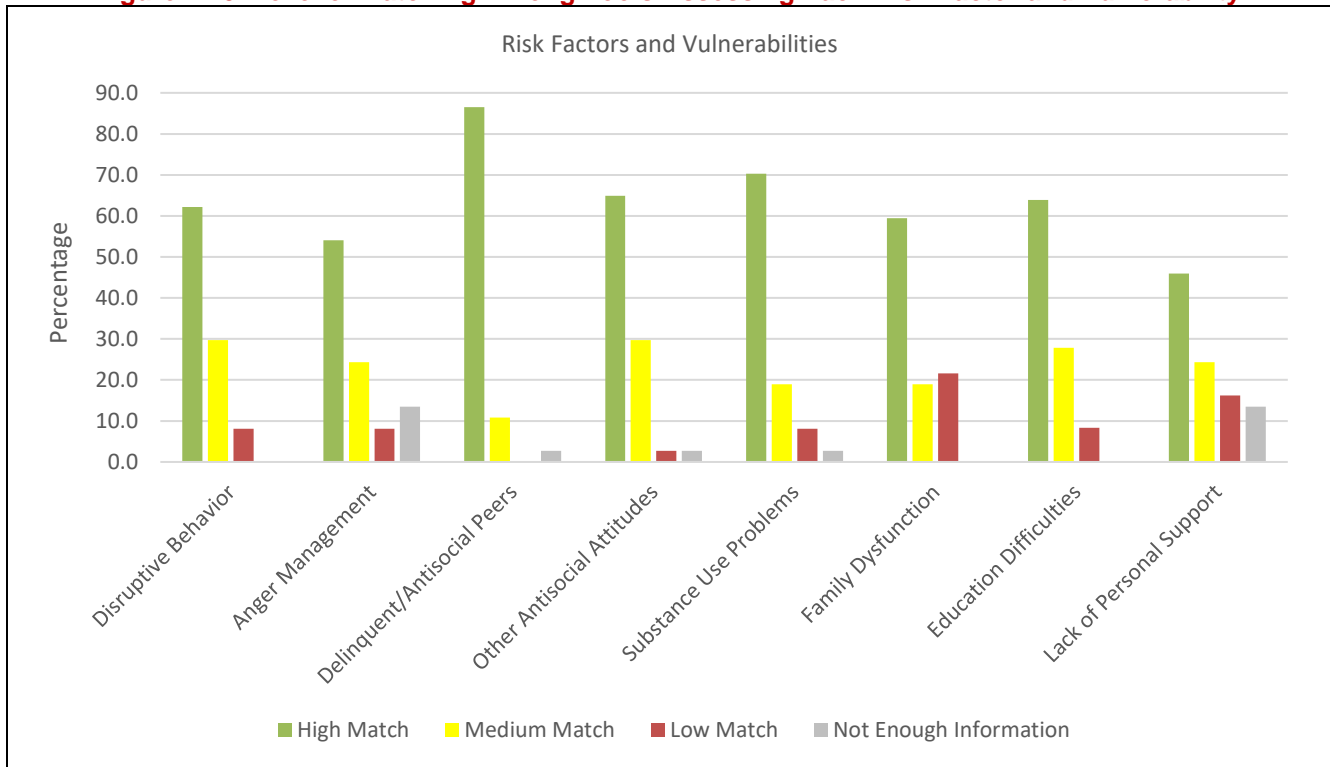
Data source: Youth files (service memos, PrediCT, START:AV, ITP). *N* = 40.

FAMILY DYSFUNCTION, PROBLEMATIC PARENTING, AND FAMILY RELATIONSHIPS. This category is assessed by six items in the PrediCT: parent/caregiver problems, problems with siblings or other family members in the home, insufficient parent supervision/monitoring, insufficient parent authority/control, parent/caregiver disruption, and family conflict. The SAVRY includes four items: parental/caregiver criminality, poor parental management, early caregiver disruption, and exposure to violence in the home. The START:AV assesses three vulnerability areas: relationships with caregivers/adults, parenting, and parental functioning. A total of 37 records had ratings related to family dysfunction from at least two assessments. Of these, 22 (59.5 percent) were coded as high matches, 7 (18.9 percent) were coded as medium matches, and 8 (21.6 percent) were coded as low matches. This risk factor had the highest percentage of low matches. Although there was no definite pattern among the eight files with low matches, the PrediCT tended to have lower family dysfunction ratings and the SAVRY tended to have more moderate-to-high family dysfunction ratings.

EDUCATION DIFFICULTIES. This risk factor is assessed by six items in the PrediCT: interest and perceived value in education, academic achievement, school attendance and unexcused absences, suspensions and expulsions, extracurricular school-based activities, and conflicts with teachers and school staff. The SAVRY includes two items: low interest/commitment to school and poor school achievement. The START:AV also assesses two items: school and work vulnerability, and risk of unauthorized absence as an adverse outcome. A total of 36 records had ratings related to difficulties in education. Of these, 23 (63.9 percent) were coded as high matches, 10 (27.8 percent) were coded as medium matches, and 3 (8.3 percent) were coded as low matches. In all three cases with low matches across the assessments, the youths were rated as having lower risk according to the PrediCT than the other assessments, particularly with regard to academic achievement.

Figure 2.16. Level of Matching Among Tools Assessing Each Protective Factor and Strength
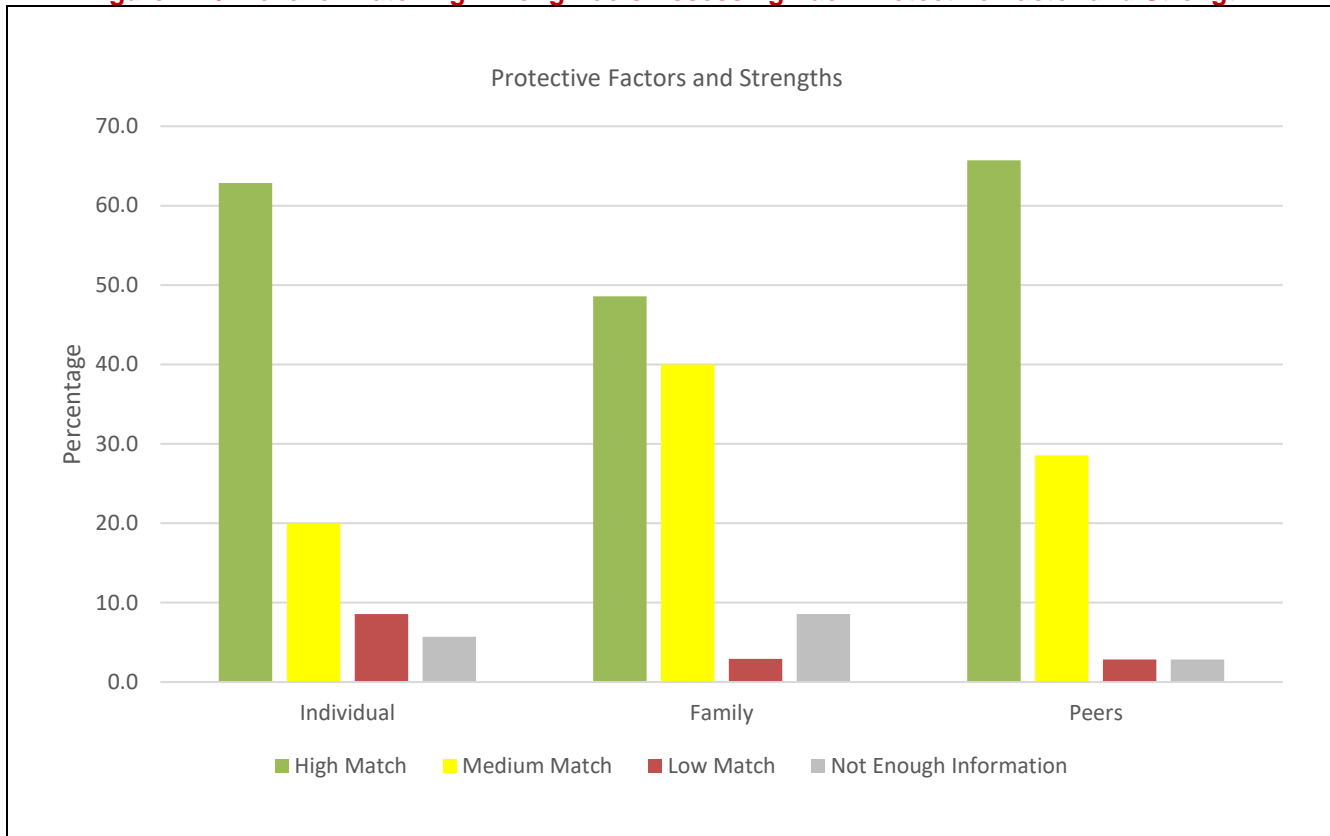
Data source: Youth files (service memos, PrediCT, START:AV, ITP). *N* = 40.

LACK OF PERSONAL SUPPORT. This category is assessed by one item in the SAVRY, lack of personal/social support, and one item in the START:AV, Social Support–Adults Vulnerability. For this risk factor we coded the extent to which the assessments matched as *high* if the risk levels were exact (i.e., high risk in both assessments); *medium* if the risk levels were close (i.e., low risk in one assessment, moderate risk in the other assessment); and *low* if the risk levels were farther apart (i.e., low risk in one assessment, high risk in the other assessment). A total of 37 records had ratings on lack of personal support in both assessments. Of these 17 (45.9 percent) were coded as high matches, 9 (24.4 percent) were coded as medium matches, and 6 (16.2 percent) were coded as low matches. Five files (13.5 percent) did not have enough information for us to make a determination. Thus, Lack of Personal Support had the highest percentage of cases without enough information of all the risk and protective factor categories. This higher percentage is understandable, given that only two assessment tools had one item each related to personal support. Of the six youths with a low match on personal/social support risk between the SAVRY and START:AV, five were rated as no or low risk according to the SAVRY and high risk according to the START:AV.

INDIVIDUAL STRENGTHS. This category is assessed by two items in the SAVRY and nine items in the START:AV. Items in the SAVRY include: resilient personality traits, and positive attitude toward intervention and authority. The START:AV includes nine areas of strength: rule adherence, conduct, coping, impulse control, mental/cognitive state, emotional state, attitudes, insight, and plans. A total of 35 records had ratings for individual strengths in these two assessments. Of these 22 (62.9 percent) were coded as high matches, 7 (20 percent) were coded as medium matches, and 2 (5.7 percent) were coded as low matches. Four files (11.4 percent) did not have enough information for us to make a determination. Both of the youths with low matches were rated as not having any individual strengths

by the SAVRY, but as having low to moderate risk by the START:AV.

FAMILY STRENGTHS. This category is assessed by two items in the SAVRY and three items in the START:AV. The SAVRY items are strong social support from family, and strong attachments and bonds with family. The START:AV considers three areas of strength: relationships with caregivers/adults, parenting, and parental functioning. A total of 35 records had ratings on family strengths from both assessments. Of these, 17 (48.6 percent) were coded as high matches, 14 (40 percent) were coded as medium matches, and 1 (2.9 percent) was coded as a low match. Three files (8.6 percent) did not have enough information for us to make a determination. The youth coded as a low match for family strengths was rated as not having any individual strengths by the SAVRY, but as having low to moderate risk by the START:AV.

PEER STRENGTHS. This protective factor is assessed by one item in the PrediCT: presence of prosocial close friends. Three items in the SAVRY assess peer strengths: prosocial involvement, strong social support from peers, and strong attachments and bonds with peers. The START:AV also assesses three items related to peer strengths: relationships with peers (friends, romantic partners, siblings, and co-residents); social support from peers; and a third peer-related item that captures whether peers model positive or negative behaviors, susceptibility to peer influence, and experiences of being bullied by peers. A total of 35 records had ratings on at least two of these assessments. Of the 35 records, 23 (65.7 percent) were coded as high matches, 10 (28.5 percent) were coded as medium matches, and 1 (2.9 percent) was coded as a low match. One file (2.9 percent) did not have enough information for us to make a determination. The youth coded as a low match for peer strengths was rated as having two or three prosocial close friends (low risk) by the PrediCT, as low to moderate risk by the START:AV, and as high risk by the SAVRY.

Summary. Agreement among how the PrediCT, SAVRY, and START:AV rate risk, protective, and resilience factors is generally high, although it varies by category. The risk factor with the highest percentage of high matches (86.5 percent) and the lowest percentage of low matches (0 percent) was delinquent/antisocial associates or peer relationships. Lack of personal support had the lowest percentage of high matches (45.9 percent), and family dysfunction, problematic parenting, and family relationships had the highest number of low matches (21.6 percent). Two patterns emerged regarding risk, protective, and resilience factors with low matches. The PrediCT tended to rate youths as having lower risk on these factors compared with the SAVRY and START:AV. The SAVRY tended to rate youths as having higher risk on these factors compared with the PrediCT and START:AV.

D. Utility of Court Clinic Data
This process evaluation examines the utility of Court Clinic data through two metrics:
- Metric 27. Evaluate timeframe for having sufficient data to allow outcomes to be evaluated.
- Metric 28. Relevance of current data collection points; and Relevance and use of Court Clinic data in CMIS (Case Management Information System).

27. Evaluate Timeframe for Having Sufficient Data To Allow Outcomes To Be Evaluated
JBCSSD eliminated this metric in 2023. It is not assessed in this report.

28. Relevance of Current Data Collection Points; and Relevance and Use of Court Clinic Data in CMIS (Case Management Information System)

This metric was assessed using information from key stakeholder interviews.

Table 2.6. CMIS Data Entered for REGIONS Juvenile Referrals

Data Field Tab	Data Entered
I. Court Clinic Details	- Order Date - Referral Source - Activity Type – **Probation with Residential Placement Consult*** - DCF Involvement - Detention Client - Prior CBA - Referral Packet Received & Date Referral Packet Received - Youth Interview Required & Date Youth Interview Scheduled (<u>not conducted, but scheduled</u>) - Report Submission Date - Assigned Clinician
II. Service Memo	- Report Type **Service Memorandum – Residential Placement*** (copied and pasted into CMIS by the CC)
III. Recommendations	- Risk Domains - Disruptive Behaviors/Personality - Attitudes/Orientation - Emotional Stability - Family - Education/Employment - Peer Relations - Substance Abuse - Risk Factors - Past Violence - AWOL **Current Treatment Amenability (*High/Middle/Low*)*** - Past Treatment Response **Future Violence (*High/Moderate/Low*)*** - Responsivity Factors - Low Cognitive Ability - Mental Illness - Lack of Family Involvement - Lack of Prosocial - Recommendations - CSSD Contracted Residential - Community Residential (*Intermediate Residential, i.e. GIRP, BIRP, TRAC/TEAMS, Hamilton*) - Staff Secure Residential - Secure Residential - Specialized Community Bed - Court Ordered Evaluations - Psychological - Academic Achievement - Adaptive Functioning - Violence Risk Assessment - Inappropriate Sexual Behavior

57

	▪ Solnit Center o Probation (used mostly to identify gender specific JPO's) o Medical Follow Up (*i.e., OBGYN, Optometrist, Gastro, PCP – all medical/health- related issues*) o Neuropsychological o Mentoring o Inpatient Substance Use Program o Medication Assessment/Management o Fire education o GAL o Vocational / Employment o Prosocial Activities o DCF Involvement o DMHAS o DDS o Restorative Justice

IV. Quality Assurance (this tab is only accessible to JCC Managers and Data Analysts for QA/CQI purposes)	• Internal Audits
	  o Supervisor Reviewed By / Supervisor Review Date
	  o QA Reviewed By / QA Review Date
	• External Audits
	  o CQI Audit Date / CQI Audit Returned Date / Audited By
	  o CQI Consultation Date / Consulted By

Summary. Court Clinic interviewees thought that the current data collection points are relevant and that Court Clinic data in CMIS are relevant and useful. JBCSSD should continue to consider whether they wish to track additional data that would answer some of the questions in this report, such as the date of the parent interview and youth race/ethnicity.

E. Recommendations

The Court Clinic's new role was implemented quickly, and there was some initial hesitation and confusion among many stakeholders. At this point, however, the Court Clinic is functioning stably after completing its initial phase of development and implementation.

DSG made several recommendations related to the Court Clinic in the interim process evaluation report, submitted to JBCSSD on Nov. 15, 2021. Below are the recommendations from the interim report, along with updates and some new recommendations.

1) In the interim report, DSG recommended that JBCSSD examine how to implement a more robust, real-time case consultation and supervision process, especially for complex cases.

   a) *Since the interim report's submission, JBCSSD has hired additional supervisors to work with clinical coordinators. The additional supervisors have helped JBCSSD implement a more robust, real-time case consultation and supervision process. Additionally, in 2022, two case consultations occurred with forensic experts (both for high profile cases). JBCSSD should ensure that real-time case consultation is regularly available for complex cases.*

2) DSG recommended that the clinical coordinators have increased supervision and dedicated supervisory staff who would be available for real-time case consultation during the evaluation and service memo writing process before the memo is filed with the Court.

   a) *Since the interim report's submission, JBCSSD has hired additional supervisors to work with*

clinical coordinators. This quick response to DSG's recommendations was an important step in strengthening a Court Clinic process that was already quite strong, especially as compared with other jurisdictions in the United States. During our last meeting with the Court Clinic in May 2023, there were three supervisors overall.

3) DSG recommended that there be greater standardization of information captured on routine forms (e.g., date of referral, date of interviews, date referral packet received, adjudication date). Similarly, it may be beneficial to include the dates the parent and child interview were scheduled if this information is not captured elsewhere (to measure compliance with the 2-day requirement in JBCSSD Policy and Procedure 6.103).

   a) *There has been improvement in the standardization of information captured in routine forms and in CMIS. For example, in the interim process evaluation report, DSG recommended that the audit form include both the date of the service memo and the date of the audit report. The new form provides spaces for both dates, which is a helpful addition. Also, the new form includes a space for the youth's first name and the first letter of the last name.*
   b) *JBCSSD should review the metrics that DSG was unable to assess owing to lack of data and decide whether they would like to track those metrics more systematically.*

4) DSG recommended that a process be established—if one does not already exist—for ensuring that all service memos taking more than 30 days are reviewed to identify the cause(s) of the delay. Timeliness also can be included as a topic in supervision meetings. It is also recommended that one of the goals of the CQI process be to drive down the number of days that youths wait in detention for the service memo to be completed, if there is no such goal currently.

   a) *The number of days to complete service memos has decreased over time. In a small number of cases, service memos still take more than 30 days. According to CMIS data, for example, 3 percent of service memos in 2022 took more than 30 days to complete.*

   b) *Also, most of the cases in CMIS still do not include the youth's adjudication date.*

   c) *DSG continues to recommend that a process be established for ensuring that all service memos taking more than 30 days are reviewed and that one of the goals of the CQI process be to drive down the number of days that youths wait in detention for the service memo to be completed.*

5) DSG recommended that clinical coordinators receive training on the distinction between adversity and trauma and on the continuum of responses to adversity.

   a) *Since the interim report, several training opportunities have been generated through the CQI process, including training in understanding trauma and coping strategies. DSG continues to recommend that all clinical coordinators receive training in, and understand, the distinction between adversity and trauma, the continuum of responses to adversity, and the roles of protective and mediating factors in buffering exposures to adversity to prevent or moderate post-adversity trauma symptoms and maladaptive responses.*

6) DSG recommended that clinical coordinators receive training in the differences between strengths, resilience factors, and protective factors and in describing more specific ways of appropriately leveraging these elements in intervention strategies with individual youths and their families/caregivers.

   a) *Since the interim report, service memos have improved in their explanations of how to leverage*

strengths toward behavior change. This improvement is to be commended. We recommend adding a statement to the service memos that probes clinical coordinators to include information on leveraging strengths (e.g., "The following strengths of the youth will be leveraged in the recommendations below: _____."

b) *Since the interim report, consideration of protective factors in treatment recommendations has improved. In the most recent service memos reviewed, 91 percent of the service memos that identified protective factors clearly considered them in the recommendations for treatment.*

c) *DSG continues to recommend more training on considering and/or mobilizing protective factors when making treatment recommendations, as warranted in individual cases.*

d) *DSG continues to recommend exploring whether it would make sense to separate the review of strengths and the review of protective factors throughout the audit tool.*

7) DSG recommended that consideration be given to whether record release policies and protocols might be established with at least the school districts and community clinical services providers involved with the youths most frequently referred for REGIONS evaluations. Such policies and procedures could minimize delays in gathering the collateral information required in the service memo and reduce the pressure to complete the evaluations without important educational or clinical information.

a) *There have been several statewide policy changes aimed at improving communication and file sharing between public schools and youths in juvenile justice residential custody. It is unclear whether there is a similar arrangement for Courts. If not, these arrangements should be established.*

8) DSG recommended examination of the requirements and policies governing training for the clinical coordinators. Training is an important part of ensuring that the clinical coordinators have the skills they need to be effective. Though the process should be transparent and follow existing JBCSSD and state rules, it should not be overly burdensome.

a) *In follow-up interviews with Court Clinic staff, we learned that the process of designing, scheduling, and implementing training with clinical coordinators has not become burdensome, as some interviewees feared during the first round of interviews. JBCSSD should continue to ensure that training is responsive to the Court Clinic's needs.*

9) DSG recommended that Court stakeholders receive more education and information on the clinical coordinator role and the forensic formulation model, to increase transparency and strengthen working relationships in Court.

a) *Communication appears to have improved over time, but it remains an important area of focus to ensure that youths are served well. Interestingly, in a few instances probation officers and reintegration mentors had similar misunderstandings and frustrations as probation officers and clinical coordinators.*

10) DSG recommended REGIONS administrators consider, in the overall assessment of risk, how to weight gun possession and other factors not specifically included in the SAVRY. The recommendation was made because several Court stakeholders indicated that they were dissatisfied with the classification of certain gun charges. This issue should be addressed by offering more information to probation officers and other Court stakeholders regarding why gun possession charges are not reflected in the SAVRY as a violence risk, and providing greater transparency and education about how gun possession charges do or should factor into the clinical coordinator's risk assessment determinations in individual cases. We have not explored this issue further since the

60

interim report.

11) Several of the interviewees shared that they missed the "overall mental health" information provided before REGIONS and the SAVRY were implemented. DSG recommended that JBCSSD either identify other ways decision-makers can obtain the "overall mental health" information they sometimes want or provide more education on why it is unnecessary. We have not explored this issue further since the interim report.

12) Considering the trade-offs of a (more resource-intensive) model of clinical coordinators being sited in courthouses versus a (more flexible but less resource-intensive) model of clinical coordinators being deployed to courthouses when REGIONS evaluations come up rather than sited at courthouses, DSG recommended that JBCSSD carefully weigh the benefits and drawbacks of each option and make an intentional decision about which is best. The rationale for the decision should be conveyed to the clinical coordinator workforce since they will have to operate within the designated model or hybrid.

   a) *This issue continues to be without a perfect solution. We recommend that JBCSSD continue to think about the best ways to place clinical coordinators, based on youths' needs.*

13) DSG recommends an audit review of no fewer than 25–30 percent of submitted service memos (separate from creating the capacity for real-time supervision and consultation). JBCSSD should consider creating the random sample to be audited exclusively from the REGIONS service memos to ensure that a sufficient number of REGIONS service memos are audited. Currently, the sample is drawn from all service memos (i.e., REGIONS service memos and non-REGIONS service memos).

Chapter 3. REGIONS Residential Treatment

Three residential treatment areas are included in the REGIONS process evaluation: a) admission and treatment plan development, b) treatment plan approach, and c) discharge planning. DSG assessed metrics in these three areas using various data sources, including interviews with stakeholders and decision-makers, policy review, observations of treatment groups, file review, and analysis of data for 354 cases from the CDCS database.

A. REGIONS Admissions and Treatment Plan Development
Thirteen metrics relate to admissions and treatment plan development:
- Metric 29. Effectiveness and quality of the admission process
- Metric 30. Number and percentage of admissions that have intake screening completed at arrival
- Metric 31. Appropriateness of instruments administered at intake
- Metric 32. Number and percentage of intakes where the initial monthly Integrated Treatment Plan meeting is scheduled at intake
- Metric 33. Average/median number of days from admission to the initial Integrated Treatment Plan meeting
- Metric 34. Number and percentage of admissions interviewed by the psychiatric staff within 10 days
- Metric 35. Number and percentage of admissions with a START:AV (Short-Term Assessment of Risk and Treatability: Adolescent Version) completed within 5 days
- Metric 36. Number and percentage of START:AVs that include the family voice
- Metric 37. Method of evaluating client motivation for change
- Metric 38. Rate of identification of different learning styles and integration into treatment planning
- Metric 39. Extent to which the clinical coordinators' work regarding the placement opinion, formulation, and service recommendations are integrated into REGIONS treatment plan development
- Metric 40. Number and percentage of Integrated Treatment Plans completed and signed within 15 days of admission
- Metric 41. Quality of the initial Integrated Treatment Plan (ITP) meeting.

29. Effectiveness and Quality of the Admission Process
The admission process for the REGIONS program begins with a Court order to the program. This order is sent to the residential gatekeeper, who reviews and determines the proper placement. The intake and placement process is an essential component of treatment. The placement decision to the correct level of care has been linked to optimal outcomes (for example, see Magura et al., 2003; Stallvik, Gastfriend, and Nordahl, 2015). According to JBCSSD Policy and Procedure 8.600 (Judicial Residential Services, REGIONS Secure Treatment Program), the residential gatekeeper sends a referral packet to the selected REGIONS program. This packet includes the universal referral form, the service memo or another behavioral/mental health evaluation, a current pre-dispositional study, a current probation risk assessment, and an order of probation with residential placement. This policy states: "The Unit Manager will admit a youth into the REGIONS secure treatment program only upon receipt of a complete referral packet from the JBCSSD Residential Gatekeeper, which includes a Court order for a period of Probation Supervision with Residential Placement in a secure setting." DSG assessed this metric primarily through interviews with key stakeholders.

Residential Treatment Staff Perspective. Thirty-one residential treatment staff responded to our question, "Are youths ever admitted without a complete referral packet from the JBCSSD Residential Gatekeeper?" Respondents included clinicians, juvenile detention officers/youth mentors, managers, and facility leadership. Of the 31 respondents, only 3 (fewer than 10 percent) stated that some referrals are admitted without the complete referral packet. Thus, it appears that admission without a referral packet is a rare event. The most common reason for admitting youths without a referral packet seems to be that youths are transferred within a facility (e.g., from the detention unit to the REGIONS unit of the same facility) and arrive before the referral packet.

We also asked 54 residential treatment staff members, "Are there any youths that you think are inappropriate for treatment in this facility? Why?" We posed these questions to determine whether program staff feel that proper services are in place for the majority of clients admitted to the REGIONS program. Research has demonstrated that admitting too many inappropriate clients disrupts the proper delivery of services and can lead to programs not achieving their intended impact (Andrews et al., 1990; Duriez et al., 2017; Farabee et al., 1999; Farringer et al., 2021; Gendreau, Goggin, and Smith, 1999).

Forty-one percent of the respondents felt that none of the admitted youths was inappropriate for the REGIONS program. Staff from secure programs were more likely to say that admitted youths were never inappropriate for REGIONS compared with staff from staff-secure programs (48 percent compared with 33 percent). Most of the respondents who felt that none of the youths was inappropriate for REGIONS felt that the assessment and placement processes worked well. Some felt that the REGIONS program could be geared toward any juvenile and that it would be beneficial to include more youths. Some respondents specifically mentioned "waiting too long" to get a child into a program like REGIONS and that sometimes, a child just enters too late for the program to be effective.

One of the interviewees said:

> We do a lot of assessments even before they get into the REGIONS programs to make sure that the kids are appropriate for the program. I think one of the biggest things may be their amenability to treatment. Some of [the youths] come in and they don't want to be in the program, so there's that barrier and that struggle. But in regard to if they're appropriate, I do feel like for the most part, all the kids that I have seen here seem to be appropriate. And obviously, if they need a higher level of care, if we notice some behaviors within their treatment with us, then we would provide them with that higher level of care maybe within like 3-months of them being with us. But for the most part, I do think that there's a lot of assessments and these kids go through so much before they get to us to make sure that they are appropriate for REGIONS.

Fifty-nine percent of the respondents felt that, at least some of the time, there were youths admitted to the residential programs who were inappropriate for REGIONS. Many of these respondents noted that it happened very rarely (e.g., "In the three and a half years, I've seen it once with one kid," "Sometimes, one may slip through"). Others felt that it happened more often.

There were several reasons staff felt that some youths were inappropriate for REGIONS. More frequently cited reasons included the following: 1) youths with certain mental health conditions required a higher level of care than the program could consistently provide; 2) youths had challenges such as limited cognitive abilities, developmental delays, or brain damage and struggled to participate in DBT; 3) youths had problems primarily related to mental health conditions (rather than antisocial attitudes and beliefs or other criminogenic needs); and 4) youths were placed in a staff-secure facility but had a history of running away from community programs. Other less-mentioned reasons included: youths did not speak English, youths had medical conditions that were difficult to manage (e.g., diabetes), and youths were too young and were negatively influenced by the older youths. Some interviewees mentioned that the appropriateness of the referrals has improved over time.

63

It is common for programs to learn more about youths after they arrive; therefore, programs often find out about mental health or other issues once youths have been admitted. However, as long as the subgroup of youths who may not be completely appropriate for the REGIONS program a) receives the needed services, and b) never represents more than 20 percent of the youths in the program (Gendreau and Andrews, 1994; Lowenkamp and Latessa, 2002, 2005), the program is adhering to evidence-based practices.

Finally, we asked residential treatment staff to rate the quality and effectiveness of the admission process, with 1 indicating extremely low quality and ineffective and 10 being high quality and completely effective. Thirty-one individuals responded, the average score was 8.2, and three quarters of the responses were 8 or higher (See Figure 3.1).

Figure 3.1. Residential Treatment Staff Perceptions of the Quality and Effectiveness of the REGIONS Residential Treatment Admission Process
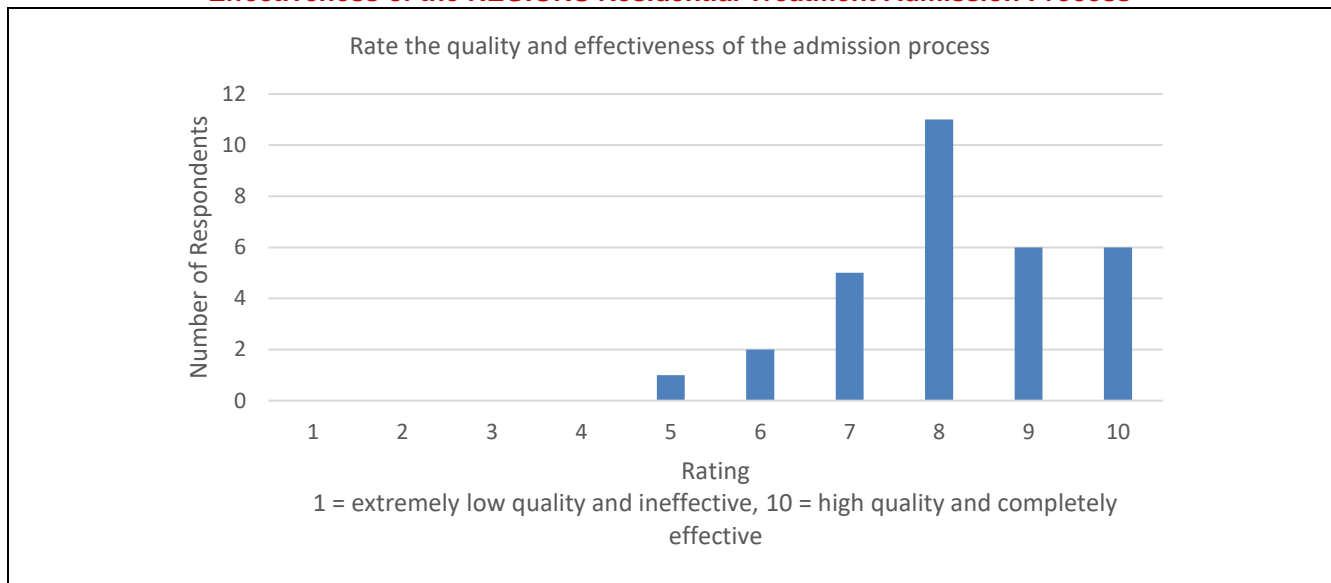
Data source: Residential treatment staff interviews. *N* = 31.

Summary. A review of policy and practice demonstrates that the REGIONS program has a high quality admission process that is implemented as intended. It appears from observations, interviews, and the review of files and other materials that JBCSSD Policy and Procedure 8.600 is being followed. Interviews with residential treatment staff indicate that most completed referral packets are received prior to admission. Most admitted youths are appropriate for REGIONS services; the number of youths who may not be entirely suited for REGIONS does not represent more than 20 percent of all participants; and the admission process is effective. Since the percentage of youths who may not be completely appropriate for REGIONS does not represent more than 20 percent of the youths in the program, the program is adhering to evidence-based practices (see Lowenkamp and Latessa, 2002, 2005). REGIONS has done a commendable job implementing and executing a high-quality admissions process.

Also, although not asked specifically in interviews, some interviewees mentioned that more youths should be admitted into the REGIONS program, and they often talked about "the pendulum swinging too far" compared with the time they were incarcerating too many youths. One of the residential treatment providers said:

> I actually think more kids could benefit from staying here and getting treatment. And those that do come,

64

> I think they should come here earlier. From a clinical lens, it just causes more damage to wait so long. At that point it's harder to get them into treatment.

30. Number and Percentage of Admissions That Have Intake Screening Completed at Arrival

JBCSSD Policy and Procedure 8.600 (Judicial Residential Services REGIONS Secure Treatment Program) states that all youth intake assessments are to be completed within 24 hours of admission to a REGIONS unit. DSG assessed this metric by analyzing data from the CDCS database and reviewing responses from key stakeholder interviews.

Dataset. Data were provided to DSG researchers on a limited number of variables from the CDCS database. We used these data to properly inspect various residential metrics. Data were available on youth admissions with an intake screening completed on arrival. Of the 354 cases in the database, 20 (5.6%) cases were missing information on the screening or admissions dates. The remaining 334 cases had a screening date that was the same as the admission date (or earlier), indicating that an intake screening was completed at or before arrival in 94.4 percent of all cases.

Residential Treatment Staff Perspective. We asked residential staff the question, "Do all youths have the intake screening completed at arrival?" Twenty-one staff responded to the question, and all reported that youth intake screening is completed at or before arrival.

Summary. Almost 100 percent of cases have an intake screening completed at or before arrival. Thus, the REGIONS program is doing an excellent job of ensuring that intake screening is completed by the time youths arrive at the program.

31. Appropriateness of Instruments Administered at Intake

Although residential treatment programs generally have information on youths before they arrive, it is important to conduct initial screenings or assessments for consistency (i.e., to see whether anything has changed since the initial screenings) and to have a baseline from which to establish service and treatment plans. Screenings and assessments should include the following: suicide assessment; drug and alcohol assessment; current medical and dental assessments; updated mental health assessment; information on vocational interests, if appropriate; educational assessment; information on religious background and interests; information on recreational interests; assessment to obtain information necessary to reduce the risk of sexual abuse; and other assessments, as needed (Nelsen, 2014).

JBCSSD Policy and Procedure 8.400 (Juvenile Residential Services Intake and Admissions) identifies the screenings, assessments, and other forms that must be completed at intake. These forms include validated tools used by many different juvenile justice systems (e.g., SAVRY, CRAFFT, MAYSI–2), and other forms created by JBCSSD. The screening process consists of three tiers (see Figure 3.2). The first tier screens for emergent risk of harm to self or other and of mental health crises; the second tier screens for mental health service needs; and the third tier identifies mental health needs and provides diagnoses for service planning and delivery of clinically appropriate care. To assess this metric, we reviewed the instruments administered at intake and interviewed youths.

Figure 3.2. Juvenile Residential Services: Three-Tier Screening Process

Tier 1. JDO Intake Screening Process

Administer SIQ (Jr./HS)

Verbally administer CRAFFT

Administer computerized MAYSI–2

Complete CMIS juvenile intake questions and parent questions

Tier 2. CPO Intake Process

Review all JDO intake and screening instruments

Complete CPO juvenile intake questions

Complete parent intake questions

Complete SAVRY

Complete PESQ*

Complete TESI

Tier 3. Mental Health Consultant Intake Process

Review all documents in mental health chart

Review room confinement in CMIS

Complete mental health assessment

Refer to psychiatric/psychiatric APRN*

Collaborate with CPO on Special Needs Treatment Plan*

Begin MI/CBT model*

* If applicable

Data source: JBCSSD Policy and Procedure 8.400, Juvenile Residential Services Intake and Admissions, Attachment I.

File Review. DSG reviewed the entire file of one youth. Instruments administered at intake to REGIONS or while the youth was still in secure detention included the following:

- Columbia Suicide Severity Rating Scale (CSSRS)
- CRAFFT (health screening tool designed to identify substance use, substance-related riding/driving risk, and substance use disorder)
- Massachusetts Youth Screening Instrument (MAYSI–2)
- Personal Experience Screening Questionnaire (PESQ)
- Short-Term Assessment for Risk and Treatability: Adolescent Version (START:AV)
- Structured Trauma-Related Experiences & Symptoms Screener (STRESS)

Other forms were also completed before or during intake. These included the pre-dispositional study (PDS), CPO Intake, Mental Health Clinician Intake, Mental Health General Notes, Mental Health SOAP Notes, Permission to Treat, Youth Questionnaire, Parent/Guardian Questionnaire, Special Needs, Mental Health Transfer Paperwork, and Discharge Planning. As described in Chapter 2. Court Clinic, clinical coordinators administer the SAVRY, which is included in the youth's REGIONS referral packet. Also, clinical coordinators review the PrediCT to form an opinion about whether the youth should be in a secure, staff-secure, or community setting.

Many of these instruments are validated tools. For example, the CRAFFT is a six-item, valid means of screening adolescents for substance-related disorders and problems (Knight et al., 2002; Winters and Kaminer, 2008). The CSSRS has been shown to be a valid tool for predicting risk of attempted suicide and non-suicidal self-injury in adolescents seeking psychiatric emergency services (Gibson et al., 2016). The MAYSI–2 is a valid tool used to identify mental health needs of adolescents in various juvenile justice settings (Archer et al., 2010; Grisso and Barnum, 2001). The PESQ is a 40-item validated self-report questionnaire that identifies teenagers who should be referred for a complete chemical dependency evaluation (Winters, 1992; Winters and Kaminer, 2008). The STRESS is a 10- to

66

15-minute validated self-report instrument designed to assess 1) lifetime exposure to several domains of potentially traumatic and other adverse experiences; 2) PTSD symptoms that map onto symptom criteria defined in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition,* and are applicable to one or more traumatic events; and 3) functional impairment (Grasso, Felton, and Reid-Quiñones, 2015; Weinberger et al., 2023). In addition, some preliminary research suggests that the START:AV is a valid tool for structuring clinicians' professional judgment in juvenile correctional settings (Singh et al., 2014). Thus, the research on these tools makes them appropriate for the REGIONS program.

Best practices in correctional interventions emphasize the risk principle (Lowenkamp and Latessa, 2004; Lowenkamp, Latessa, and Smith, 2006). According to the risk principle, correctional programs should a) screen clients using an objective, empirical, and validated assessment tool to obtain the information needed to match the client with a program suited to the client's risk of recidivating; b) target (i.e., admit) youths who are at the highest risk; and c) not target those who are at low risk. Because the START:AV tool is not purely empirical, the REGIONS program may wish to ensure that staff conducting the START:AV do so after they have reviewed the results of a validated risk assessment tool (e.g., PrediCT, SAVRY).

Youth Perspective. We also sought the perspective of REGIONS youths. We started by asking, "When you first arrived, do you remember staff members trying to get information from you and filling out forms?" In addition, we asked some follow-up questions. Ten youths from each of the seven residential programs answered the question, "Do you think the questions they asked made sense?" Nine said "yes," and one said "no." Eleven youths answered the question, "Were they easy to answer?" All eleven youths said the questions were easy to answer, although one youth said he was a little confused about when to choose "sometimes," "never," and "always" in the responses. Another youth said the staff would explain the questions if there was any confusion.

Eleven youths responded to the question, "Shortly after you arrived here, did anyone meet with you to learn about your strengths, including your skills, behaviors, attitudes, and beliefs?" JBCSSD Policy and Procedure 8.600 states that "leveraging strengths" is part of the REGIONS program. Within 5 business days of admission, the clinician is supposed to complete the START:AV, which includes an initial individualized assessment of strengths that can be leveraged to help protect against vulnerabilities contributing to adverse outcomes. The clinician will use the results of the START:AV to guide the development of the treatment plan. Sixteen youths said "yes" (i.e., someone did meet with them to learn about their strengths) and two said "no."

We asked eleven of the youths, "Has anyone in the program talked to you about these test or assessment results?" The purpose of this question is to determine if youths understand the specific areas of their life that relate to their trouble with the legal system. Three said that they remembered someone talking about the test results. One of the youths said that the clinician talked to him and that "it was a good conversation." The other six indicated that no one spoke to them or they did not remember. Finally, 14 youths answered the question, "Do you think staff got enough information about you to take good care of you?" Thirteen answered "yes," and one said, "I don't know."

Summary. The REGIONS admission instruments are appropriate for the program—both the START:AV and CSSRS are suitable tools. However, REGIONS may want to include more tools in the intake process. After the admission decision is made (based on the youth's assessed risk), REGIONS should ensure that the Integrated Treatment Plan (ITP) specifically addresses the criminogenic needs driving the youth's risk level (for both violence and general criminal behavior), as assessed by the PrediCT and SAVRY. Addressing the criminogenic needs in the ITP is vital, because the results of the criminogenic needs assessment are the drivers of risk—targeting them reduces each youth's specific needs related

67

to future offending (either violent or general). Since the REGIONS model is concerned with addressing trauma, assessment results from the STRESS assessment should be used to identify who needs these services. Those not identified as having a trauma need (by means of the STRESS) should not be targeted for trauma services.

32. Number and Percentage of Intakes Where the Initial Monthly Integrated Treatment Plan Meeting Is Scheduled at Intake

JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program) states that the classification and program officer (CPO) will schedule the initial monthly Integrated Treatment Plan (ITP) meeting within 15 business days of admission. No additional policy information was found about the initial ITP meeting being scheduled at intake. However, in accordance with this policy, the CPO should document all scheduling and meeting information in the youth's case notes. We assessed this metric by reviewing interview responses from residential treatment staff.

Dataset. Ninety-one percent of all cases in the Contractor Data Collection System (CDCS) dataset given to DSG were missing this information. Thus, no conclusive results could be obtained for this interim report.

Residential Treatment Staff Perspective. We asked two milieu specialists, 18 residential treatment staff (from each of the seven residential programs), and the manager of REGIONS contracted programs, "Do all youths have the initial monthly Integrated Treatment Plan meeting scheduled at intake?" All 21 respondents said the meeting is always scheduled at intake. A few respondents replied that the initial ITP meeting scheduling is sometimes delayed if program staff members cannot reach the youth's parent.

Summary. Interviews with staff indicate that the monthly ITP meeting is scheduled at intake or shortly thereafter. Site visits and observations corroborated our interviews. It appears that for some youths, the intake meeting may be delayed slightly while a parent is contacted. Delaying the intake meeting for this reason is common for juvenile correctional programs. Thus, it appears that the REGIONS program adheres to policy on scheduling the initial monthly ITP meeting. The most efficient way to determine fidelity to this policy and practice would be to track dates in CDCS, specifically the date the initial ITP meeting was scheduled. When deciding whether to augment CDCS with more data collection fields (e.g., the date the initial ITP meeting was scheduled), JBCSSD should weigh the data entry demands currently placed on staff and the need for the information that would populate the new fields.

33. Average/Median Number of Days From Admission to the Initial Integrated Treatment Plan Meeting

According to JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program), the multidisciplinary team should hold an Integrated Treatment Plan (ITP) meeting within 15 business days of admission to assist with completion of the ITP. During this meeting, the clinician should synthesize into an ITP all clinical findings as well as input from staff, family, the youth, the juvenile probation officer, the attorney, and the DCF (Department of Children and Families) worker (if applicable). By the 15th business day, the initial ITP should be signed. We assessed this metric by reviewing a sample of youth files.

Dataset. Ninety-one percent of the cases in the CDCS dataset were missing this information. Given the large number of missing cases and large outlying values, DSG could not assess this metric using data from the CDCS database.

File Review. Files were from a sample of 40 youths who were selected using random stratified sampling (for more information on our approach, see Appendix A). The sample of 40 cases included 36 files with

ITPs. To assess this metric as well as Metric 40, which is also part of the Admission and Treatment Plan Development subcomponent, we extracted the following information from the ITPs:

- Date of admission (provided in all 36 files)
- Initial ITP date (provided in all 36 files)
- Date [ITP meeting] completed (provided in all 36 files)
- Date [ITP] signed (provided in 20 of 36 files)

Each of the ITP meetings was completed between Sept. 3, 2018, and Dec. 29, 2021 (8 percent were completed in 2018, 44 percent in 2019, 25 percent in 2020, and 22 percent in 2021). All seven residential programs were represented.

In 26 of the 36 reports, the initial ITP date was the same as the date completed. In seven cases, the date completed was later than the initial ITP date, and in three cases, the date completed was before the initial ITP date. Also, the date signed was the same as the date completed in 15 of the 20 files that included the date signed.

The ITPs indicate that in 26 of the 35 cases (74 percent), the initial ITP date was within 15 business days of the admission date. The average number of business days from admission to ITP completion was 12.6, with a median of 11 (meaning that the number of business days from admission to the initial ITP meeting was fewer than 11 in half the cases and more than 11 in half the cases). The average number of days appears to be decreasing since REGIONS started: for the youths admitted in 2018 and 2019, the average number of business days from admission to the initial ITP meeting was 13.8 (with a median of 14), and for the youths admitted in 2020 and 2021, the average was 11.4 (with a median of 11). In 2020 and 2021, the initial ITP date was within 15 business days of the date of admission in 82 percent of the cases (compared with 63 percent in 2018 and 2019) [see Figure 3.4].

Summary. Although no conclusive results could be obtained from the CDCS data, the sample of files provided helpful information to assess this metric. A review of the 36 files suggests that most REGIONS cases receive an ITP meeting within the first 15 days. Moreover, the average number of business days from intake to the initial ITP meeting appears to have improved over time. Thus, it appears the REGIONS program does well in ensuring that the multidisciplinary team meets quickly to review all new intakes. Given the high number of missing data items from CDCS, JBCSSD should consider monitoring the fidelity of data entry. When deciding whether to augment CDCS with more data collection fields (e.g., the date of the initial ITP meeting), JBCSSD should weigh the data entry demands currently placed on staff and the need for the information that would populate the new fields, as noted in Metric 32.

34. Number and Percentage of Admissions Interviewed by the Psychiatric Staff Within 10 Days
According to JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program), the psychiatrist/psychiatric APRN will complete a psychiatric evaluation of the youth within 10 business days of admission. This metric was assessed by analyzing information gathered from interviews with residential treatment staff.

Dataset. A field to track the psychiatric assessment date was only recently added to CDCS. Thus, not enough data were available to assess this metric.

Residential Treatment Perspective. During onsite and remote interviews with residential treatment staff, we asked, "Are all youths interviewed by psychiatric staff within 10 days of admission?" Respondents included staff from each of the seven residential programs, the two JBCSSD milieu specialists, and staff members who direct and manage REGIONS treatment and programming. Many interviewees were unsure because they were not involved in these meetings. However, 19 staff

answered "yes" and 1 answered "no." The person who did not think these interviews were occurring within 10 days of admission explained that they only take place when the youths need them. Others said that everyone meets with the psychiatrist and often the interview occurs much sooner than 10 business days after admission.

Summary. DSG was unable to adequately assess this metric owing to lack of data, but interviews indicate that most or all youths are interviewed by a psychiatrist within 10 days of REGIONS admission. A field to track the psychiatric assessment date was recently added to CDCS, so this metric can be measured in the future.

35. Number and Percentage of Admissions With a START:AV Completed Within 5 Days
According to JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program), the clinician will assess each youth using the START:AV within 5 business days of admission and reassess each youth using the START:AV every 90 days. The START:AV is a clinical guide designed to assist in the assessment and management of a youth's risk for adverse events, such as violence, suicide, victimization, and general offending. It focuses on short-term assessment of dynamic factors and is designed to be re-administered at least every 3 months (Viljoen et al., 2012a and 2012b; Webster et al., 2004, 2009). The instrument includes 25 strength and vulnerability items rated as "high," "moderate," or "low" (e.g., school and work, conduct, social support). Also, history and future risk are measured through nine additional items (e.g., violence, suicide, health neglect). The START:AV uses a structured professional judgment model of risk assessment, which means that it does not rely on total scores; instead, it guides evaluators in making a final risk estimate of low, moderate, or high risk on each of the outcomes after they systematically consider an adolescent's current vulnerabilities, strengths, and prior behaviors (Viljoen et al., 2012a). To assess this metric, we reviewed CDCS data, information from youth files, and findings from interviews with key stakeholders.

Dataset. DSG received CDCS data for 354 unique REGIONS program referrals and assessments. Seventeen cases were removed because they lacked an admission date in the system. The remaining 337 stays represent 193 juveniles. Of the 337 admission reviews, 147 (44 percent) contained valid data on the START:AV date and admission date, leaving 190 (56 percent) referrals missing START:AV dates. (See Table 3.1 for a breakdown of missing data by year of admission.) All 2018 data on START:AV dates were missing, and 83 percent of data from 2019 were missing. In 2020, only 16 percent of START:AVs were missing, but this percent rose to 32 percent in 2021.

For the 147 valid cases, the average number of days from admission to the START:AV was 24, with a median value of 6. This high average is the result of 33 outlier cases—admissions with a value of greater than 15 days. The range of these outliers is 15–259 days. The large range in outlying values suggests that there were meaningful data entry errors. Removing the outliers from the calculation results in an average time between admission and START:AV of 4.97 days, with a median of 5. Thus, 57 of 147 cases (38.8 percent) were completed within 5 days. Nevertheless, due to the significant number of missing values and the issue of likely data entry errors, we turned to file review and interviews to assess this metric.

Table 3.1. START:AV Dates Entered Into CDCS, 2018–2021

Indicators	Year of Admission			
	2018	**2019**	**2020**	**2021**
Total Number of Admissions	36	142	94	65
# Missing START:AV Date	36	118	15	21
% Missing START:AV Date	100.0	83.1	16.0	32.3

N = 337.

File Review. Due to the missing data fields in the CDCS dataset, DSG extracted the dates of the START:AV reports from a sample of 40 youths (for more information about the sample, see Appendix A). There were 35 cases with START:AV dates. Each of the seven residential programs was represented. The average number of business days between admission and START:AV completion for these 35 cases was 5.4 days, with a median of 5 days. In slightly more than half of the cases (18 of the 35), the START:AV was completed within 5 business days of admission. None of the START:AVs in the sample was completed later than 11 business days after admission. Efficiency appears to be improving: the average number of business days from admission to START:AV completion in our sample in 2018 and 2019 was 5.9 days; it was 4.7 days in 2020 and 2021.

Residential Treatment Staff Perspective. Interviews suggested that the START:AV may be delayed if the counselor lacks access to all the needed information (e.g., a family member cannot be reached, school records are missing). Also, one interviewee shared that even if they do have all the information to complete the START:AV within 5 days, there is a fear that the information may not be as accurate as they would like, given that they do not yet have a strong relationship with the youth. Finally, some interviewees said that they do not need to complete a START:AV within 5 days if one was completed in the past 3 months.

One of the interviewees shared:

> It's always attempted within 5 days. It's a culmination of reading service memos, collaborating with parents, meetings with the probation officer, and getting info from the child. Sometimes, that information is not available within 5 days. It's a lot of front-heavy work. And during this time, you have other kids to see as well. So, you don't want to spend too much time doing this work when you have to work with the kids who were already here, too. It's a lot of work to get all that information.

Another interviewee said:

> If this is our first time meeting the youth, and they're not opening up to us, we may not be getting accurate information in just 5 days. Maybe in a month, when the youth is comfortable with us, we get better information. In just 5 days, there's so much stuff that I don't know. Obviously, you can update it at some point, but within 5 days, you're not going to get a good overall perspective on the case.

Summary. Since so few cases had this information in our dataset, no conclusive results could be obtained. However, it is clear that at least some percentage of the START:AVs (49 percent of the sampled files and 39 percent of the cases in CDCS) are being completed outside of the 5-day window. JBCSSD should consider implementing quality assurance practices related to data entry. We recommend that JBCSSD collect and enter these data in CDCS consistently and accurately for all cases, if it is not doing so currently. Over half of the cases were missing information on the START:AV. This missing information is partly the result of database development (i.e., the database fields for the START:AV are relatively new to the database). Thus, we recommend that JBCSSD institute data auditing procedures to verify that the data have been added to the appropriate data management systems correctly and in a timely manner.

36. Number and Percentage of START:AVs That Include the Family Voice

The developers of the START:AV emphasized the importance of collecting information on each assessment item from multiple sources, including the youth, family or other caregivers, other collaterals, and records (Beltrani, 2022; De Beuf, 2023; De Beuf, de Vogel, and de Ruiter, 2020; Desmarais et al., 2012). Also, according to JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program), families are an integral part of the youth's treatment and should be included consistently in every aspect of the treatment program throughout the youth's stay, starting with admission. To assess this metric, we used information from youth files, the CDCS database, and findings from key stakeholder interviews.

Dataset and File Review. The START:AV Comprehensive Rating Form includes a section to indicate the sources of information that were used in the assessment (see Figure 3.3). However, this information was not included in the CDCS data that JBCSSD sent to DSG and was only included in a few of the sample files. The information available from the CDCS dataset and youth files was not enough to assess this metric.

Residential Treatment Staff Perspective. Nineteen of the residential treatment staff felt comfortable responding to the question, "On a scale of 1 to 10 with 1 being not enough and 10 being very well, how well is the family voice (or perspective or opinions) included in the START:AV?" At least one person from each of the seven residential programs responded. The average score was 6.6, the median score was 7, and the scores ranged from 4 to 10.

Most respondents indicated that they make an effort to ensure that the family voice is included, but this may be difficult sometimes, especially in the initial START:AV, since it is due within 5 days (see Metric 35). Others noted that they always include the family voice. One respondent said: "We always connect with parents and include them in the process." Some of the interviewees indicated that there is more inclusion of the family voice in the second START:AV, which is due 90 days after the initial one, because there is more time to complete it. However, others mentioned that once the youth is in the program, family engagement can decrease. One respondent noted: "Sometimes, after intake, some parents go missing. It's hard to reach them. I think sometimes they don't understand the importance of their involvement. Sometimes they live far away. Sometimes the call doesn't work because of work." However, when parents do remain engaged, communication can improve over time. One interviewee said: "I feel that now the guardians are actually having a say and telling us, 'These are the areas that I see my child's struggling in and these are some of the goals I want them to work on.'" An additional challenge is that a youth being 18 years old may result in less involvement from family. Finally, a few respondents mentioned that the START:AV information was based more on history and files rather than based on a meeting or call with family.

Figure 3.3. START:AV Comprehensive Rating Form

Summary. Our main source of information to assess this metric was interviews with residential treatment staff. Family voice is incorporated in some, but not all, START:AVs. Inclusion of the family voice is difficult to track, given that this information is not entered into the CDCS database. If tracking this item is a priority, JBCSSD should add an appropriate data field in CDCS. For more information about family engagement, see Metric 43.

37. Method of Evaluating Client Motivation for Change

A youth's motivation for change is an important responsivity or non-criminogenic factor to consider when determining appropriate treatment and services, because it can greatly affect the youth's ability to engage and respond to treatment and programming (DSG, 2015; Vincent, Guy, and Grisso, 2012; Van der Helm et al., 2014; Van der Stouwe et al., 2018). Research finds that low internal or personal motivation for change is a potential barrier to achieving positive treatment outcomes (Curry et al., 1991; Deci and Ryan, 1985; DiClemente et al., 1999) because it is associated with lower therapeutic engagement (Joe et al., 2014). Therefore, evaluating motivation for change is important, especially when assessing juvenile justice system-involved youths with problem behaviors (such as aggression) and psychiatric needs (Van der Helm, 2012).

A youth's motivation for change can be affected by intrinsic and extrinsic motivators. Legault (2016) describes intrinsically motivated behavior as the performance of an action or behavior that is "not contingent upon any outcome that is separate from the behavior itself." (In other words, the means and end of a behavior are the same and no reason is influencing the behavior other than personal interest or gain.) Conversely, extrinsically motivated behavior is described as "the performance of behavior that is fundamentally contingent upon the attainment of an outcome that is separable from the action or behavior itself (Legault, 2016)."

To reduce the likelihood of extrinsic motivators undermining intrinsic motivators for behavior change (e.g., a youth performing a behavior contingent on receiving a social reward rather than for personal enrichment or growth), researchers suggest assessing motivation before treatment and having youths attend programs that improve internal motivation for change early in the treatment process (Knight et al., 2019; Legault, 2016; Van der Helm et al., 2014; Van der Stouwe et al., 2018).

According to JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program), motivation is assessed through the behavior motivation phase system.

Residential Treatment Staff Perspective. Interviews with staff indicated that motivation to change is assessed clinically and not through a validated instrument. In other words, youths in the REGIONS program receive a subjective motivation assessment.

Summary. Interviews with staff indicated that motivation to change is assessed clinically and not through a validated instrument. Subjective clinical judgments are not considered to be evidence based, as research indicates that valid tools provide more stable and reliable estimates. If motivation is a responsivity concern for the REGIONS program (e.g., if youths are failing because of lack of motivation), we recommend that JBCSSD implement an assessment tool to measure motivation. Several studies have used valid and reliable instruments to evaluate motivation for change in youths committed to a secure residential treatment facility. These instruments include the Adolescent Treatment Motivation Questionnaire (Roest et al., 2016), Motivation for Treatment Questionnaire (Van Binsbergen, 2003; Van der Stouwe et al., 2018), and the Readiness to Change Questionnaire (Rollnick, Heather, and Bell, 1992; Van der Helm et al., 2014). Examples of free, validated tools that assess motivation include the University of Rhode Island Change Assessment (URICA) and the Texas Christian University Client Evaluation of Self at Treatment (TCU CEST). The value of assessing motivation is enhanced when motivation is assessed often. Frequent assessment allows for the program to note when a client

experiences changes in motivation, which may signal a need for an intervention to enhance motivation. The use of a tool to assess client's motivation will give JBCSSD a consistent approach for determining if motivation is waning and an intervention is needed.

38. Rate of Identification of Different Learning Styles and Integration Into Treatment Planning

The usefulness of identifying learning styles and designing programming to align with different learning has not yet been identified as a research-based practice with juvenile justice youths. The phrase *learning styles* refers to the concept that individuals learn more effectively when they receive instruction by means of strategies conforming to their individual preferences for how to process information (Cuevas, 2015; Pashler et al., 2008). The Kolb inventory, used mainly in research studies, classifies learners along two dimensions: a preferred mode of perception (concrete or abstract) and a preferred mode of processing (active experimentation or reflective observation) (Gogus and Gunes, 2011; Kolb, 1984; Kolb, 1985; Pashler et al., 2008; Zacharis, 2011). Based on these categories, learners are placed into one of the four categories: 1) divergers who favor feeling and watching (concrete, reflective), 2)

> **We asked 17 youths, "Is it easy for you to understand the new things you're learning in your groups and individual treatment sessions?" Fourteen answered, 'Yes,' and the other three said that they understood with help from one of the clinicians in the program.**

assimilators who favor thinking and watching (abstract, reflective), 3) convergers who favor thinking and doing (abstract, active), and 4) accommodators who favor feeling and doing (concrete, active). In practice, the visual/auditory/kinesthetic (VAK) or visual/ auditory/read–write/kinesthetic (VARK) taxonomies are more widely used and have become commonplace at all levels of education and through a wide range of commercial products (Bishka, 2010; Cuevas, 2015; Riener and Willingham, 2010).

Research on evidence-based corrections clearly indicates that structured assessments are preferred to clinical judgment (Andrews et al., 1990; Andrews et al., 2007; Andrews, Bonta, Wormith, 2006; Hannah–Moffat, 2005); however, there is no body of research indicating that learning style or learning style assessment with corrections populations should be an evidence-based practice. In addition, there is considerable debate in the field of education about whether learning styles affect educational outcomes, with the most rigorous research indicating that no evidence exists to justify incorporating learning-style assessments into general educational practice to improve learning outcomes (Cuevas, 2015; Pashler et al., 2008; Pashler et al., 2009). Nevertheless, providing opportunities for youths to learn skills using a variety of information-sharing styles and skill-building techniques 1) is likely the best way for them to learn, and 2) considers responsivity issues that may impact learning.

Youth Perspective. We asked 17 youths, "Is it easy for you to understand the new things you're learning in your groups and individual treatment sessions?" Fourteen answered, "Yes," and the other 3 said that they understood with help from one of the clinicians in the program. We also asked, "If you need extra help understanding new information in individual or group treatment, does anyone help you with this?" Almost all the youths answered that someone helps them when they need help (some thought they never needed help understanding). Youths mentioned that juvenile detention officers/mentors, clinicians, classification and program officers, or reintegration mentors have helped them. They made comments such as the following: "If I don't understand, I ask again"; "If I don't understand, they talk to me about it more, and slowly, give an opinion if it was their life"; and "It's not like I understand everything; If I ask, she'll explain it and then I'll understand."

Residential Treatment Staff Perspective. Interviews with staff indicated that the assessment of learning styles is informal, and no specified process or assessment tool is implemented. Many interviewees mentioned special education status and how this is accommodated within the school, and others described the strategies they use to work with youths with lower IQ. For example, one of the interviewees said: "For lower-IQ youth, we may go outside for a walk and make things more tactile so that we can rely less on in-group conversation, which may be difficult for them to understand."

An interviewee from a staff-secure program mentioned that the staff reviews the youth's background before they participate in programming groups, saying:

> The clinicians usually assess and receive background information about the youth and their education to see where they're at educationally and cognitively. Nothing is skipped over. For example, we don't want to ask someone to read, if he can't read. We want them to comprehend what's going on. We can always slow down the language and the verbiage. We are able to sustain more clients by doing this. In the past, kids didn't understand fully what was going on, and this triggered them to run. They felt people were pulling one over on them. They generally wouldn't ask questions; they would just run. Now we talk more with probation and the sending facility. We go through things more slowly. Probation really helps us understand if there is really a need. And the previous residential facility will tell us what worked well in the secure setting…Everything needs to be fully connected.

However, the interviewees did not have specific feedback about how learning styles are integrated into treatment planning for all youths.

Observations. Our observations indicate that most of the programs provide opportunities for youths to learn DBT skills using each of the four methods in the visual/auditory/read–write/kinesthetic (VARK) taxonomy. For example, the facilitators read a scenario or explain the directions (auditory), there are usually handouts or other visual supplements to review (visual), youths are supposed to role play (kinesthetic), and finally homework is assigned (read–write).

Summary. Although learning styles-based instruction enjoys broad acceptance in many educational settings, most research studies have failed to find that it has measurable benefits for student learning (Cuevas, 2015; Pashler er al., 2008). Similarly, no body of research indicates that learning style assessment with corrections populations should be an evidence-based practice. Although the assessment of learning styles is accomplished informally in REGIONS, youths shared that they understand information provided during treatment. Also, our observations indicate that most programs incorporate each of the four methods of learning in their groups (auditory, visual, kinesthetic, and read–write). Finally, the PbS Re-entry Survey found that most of the 94 youth respondents agreed with the statements "I understand what is expected of me when I leave" (72 percent, strongly agree; 24 percent, agree; 3 percent, not recorded) and "I am a good learner" (67 percent, strongly agree; 26 percent, agree; 4 percent, not recorded; 3 percent, disagree).

39. Extent to Which the Clinical Coordinators' Work Regarding the Placement Opinion, Formulation, and Service Recommendations Are Integrated Into REGIONS Treatment Plan Development
To assess this metric, DSG extracted data from youth files and analyzed the extent to which the placement opinion, formulation, and service recommendations developed by the clinical coordinators in the service memos were incorporated in the initial Integrated Treatment Plans (ITPs).

File Review. As described in Appendix A, Process Evaluation Methodology, we examined a sample of about 40 REGIONS adolescents. Of those, 22 individuals had a service memo and initial ITP that were completed within 2 months of one another. First, we examined whether each youth was placed in a facility according to the clinical coordinator's placement opinion. Next, we compared the formulation of

the youth's experiences, challenges, and current ways of coping reported by the clinical coordinator in the service memo with the case formulation from the initial ITP, which lists the youth's vulnerabilities according to the START:AV. Finally, we compared the clinical coordinator's recommendations with the need areas, goals, and interventions mentioned in the ITP.

When comparing the clinical coordinator's placement opinion (i.e., secure or staff secure) with the type of facility where the youth was placed, 86.4 percent of the cases matched. In three cases, the clinical coordinator's recommendation did not match the facility type where the youths were placed. In all three cases, the clinical coordinator recommended a secure placement, but all three youths were placed in Milford Boys & Girls Village, which is a staff-secure facility.

Almost three fourths (73.8 percent) of the issues presented in the clinical coordinators' formulations were also mentioned in the case formulations presented in the ITPs. The most common issues that were not present in the ITP included those related to the youth's home, family, and parenting (e.g., poor parental supervision, inconsistent limit setting, poor family functioning). These issues were mentioned in 13 of the 22 service memos examined, but not in the ITPs. Antisocial attitudes and beliefs (e.g., lack of remorse or empathy, does not accept responsibility for actions) were mentioned in 8 of the 22 service memos, but none of the ITPs. Other issues mentioned in the service memo formulation but not the ITP case formulation were substance use, emotional dysregulation, negative peers, lack of prosocial involvement, school, and previous treatment non-compliance.

The clinical coordinators' recommendations were incorporated in the initial ITP at a rate of 61.5 percent. The most common clinical coordinator recommendations that were not included in the ITP were substance use (nine youths) and home, family, and parenting (nine youths). Other clinical coordinator recommendations that were not included in the ITP were negative peers, school, negative attitudes/beliefs, trauma, lack of prosocial involvement, consultation for psychotropic medication, and vocational/employment programming.

Residential Treatment Provider Perspective. Twelve residential treatment staff members from five of the seven residential treatment programs answered the question, "How well do you think the opinion, formulation, and service recommendations are integrated into the development of the REGIONS treatment plan? Please rate this on a scale of 1 to 10, with 1 indicating 'not well at all' and 10 being 'very well.'" The respondents included mental health staff (e.g., licensed mental health clinicians, psychiatrists), classification and program officers, program managers, and administrators. The average score was 8.9 and the range was 6 to 10. (For more information about residential treatment staff's perspectives on the clinical coordinator's service memo, see Metric 5.)

Summary. Although our review of this metric only included 22 case files, several clear patterns emerged. First, there was a high rate of agreement between the clinical coordinator's placement opinion and the facility where the youth was placed. There were only three mismatches, with all three youths being recommended for a secure residential facility, but placed in Milford Boys & Girls Village, a staff-secure facility. It is possible that these mismatches were due to external factors unrelated to the youths or the clinical coordinators.

Second, there was a relatively high rate of agreement between the clinical coordinator's formulations and recommendations addressed in the service memo and the formulations and need areas, goals, and interventions described in the ITP. Almost three fourths (73.8 percent) of the issues presented in the clinical coordinator's formulations were also mentioned in the case formulations presented in the ITPs. The rate at which the clinical coordinator's service recommendations were incorporated in the ITP was lower (61.5 percent). The issue most mentioned in the service memo formulation but not the ITP formulation related to the youth's home and family functioning, and it was also one of the issues most

often recommended as a service need in the service memo but not included in the ITP. It is possible that this issue related to the youth's home and family functioning is not addressed while the youth is in the facility because there is no reunification plan, or maybe the issue is addressed closer to discharge.

40. The Number and Percentage of Integrated Treatment Plans Completed and Signed Within 15 Days of Admission

According to JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program), within 15 business days, an Integrated Treatment Plan (ITP) meeting should be held by the multidisciplinary team to assist with completion of the ITP. During this meeting, the clinician will synthesize into an ITP all clinical findings as well as input from staff, family, the youth, the juvenile probation officer, the attorney, and the DCF (Department of Children and Families) worker (if applicable). By the 15th business day of admission, the initial ITP should be signed.

Dataset. Of the 354 cases in the file provided to DSG, only 2 included the completion date of the first treatment plan (August 2021 in both cases). Thus, DSG could not assess this metric using data from the CDCS database.

File Review. The sample of 40 cases included 36 files with ITPs (for more information on our sampling approach, see Appendix A). In these reports, we extracted the date of admission, the date of the initial ITP meeting, and the date the initial ITP report[11] was completed. The dates indicated that all ITP reports were completed between Sept. 3, 2018, and Dec. 22, 2021 (8 percent were completed in 2018, 44 percent in 2019, 25 percent in 2020, and 22 percent in 2021). Each of the seven residential programs was represented. The ITP meeting occurred between Sept. 3, 2018, and Dec. 29, 2021.

For two thirds of the youths (24 of the 36 cases) the ITP report was completed within 15 business days of admission. The average number of business days from admission to ITP completion was 13.7, with a median of 11 (meaning that the number of business days from admission to the initial ITP was fewer than 11 in half the cases and more than 11 in half the cases). The average number of business days from admission to initial ITP meeting was 12.6, with a median of 11.

Over time, the average number of days both to hold the initial ITP meeting and to complete the initial ITP report has decreased:

- **Initial ITP Meeting.** For youths admitted in 2018 and 2019, the average number of business days from admission to the initial ITP meeting was 13.8 (with a median of 14), and for youths admitted in 2020 and 2021, the average was 11.4 (with a median of 11). In 2020 and 2021, 82 percent of youths had their initial ITP meeting within 15 business days (compared with 63 percent in 2018 and 2019) [see Figure 3.4]).

- **Completion of Initial ITP Report.** For youths admitted in 2018 and 2019, the average number of business days from admission to the initial ITP meeting was 14.2 (with a median of 14), and for youths admitted in 2020 and 2021, the average was 13.2 (with a median of 11). In 2020 and 2021, 71 percent of youths had an ITP completed within 15 business days (compared with 63 percent in 2018 and 2019) [see Figure 3.4]).

---

[11] In other parts of this report, we refer to the *ITP report* as the *ITP*. In this section, however, we use the term *ITP report* to distinguish it from the ITP meeting.

Figure 3.4. Percent of Initial ITP Meetings and ITP Reports Completed Within 15 Days
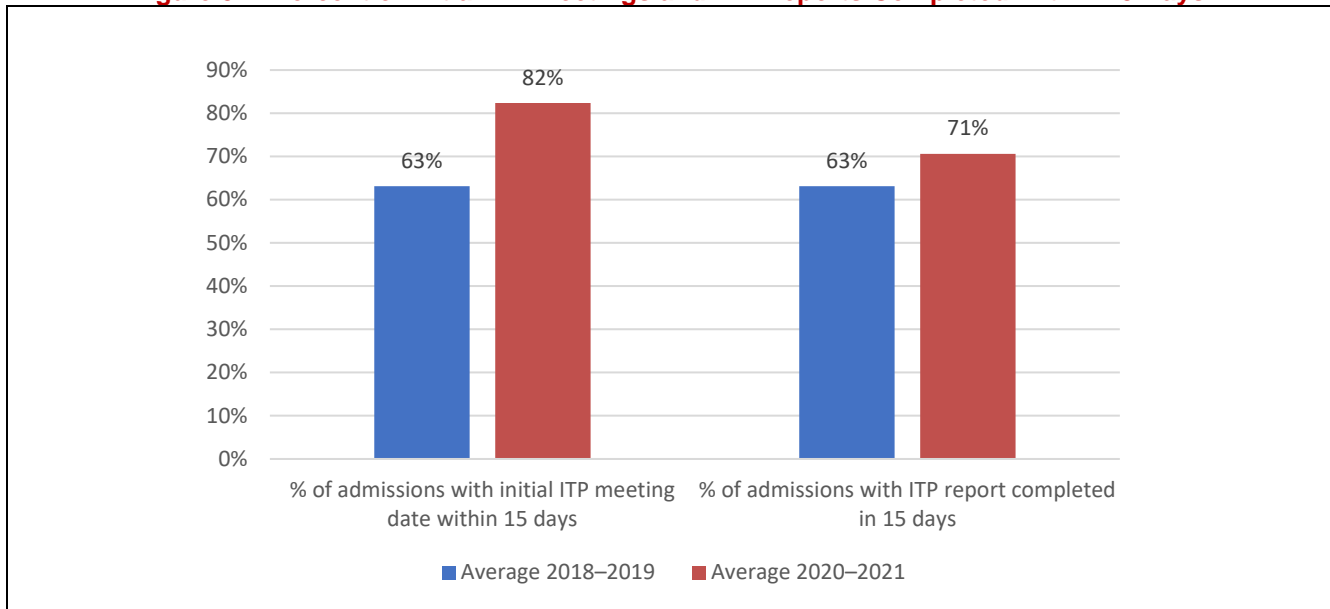
Data source: Youth files. *N* = 36.

Summary. Although no conclusive results could be obtained from the CDCS data, information from our sample of files provided helpful information to assess this metric. A review of 36 files suggests that most ITPs were completed within 15 days and that timeliness is improving. In 2020 and 2021, 71 percent of the cases had an ITP completed within 15 business days (compared with 63 percent in 2018 and 2019).

41. Quality of the Initial Integrated Treatment Plan (ITP) Meeting
This metric was assessed by analyzing information gathered from key stakeholder interviews.

Residential Treatment Staff Perspective. To assess the quality of the ITP meeting, staff who indicated that they participate in these meetings were asked a series of questions. First, staff were asked if "everyone's voice was heard" during the ITP meetings, including the initial meeting. All 30 staff who participated in these meetings felt that everyone's voice was heard. Staff reported that everyone has an opportunity to speak, be heard, and contribute their thoughts on the case. If disagreement occurs, staff work together politely until consensus is achieved. Next, interviewees were asked if the meeting "was focused" and if "there was enough time" at the meeting. Again, all respondents felt the ITP meeting was focused and there was enough time.

We asked 31 residential treatment staff members to rate the utility and effectiveness of the initial ITP meeting, with 1 being very low quality and 10 being very high quality. Most felt that this meeting was both useful and effective, giving it an average rating of 8.5. Almost everyone rated the utility and effectiveness of this initial meeting as a 7 or above (see Figure 3.5).

Youth Perspective. Thirteen of the interviewed youths indicated that they had attended at least one ITP meeting, and 10 said they remembered their first ITP meeting. When we asked, "Does everyone talk?" all said "yes." When we asked, "Do you talk?" all said yes, indicating at least some level of engagement and buy-in into the process. We then asked, "Do people listen to you?" All responded that they did. One boy said: "I sometimes talk…Yes, they listen to me…. I know this because they make eye contact with me." Many responses indicated that the meetings revolved around discussing the youth's progress, current and future goals, and the steps required for discharge. One respondent stated that "it's helpful to know I'm not being forgotten." Most of the respondents felt the meeting was long enough,

while a few said it was too long for them. Some said that they were nervous or anxious at first, but all had positive comments about both the initial ITP meetings and subsequent ITP meetings. A respondent did add that they would prefer meeting in person or on the Zoom platform "but in person would be the best."

Figure 3.5. Residential Treatment Staff Perspectives on the Quality of the Initial ITP Meeting

Rate the quality of the initial ITP meeting
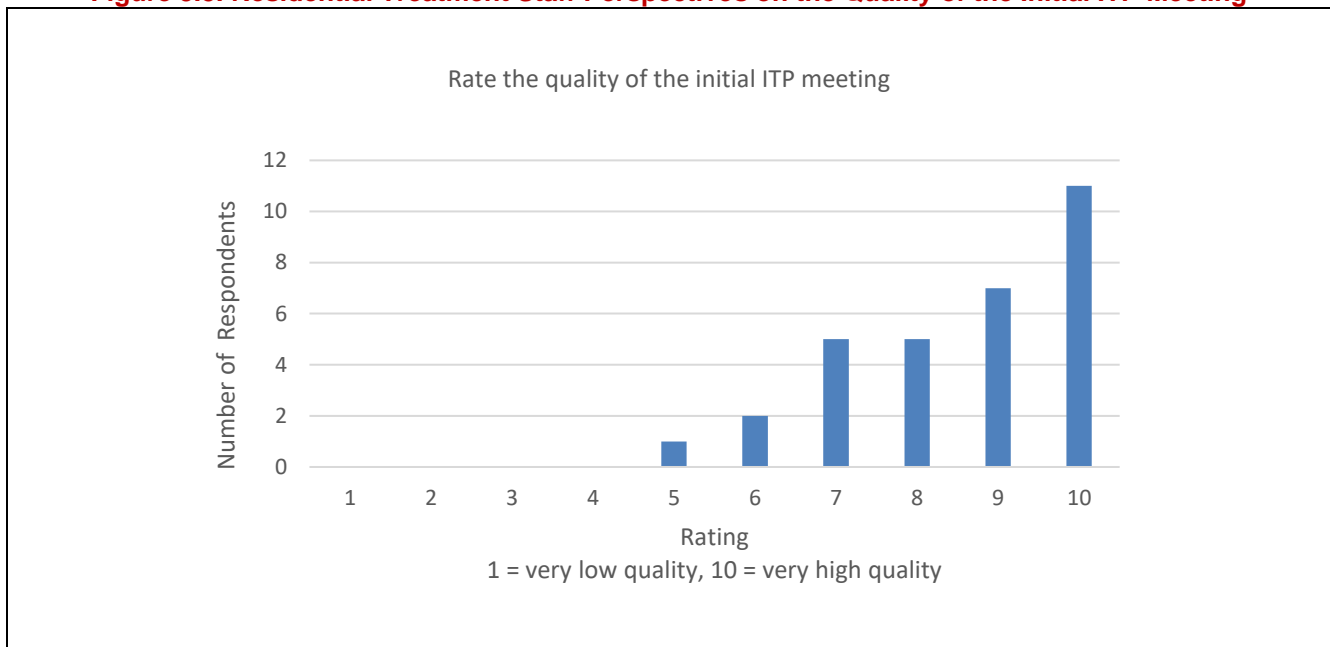
Data source: Residential treatment staff interviews. *N* = 31.

Court Perspective. DSG interviewers also asked judges, attorneys, and probation officers about the quality of the initial ITP meeting. They, too, felt that these meetings were focused, useful, and of an appropriate length.

Summary. Based on the totality of interviews and observations, it is clear that the REGIONS ITP meetings are of high quality, including the initial ITP meeting.

B. Treatment Approach
The process evaluation includes 20 metrics related to the REGIONS treatment approach. These metrics are as follows:
- Metric 42. The quality and effectiveness of client engagement strategies
- Metric 43. Quality and effectiveness of family engagement strategies
- Metric 44. Utility of the weekly team meetings
- Metric 45. Rate of participation of non-REGIONS staff in monthly ITP meetings
- Metric 46. Degree of overlap or correspondence to other identified vulnerabilities/risk areas as determined by the START:AV, the clinical coordinator recommendations, and the juvenile probation assessment/case plan
- Metric 47. The extent to which written treatment summaries are shared monthly with the JBCSSD residential liaison and the juvenile probation officer, and are used to enhance communication and team approach
- Metric 48. Number and percentage of clients who receive weekly group and individual therapy sessions that specifically address their treatment goals associated with identified vulnerabilities/risk
- Metric 49. Average number of clinical group sessions per week, average number of individual

sessions per week, and average number of groups per week
- Metric 50. Number and percentage of clients receiving weekly family treatment sessions
- Metric 51. The extent to which substance use treatment needs are met
- Metric 52. The extent to which psychiatric treatment needs are met
- Metric 53. Effectiveness of milieu coaching to increase prosocial skills and decrease negative behaviors
- Metric 54. The appropriateness and effectiveness of programming to meet treatment goals, such as non-clinical groups, prosocial activities, recreation enrichment, family activities, and community home passes
- Metric 55. The appropriateness of staffing type and number
- Metric 56. Extent to which trauma, culture, and gender inform treatment and programming
- Metric 57. Extent to which educational and vocational needs are met
- Metric 58. Extent to which demonstrable educational gains are evident
- Metric 59. Any evidence of disparate treatment based on race, ethnicity, or gender
- Metric 60. The presence or absence of objective and subjective determinants of treatment plan goal attainment and a QA (quality assurance) process to gauge consistency across clients and clinical teams
- Metric 61. The extent to which data from the START:AV is being used to evaluate the effectiveness of the REGIONS program model.

42. Quality and Effectiveness of Client Engagement Strategies

Treatment can only work if an individual participates in it. The REGIONS program uses DBT (Dialectical Behavior Therapy) as the main treatment intervention for youths. DBT is designed to treat mental health, trauma, substance misuse, and management of difficult emotions (Klodnick, Kissane, Johnson, Malina, Ewing, and Fagan, 2021). DBT attempts to do this by engaging youths to define a life worth living and to develop needed skills by means of therapy, skills groups, milieu structure, and coaching (JBSSD Policy and Procedure 8.600, Judicial Residential Services REGIONS Secure Treatment Program). Research has demonstrated that being engaged in treatment is an important mediating variable between criminogenic targets and recidivism (see, for example, Maldonado and Murphy, 2021; Yang et al., 2013). Both the actual treatment and successful strategies for promoting engagement with that treatment are necessary for DBT to have an impact.

The REGIONS residential programs implement systems of levels to help the youths manage their behavior and engage with treatment and programming. Each level includes responsibilities related to engagement with treatment. For example, a few of the programs use the level system below.

- **Prospect level/Aspiring Artist:** The first level, when youths enter the program.
- **Rookie level/Silver:** Ability to state treatment goals in own words; willingness to participate in the assessment process; willingness to attend all scheduled groups and individual treatment sessions and take medications as prescribed.
- **Pro level/Gold:** Active participation in scheduled groups and individual treatment sessions and taking medication as prescribed; role model REGIONS expectations for Rookie members.
- **All-Star level/Platinum:** Ability to attain treatment goal(s).

Stage 1 of treatment in REGIONS is called the REGIONS Engagement Program. Its goal is to "ready youth in pre-trial juvenile detention awaiting placement in a REGIONS unit" (JBCSSD Policy and Procedure 8.600). It is designed for youths on the REGIONS Secure wait list.

Residential Treatment Staff Perspective. Forty-seven residential treatment staff members rated the quality and effectiveness of the client engagement strategies (with 1 indicating very low quality and

effectiveness and 10 indicating very high quality and effectiveness). More than three fourths of the respondents rated client engagement strategies in their own facilities as an 8 or higher, and none of them rated this item under a 5 (see Figure 3.6). The average rating was 8.3.

When staff were asked how they engage youths in treatment, they shared strategies including the following:

- Listening to them and not pushing them or forcing them into treatment or programming. Taking the time to talk to them and find out why they may not want to engage.
- Building rapport and positive relationships. Interacting with them one-on-one and in groups.
- Using encouragement along with consequences.
- Meeting them "where they are," finding out what they enjoy, and working from there.
- Constantly reminding them of their goals and the positive things they want to achieve.
- Stopping them in the moment to remind them to use their DBT skills.
- Mindfulness activities.
- Boys' council and other activities for leadership and input.

For example, one of the interviewees said:

> DBT segues into the first few conversations about goals, what do they want to do there, why are you here, what are you going to do differently this time, what tools do you need to be successful, what would you tell your past self. We're try[ing] our best to NOT let the kid just come here and settle in. We talk about the point system, which translates into a reward or gift card or order clothes or request a book. We have many different options. We do our best to give them what they want and individualized rewards. We find out about their backgrounds, and where they're from.

Another interviewee said:

> We talk to them. We try to be as encouraging as possible for them to do their treatment. If they refuse, it doesn't go away. We explain why they have to do it. We have pretty good staff that can explain why it's important. A lot of the staff are from the same neighborhoods as the youth, so they can build that relationship well. In the beginning, some of the youths may want to just do their time and get out. But when they see others getting levels and more activities to participate in, and that they don't have to put on a show about how tough they are, they start to buy in.

Finally, a third interviewee commented on the importance of staff in the juvenile detention officer/mentor role to be trained in DBT and youth engagement strategies and to be able to work with youths who are struggling. He said:

> All line staff are considered mental health workers. They are trained in DBT: they can de-escalate, teach skills, and help run skills groups. The line staff used to call the therapist when kids were escalating or emotional or had an issue. Now I want the line staff to have this role. This is instituted and in place.

Youth Perspective. We also asked 15 youths how much input they felt they had into the program. Their responses were mixed. Some felt that they did not have much input while others felt that sometimes they did have meaningful input. One way to have input into the program is through the youth council.[12] Some of the youths mentioned that they participated in the youth council, were happy with the impact they had on some decisions in the program (decisions about workout equipment, movies, types of rugs and pillows, etc.), and enjoyed holding leadership positions on the council. They said that it was a good

---

[12]The youth council is a formal group enabling youths to engage in discussions with each other and adults on a wide variety of community- and youth-related issues and contribute to decision-making. The weekly youth council meetings are a time when the unit manager can solicit input and feedback from the youths (JBCSSD Policy and Procedure 8.600).

opportunity to engage with adults in the program and that they felt heard. Others said they did not participate, either because they had not yet reached that level of the behavior management system or they did not want to participate (and points are not deducted for this, as it is an optional activity). One of the youths said about the youth council:

> It's a safe place. We have a president, vice president, and secretary. The secretary writes in a book. It's our time to talk about what we'd like to change about the program. Then it gets approved or not. We got approval for new movies, new video games, new chairs. A lot of stuff. The adults just let us talk. We can include them if we want, and they listen to us.

Figure 3.6. Residential Staff Perspectives on Quality and Effectiveness of Client Engagement Strategies

Data source: Residential treatment staff interviews. *N* = 47.

Some of the PbS survey questions also examined aspects of client engagement. For example, 91 percent of the respondents agreed with the statement, "I know youths participate in youth councils or youth boards to provide input into what happens here." Also, 96 percent of the respondents agreed that incentives and rewards helped them keep working toward their goals, and 96 percent indicated that they had input into decisions about the incentives and rewards to help them keep working on their goals. Also, 94 percent of respondents indicated that they had input into meetings about them.

Summary. Based on the totality of interviews and observations, DSG concludes that the policies and practices of the REGIONS program provide quality engagement strategies. During the interviews, staff noted the many ways that they attempt to engage clients in treatment (e.g., point system, encouragement/motivation, remind them of goals, build rapport). Additionally, they said that they felt the engagement strategies were high quality. However, staff also felt that more training on how to engage clients in the DBT milieu was important. Several of the interviewees who commented on the engagement strategies requested more training.

43. Quality and Effectiveness of Family Engagement Strategies

For youths in the juvenile justice system, the family's role has historically been studied as more of a cause of delinquency than a protective factor (Hoeve et al., 2009; Norman et al., 2012; Pennell, Shapiro,

and Spigner, 2011), and the family's role in the rehabilitation of justice system-involved youths has often been minimized. Historically, policies and procedures have failed to provide a space for family participation, and many families feel excluded from the system charged with caring for their children (Osher and Hunt, 2002).

However, this trend has changed in recent years. According to Performance-based Standards (PbS), "the historic wall separating youths in juvenile justice facilities and residential placements from their families is slowly coming down" (Lovett and O'Neal, 2020). Residential programs are realizing that both parents and siblings can serve as protective factors in some circumstances, and juvenile justice systems are increasingly trying to figure out how to get families more involved (e.g., Osher et al., 2012; Shanahan and Agudelo, 2012; Shanahan and diZerega, 2016). Family members' participation is thought to help reinforce the importance of treatment, provide youths with advocates who can help articulate their needs, and increase the probability of a smooth transition to home at the end of out-of-home placement (National Center for Mental Health and Juvenile Justice, 2016). Some organizations also suggest that families benefit when they know their children's whereabouts and what is happening to them, understand the system's process and expectations, and feel valued for their information-sharing ability (e.g., regarding their children's treatment and medication history, behavioral patterns, educational background) [National Center for Mental Health and Juvenile Justice, 2016].

Research studies have examined the effect of family engagement on youths in residential settings (DSG, 2018). A study of 62 juvenile correctional programs participating in PbS found that greater family visitation was associated with fewer total incidents in facilities (Mikytuck and Woolard, 2020). Another study examining length of stay, therapeutic change, and recidivism among more than 600 youths found that cognitive and emotional skills acquisition among incarcerated youths was positively associated with parent visits (Walker and Bishop, 2016). In other words, having contact with at least one parent during incarceration was associated with higher skill acquisition (the study also found that skill acquisition was associated with reduced recidivism). The study authors emphasized that the association between parent contact and skills acquisition was notable because of the insignificant relationship between family cohesion and skills acquisition, which suggests that the improvement in contact is not simply due to better overall family functioning or family structure.

The REGIONS program integrates the family in various ways. JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program) contains several family-related requirements. For example:

- Parent/guardian engagement is a component of the REGIONS Engagement Program (i.e., stage 1). This program readies youths in pre-trial juvenile detention awaiting placement in a REGIONS unit.
- The unit manager is charged with ensuring that families and supportive individuals are included in every aspect of the treatment program.
- Staff and contractors are supposed to engage the family and other supportive individuals in the treatment program at admission and consistently throughout the youth's stay.
- The classification and program officer will contact the youth's parent/guardian on a weekly basis to engage and educate the parent/guardian about the REGIONS program and solicit their input into the stage 1 treatment plan.

Residential Treatment Staff Perspective. JBCSSD Central Office administrators and residential treatment providers from each of the seven residential programs commented on the quality and effectiveness of family engagement strategies in the residential treatment component of REGIONS. Most staff understood that parent engagement was important, especially the reintegration mentors. One of the reintegration mentors said: "When parents are on the same page as the client it works well. That

keeps consistency."

Most interviewees stated that families/guardians regularly participated in REGIONS meetings, primarily the monthly ITP meetings,[13] and that most youths had regular contact with parents/guardians through virtual visits and phone calls. They also mentioned that staff often provide parents with weekly updates on progress. Twenty-six of the interviewees rated the quality and effectiveness of family engagement strategies in the residential programs on a scale from 1 (very low quality) to 10 (very high quality). The average score was 7.3 out of 10. The scores ranged from 2 to 10 (see Figure 3.7). The median score was 7. Many felt that although the quality of the program's family engagement strategies was strong, the strategies may not result in measurable increases in family engagement (i.e., the strategies' effectiveness may be low). One of the interviewees said:

> I think that is an area for improvement. I think this is something the parents are learning as well. I'd say we have improved family engagement since the beginning, from a 4 to a 6, by incorporating incentives, like family nights, grocery gift cards, and things like that. But to get it to an 8, I don't know. If you find something, please let me know.

We asked interviewees what may impact a parent's level of engagement. They mentioned that many parents are tired of dealing with their child's issues. By the time they get to REGIONS, most adolescents have been involved with several different programs and service providers. Parents have already missed many days of work, and they may have other children at home that they need to focus on. One of the interviewees said: "We do a good job, but some are at the end of their rope and others have their own stuff to deal with." Another said: "They've been through this before, and some of them are just over it."

Another interviewee mentioned that parental engagement is not a Court requirement, although it is encouraged by the residential program. She said:

> When the kids are sentenced to REGIONS, does that order from the Court also require that parents must participate (so that you have a little leverage over them)? I don't think I've seen anywhere where it states that parents have to participate. So when you get them, then you tell the parents we're expecting them to participate. Sometimes they are surprised, and often it can be challenging.

However, some interviewees felt that most of the parents were engaged, with one interviewee saying, "It's rare that you have parents that aren't willing to engage." Another said:

> The parents have meaningful input into their treatment. They have to do this in order for kids to be successful. I have not seen many times when family is not involved. Most families still want input. The probation officer makes sure the parent is well informed, and we still have the Courts and attorney who are also on team.

When asked whether parents/guardians visit their children in person, many interviewees said that this is challenging. Although programs offer financial support for these visits (e.g., some programs mentioned that they pay for the parent's transportation), generally parents/guardians do not regularly visit their children in person. One of the residential treatment providers said: "Some just don't want to come to visit, especially if it's after multiple placements."

Similarly, when probed about the role of family in treatment, staff reported that family rarely participated in treatment groups. One of the interviewees said:

> We may need more incentives for the parents to participate. Lack of parent participation in groups makes it difficult to prepare the home for when the youth go home. Parent participation is very difficult. Getting

---

[13] For more information about parent participation in the monthly ITP meetings, see Metric 45.

families ready for when their child returns home is an area for growth and a constant challenge for us.

However, the program already provides parents with several incentives to promote their engagement, including financial assistance with transportation. One of the respondents called the residential programs "well-resourced" and said that the issue is not lack of funding.

Figure 3.7. Residential Treatment Staff Perspective on
Quality and Effectiveness of Family Engagement Strategies

Rate the quality and effectiveness of the family engagement strategies on a scale of 1–10

Rating
1 = very low quality and effectiveness, 10 = very high quality and effectiveness
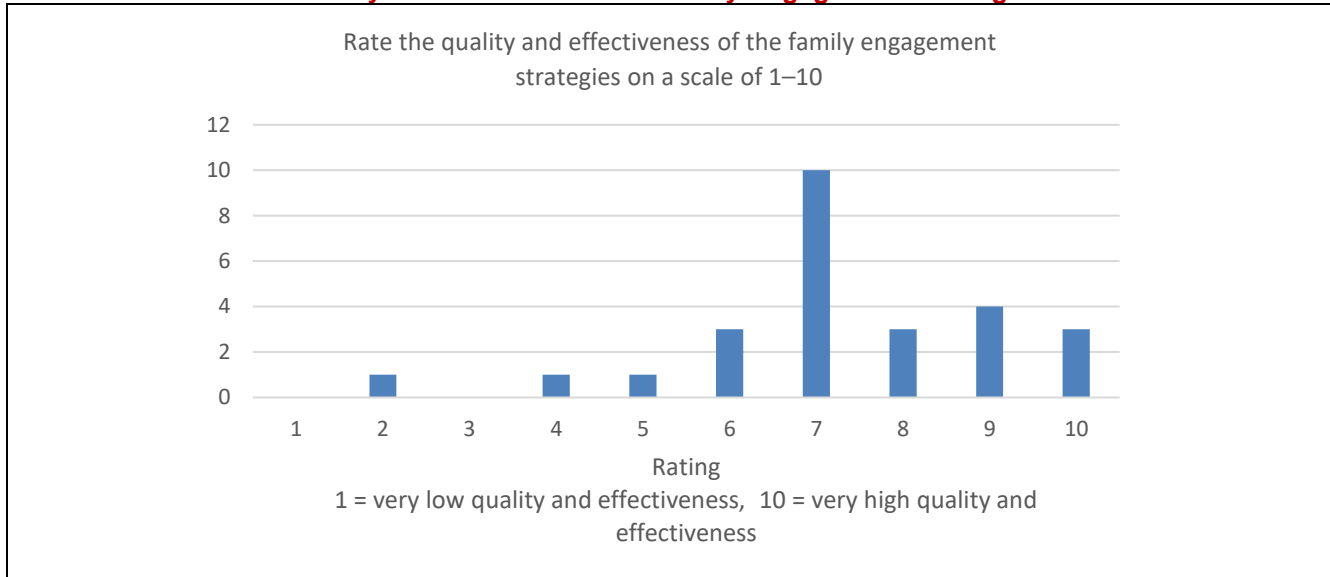
Data source: Residential treatment staff interviews. *N* = 26.

To improve family engagement, some of the residential treatment staff felt that ensuring parents do not feel judged can help. One of the interviewees said:

> It is working well now. To improve it, it would be helpful to hone in on actual behaviors and tying those into something you might see in the community. Families have a lot of feelings when they go to those meetings (feel like being judged). We could tie it into that and make it more feel like it's not anyone's fault.

Youth Perspective. We asked 17 youths, "Do you participate in any treatment groups with your family? If yes, how often?" Four of the youths said they participated in treatment groups with family weekly (all in staff-secure programs), and two mentioned that their family attended a group "once or twice." The other 12 youths, who were from both secure and staff-secure programs, said that they did not participate in treatment groups with their families.

We also asked, "In what other ways does your family help with your treatment?" and "How else is your family involved in your treatment here?" Most said they had phone calls, video calls, and in-person visits with at least one family member and that a family member participates in the monthly ITP meetings (although one youth said his family was not involved at all). Some of the boys said they also had contact with friends and girlfriends, if they had not been arrested (or deemed a "bad influence"). Some mentioned talking to their family every day or even multiple times per day. Some youths shared that phone call access is related to the level a youth has reached in the behavior management program. In some programs, youths can also buy extra phone time from the program's store. One of the youths said: "Everyone gets a call every day on second shift at 4 p.m. I only get one phone call, and I always call my mom. But you can buy 15-minute phone calls from the store."

85

Some youths mentioned that their family members are helpful in different ways, increasing their motivation or helping them to adjust. One of the youths said: "My mom helps because she always calms me down." Another said:

> My mom is a big support. We talk twice per day on the phone or on video. We can do video if we're with a therapist. Sometimes it's three times if I decide to do a video call. Video calls count as a therapy session.

While some youths mentioned that they prefer in-person visits to phone calls or computer visits, at least one youth said he preferred the computer visit because she lives too far away, and the drive would be too long.

As part of the *2020–2022 PbS Youth Reentry Survey,* youth respondents answered several questions about their families. Each of the 90 youths who replied stated that they had talked on the phone or by video conference with their parents or primary caregivers since being at the program. Ninety-three percent said that they had received visits from parents or caregivers since they arrived, and 98 percent said that when they asked staff to arrange a call or visit with their families, the staff helped do this. Among the youths who said they had children of their own, 85 percent stated that they had talked to them by phone or video conference since being admitted to the REGIONS program, and 74 percent had had visits with them.

Parent/Guardian Perspective. DSG interviewed seven parents/guardians by Zoom, Teams, or phone. All had children who were currently in one of the secure programs, though some had experience with previous REGIONS placements and discharges as well. We asked several questions related to their engagement in their child's treatment, visits with their child, attendance at meetings, and communication with REGIONS staff.

When asked about participating in treatment groups, therapy, or counseling, many parents/guardians commented that their ability to meet in person (or at all) was hindered by the scheduled times for the sessions, and (in the case of in-person groups) the distance to the program. One parent's response to whether they attended group therapy was: "No, we didn't do it [be]cause so we live an hour away from the detention center, and my work schedule was hard for me to get up there all the time." However, even virtual groups were difficult for some of the parents/guardians because of scheduling conflicts.

Some parents also reported that contact with their child depended on the behavioral system implemented by REGIONS (see [Metric 42](#)). The higher the child's level, the more phone calls the parent/guardian could have with their child, which affected the quantity of contact. Several parents shared that they thought this was unfair. One parent said: "I think they should have more phone calls." Also, a few parents stated that there were times when a call would drop, or they missed a call, and they would be unable to contact their child again that same day. This limited contact was disappointing. Parents also shared that visiting their children in person was challenging. In addition to the logistical issues, one parent reported that it was hard to visit in person because she would want to "take him back home." At least two parents, however, indicated that they regularly visit their child in person.

Six of the seven respondents had a child who had been in REGIONS long enough to have ITP meetings scheduled. All six shared that they participated in at least a couple of the monthly ITP meetings, with most saying that they participate every month. All participated by video call, and none indicated that they participated in person. Most parents indicated that they enjoyed the meetings, and that they were helpful to them as well as their child; they also understood the need for therapy. Outside of the monthly meetings, some parents reported that staff would contact them to keep them informed about how their child was either progressing or regressing.

86

Additionally, we asked, "Did you know whom you could contact if you wanted to speak to your child or have a question? If yes, was this person easy to reach?" All indicated that they knew whom to contact and that this person was generally easy to reach. However, five out of seven parents indicated they had experienced an issue with the REGIONS program either overstepping professional boundaries or not being consistent with expectations. These complaints mainly involved treatment of their child that they felt was unfair, being informed after the fact of certain decisions that affected their child, or staff being overly familiar. Parents reported that when they encountered a problem, staff often disregarded their complaints or did not follow up.

Finally, we asked, "How satisfied are you with how the REGIONS program involves and supports families while their child is in REGIONS residential placement? (1=very unsatisfied, 2=somewhat dissatisfied, 3=neither satisfied or unsatisfied, 4=somewhat satisfied, 5=very satisfied)." The average score was 4, which indicates that on average, the parents/guardians were somewhat satisfied with how the programs involve and support them. The scores ranged from 2 to 5.

Perspectives of Community-Based Providers and Probation. Probation officers and other stakeholders who work with youths in the community shared their perspectives on the quality and effectiveness of family engagement strategies. Most recognized both the importance of and the difficulty of engaging families in the youth's treatment. One of the probation officers commented:

> Usually there's a lot of collaboration that happens between the probation officer and the parent because you know, we're planning for what services that the parent might be interested in cooperating with when the kid is discharged from REGIONS. So that collaboration remains intact while the while the young person is at REGIONS because we need the parent most times to be a part of whatever recommendations have been made as it relates to treatment.

One community-based provider said:

> Well, that's been one of our most difficult engagements, with the families. Because a lot of time when we get the case, they've already had multiple services in the past that they've been through. So, when we get there, it's kind of like, 'Ugh, another one.' So, then it's kind of difficult for us to even meet with them because they have other things going on. For example, they'll say they have other kids and they have jobs, so it's quite difficult for us to actually get the parent involved. Or, what we see is that they'll engage in the beginning, and then once the kid gets home, then the engagement decreases.

Although not often mentioned, a few interviewees identified the role of DCF (Department of Children and Families) in engaging parents and how this should be improved. One of the interviewees said:

> If you had a little more cooperation between DCF and Courts, it might be better. In the past, if there were no parent visits when the youth was in the facility, they would call DCF. Now DCF won't intervene unless it's really extreme. If you have a 17-year-old kid, they want to get involved even less. A little more cooperation there might be helpful. Sometimes there is an incentive for parents not to participate. If they don't participate, the child goes to REGIONS, and sometimes the parents are happy with that because either they need a break or they feel the child is safer there than in the community.

Summary. The authors recognize the difficulty of obtaining and securing active parental/guardian involvement. However, research consistently demonstrates that it is important for the family to be engaged in the treatment process so they understand what behaviors should be reinforced, how to properly reinforce them, and/or how to properly monitor the child upon release. In other words, the family ideally should be a part of the intervention, not just informed of the intervention.

Regarding quality and effectiveness of family engagement strategies in the REGIONS residential programs, there are both strengths and areas for improvement. First, it is important to acknowledge that

87

the REGIONS program includes the family in its monthly meetings. Providing a voice for parents during REGIONS is vital. According to CDCS data, parents/guardians attend about 90 percent of the monthly ITP meetings (see Metric 45). However, most parents do not regularly participate in treatment groups or visit the youth in person while in the residential program. One of the community-based providers said: "The residentials are doing well, especially if they just add a bit more family work." However, achieving this increased family involvement is a challenge.

Second, we highly recommend that REGIONS engage families more in the DBT program. The main behavioral component of REGIONS DBT programming is the teaching of skills. Families should be aware of the skills being taught, what those skills look like (i.e., the steps that make up each skill), when the skills should be used, and how to reinforce the use of the skills. This information can be introduced during meetings with family members/guardians. If the program expects the youths to replicate these skills in the community, then members of the community (i.e., family/guardians) need to be trained in the skills, too.

44. Utility of the Weekly Team Meetings

Research indicates that routine, consistent staff meetings are associated with effective programs (see Makarios et al. 2016; Smith and Schweitzer, 2012). According to JBCSSD Policy and Procedure 8.600 (Judicial Residential Services, REGIONS Secure Treatment Program), "The clinician will facilitate a weekly MDT [multidisciplinary team] goal review meeting on a set day/time. The meeting includes a review of all youth in the REGIONS program and their progress towards meeting weekly goals." The MDT is specific to each youth and "will guide treatment, behavioral interventions, and discharge planning. The MDT consists of the youth, parent/guardian, juvenile probation officer, attorney, DCF (Department of Children and Families) worker if applicable, and all REGIONS staff, including but not limited to JDOs [juvenile detention officers], CPOs [classification and program officers], clinicians, education and healthcare providers, and facility administration." However, only some of these MDT members attend the weekly meetings.

Residential Treatment Staff and Court Perspective. Interviewed staff clearly feel that the weekly team meetings are useful. They mostly mentioned that during the meetings, they go over the youth's levels (and readiness to move up), talk about the youth's behavior on the unit, and discuss how well they are doing in treatment. They described the meeting as a collaborative effort with several stakeholders giving different perspectives on the adolescent's progress (e.g., JDOs, clinicians, CPOs, reintegration mentors, teachers, medical staff). One licensed mental health clinician said:

> Having all of the different feedback is good. I have my perspective from my individual sessions, family sessions, and groups. But at the weekly meeting I can also hear from the school or youth mentors, and there is a different version of the kid than I see him. We can discuss why we are seeing him in different ways and what skills we might work on to help him.

The weekly team meetings are also a time to ensure that all staff understand any specific needs. One interviewee said: "It keeps everyone on the same page. There was a youth that had two friends pass away, and these meetings helped us be more aware to why the youth may be agitated that day and help them through these emotions."

Summary. Research indicates that routine, consistent staff meetings are associated with effective programs. Interviews indicate the weekly meetings in the REGIONS program are useful for staff—they clearly help staff work more effectively with the youths in their care. The weekly team meetings and the MDT approach to treatment planning are valued, useful, and effective in REGIONS.

45. Rate of Participation of Non-REGIONS Staff (Client's Family, Juvenile Probation Officer, Attorney or Others) in Monthly Integrated Treatment Plan Meetings

According to JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program), the clinician is responsible for facilitating monthly Integrated Treatment Plan (ITP) meetings. Members of the multidisciplinary team (MDT), such as the youth's parent/guardian, probation officer, attorney, education representative, healthcare provider, and DCF (Department of Children and Families) worker (if applicable) are encouraged to participate. The classification and program officer (CPO) is supposed to notify MDT members of the day and time in advance of the meeting.

Dataset. CDCS data were provided for a limited number of cases involving youths who attended the monthly ITP meetings. Data were available on 23 unique juveniles representing 27 stays at a REGIONS program (some juveniles had multiple REGIONS stays; the majority of juveniles had multiple case reviews). Table 3.2 displays the percentage of ITP meetings at which non-REGIONS and REGIONS staff were present.

Table 3.2. Non-REGIONS Staff Attending Integrated Treatment Plan Meetings

Title	Percent of Meetings Attended
Program Clinician (REGIONS Staff)	100
Attorney (Non-REGIONS)	**95**
Probation Officer (Non-REGIONS)	**93**
Parent/Guardian (Non-REGIONS)	**89**
Line Staff Member (REGIONS Staff)	87
Educational Provider (Non-REGIONS Staff)	**64**
Facility Administrator (REGIONS Staff)	55
Reintegration Mentor (REGIONS Staff)	20

Stakeholder Perspectives. Interviews with residential treatment staff, probation officers, parents/guardians, attorneys, and youths all indicated that several MDT members are represented at most of the monthly ITP meetings. This diverse representation was largely viewed as a strength of the program. Probation officers particularly indicated that they felt it is important for them to be at each of these meetings, and they said that the supervisor attends if the probation officer cannot. Probation officers also noted that some programs differ in terms of ITP meeting invitations and other processes.

Some interviewees pointed out that it is difficult at times to get parents to participate, which may have to do with scheduling. A few interviewees mentioned the challenge of obtaining meaningful participation from MDT members other than the clinician; other stakeholders questioned whether there may be too many individuals in the meetings. One of the interviewees said:

> CSSD try to make sure everything flows correctly. But sometimes it may be better with just the parent. Sometimes it seems like people are there that don't need to be there. When the PO is invested, it's nice that he is there. When he isn't, it takes away some of the energy. When others from CSSD get on the call, sometimes the kids won't want to talk. Sometimes they put so many people in to watch you and look at you.

Overall, however, most interviewees commented that the ITP meetings work well because of the input of the MDT members, who all bring their own unique and important perspectives about the youth. And at least one interviewee said: "Kids really express what they want in these meetings. They wouldn't do that if they didn't feel heard."

Six of the interviewed parents had a child who had had at least one ITP meeting. Each of the parents/guardians stated that they had participated in at least two of the ITP meetings, and all shared that they participated by video call (e.g., Zoom). All parents/guardians indicated that they spoke in the

meetings, and they said people listened to them either "sometimes" or "always." Most of the parents/guardians felt the meetings were an appropriate length, and most did not have any recommendations for improvement. One parent said: "They are good and informative." However, a couple of parents/guardians expressed concern that their perspective sometimes weighed less than the clinician's.

Similarly, some of the probation officers, reintegration mentors, and other non-clinical staff mentioned that their perspective was not as important as the clinician's. Regardless of whether they have the final say in decision-making, some of the interviewees felt that a better effort should be made to incorporate their perspectives. Some of the interviewees felt that decisions are often already made before the meeting, and during the meeting, partners are given updates rather than treated as equal partners in decision-making.

Some of the interviewees also mentioned that they would like more participation from the youth. Currently, youths enter the meeting after some of the discussion has already occurred. One of the interviewees said:

> During these meetings they will say to the youth, "Let's talk about what you have identified as your treatment goals. What are you working on? What do you think is important?" And they sometimes try to get the youth to articulate it. And it's difficult because you're in this meeting, you've got all these people there and the client's a little bit nervous to try that. And, you know, they'll usually be able to get to two, maybe two or three treatment goals that they've been working on. Some of the clients are very good advocates for themselves, and they can identify everything. But it's a struggle for some kids. I mean, it's difficult for them when they join the meeting later. Some will come and be very quiet, even youth who normally talk a lot. Some of them are very uncomfortable.

However, youths who were interviewed did not share that they felt excluded from these meetings. Also, a PbS survey of 96 REGIONS youths conducted between April 1, 2020, and Nov. 23, 2022, found that 94 percent of the youths responded that they agreed or strongly agreed with the statement, "I had input into meetings about me." (For more information on the youth perspective, see Metric 41.)

Summary. The exact rate of participation of non-REGIONS staff in the monthly ITP meetings is unclear, but CDCS data and interviews with stakeholders indicate that youths, parents/guardians, probation officers, and attorneys regularly participate.

46. The ITP Prioritizes Violence Risk and Absconding Risk; Determines the Degree of Overlap or Correspondence to Other Identified Vulnerabilities/Risk Areas as Determined by the START:AV, the Clinical Coordinator Recommendations, and the Juvenile Probation Assessment/Case Plan

The approach to assessing this metric was similar to that used for Metric 26. DSG extracted data from a sample of youth files to assess the degree of overlap or correspondence between identified vulnerabilities/risk areas in the service memo, the START:AV, and the juvenile probation case plan.

File review. We identified 10 cases from our sample of 40 that had a service memo, START:AV, and probation case plan in logical order[14] (for more information on our sampling approach, see Appendix A). Table 3.3 organizes the items in each assessment under the appropriate broad domain. Some items are included in multiple domains, as appropriate.

---

[14] We excluded cases that lacked all three files. Also, we excluded some cases owing to the order in which the files were obtained (e.g., if the probation case plan was completed a year before the service memo, or the START:AV was completed a year after the probation case plan).

Table 3.3. Items Assessing Each Vulnerability/Risk Area

Vulnerabilities/ Risk Areas	Service Memo (SAVRY)	START:AV	Probation Case Plan
Disruptive Behavior Factors, Oppositional, Impulsive	Risk Taking/Impulsivity Stress and Poor Coping	Vulnerabilities: Impulse Control Conduct Rule Adherence Coping	Impulsive/Oppositional
Anger Management	Anger Management Problems Early Initiation of Violence History of Violence		Anger and Aggression
Delinquent/Antisocial Associates or Peer Relationships	Peer Delinquency Peer Rejection	Vulnerabilities: Relationships – Peers Social Support – Peers Peers	Antisocial Peers
Substance Use Problems	Substance Use Difficulties	Risk of Substance Abuse as an Adverse Outcome Substance Use Vulnerability	Substance Use
Family Dysfunction, Problematic Parenting and Family Relationships	Parental/Caregiver Criminality Poor Parental Management Early Caregiver Disruption Exposure to Violence in the Home	Vulnerabilities: Relationships – Caregivers/Adults Parenting Parental Functioning	Family Distress
Education and Employment Difficulties	Low Interest/Commitment to School Poor School Achievement	School and Work Vulnerability Risk of Unauthorized Absence as an Adverse Outcome	Academic Disengagement

DISRUPTIVE BEHAVIOR. This category is assessed by two items in the SAVRY: risk taking/impulsivity and stress and poor coping. It is assessed by four vulnerabilities in the START:AV: impulse control, conduct, rule adherence, and coping. It is also assessed by the impulsive/oppositional risk domain of the probation case plan. Of the 10 records assessed, eight (80 percent) were coded as high matches, one was coded as a medium match (10 percent), and one was coded as a low match (10 percent). All youths with a high degree of overlap across the tools had either a high or moderate-to-high risk due to disruptive behavior. No discernible pattern emerged from the youths with a low or medium degree of overlap.

ANGER MANAGEMENT. This category is assessed by three items in the SAVRY: anger management problems, early initiation of violence, and history of violence. It is also assessed in the probation case plan by the anger and aggression risk domain. Of the 10 records coded, six had high matches (60 percent), three had a low match (30 percent), and one (10 percent) could not be coded due to missing data from the SAVRY and START:AV for this category. Of the six youths with a high degree of overlap across the tools, half were rated as being at high risk due to anger management issues and half were rated as being moderate-to-high risk. There were no discernible patterns for the three youths with a low degree of overlap across the tools.

DELINQUENT/ANTISOCIAL ASSOCIATES OR PEER RELATIONSHIPS. This category is assessed by two items in the SAVRY: peer delinquency and peer rejection. The START:AV includes three items regarding delinquent or antisocial peers: vulnerability with respect to peer relationships, peer social support, and a negative peer network. The probation case plan includes the antisocial peers domain. All 10 of the records were coded as high matches, with all three tools showing that the youths had a moderate-to-

91

high risk due to their involvement with delinquent/antisocial associates or peer relationships.

SUBSTANCE USE PROBLEMS. This category is assessed in the SAVRY by a rating for substance use difficulties. The START:AV includes two items for substance use problems: vulnerabilities regarding substance use and risk of substance abuse as an adverse outcome. The probation case plan includes the substance use domain. Of the 10 records, seven (70 percent) were coded as high matches, one (10 percent) was coded as a medium match, and two (20 percent) were coded as low matches. One youth with a high match across the tools was rated as having a low risk due to substance use problems across all three tools. The remaining youths with a high degree of overlap among the tools were rated as having a high or moderate-to-high risk level. The three youths who did not have a high match across the tools were rated as having a low risk due to substance use problems in the probation case plan. The two youths with a low match across tools had a high or moderate-to-high risk in the other two tools. The youth with a medium match across tools had a low risk as assessed by the SAVRY but a high risk as assessed by the START:AV.

FAMILY DYSFUNCTION, PROBLEMATIC PARENTING, AND FAMILY RELATIONSHIPS. This category is assessed by four items in the SAVRY: parental/caregiver criminality, poor parental management, early caregiver disruption, and exposure to violence in the home. The START:AV assesses three vulnerability areas: relationships with caregivers/adults, parenting, and parental functioning. The probation case plan assesses the family distress domain. Of the 10 records, eight (80 percent) were coded as high matches, one (10 percent) was coded as a low match, and one was unable to be coded. The eight youths with a high degree of overlap across the three tools in terms of risk due to family dysfunction, problematic parenting, and family relationships were about equally distributed across having low-to-moderate risk, moderate-to-high risk, and high risk. The one youth with a low match was missing the SAVRY, rated as high risk by the START:AV, and low risk as indicated in the probation case plan.

EDUCATION DIFFICULTIES. This risk factor is assessed by two items in the SAVRY: low interest/commitment to school and poor school achievement. The START:AV also assesses two items: school and work vulnerability, and risk of unauthorized absence as an adverse outcome. The probation case plan includes the academic disengagement domain. Of the 10 records, nine (90 percent) were coded as high matches and one (10 percent) was coded as a low match. Of the nine youths with a high degree of overlap, two were rated as having low risk due to education difficulties, while the remaining seven were rated as having high or moderate-to-high risk. The youth with a low degree of overlap across the tools was rated as having low risk based on the probation case plan, but moderate-to-high risk based on the other two tools.

Summary. Agreement among the SAVRY, START:AV, and probation case plan on risk and vulnerability factors is generally high, although it varies by category. Similar to Metric 26, the risk factor with the highest percentage of high matches (100 percent) and the lowest percentage of low matches (0 percent) was having delinquent/antisocial associates or peer relationships. Anger management had the lowest percentage of high matches (60 percent) and the highest percentage of low matches (30 percent). There were too few records coded to determine whether any patterns emerged across the risk/vulnerability categories for cases with a low degree of overlap across the three tools.

47. The Extent to Which Written Treatment Summaries Are Shared Monthly With the JBCSSD Residential Liaison and the Juvenile Probation Officer, and Are Used To Enhance Communication and Team Approach

To assess this metric, we conducted interviews with residential treatment staff and probation officers.

Residential Treatment Staff Perspective. We asked classification and program officers, licensed mental health counselors, case and education coordinators, program managers, program and services

supervisors, superintendents, probation officers, milieu specialists, the JBCSSD liaison, and other JBCSSD administrators whether written treatment summaries were shared monthly with the JBCSSD liaison and with probation. Nineteen residential treatment staff from each of the 7 residential programs replied that written treatment summaries were consistently shared with probation. However, when asked about sharing with the JBCSSD liaison, answers from both the residential program staff and JBCSSD administrators were mixed: some interviewees indicated that the summaries were always shared monthly with the JBCSSD liaison, a few stated that it depended on the residential program, and others said that they were not shared monthly.

We also asked the residential treatment staff, "How strong is the communication between the staff here and probation?" Most of them said it was good. One of the residential treatment staff members said about working with probation officers:

> Most of them are good. We do a weekly update on our kids. We send an email to let them know how our kids are. We let them know about their levels. Once the kids are in the community, the POs send weekly updates to us. So, roles are kind of reversed. We tag team. I think it helps.

However, some of the respondents shared that it depends on the individual probation officer. One of the reintegration mentors said: "Some are great, and I talk to them on a daily basis. Others are really hard to get a hold of." Some have used different strategies to ensure that probation is part of the process. One of the interviewees said:

> The [residential treatment providers] may say that they struggle sometimes to get in contact with probation. But one of the things that we encourage them to do is to always include the probation supervisor on emails and other correspondence, just in case if the probation officer is out on vacation. Also, we've had a lot of retirements. So, this way, there is at least someone who can catch it because sometimes they don't know the probation officer's schedule.

Finally, we asked residential treatment staff, "How strong is the communication between the staff here and the JBCSSD liaison?" The interviewees who were involved in communication with the JBCSSD liaison mostly had positive things to say, describing the communication as "very strong," "incredibly strong," and "good." Staff mentioned the JBCSSD liaison and the milieu specialists as individuals with whom they have good communication. One of the clinicians said: "Documentation keeps people on the same page. This way, we can get updates on potential problems."

Probation Officer Perspective. Most of the interviewed probation officers indicated that the written treatment summaries are shared regularly with them. One of the probation officers said:

> There is an ongoing open line of communication and monthly team meetings. For youth in the REGIONS programs, the communication is phenomenal. Once the team is created, it's a strong team. An email goes out with everyone added, and the communication is very effective.

However, some of the respondents said that this does not always happen and that it depends on the residential programs.

We also asked probation officers about communication with the residential programs more generally and how well they work with the residential programs as a team. Many of them shared that communication is normally good but often is inconsistent, varying from program to program. Many of the interviewees indicated that improvements in communication would be helpful. Also, some mentioned that the probation officer is sometimes notified after the fact when a child goes from a secure program to a staff-secure program. One interviewee noted that she appreciated the contact and communication through the treatment meetings, but that probation sometimes is not involved in the

discussions when youths are ready to step down.

Summary. It is unclear the extent to which written treatment summaries are shared monthly with the JBCSSD residential liaison and with probation. Interviews indicate that these summaries are more consistently shared with juvenile probation officers than with the JBCSSD liaison. However, responses were mixed. There is also no consistent pattern suggesting why treatment summaries are not consistently shared. Written treatment summaries are useful for documenting past behavioral targets and progress as well as future targets and goal attainment progression. REGIONS is encouraged to develop a fidelity monitoring system. This system should track each REGIONS participant for each program to monitor whether treatment summaries are shared. Initially, CQI monitoring can help a program establish baselines and identify opportunities for policy/practice training. For example, one program may show that only 60 percent of treatment summaries were shared. That program can establish a goal of 80 percent attainment at 3 months, 90 percent at 6 months, and 100 percent by the third and fourth quarters. This information is currently not assessed in the yearly audits.

48. Number and Percentage of Clients Who Receive Weekly Group and Individual Therapy Sessions That Specifically Address Their Treatment Goals Associated With Identified Vulnerabilities/Risk Areas

To assess this metric, we reviewed CDCS data and conducted interviews with residential treatment staff.

Dataset. Data from CDCS were available for 136 clients. Of these 136 clients, all received individual and/or group sessions. Data were unavailable about the content of these sessions or how it aligns with identified risk areas. There is currently no data collection process to quantitatively evaluate this metric.

Residential Treatment Provider Perspective. We asked 23 residential treatment providers, "How do you ensure that youths' weekly group and individual therapy sessions address their treatment goals?" The respondents included staff from all seven residential programs as well as the two milieu specialists.

All respondents indicated that normally, all the youths receive group therapy and individual therapy each week. One of the clinicians said: "We go over the treatment goals and try to incorporate them into the group sessions." Another said: "Throughout the individual sessions, we make sure we bring it back to the goals."

One of the respondents said: "Everyone gets four groups a week and at least one individual session a week. In terms of the group schedules, it's the same for all our kids. Individual stuff is going to look different." The respondent continued by saying that some youths may need more individual one-on-one sessions than others, including youths with cognitive deficits and others who may not quickly understand the material in group. For these youths, they will do extra individual sessions so youths have more opportunities to repeat the new skills and receive support. The interviewee also noted that sometimes youths do not want to engage in treatment, and that during those times, staff members are accepting of this and spend their time "just talking" with the youths and trying to engage them.

> **The interviewees who were involved in communication with the JBCSSD liaison mostly had positive things to say, describing the communication as "very strong," "incredibly strong," and "good."**

Also, some of the interviewees mentioned that the clinicians will tell the juvenile detention officers and mentors what to focus on in a particular week, to augment what the youths are learning in their groups. They indicated that the mental health staff set the agenda for the youths' treatment goals in groups and

individual sessions and that they discuss treatment topics with juvenile detention officers and other staff in the weekly multidisciplinary meeting.

To ensure that the individual and group sessions are occurring, some of the managers said that they check the monthly ITPs and try to check what is entered into the CDCS database. One of the managers said:

> I think for the most part, I just review whatever treatment summary is brought to the table once a month. I do have access to CDCS, but it's not really user-friendly. I do an audit on CDCS to make sure that Mindfulness is being done and DBT skills groups are being done. I want to make sure that I can see what their skills worksheet says to check whether it correlates with whatever is on their treatment plan, but this is not always easy to find. Others audit that stuff too, to make sure that everything is connecting. So, I think everyone plays their own part in that. I ensure that things are getting logged into the system, because if it's not logged in, then to us, it didn't happen.

Observations. Onsite observations of group sessions indicated a lack of consistency in how treatment goals are being addressed. Also, interviews with clients and staff in 2021 revealed inconsistencies in how treatment goals were being targeted in therapy. Treatment staff reported that "this [consistency between treatment goals and identified vulnerabilities/risk areas] was easier to accomplish in individual therapy" and that group therapy was focused more on general issues. Furthermore, in 2021 staff reported feeling less comfortable with DBT groups as a result of Covid–19's disruption to training. This discomfort was often expressed as "clinicians share treatment goals with staff and then you hope that staff are providing feedback to clients." This discomfort lessened in 2022 because more frequent in-services related to DBT training were offered, and staff reported feeling more at ease with the intervention model. In 2022, observations and interviews indicated staff were more comfortable completing the START:AV and creating treatment goals based on the START:AV. Line staff also expressed more ease, reporting that "you can see [DBT] start to work" and "[staff] understand that terminology better."

Summary. Treatment goals should be based on objective assessments of criminogenic needs (i.e., the PrediCT and/or SAVRY). Research on case plan development in correctional settings suggests that the more case plans stray from the results of objective assessments, the less impact case management has on recidivism. Linking treatment goals to objective assessments is a direct application of the need principle (Borseth, 2021; Borseth, Myer, and Makarios, 2021). REGIONS assesses youths using valid and objective assessments and develops treatment plans that are informed by these assessments. Initial observations and interviews suggested that group treatment lacked consistency in tying treatment plans to group lessons; however, consistency increased over time as staff grew more comfortable with the treatment model (and received more frequent in-services on the treatment model). The improvement was noticeable during later group observations.

REGIONS can continue to build on this progress by consistently reviewing treatment goals with youths and staff. Treatment goals should be SMART—Specific, Measurable, Achievable, Relevant, and Time-bound. Structuring treatment goals in this manner and consistently reviewing progress allow staff and youths to note how often goals/objectives are accomplished, if they are being accomplished on time, and how group topics relate to each of the youths' goals. Since REGIONS' intent is to produce long-term behavior change, the program should focus on the issues that are causing problems for the client in the community. The focus should not prioritize changing behaviors to gain compliance while in the program (short-term behaviors). Gaining compliance while in the unit is part of any residential program, but compliance should be the byproduct of a focus on longer term behavior changes (i.e., modification of behaviors in the community). This focus comes from targeting objectively assessed criminogenic needs and teaching skills to cope and deal with situations in the youths' home environments by means of role plays.

49. Average Number of Clinical Group Sessions per Week, Average Number of Individual Sessions per Week, Average Number of Non-clinical Groups per Week

The research examining the appropriate dosage of correctional interventions focuses on adult inmates (Makarios, Sperber, and Latessa, 2014; Sperber and Lowenkamp, 2017; Sperber, Latessa, and Makarios, 2013a; Sperber, Latessa, and Makarios, 2013b), not youths. However, there is some helpful research related to youths: Lipsey (1999a) analyzed more than 550 juvenile studies and found that juveniles who were in programs lasting longer than 6 months had lower recidivism than juveniles in shorter programs. Lipsey's (1999a) review along with others indicate that youths who are at higher risk should receive more interventions than those who are at moderate risk.

Dataset. CDCS data were available on individual programming for 136 juveniles representing 212 unique stays (i.e., some juveniles participated multiple times in a REGIONS program) from 2019 through August of 2021. The following activities were categorized as individual sessions: Experiential Counseling, Individual Sessions, Individual/Family Sessions, Family Sessions, and MET/CBT (motivational enhancement therapy/cognitive behavior therapy) Individual Sessions. Dialectical behavior therapy (DBT) was categorized as a clinical group session. The following activities were categorized as non-clinical group sessions: Boys Council, Girls Council, Life Skills, Operation New Hope, and Restorative Circle. The number of weeks a juvenile spent in the program was calculated from their admission and discharge dates. Based on these data, the average number of services per week were calculated. The average number of individual sessions per week per youth was 1.85, with a median of 1.56. The average number of non-clinical group sessions per week per youth was 0.69, with a median of 0.67. The average number of clinical group sessions per week per youth was 1.83 with a median of 1.48.

REGIONS developed a separate dataset to track group activities more accurately and provided the dataset to DSG researchers. Data were entered into this dataset beginning in late November 2020 and include data through mid-August 2021. These data were on 30 juveniles representing 31 unique stays. Non-clinical groups included: Boys Council, Girls Circle, EMPLOY, Life Skills, Not a Number, and Restorative Circle. DBT was coded as a clinical group. Finally, the number of weeks between admission and discharge were calculated. Results indicate that the average number of non-clinical groups per week was 2.47 with a median of 0.60.[15] The average number of clinical groups (i.e., DBT) per week was 6.3 with a median of 3.9.

Review of Residential Program Schedules. To get a sense of how many clinical group and individual sessions were *available* to youth, DSG reviewed the seven residential program schedules provided at the time of DSG's site visits. We found that the number of clinical groups varies by program. In one of the programs, "DBT group" is listed once per week. In other programs, DBT groups are offered at least once per weekday. For example, at Hamden CPA, "DBT" was scheduled Monday through Friday at 12:30 p.m. (after lunch), and "DBT Skills in School" was scheduled daily at 2:30 p.m. Also, daily from 3:30–7:00 p.m., the schedule states, "Each youth is scheduled to meet individually with staff." In some program schedules, DBT homework times are listed. For example, "Transition/DBT Diary Cards" at Journey House from 7:15–7:30 p.m. on weekdays, and at Bridgeport REGIONS, "DBT Homework" occurs from 2:50–3:50 p.m. on Thursdays. The schedules also indicate that individual sessions are offered daily on weekdays for each of the programs.[16]

---

[15] For more information on non-clinical groups, see <u>Metric 54</u>.
[16] In one program, this information was not provided on the schedule, but we learned in interviews that individual counseling is provided daily.

Summary. Currently, there is not a body of research to guide dosage recommendations for juveniles in the criminal justice system; however, there is strong evidence supporting the risk principle. Therefore, we recommend that REGIONS adhere to the risk principle: those who are assessed as high risk with the PrediCT should receive more intervention (i.e., more structured services targeting assessed criminogenic needs should be provided to high-risk youths than to moderate-risk youths). Moderate-risk youths are still appropriate for REGIONS, but they may need less time in programming. REGIONS should follow the risk principle by tracking the risk level of youths admitted to the program. REGIONS should ensure that clinical interventions consistently use a structured approach (i.e., target a criminogenic need, teach a skill in a concrete manner, have everyone role-play the skill, and give homework). The program should work to have more (and consistent) role-playing of all skills that are taught. Non-clinical interventions, or interventions that do not target criminogenic needs, should not count toward dosage. These activities provide structure and keep youths busy, so they have value, but they should still not be regarded as long-term behavioral change interventions.

50. Number and Percentage of Clients Receiving Weekly Family Treatment Sessions
This metric was assessed by reviewing CDCS data and information gathered through key stakeholder interviews.

Dataset. CDCS data were provided on whether a juvenile had a family session with a clinical provider. These data were either coded as a family session or as an individual/family session. A text field was used to identify which individual/family sessions were clinical sessions. This variable was recently added to CDCS and paired with the family session variable to obtain a more accurate representation of family sessions. The results of this pairing using the available data indicated that 122 of 212 valid unique stays received a family session. Next, the average sessions per week were calculated to determine if family sessions occurred weekly. The resulting average was 0.17 with a median of 0.08.

Youth Perspective. We asked 17 youths, "Do you participate in any treatment groups with your family? If yes, how often?" The majority of the respondents (71 percent) answered "no." Also, two of the youths expressed the desire to participate in such groups. One youth said: "Family is very busy—they work a lot." Another adolescent stated that the length of the treatment time is a reason for non-participation: "I don't get regular in-person visits because it's only 30 minutes. Drive would be longer." Two youths mentioned that they participated in monthly sessions, but they may have been referring to the ITP (Integrated Treatment Plan) meeting. Two other youths stated that family involvement was non-existent or difficult because family members were either not involved or had been hurt by their actions. All respondents except one said they could have family participation in other ways: phone calls and virtual video chats.

Parent/Guardian Perspective. All seven of the parents/guardians who were interviewed reported having contact with their child outside of update meetings. This contact occurred through in-person meetings, video calls, and phone calls. Among the six parents/guardians whose child was in REGIONS for more than a few weeks, all but one parent indicated that they participated in family therapy sessions at least once. Most parents had a set schedule to meet or call at a specific time every week or every day. However, some conflicts limited parents' contact with their children. (For more information about family engagement, see Metric 43.)

Summary. The research on family involvement is clear: youths in residential facilities who have more positive family relationships exhibit greater overall emotional well-being, better behavior, and are less likely to become depressed while in placement (e.g., Agudelo, 2013; Caldwell et al., 2004; Monahan et al., 2011; Stice, Ragan, and Randall, 2004). Family involvement and visitation are also helpful strategies for reducing future recidivism and detentions (e.g., Farrington and Welsh, 2003; Lipsey, 1999a; Young and Turanovic, 2022). However, engaging families in juvenile corrections can be difficult (Mikytuck,

Woolard, and Umpierre, 2019; Schwalbe and Maschi, 2010). REGIONS data suggest that more than half (57.5 percent) of REGIONS stays involve the family in therapy. Difficulty with family engagement is illustrated by the low average number of weekly family therapy sessions, which demonstrates that it is hard to involve families on a weekly basis. REGIONS is encouraged to keep up efforts to engage families in program interventions. Research also indicates that juvenile justice family interventions should focus on teaching family members how to recognize and reinforce the skills being taught in clinical sessions (Barnoski, 2002; Taylor, 2016). In other words, family treatment sessions should devote a considerable amount of time to teaching family members the DBT skills REGIONS youths are learning. For example, the STOP (**S**top, **T**ake a step back, **O**bserve, **P**roceed **M**indfully) skill should not merely be reviewed; rather, family members should understand when to use the STOP skill, what the STOP skill looks like in practice (so they can recognize and reinforce it), and what proper reinforcement looks like. Structuring part of family treatment sessions in this manner allows one to prepare families for step-down, re-entry, and future conflict.

51. Extent to Which Substance Use Treatment Needs Are Met
Substance misuse has been identified as one of the major risk/need factors for reoffending (Basto-Pereira and Farrington, 2022; Latessa, Listwan, and Koetzle, 2015). For youths admitted to the REGIONS program, the START:AV assesses a youth's history (or short-term risk) of substance misuse. Additionally, a youth's history of substance use is included in the service memo by the clinical coordinator. According to JBCSSD Policy and Procedure 6.116 (Clinical and Educational Services, Service Memorandum for Residential Placement), the clinical coordinator is expected to provide information on substance use (e.g., onset, duration, and extent/severity of use for each regularly used substance; names of substances used experimentally; youth-initiated violence in the context of substance use) in the Relevant Information section of the service memo. Based on the information from the START:AV and service memo, it is assumed that a youth's Integrated Treatment Plan (ITP) will include substance use as a need area to be addressed while in REGIONS. The PrediCT also gathers information related to substance use. We assessed this metric by analyzing responses from interviews with key stakeholders.

Youth Perspective. DSG asked 17 youths, "What kind of services are available here (at REGIONS) for youth who struggle with substance use?" Most youths said they were unaware of services for substance use. However, some said that if youths did struggle with substance use, they were most likely to be sent to a specialized program outside of REGIONS or referred for services after being discharged from the program. Some youths noted that residential treatment staff (such as mental health staff, clinicians, and senior mentors/juvenile detention officers) would help them, and that substance use may be talked about in community meetings. Some youths mentioned that struggles with substance use are usually dealt with in detention during the 2 weeks of quarantine, not in REGIONS. One respondent recommended that they have more hands-on groups related to substance use.

Residential Treatment Staff Perspective. Forty residential treatment staff responded to the question, "What substance use treatment is available here?" Most staff said that substance use was not a major issue at their facility, but if a youth had a pre-identified or discovered substance use need, the clinical team would make sure substance use was added as a need area in the youth's ITP. Mental health residential treatment staff mentioned that REGIONS does not include a specific program for substance use, but they are trained in DBT techniques for substance use. These techniques enable the staff to teach youths how to address substance use urges and judge the risks and effects of substance use. One of the licensed mental health counselors said that they treat a substance misuse problem "only if it's a big enough problem and driving their behavior, [which is] only about 10 percent of the time. We don't focus on drugs unless it's a harder substance…it's not ignored; it's just not a primary goal."

When asked whether the clinical coordinator's opinion in the service memo is incorporated into the ITP (see Metric 39), respondents cited substance use as one of the few areas for which this information is *not* incorporated, because the youth will be in a controlled environment without access to substances. Thus, substance use treatment needs are not prioritized. One interviewee said: "We kind of work around it as we're addressing some of the other risk areas, but we're not kind of putting into place the substance-use intervention because it's a controlled environment." Some of the staff from the secure programs stated that addressing substance use is the job of the step-down programs. However, staff from the REGIONS staff-secure step-down programs did not feel they were addressing substance use any better than staff from the secure programs. Many of them commented that addressing substance misuse was more of a discharge planning issue although it should be addressed more while in the residential program. One of the reintegration mentors said: "We don't have the services, the people, to even tackle this situation. A lot of the kids consume a lot, besides just marijuana. Sometimes it's blatantly obvious. But this kind of service and support is not met here. I guess allegedly DBT should address this, but it doesn't." Others suggested that more staffing is needed related to substance use, including licensed alcohol and substance use counselors. One of the interviewees said: "Honestly, I stopped reviewing their paperwork because we can't address their issues anyway."

Also, 39 residential treatment staff members rated the extent to which they thought substance use needs were being met at their facilities, on a scale from 1 (not met) to 10 (completely met) [see Figure 3.8]. The scores varied widely, ranging from 1 to 10. The average score was 3.9 with a median of 5. Ratings from staff who work completely within the residential programs (e.g., juvenile detention officers, managers, superintendents) were higher than ratings from staff who also work with youths in the community or who work with outside partners (e.g., reintegration mentors, JBCSSD Central Office staff). Many staff members felt that programs only address substance use needs if they are seen as a driving force in at-risk and violent behaviors. Although youths may use recreational drugs (such marijuana), the major focus would be on harder drugs or on heavy marijuana use that is impacting everyday behaviors. One shift supervisor/senior mentor said: "No big substance use issues. Kids smoke, but it's not that serious. But if it is, we [send] them to Rushford."

> **Substance misuse needs are addressed "only if it's a big enough problem and driving their behavior, [which is] only about 10 percent of the time. We don't focus on drugs unless it's a harder substance…it's not ignored; it's just not a primary goal."**
>
> **—Licensed Mental Health Counselor**

Reintegration mentors and other staff-secure residential treatment staff mentioned that they frequently have realistic, one-on-one conversations with youths about the substance use temptations they may face when they return to the community. One reintegration mentor said that if substance use were an issue for an individual youth, they would make sure to include a referral for services in the community post-discharge. However, reintegration mentors viewed substance use as more of an impediment to achieving treatment goals than the staff who only work with youths while they are in the residential programs.

**Figure 3.8. Residential Treatment Staff Perspective on Extent to Which
Substance Use Treatment Needs Are Met**

Rate the extent to which substance use treatment needs are met
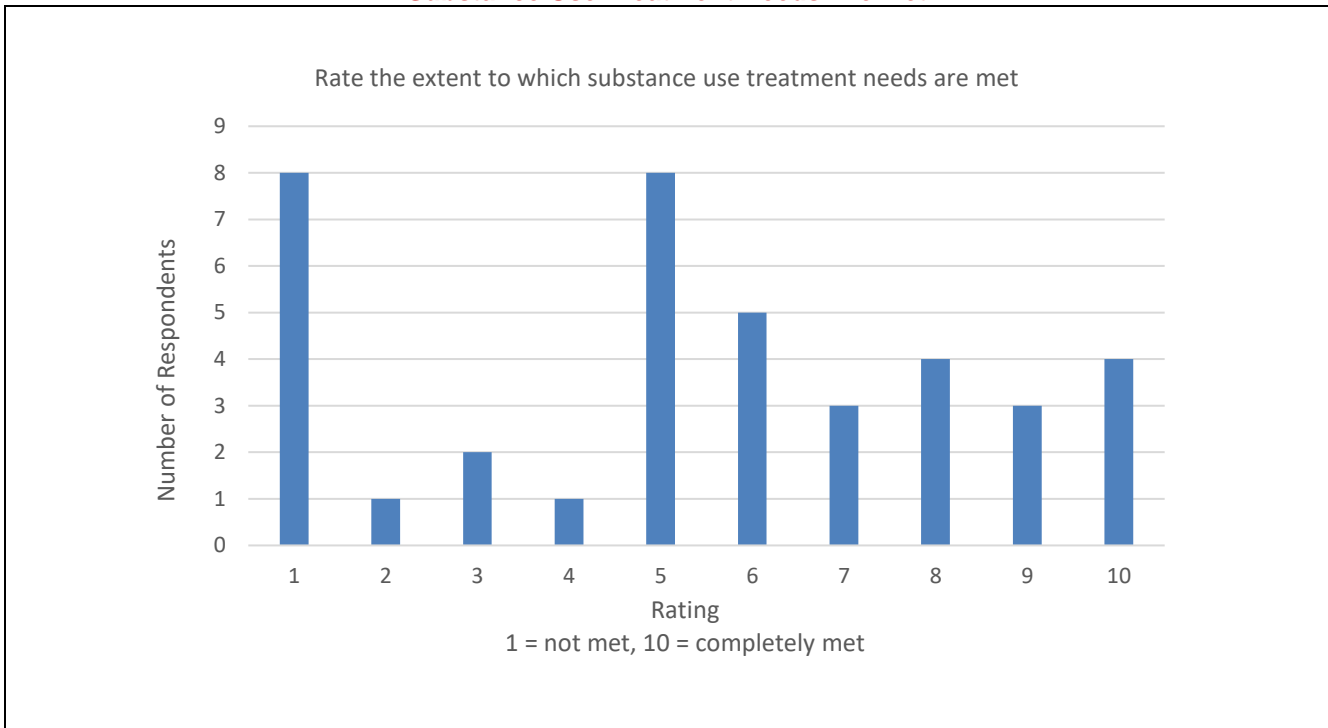
Data source: Residential treatment staff interviews. *N* = 39.

Summary. Interviewees consistently mentioned that substance misuse is not one of the primary focuses of treatment in the residential programs, mostly because these services are not needed while youths are in the programs. Although marijuana use tends to be prevalent, it does not appear to be prioritized, as interviewees felt that marijuana use was not a cause of behaviors that resulted in placement into REGIONS. Licensed mental health counselors said that when a substance-use need is identified, it is addressed through the DBT program or an outside provider. JBCSSD administrators also shared that youths with intense substance misuse are treated at substance use treatment facilities (and not in REGIONS). Interviews revealed that treatment in the residential programs focuses more on aggression and impulsivity.

On the other hand, several interviewees in step-down programs, interviewees who work with youths in the community, and interviewees who work with community partners expressed concern about the lack of focus on substance use. Some of the probation officers expressed a similar concern (for more information, see Metric 71 and Metric 76).

One program cannot do everything. The youths in REGIONS generally have multiple criminogenic needs. REGIONS is designed to address behaviors focused on violence as a way to prioritize treatment goals and ensure that youths are not confined for excessive periods of time. Thus, it is important to make sure youths receive discharge referrals to address substance use needs when appropriate. To determine whether substance use is a relevant target for a youth, REGIONS should look at results from risk assessment tools that specifically measure substance use.

If REGIONS begins prioritizing substance use as a treatment target, we recommend that a substance-misuse specific assessment tool be employed. Currently, REGIONS uses the CRAFFT at intake. REGIONS should use the results of the CRAFFT to identify youths who have substance abuse as a targeted criminogenic need.

100

Since the draft findings and recommendations for this report were presented, JBCSSD shared some updates related to the extent to which substance use treatment needs are met:

- *Clinical coordinators are now focusing more on the role of substance misuse in the youth's delinquency involvement and incorporating this information in their service memos.*
- *Residential treatment programs are adding an additional substance misuse screener to the REGIONS admission process.*
- *Residential treatment clinicians address substance misuse through DBT.*

52. Extent to Which Psychiatric Treatment Needs Are Met

According to JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program), the psychiatrist/psychiatric APRN (Advanced Practice Registered Nurse) will complete a psychiatric evaluation of the youth within 10 business days of admission (see Metric 6). This policy also requires that a psychiatric team review the youth's needs and progress on a weekly basis. Also, according to JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, Intake and Admissions), if the youth is currently taking medication, during intake the program is required to obtain Permission to Treat (JD-JM-206) and other information and permissions from the parent or guardian. This metric was assessed using information from key stakeholder interviews.

Residential Treatment Staff Perspective. Interviewees mostly felt that the youth's psychiatric treatment needs were met in the residential programs. DSG asked interviewees, "Please rate the extent to which psychiatric treatment needs are met on a scale from 1 to 10, with 1 being not met and 10 being completely met." Thirty-seven respondents felt comfortable rating this item. The average score was 8.1 and the median was 9.0. The scores ranged from 2 to 10 (see Figure 3.9). Respondents included staff from all seven residential programs, the two milieu specialists, and JBCSSD management staff. They mentioned that there were policies guiding the decisions made about psychiatric treatment needs, and that these needs were met. They also noted that youths normally arrive at the residential program with sufficient information in their files (from probation, detention, or a previous residential program). When a staff member identifies a potential unaddressed need, they either request that the APRN complete a screening or ask the clinical staff to make an appointment with psychiatrist. A few interviewees mentioned that it was sometimes difficult to reach a parent, whose permission is required for the residential programs to administer medication. One of the interviewees said:

> Usually, if there's a kid on medication or anything like that, coming from the REGIONS secure, they just continue on with that when they transition down to the staff secure. But if not, and they get into the program and then the clinician or the staff are seeing things, they'll have them meet with the psychiatrist. The psychiatrist will do their assessment and determine what the needs are as far as like medication and those types of things.

Others mentioned that care is taken to include the parents' and youth's voices in the medication decision-making process. One interviewee said:

> We definitely have a fairly good team…they're really good at meeting the kids' needs. They are also good at including the parent if there is medication that they feel that the youth needs. And including the kids, especially in REGIONS—it's kind of like, "Okay, you're 16, how do you feel about taking these meds?" Sometimes the kids are like, "No", and they will tell them the benefits of it, but not try to force them to take it. I do think that our team is strong.

101

Figure 3.9. Residential Treatment Staff Perspective on Extent to Which Psychiatric Treatment Needs Are Met
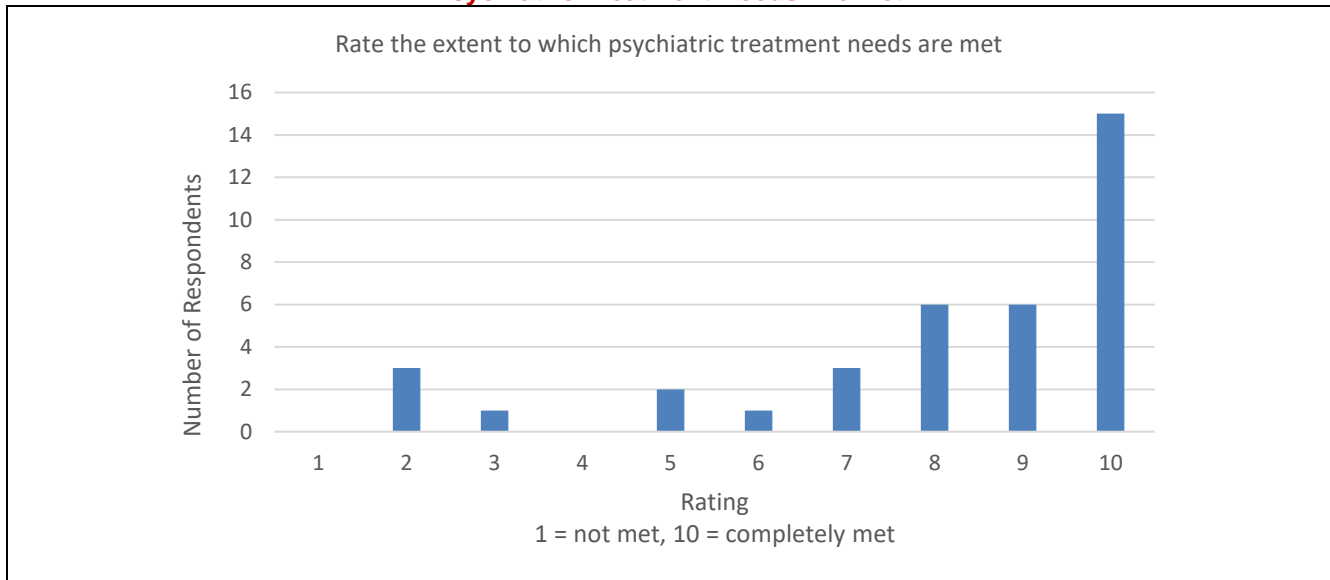
Data source: Residential treatment staff interviews. *N* = 37.

Summary. Interviewees mostly felt that the youth's psychiatric treatment needs were met in the residential programs and that JBCSSD policies were being followed. Some mentioned the challenge of continuing to address these needs during re-entry. (For more information, see the Re-entry and Probation section.)

53. Effectiveness of Milieu Coaching To Increase Prosocial Skills and Decrease Negative Behaviors

Research demonstrates the importance of several milieu strategies for increasing prosocial skills and decreasing negative behaviors. For example, the value of incorporating consistent role-play (i.e., structured skill practice) into the curriculum cannot be overstated (Dowden and Andrews, 2004; Sperber and Lowenkamp, 2017). Role-play is a hallmark of effective interventions in correctional treatment, namely treatment using a cognitive behavioral modality.

The REGIONS programs use Dialectical Behavior Therapy (DBT) as its primary treatment approach. DBT is a psychosocial treatment modality that incorporates aspects of cognitive behavioral principles, with an added focus on emotion regulation and mindfulness. This treatment modality was developed in the 1970s as a modality for individuals (specifically women) with borderline personality disorder who were suicidal (Linehan and Wilks, 2015). Meta-analytic reviews of DBT suggest that it is effective at reducing suicidal behavior and parasuicidal behavior for those diagnosed with borderline personality disorder (Panos, Jackson, Hasan, and Panos, 2014). There is some evidence to suggest that DBT can reduce substance dependence with borderline personality disorder (Haktanir and Callender, 2020). As a result, DBT has been applied to other populations beyond those with borderline personality disorder. One such population is those under correctional control.

Research on reducing recidivism has consistently demonstrated that cognitive–behavioral therapy (CBT) programs to reduce recidivism (for example, see Lipsey, 1999a, 1999b). The popularity of CBT has led some to examine whether DBT—which incorporates CBT principles—can also lead to consistent reduction in recidivism. Research on the application of DBT with criminal justice populations has failed to produce consistent findings. While studies using pre-posttest methodologies may show a reduction in offending behaviors or criminogenic needs, studies that use more rigorous methodological controls reveal limited impact (Tomlinson, 2018). Tomlinson's (2018) review of 34 studies reporting

102

findings of DBT's application with justice system-involved populations suggests that DBT's impact on these populations cannot be determined because DBT is often implemented differently across programs. Tomlinson's review suggests that DBT is promising if incorporated into the Risk–Need–Responsivity model of correctional intervention. A study by Fox and colleagues (2020) using data from more than 1,000 youths in multiple secure residential facilities in the state of Washington also found inconsistencies in the application of DBT across facilities. The same study determined that individual DBT sessions and group DBT interventions did not demonstrate reductions in recidivism; however, milieu coaching was associated with reductions in recidivism. Interestingly, Fox and colleagues (2020) note that milieu coaching—in which staff validate the youths, teach DBT skills informally, coach youths to generalize the skills, model effective interpersonal skills, reinforce effective behaviors, and connect skills to the youths' goals—produced reductions in recidivism.

DSG assessed this metric by reviewing the literature on DBT (see above), observing groups, and analyzing information gathered through key stakeholder interviews.

Observations. DSG researchers observed DBT programs in 2021 and 2022 at each of the seven residential programs. Staff and clients at each location were asked about DBT and milieu coaching. Group sessions and individual sessions focused on teaching various aspects of the DBT approach (e.g., mindfulness skills, emotional regulation). A major component of DBT is the teaching of skills to deal with wide-ranging situations. An example is the STOP skill. Clients are taught to identify a situation that may cause them trouble and: 1) **S**top (pause to stay in control and not let your emotions over take you); 2) **T**ake a step back (remove yourself from the situation and calm down to regulate your emotions); 3) **O**bserve (do not jump to conclusions, observe others around you, note how you are thinking); and 4) **P**roceed mindfully (determine what you want to get out of the situation and act accordingly). However, there is no standardized DBT curriculum being used for the REGIONS program.

DBT implementation improved over the course of the process evaluation. By 2022, counselors had created lesson topics for a number of weeks. Staff would add homework or other material appropriate to each of the topic areas. This approach is a great way to move towards standardization, but it also can lead to concerns related to consistency. Specifically, the same topic can be taught multiple different ways across the REGIONS program locations.

Youth and Staff Perspective. Interviews with youths and staff produced some additional concerns: clients and staff all said they like the skills and could repeat skill acronyms; however, clients repeatedly said "the skills are good in REGIONS, but not on the streets." Staff said: "When a client acts out on the unit, I tell them to use a skill. If they are not acting out, I don't know when to teach a skill." In short, the generalizability and the reinforcement of skill acquisition are currently lacking in the REGIONS programs. Thus, skills are not consistently being generalized for clients and the use of skills is not being consistently taught or reinforced in a generalizable manner. Staff focus on unit behaviors and on achieving short-term compliance, but failure to generalize these behaviors can lead to failure to produce long-term behavioral change.

We asked 14 youths, "Are you taught new things, like new ways to think or behave?" All of them answered that they were, indeed, taught these things. They mentioned learning coping skills (e.g., ways to calm down), interpersonal and interaction skills, how to talk to people, being aware of their own emotions, dealing with urges of violence, setting goals, mindfulness, following group rules (e.g., "don't be disrespectful," "don't put other people down"), empathy, self-acceptance, and DBT (Dialectical Behavior Therapy) tools (STOP, TIP [**T**ip the temperature, **I**ntense exercise, **P**aced breathing]). They said that they are taught these things through scenarios, role plays, practicing skills, and using cards (although some said they never role-played). About the scenario activities, one youth said: "It will say, 'list a scenario this week when we used this skill.' I tell them how when I played cards someone cheated

103

and I wanted to punch them, but I got away from the table instead."

We asked 17 youths whether they got homework in their treatment groups. All but one responded that they did get homework. Some said the group leaders collected and reviewed the homework while others said they do not correct the homework "because there are no right or wrong answers." Some said they got homework every day while others said they got homework less often—for example, one to two times a week. Some mentioned that they only get homework if they do not finish their work in the group. The program should consider this information, as correctional programs that include homework have better mental health and legal (e.g., recidivism) outcomes (McDonald and Morgan, 2013; Morgan and Flora, 2002).

Although this information represents an important snapshot of the youths' perceptions of milieu coaching and clinical group sessions, the youths were generally unable to distinguish between actual treatment groups (e.g., DBT) and non-clinical groups (e.g., Boys Council, informal groups that the juvenile detention officers and youth mentors run in the afternoons). This finding is important for the

One of the youths said: "They teach me new ways to cope with stressful or any situation. Hopefully when I go home, I'll use those new ways."

REGIONS program to consider, given that the desired result of the program is for the youths to use the skills learned in DBT in the community. One youth said: "They teach me new ways to cope with stressful or any situation. Hopefully when I go home, I'll use those new ways."

Summary. REGIONS should consider adopting or adapting a standardized DBT curriculum for group interventions. A standardized DBT curriculum can address issues related to inconsistent practice across facilities and increase fidelity to the model—and allow for fidelity monitoring. REGIONS should also incorporate more modeling (i.e., demonstrating) and role-playing (i.e., practicing) into group sessions and on-unit activities. Line staff should feel comfortable teaching DBT skills and should understand when to teach and reinforce skills. Role-plays are not acting—they are not a time for jokes or over-the-top characterizations. Role-plays are practice opportunities and should be conducted in a serious manner. Role-plays should be structured so they are non-threatening (i.e., simple and achievable). Once a client has practiced the skill in non-threatening situations and expresses comfort with the skill, role-plays in increasingly difficult situations should be added. This progression to more challenging scenarios is known as advanced practice. Clients and staff should work together to identify real-world situations that the client will encounter when they complete REGIONS. Skills should be practiced while role-playing these difficult situations. All staff should reinforce (verbally, and, if possible, using tangible reinforcers) the application of DBT skills in all situations.

Since the draft findings and recommendations for this report were presented, JBCSSD shared the following updates regarding to the extent to which substance use treatment needs are being met:

- *The residential programs are increasing and continuing with DBT Training and Implementation Support.*
- *Programs are moving to DBT Adherence.*
- *JBCSSD is increasing quality assurance staff capacity to monitor DBT adherence.*
- *A DBT manual specific to the juvenile justice population (to incorporate lived experiences and standardize DBT among the programs) is being developed.*

54. Appropriateness and Effectiveness of Programming To Meet Treatment Goals (Non-clinical Groups, Prosocial Activities and Recreation, Enrichment Activities, Family Activities, Community Home Passes)

Targeting non-crime-producing needs, such as self-esteem, creative abilities, physical conditioning, and other enrichment activities, will not change offending behaviors (Latessa, Listwan, and Koetzle, 2015). However, non-clinical activities are important for adolescents' well-being and development, and leisure time is an important component of residential programs. Some programming can enhance responsivity to treatment. Individual-level responsivity factors include motivation, cognitive ability, personality, and mental health (Latessa, Listwan, and Koetzle, 2014). Thus, programming that aims to increase these factors may also increase responsivity to treatment.

However, non-clinical activities do not need to be linked to treatment goals. Given that many justice system-involved youths have not experienced the encouragement and direction needed by all children and youths, providing them with access to positive, pro-social experiences and opportunities to develop new skills while in residential treatment is encouraged (Liddell and Clark, 2014). High-quality programming requires adequate space and equipment, should be chosen with thought and care, should be scheduled for a specific time within the daily schedule, and should be adequately supervised (Liddell and Clark, 2014).

This metric was assessed through analysis of CDCS data, key stakeholder interviews, and review of programming schedules.

Dataset. As mentioned in [Metric 49](), CDCS data were available on programming for 136 juveniles representing 212 unique stays from 2019 through August of 2021. These data indicate that the average number of non-clinical group sessions per week per youth was 0.69, with a median of 0.67. The following activities were categorized as non-clinical group sessions: Boys Council, Girls Council, Life Skills, Operation New Hope, and Restorative Circle. Additionally, REGIONS developed a separate dataset to track group activities more accurately. Data were entered into this dataset from November 2020 through mid-August 2021. These data were on 30 juveniles representing 31 unique stays. Non-clinical groups in this dataset included: Boys Council, Girls Circle, EMPLOY, Life Skills, Not a Number, and Restorative Circle. DBT was coded as a clinical group. This data indicates that the average number of non-clinical groups per week was 2.47 with a median of 0.60.

Residential Treatment Perspective. We asked residential treatment providers, "How well does the non-clinical programming help to meet treatment goals?" Most of the respondents gave positive examples of the programming they provide. They mentioned regular activities, such as sports, yoga, poetry, theater, journalism, life skills, girls' circle, boys' council, ping pong, interest-based groups (e.g., a group about cars), dance, religious groups, wellness programs, young fathers' programs, and music, as well as larger one-time events. One of the interviewees said: "I think it helps engagement and get their mind off things. Also, they socialize with others." Another interviewee said: "They feel valued when we do other activities and engage." A third interviewee said: "Basketball is a coping skill."

Other residential treatment interviewees said:

> It gives us balance. Too much treatment would lead to boredom or over-stimulation. These extra activities allow them to just be kids and to build relationships with staff and talk about real-life situations.

> We asked [the superintendent] to do a field day. He approved it. We went outside. [A JBCSSD administrator] came. We had a cookout and a bunch of fun activities, like balloon games and potato sack races. We used this time for team building. They made tie-dyed shirts. They all got prizes because they all did well.

> We have volunteer church services. Street Faith Ministry comes in. It's unique. They use religion to teach other things. It's different. They will take a word (e.g., respect) and tie in religion, but they are really talking about respect. It's more than just a church service.

Some also indicated how programming can act as a motivator to comply with the behavior management system and follow the rules by using activities as incentives for good behavior. One of the interviewees said: "The ability to go outside and do an activity is a huge motivator." Another said: "We have ice cream socials here and there and movie nights every other Friday, if the kids get their behavioral checks."

Others mentioned how programming can be used to reinforce the skills they are using in the treatment groups. By having all staff trained in DBT skills, these approaches can be reinforced during non-clinical programming. One of the interviewees said:

> I know we sometimes throw a lot at the kids, but they actually really tend to like the groups. It's something different from DBT in that it's just talking about life…I know in one of the projects, they focus on role playing and they ask really, "If you were in the community doing this, and this happened, how would you handle that situation?" That right there can definitely help them with their treatment goals and in regard to decreasing negative peer interactions or criminogenic needs, things like that.

The amount of programming and extent to which it is appropriate and effective in meeting treatment goals vary by program, and in most of the programs, interviewees acknowledged that they could be improved. One of the interviewees said:

> I would probably say that we could do a little bit more of that, especially for those kids that we have a hard time of getting them to buy-in. We have a lot of kids that are into art, making music, and those types of things. If we can just tap into those things a little bit more, you might get better buy-in from some of the kids as well. I think it depends on certain programs, too. Some of our programs are a little bit better at tapping into those types of interests.

Some of the staff discussed the role of community home passes, their benefits, and their challenges. The identified challenges included youths running from the program, using substances, and losing focus on their treatment goals. The comments about challenges came from staff in the staff-secure programs specifically. For example, one of the interviewees said: "We've found that kids run if we bring them back to their neighborhood, so we don't bring them there in the beginning." Another interviewee said: "We try to do home passes, but then they are just focused on being home, and their buy-in decreases here in the program. They don't want to do things here anymore, and they withdraw."

Residential treatment staff also mentioned the benefits of community home passes and their importance in preparing the youth for re-entry. The benefits included being able to assess how youths interact with family as well as gaining an overall understanding of what needs may still exist when the youth leave the residential program. Residential program staff indicated that home passes work best when they are implemented gradually[17]. One of the reintegration mentors said:

First, we will do passes for a family function or a special occasion. Then, we will go into the community and stay with them. Then, we will leave them for only a few hours and then pick them up. When they are closer to discharge, we will give them an overnight pass to get used to it. Then when we transition them back home, the parent will be ready, too.

---

[17] In separate interviews and focus groups, some of the probation officers indicated that there should be more home passes to better prepare the youths for re-entry.

**Figure 3.10. Residential Treatment Staff Perspective on
Appropriateness and Effectiveness of Programming**
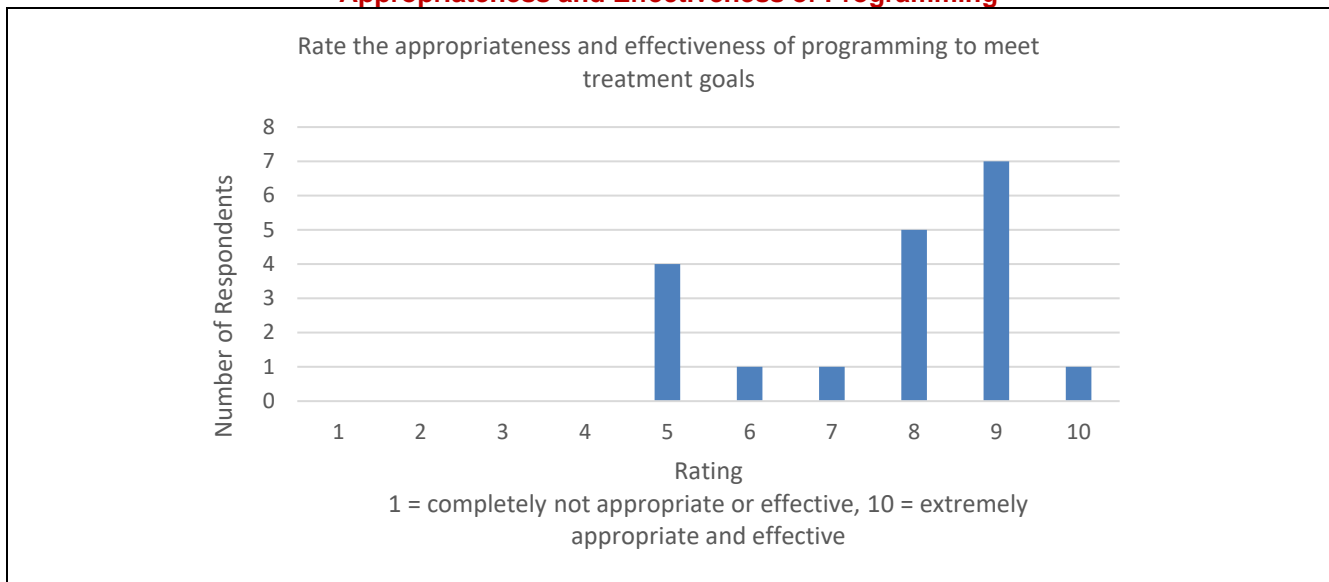
Data source: Residential treatment staff interviews. *N* = 19.

Finally, 19 of the residential treatment interviewees rated the appropriateness and effectiveness of programming to meet treatment goals, on a scale from 1 to 10 (with 1 being completely not appropriate or effective and 10 being extremely appropriate and effective). Interviewers explained that this programming included non-clinical groups, prosocial activities and recreation, enrichment activities, family activities, and community home passes. The average score was 7.7 and ranged from 5 to 10 (see Figure 3.10). The median was 8, and more than two thirds of the respondents rated this item as an 8 or above. Interestingly, the rating of programming to meet treatment goals did not vary much by whether the residential program was in a private facility or in a detention center with much less space (e.g., Bridgeport REGIONS secure, Harford REGIONS secure).

Youth Perspective. When asked what they liked the most about the residential program, most of the youths mentioned that they liked the staff (see Metric 55). Many of the youths also mentioned programmatic aspects, including "Fun Fridays," ordering food, watching movies, playing games, the garden, going off-grounds, basketball, the weight room, and improving their communication skills. Many of the youth interviews occurred when home passes were unavailable because of Covid–19, but even during later interviews, most of the interviewees had not had the opportunity to use home passes.

Observations and Review of Daily Schedules. Each of the seven residential programs has a written daily schedule. Mindfulness is on the schedule up to three times daily, depending on the program. Some researchers have examined mindfulness activities as "adjunctive therapy" (e.g., Winters and Beerbower, 2017), which means these activities can serve to assist the primary treatment (which is DBT in the case of REGIONS). Mindfulness activities in juvenile justice settings, such as mindfulness meditation, have been shown to increase mindfulness and attention (Nicotera and Viggiano, 2021), to increase the ability of older youths to suppress unwanted reactions in interpersonal contexts (Evans–Chase, 2013), and to decrease perceived stress and increase healthy self-regulation (Himelstein et al., 2012).

Other groups and activities on the schedules, which were generally run by juvenile detention officers, classification and program officers, and other REGIONS staff, included broad categories such as workout groups, employment groups, fitness, movies, indoor recreation, outdoor recreation, unit recreation, life skills, and video games, as well as more specific activities such as drumming, yoga,

spades tournament, book club, weight room, basketball, critical thinking and decision-making, quote of the week + discussion, and art therapy (see Table 3.4 for an example of one program's weekly activities schedule). For all seven programs, activities were generally scheduled in the afternoons and evenings during school days and throughout the day during non-school days.

Table 3.4. Examples of Non-Treatment Program Activities at a REGIONS Program

Activity Name	Description
Quote of the Week + Discussion	Clients and staff can pick inspirational quotes and discuss how they feel about it. (Pro and All-Star phase clients[18] can run the group)
Community Building	Take time to reflect on week so far. Is there anything we would like to change, create or improve? Give shout-outs to peers and staff.
Movie Night + Discussion	Can make popcorn and watch a movie for this week. Lead brief discussion at the end to clients' goals
Teamwork & Problem Solving Activity	This can be a PA activity led by a PA staff or any other activity that encourages teamwork and problem solving
Life Skills	Can use PAYA[19], LIST[20], etc.
Cooking Group	If doing a cooking group, it must be planned at least a week in advance.
Fitness Exercise Activity	Can create exercise regimen or any other fitness group (i.e., it must be sports drill based or similar to an exercise class – no basketball game)
Sportsmanship activity	This should be an activity that encourages working together as a team, or some team building activity
Gentleman's Round Table Activity	Learning about table manners, proper attire and dressing for different occasions, how to tie a tie, demonstrating social skills and interviewing skills
Critical Thinking and Decision-Making Group	These activities should focus on problem solving and can include acting out scenarios
Other Activities	Arts and imagination activity; PA activity to be constructed by PA instructor

DBT groups and individual counseling opportunities tend to be in the afternoon, between 12:30 and 4:00 pm. (For more information about treatment groups and individual treatment, see Metric 49.)

Summary. REGIONS programs appear to design their non-clinical programming intentionally and in alignment with best practices. Some non-treatment programming (e.g., mindfulness activities) can enhance responsivity to treatment, thus enhancing the treatment's effectiveness. However, non-clinical programming does not have to align with treatment goals, as long as it serves other youth development needs. Programming always should be reviewed and refreshed, to ensure that it matches the youths' interests. A basketball league may be a great motivator for some youths, but the next group may be motivated by other interests such as art, cars, or music. Understanding the youths' interests is important to ensure the programming accomplishes its goals. Finally, REGIONS should keep an eye on how programming varies from program to program.

---

[18] "Pro and All-Star" indicates youths who have earned higher levels in the behavior management program. (For more information see Metric 42).
[19] Preparing Adolescents for Young Adulthood (PAYA) is a life skills curriculum designed to help youths build concrete skills and relationships needed to live successfully as young adults.
[20] The LIST (Learning Inventory of Skills Training) module emphasizes the acquisition of hard and soft skills through experiential learning and interactive activities.

55. Appropriateness of Staffing by Type and Number

The caliber of staff who work with youths—their personal qualities, expertise, and professionalism—are vitally important to the youths' psychological, social, and emotional development (Clark, 2014). Quality of staff is an important component of effective program delivery (Makarios et al., 2016). However, juvenile justice systems across the United States have been facing serious staffing challenges, especially related to recruitment and retention (e.g., Beard, 2023; Kentucky Tonight, 2023; Livengood and Howerton, 2022; Lyons, 2022; Miller, 2022; Person, 2023; Swift, 2022; Tabb, 2022; The Council of State Governments Justice Center, 2023). Findings from a study of youths in juvenile justice residential programs in Florida suggest that youths placed in residential programs that are experiencing staffing challenges, such as high staff vacancy rates and absenteeism, are at a disadvantage in terms of treatment progress and future success (Wolff, Limoncelli, and Baglivio, 2020). DSG gathered information to assess this metric through key stakeholder interviews.

Residential Treatment Staff Perspective. More than 40 staff members commented about specific types of staff and the appropriateness of these staff and staffing levels. They consistently indicated that the REGIONS program had the appropriate type of staff. All thought having juvenile detention officers/mentors, classification and program officers, and clinicians/counselors was appropriate. Some mentioned how helpful it was to have the milieu specialists who serve several different programs. Several of the staff members also mentioned that there were benefits to having a consistent staff team working with the youths (rather than staff who rotate more often, as is the case in detention). One of the interviewees said: "All staff is consistent. They all have the same standards. We don't use staff from other units with the REGIONS kids."

In addition, most interviewees reported having the appropriate numbers of staff in the REGIONS program, though some wished they had additional juvenile detention officers/mentors, classification and program officers, and licensed mental health counselors. Interviewees indicated that the private facilities have slightly more need for additional staff, mainly owing to challenges in filling positions (not to the lack of such positions). Some mentioned that the pay is low in the private facilities, which can be a deterrent in hiring and retention.

Interviewees in the two state-run facilities spoke a bit about the role of shift supervisors (SSs) and other senior staff in the building who were not assigned specifically to the REGIONS program. Most mentioned that they attempt to handle all situations on their own and try their best not to call on non-REGIONS staff for help. One of the interviewees said:

> The shift supervisors work in the whole building. If a kid refuses to go to his room or something like that, the JDOs won't call the SS. They will do this in detention, but not in REGIONS. JDOs have the skills to figure it out themselves, the CPOs, too.

Senior staff in the two state-run programs mentioned that they allow REGIONS staff the flexibility to experiment, adjust, and try new things. One manager said: "I teach my staff to handle as much as they possibly can handle until they need [the broader facility staff]. Because JDOs are really the most important part of REGIONS." Managers shared that they gave the REGIONS units a lot of freedom and supported them. One of the juvenile detention officers said the shift managers "give us the power, don't tell us what we need to do, but may ask what is needed."

However, a few interviewees in the state-run programs mentioned that it would be helpful to have a REGIONS-specific shift supervisor and that they could use more freedom. One interviewee said:

> The only thing with the REGIONS side, we could skip the supervisor part. We look into making the unit run itself. We do that ourselves. If I have an issue with one child, we figure it out. We're good at tapping out when one staff member isn't working well. Staff isn't switched around. We tell the kids they need to

109

find a way to get along with staff and kids.

Youth Perspective. We asked 17 youths, "What do you think of the staff here?" and "How supportive are they"? All the youths said at least some of the staff were supportive, using terms like "super supportive," "very supportive," "supportive," "helpful" or "good." Most of the youths mentioned that they liked the staff, that the staff helped them achieve their goals, that the staff want them to succeed, or that the staff feel like family. They also mentioned that they liked having the same staff members on the units regularly. And although some of the youths said that they did not get along with some of the staff, they overwhelmingly had positive comments, saying that the staff members are nice, that they treat the youths with respect, that they take care of them, and are consistent.

One of the youths said: "Some staff is cool; some is nice; some is strict. They're all by the book." One youth even said, "I love the staff here." Another youth said: "They treat you with respect. They take care of you. They feel safe, and they're consistent. We get the same staff every day. It's consistent. It's not like pre-dispo."

We asked the youths, "What changes would you make?" Some of them mentioned adding more staff members, but most said they wouldn't change anything. At the end of the interview, we asked the youths, "What do you like most about this program?" At least 6 of the 15 youths who answered this question mentioned the staff. One youth said: "They want you to do good; they don't want you to fail. They want you to succeed."

In a PbS survey of 93 REGIONS youths, 96 percent of respondents indicated that they were treated fairly by staff, and 92 percent indicated that they felt respected by staff. Also, 90 percent of youths said that they were told ahead of time when staff were changing positions or leaving. The data for this survey were collected between April 1, 2020, and Nov. 23, 2022.

Summary and Next Steps. The REGIONS treatment programs should be commended for having appropriate staffing structure and levels, which many jurisdictions nationally lack. Another positive feature is the consistent, dedicated staff in the treatment programs, which both staff and youths repeatedly noted is an asset. Finally, within the detention center buildings, REGIONS staff appear to be given the freedom to run their program as a proper treatment program, rather than as just another pod in a large facility. However, the private facilities face challenges related to turnover and filling positions, including turnover in positions that are responsible for transition and re-entry, such as the reintegration mentors (for more information, see Metric 76). *Since the draft findings and recommendations for this report were presented, JBCSSD has added family support specialist positions to the private/contracted REGIONS programs and increased contracted staff salaries (as of 7/1/2023) to support recruitment and retention of experienced staff.*

56. Extent to Which Trauma, Culture, and Gender Inform Treatment and Programming

As mentioned in Metric 21, trauma, gender, and culture are regarded as responsivity characteristics in the correctional literature (Bonta and Andrews, 2007; Fritzon et al., 2021; Taxman, 2014). Addressing them is important, because not doing so may impede treatment. According to the National Institute of Corrections' *Desktop Guide to Working with Youth in Confinement*, service and treatment plans need to consider several responsivity factors, including cultural sensitivity, sexual orientation, spiritual and religious beliefs, gender-responsive programming, and trauma-related issues. These factors can be addressed by establishing clear policies and procedures; providing ongoing staff training in cultural competency, sexual orientation, and gender identity issues; ensuring that service plans and programs seek to foster healthy gender identity development; and incorporating trauma-informed care throughout rule development, behavior management, service delivery, staff training, and other basic program elements (Griffis and Sloan, 2014). Programs should assess for these responsivity issues to determine

110

whether they should be addressed or how well they are currently being addressed, so that the REGIONS interventions achieve their full intended impact. We assessed this metric using information from youth files and key stakeholder interviews.

File Review. As mentioned in other metrics, REGIONS gathers information about each youth through several tools. The Structured Trauma-Related Experiences and Symptoms Screener (STRESS) is administered to assess lifetime exposure to potentially traumatic and other adverse experiences and to identify traumatic events and functional impairments. Also, the PrediCT contains an item for trauma and abuse, the SAVRY includes items related to exposure to violence in the home and history of maltreatment, and the START:AV features items related to mental/cognitive state and external trauma response activators. None of these tools solicits meaningful information about gender or culture aside from the sex of the child. However, the REGIONS Stage 1 Treatment Plan form in JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, Intake and Admissions) [Attachment B] provides space specifically for addressing barriers to treatment, including sociocultural factors such as cultural differences; the role of stigma, bias, and racism; societal attitudes; disparity in health services; and attitudes of healthcare providers toward women.

Figure 3.11. Perceptions of Residential Treatment Staff on the Extent to Which Trauma Informs REGIONS Treatment and Programming
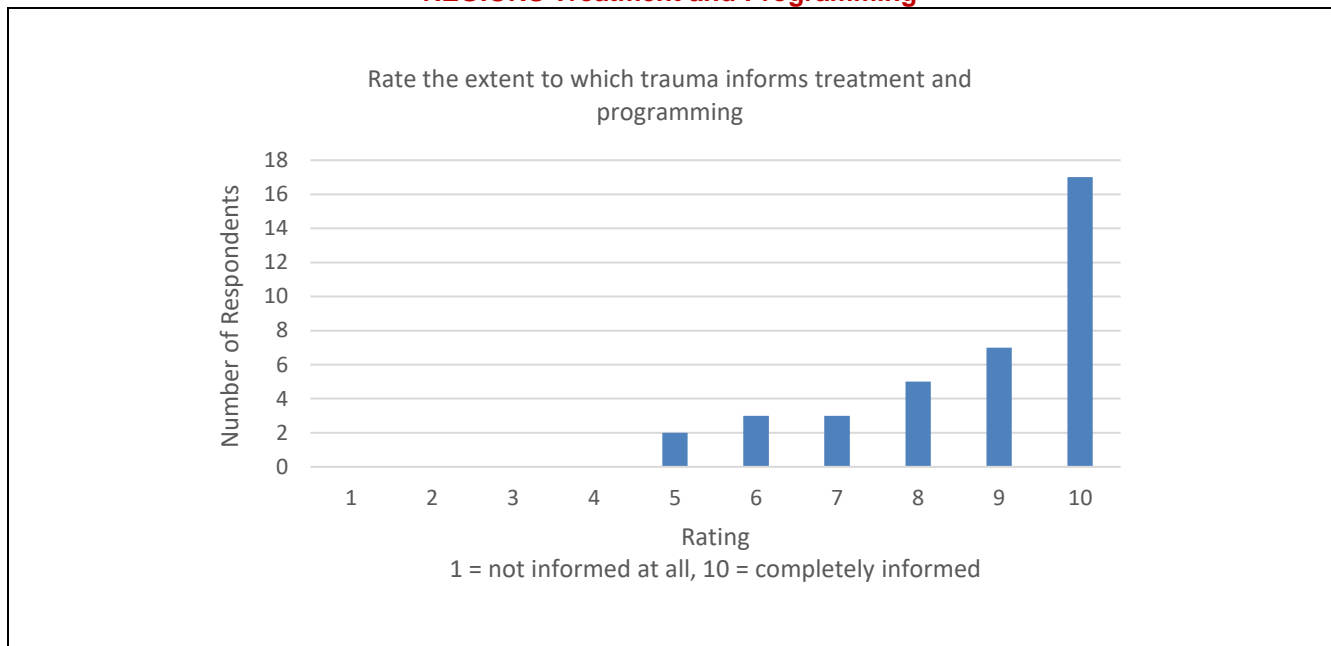
Data source: Residential treatment staff interviews. *N* = 37.

Residential Treatment Staff Perspective. We asked 37 residential treatment staff members from the seven residential programs and from the JBCSSD Central Office to rate the extent to which trauma informs treatment and programming (on a scale to 1 to 10, with 1 being not informed and 10 being completely informed). The average score was 8.7 and ranged from 5 to 10 (see Figure 3.11). The median was 9. Interviewees mentioned that staff members are well trained, they incorporate as much information from assessments as possible, they get information on activators so they can be prepared, and they incorporate trauma-informed approaches throughout the program. Education staff shared similar opinions, noting that participating in the weekly meetings helped them be more trauma informed.

111

One interviewee from a residential program said, "It's everywhere; we've always done it," although he did not give a rating of 10 because of turnover and the need to keep retraining staff. One of the clinicians said:

> We always will have a special needs plan for the youth that identifies specific interventions, if needed (e.g., tone of voice, avoid hands-on, number of people involved when in crisis). Clinicians will communicate with the team about this so staff are aware of how best to support the youth. DBT doesn't require processing of past trauma, though it does give youth the skills to cope with the symptoms. If youth want to talk about it, we won't say no. We are mindful of their current functioning and any symptoms that might interfere. In DBT, we talk about bio-social theory. It helps the youth understand how all systems mesh with each other.

Thirty residential treatment staff members felt comfortable rating the extent to which culture informs treatment and programming (on a scale to 1 to 10, with 1 being not informed and 10 being completely informed). Eighty percent of the respondents gave this item a rating of 8 or above (see Figure 3.12). The average rating was 8.7, and the range was from 3 to 10. The median score was 9. Staff members, including the educational staff, mentioned the importance of understanding the youth's culture, ensuring that the program is culturally competent, and having a diverse staff. They mentioned learning about and understanding the youth's religious preferences, food, customs, superstitions, and signs of respect and disrespect that may differ based on culture.

One of the residential treatment staff members said:

> The program has many different cultures. We are pretty open, and very open to accepting everybody. We have had different races, cultures, ethnicities, and genders. We are very diverse. I believe it's also used as a learning tool for youth and for staff. The staff is also very diverse. We celebrate different holidays, and the kitchen staff do a great job with meals. Also, in school they provide a wide variety of lessons on different cultures.

One of the clinicians said:

> It informs my treatment, but I'm not sure how mindful staff are about this in how to interact. I acknowledge that everyone is different. They might have the same skin color, but they all have different cultural backgrounds, families, and identities. It's easy to think that all the boys who do 'bad things' are from 'bad areas of town,' and we cannot do that.

However, some interviewees felt the programs could do better. They suggested providing training for new staff in addition to each residential program's standard training.

Fewer residential staff members had opinions on the extent to which gender informs treatment and programming (compared with trauma and culture). Twenty residential treatment staff members rated the extent to which gender informs treatment and programming (on a scale to 1 to 10, with 1 being not informed and 10 being completely informed). Ninety percent of the respondents gave this item a rating of 8 or above (see Figure 3.13). The average rating was 9.2 and the range was from 6 to 10.

112

Figure 3.12. Perceptions of Residential Treatment Staff on the Extent to Which Culture Informs REGIONS Treatment and Programs

Rate the extent to which CULTURE informs treatment and programming

[Bar chart: x-axis "Rating" from 1 to 10 with note "1 = not informed, 10 = completely informed"; y-axis "Number of Respondents" from 0 to 16. Bars: rating 3 = 1, rating 6 = 2, rating 7 = 3, rating 8 = 5, rating 9 = 4, rating 10 = 15]
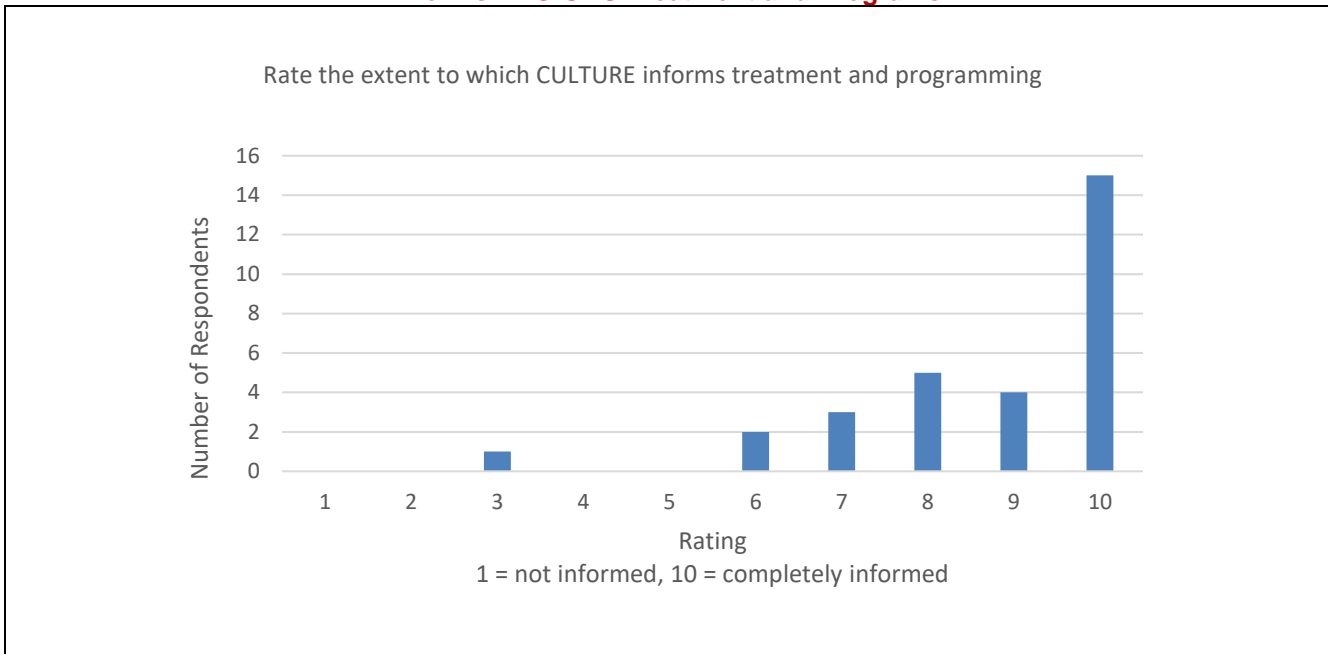
Data source: Residential treatment staff interviews. *N* = 30.

Many of the comments related to addressing the needs of transgender youths, which most of the respondents felt were addressed successfully on a case-by-case basis. Others mentioned that when working with diverse groups of youths, staff need to be responsive to their individual needs (whether concerning gender, race, culture, or other issues) and provide them with a safe space. Most of the interviewees felt that the residential programs embrace this approach.

Figure 3.13. Perceptions of Residential Treatment Staff on the Extent to Which Gender Informs REGIONS Treatment and Programming

Rate the extent to which GENDER informs treatment and programming

[Bar chart: x-axis "Rating" from 1 to 10 with note "1 = not informed, 10 = completely informed"; y-axis "Number of Respondents" from 0 to 12. Bars: rating 6 = 1, rating 7 = 1, rating 8 = 3, rating 9 = 4, rating 10 = 11]
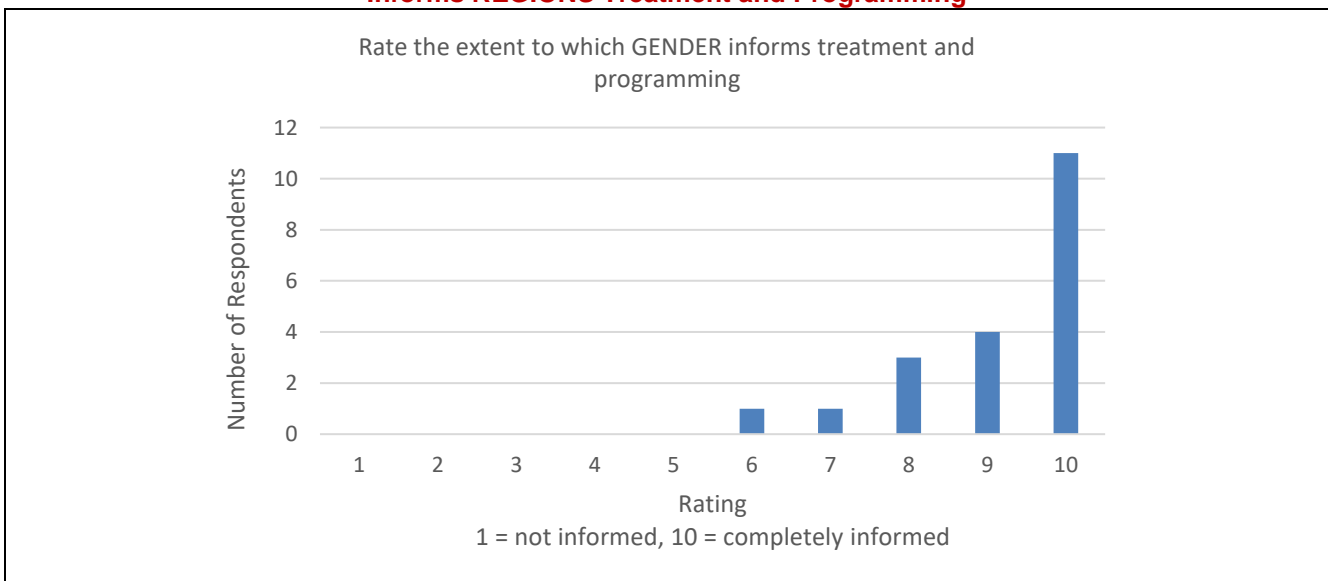
Data source: Residential treatment staff interviews. *N* = 20.

Youth Perspective. A PbS survey given to youths in REGIONS programs between 2020 and 2022 found that 95 percent of respondents believed their race and cultural heritage were respected, 97 percent felt their gender and gender identity were respected, and 96 percent thought their sexual orientation was respected.

Summary and Next Steps. Residential treatment staff and youth shared through interviews and surveys that culture, gender, and trauma are generally addressed well in treatment and programming.

57. Extent to Which Educational and Vocational Needs Are Met
This metric addresses both educational and vocational needs. Our analysis is presented separately for each factor: 57a addresses educational needs and 57b addresses vocational needs. The assessment was informed by a review of policies and practices as well as key stakeholder interviews.

57a. Extent to Which Educational Needs Are Met
Children involved in the juvenile justice system are less likely to benefit from education-related protective factors than other children their age; they are also more likely to experience negative outcomes related to learning challenges and school failure (DSG, 2019a; Foley, 2001; Sedlak and Bruce, 2010). Providing education for detained and confined youths is particularly challenging, given their highly transient status and their complicated mental health and academic needs (Foley, 2001; Gagnon and Barber, 2010; Sedlak and McPherson, 2010). However, youths who achieve higher levels of education while in the juvenile justice system are more likely to experience positive outcomes in the community once released (Blomberg et al., 2011; Cavendish, 2014).

> **One of the JDOs said about meeting educational needs: "It's a great staff. A few of the kids feel they aren't being challenged enough. Some of the smarter kids are stuck in 6th grade work. It hard for the teacher to split work in one classroom. It's tough."**

According to JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program), during stage 1 of treatment in a REGIONS program, "The CPO will notify the education provider in the facility of a newly identified REGIONS student. The education provider will work with the student, his family, and the student's home school district to address any educational needs, including but not limited to, initiating testing and/or requesting a planning and placement team meeting (PPT) as needed, credit recovery, or other needed interventions to support academic success."

The Connecticut REGIONS program has several strategies for meeting educational needs:

- Educational updates are required in the REGIONS Integrated Treatment Plan.
- An education update is required in the REGIONS Recommendation/Discharge Summary.
- The level system includes education requirements. To move from the Prospect level to the Rookie (or Silver) level, youths need to participate in school, attend daily, and complete homework. To move to the Pro (or Gold) level, youths must participate actively in school.
- In all three levels, youths must attend the full day of school (be on time, participate in class, follow rules) to earn REGIONS bucks.

The schools are ran by several different entities depending on the facility:

- Hartford REGIONS Secure – Domus Kids, Inc.

114

- Bridgeport REGIONS Secure – Bridgeport Public Schools
- Hartford REGIONS Community Partners in Action (CPA) Staff-Secure – ACES
- Hamden REGIONS CPA Secure – ACES
- Milford REGIONS Boys & Girls Village (BGV) Staff-Secure – onsite school run by BGV

In the Bridgeport and Hartford secure facilities that share the building with predisposition detention, the youths are not mixed with the predisposition youths, which is a best practice.

Also, Public Act 18–31 established an Education Subcommittee within the Juvenile Justice Policy and Oversight Committee (JJPOC) to develop a detailed plan to address concerns with overall coordination, provision, supervision, and direction of all academic services and programs for school-age youths/children who reside in juvenile justice facilities or are incarcerated.[21] Planning for this unit was ongoing while DSG was conducting this process evaluation. During this time, a system of education liaisons was established, and we were able to interview three of the liaisons.

> In accordance with Connecticut Public Act 18–31, each public school district with a student enrollment of at least 6,000 is required to designate a juvenile justice liaison/re-entry coordinator to facilitate student transitions between public schools and the Connecticut juvenile justice system, including the timely transfer of records of justice [system]-involved students to and from juvenile justice agencies and facilities.

Among other things, the juvenile justice liaisons/re-entry coordinators are tasked with assisting schools, the Department of Children and Families (DCF), JBCSSD, and any other relevant schools or educational service providers to ensure that, no later than 10 days after receiving notification, the school district transfers all relevant education records for students entering justice system custody to the appropriate juvenile justice system facility, pursuant to Connecticut General Statutes Section 10–220 (for more information, see Metric 77).

Residential Treatment Staff Perspective. Thirty residential treatment staff were asked to rate the extent to which they thought educational needs were being met at their facilities. Over 85 percent of the responses were 7 or higher (see Figure 3.14). The average rating was 8.2. One of the juvenile detention officers said: "It's a great staff. A few of the kids feel they aren't being challenged enough. Some of the smarter kids are stuck in sixth grade work. It's hard for the teacher to split work in one classroom. It's tough." Another interviewee said: "The teachers and the principal are amazing. The teacher spends a lot of time with them. They are awesome people. The boys do very well. Even though they complain, they do very well in school." Many comments were made about the dedicated staff who truly care about their students. The ACES principal was mentioned various times as outstanding. Comments seemed to be slightly more positive in the private programs.

Youth Perspective. Seventeen youths answered the question, "What's school like here?" Most of them responded positively, saying, for example, that school was "good," "laid back," "fine," or "fun." Some youths pointed out that they liked the summer program better than the regular school year, but others said they liked the regular school year better. The interviewees mentioned that the teachers were able to "connect" with them, that they learn new things, and that they earn credits. Some noted that the work was similar to what they were doing in their home schools. One of the youths said: "When I came here, they started teaching me more and everything started clicking in my head. Now, when I do need help, I'll ask for it. I wasn't doing that before." However, some felt the curriculum was not rigorous enough, saying that school was "repetitive "and "easy."

---

[21] https://portal.ct.gov/DCF/Juvenile-Justice-Education-Oversight/Home

**Figure 3.14. Residential Treatment Staff Perspective on How Well
Educational Needs Are Being Met**

Rate the extent to which educational needs are being met
on a scale of 1 to 10
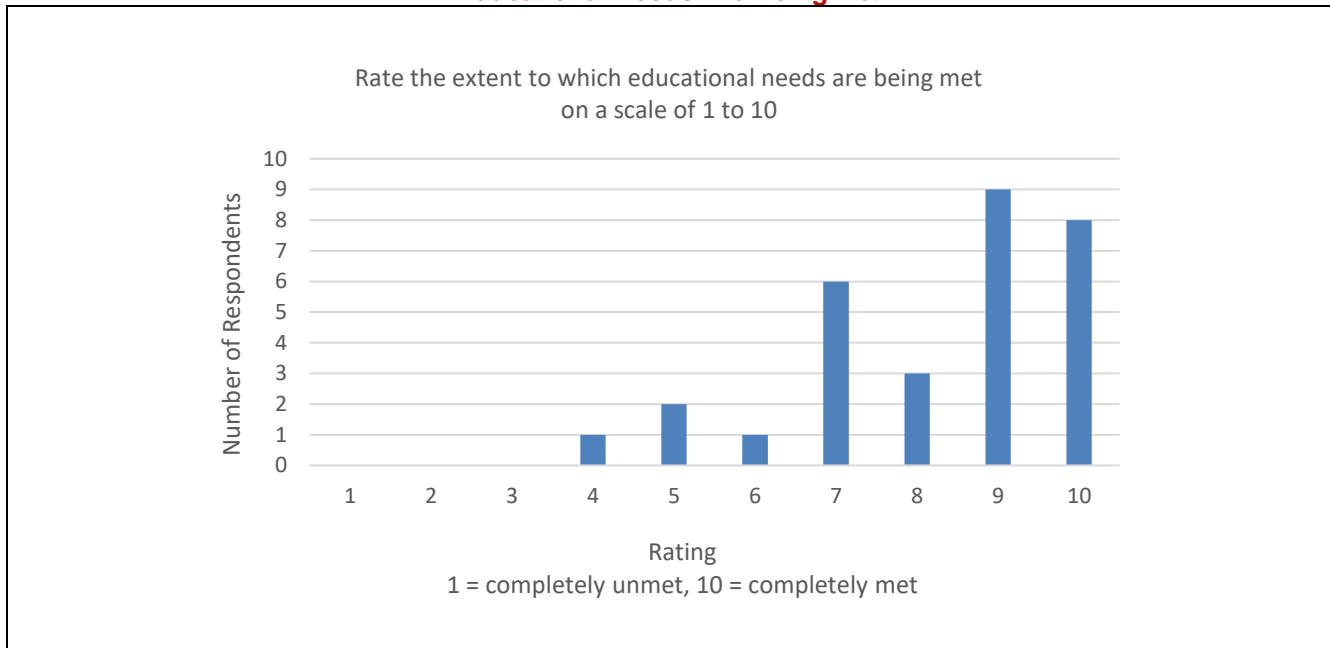
Data source: Residential treatment staff interviews. *N* = 30. Note: One of the staff members ranked two different facilities.

We asked 16 youths, "Do you think your educational needs are being met? Why do you think that?" Twelve respondents said they felt their needs were being met (75 percent), 2 said their needs were not being met, and 2 were ambivalent. About half of the respondents said that they had received credits or finished a grade. One youth said that he had already graduated, while three mentioned that they will graduate when they leave the program. However, at least one youth felt that school was too easy. He said: "If you're about to graduate or you're a freshman it's the same. It should be more based on what grade you're in. They should find a way to get different kind[s] of work for different kids. Sometimes you do the same things over and over. It's repetitive…This makes us mess up and get in trouble."

Community-Based Provider Perspective. Community-based providers shared a broader perspective on the education of REGIONS youths as they go through the various components of REGIONS. Similar to residential program staff, community-based providers had both positive and negative comments. Overall, they acknowledged both the challenges of educating these youths, (specifically owing to the short time they are in each placement) and the commendable efforts made by the education staff, given these challenges.

One of the interviewees said: "We're not even academically meeting their needs because we don't have enough time. The kids are so guarded when they first arrive. It takes them a while to loosen up and to get to know them. And by the time you get to know them, they're on to the next place." Another said: "You're grouping kids not based upon what grade they're in or what level they're in. You're grouping kids based upon some other thing that's not educationally sound."

However, other stakeholders in the community felt that REGIONS did a good job of preparing youths educationally. One of the interviewees said:

> I think the system there pretty much matches up with the system we have, and they're coming back prepared, I feel, as best they can. I mean, they didn't go in [to the program] with straight A's. Actually, their grades tend to be better there because I think you can't really skip school there. So, the attendance is better. Their grades come back a little better. How actually prepared they are? I don't know, but it seems

116

to be a smooth transition when they come back.

Summary. Three main themes emerged in interviews with both Court and residential treatment staff about meeting youths' educational needs in REGIONS residential placement:

1. It is challenging to meet the needs of all youths in their care. Regardless of their varying levels and needs, all students are in the same classroom in their assigned facilities. It appears to be especially difficult to meet the needs of students who are performing above average (and may have a "realistic chance at college") and those with special needs. Interviewees expressed that most of the teaching is geared to the majority of the youths who are performing under grade level.
2. Staff feel that the education staff try their best and do a good job, given the challenges, especially with the lower-functioning youths.
3. The facilities do a very good job with credit recovery.

57b. Extent to Which Vocational Needs Are Met

Having low levels of personal, educational, vocational, or financial achievement is one of the eight major risk factors for criminal conduct (Latessa, Listwan, and Koetzle, 2015). In the juvenile justice system, addressing vocational needs is especially important for older youths who may not want to continue with their formal education. According to JBCSSD Policy and Procedure 8.600, when REGIONS youths are not already participating in vocational programming, the classification and program officer will place the youth in the EMPLOY group and Work Study. Programs focused on job-related skill building have positive effects on juvenile recidivism (Lipsey et al., 2010), Although they tend to have less of an impact than other types of interventions.

Residential Treatment Staff Perspective. Forty-three interviewees working in residential treatment rated the extent to which they thought vocational needs were being met at their facilities (with 1 meaning "completely unmet" and 10 meaning "completely met"). More than 80 percent of the responses were 7 or higher (see Figure 3.15). The average score was 8.0, and the range was 3 to 10. The median score was 8.5.

Although not enough data were available for a meaningful comparison, it appeared that staff felt vocational needs were met better in the staff-secure facilities and in the private facilities than in the state-run secure facilities. This makes sense since there are more opportunities for vocational training in the less-secure environments, which are often used as step-down programs. For example, the Milford Boys & Girls Village REGIONS Staff-Secure Treatment Program had recently opened a state-of-the-art vocational building that included classes in computer programming, auto repair, kitchen staff training, and imprinting tee shirts. Also, phase 2 of the Hamden CPA REGIONS Secure Treatment Program includes a much greater emphasis on vocational training through on-site opportunities such as a forklift simulator, music studio, construction area, and barber shop.

> **One of the youths said: "When I came here, they started teaching me more and everything started clicking in my head. Now, when I do need help, I'll ask for it. I wasn't doing that before."**

However, staff in the two public, secure facilities also showed pride in their employment programs, especially given the space limitations. In the state-run facilities, they emphasized vocational "soft skills" such as filling out applications, making eye contact with adults, interview skills, and building confidence. They also assigned the youths jobs in the facilities,

such as cashier in the program's store, recreation assistant, laundry assistant, and library assistant. One of the juvenile detention officers said: "Each juvenile starts off at a job. They do the application for one position or another. Then they are promoted from one to another. They get the chance to move up. It helps them build confidence and takes them to that mindset."

In the private and staff-secure facilities, staff also take advantage of vocational opportunities associated with the day-to-day care of their buildings, such as assigning youths to work with the custodian, assist with gardening, and work in the kitchen. In each of these opportunities, "soft skills" are also emphasized. One of the staff members at a staff secure program said: "What I do is more emotional intelligence building than vocational training." Another opportunity only available in the step-down programs is being able to leave the facility to work. Some programs also partner with outside groups to provide vocational programming, such as the partnership between Journey House and EASTCONN.

In both the private and public facilities, staff and youths also mentioned the ServSafe certification opportunity, culinary arts experiences, and receiving training in CPR, which were seen as benefits. Interviewees shared the belief that addressing the youths' vocational needs was very important. The general consensus among interviewees was that the effort is being made to address vocational needs, and staff understand it is important, but the services provided vary greatly by program.

Figure 3.15. Residential Treatment Staff Perspective on the Extent to Which Vocational Needs Are Being Met
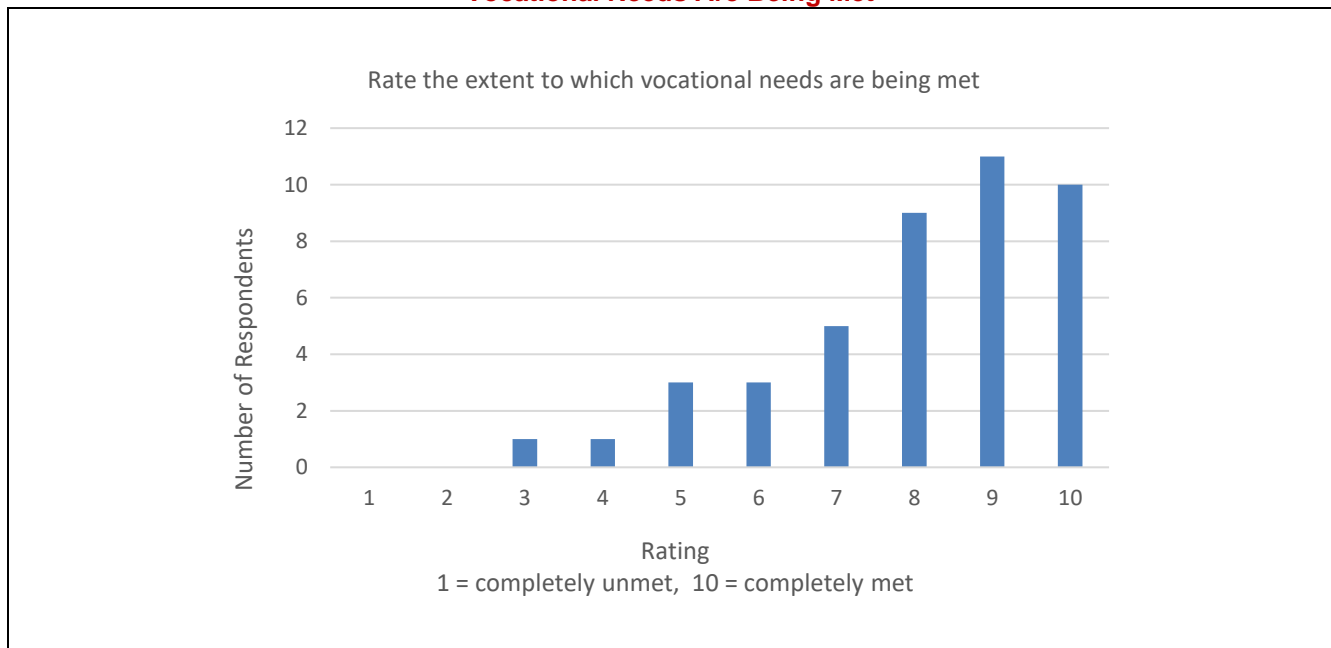
Data source: Residential treatment staff interviews. *N* = 43.

Youth Perspective. Seventeen youths were asked about their vocational experiences in the residential programs. When asked, "Do you think your educational and vocational needs are being met? Eighty percent responded "yes." Fifty-three percent of the youths reported an interest in the culinary program partly to the opportunity to earn the ServSafe certificate in REGIONS. Most reported that they gained experience they can use in the future such as completing job applications and interviews, earning certificates, and being able to receive a paycheck. Auto mechanic and babysitting were the second jobs with a high interest. Several youths also discussed future job opportunities and goals they had for their career. One respondent said: "I want to be a firefighter. It's certain classes you have to take. I want to finish HS diploma and get college credit." Another answered: "CPR. I enjoy them. I want to go for my CNA." When asked: "Are you (or were you) in any vocational programs? Which ones? Did you enjoy them? Can you use the skills in the future?" 97 percent of the youths stated they have participated in, or will participate in, a vocational program.

Summary and Next Steps. The REGIONS program has done a good job of bringing in vocational opportunities for REGIONS youths. While some private programs have done an excellent job of expanding opportunities for vocational training (e.g., Hamden CPA, Milford Boys & Girls Village), some secure facilities do not always have the structure or resources needed to provide those opportunities. DSG recommends that REGIONS secure facilities continue to work on opportunities for vocational needs training (e.g., by offering jobs in the detention center and on the unit, role-playing jobs on the unit). (For more information about addressing vocational needs, see Metric 79.)

Since the draft findings and recommendations for this report were presented, JBCSSD shared that they are in the process of increasing vocational opportunities at the residential programs.

58. Extent to Which Demonstrable Educational Gains Are Evident
Education data are not tracked in the current state data management systems. Instead, they are maintained by the individual education provider. To assess this metric, we provide some information from interviews with key stakeholders.

Residential Treatment Perspective. We asked education staff, other residential program staff, and directors from each of the seven residential programs, "How does the program measure education gains?" Respondents mentioned tracking credit completions and credit recovery, discussing progress at the weekly MDT meetings, report cards, moving to the next grade, graduation rates, weekly awards, and increases in test scores.

We then asked, "Do you think that most clients demonstrate educational gains? If so, how?" The interviewees' responses ranged widely. Some responded that none of the youths made educational gains, others thought some or most of the youths made educational gains, and other felt that all the youths made educational gains. Some of the more negative responses were related either to not having enough time to determine gains or to youths not being interested in engaging in school. One of the interviewees said: "They go because it's mandatory and provides structure, but I don't think anyone pays attention, and I don't think they're learning anything." Others had much more positive comments, referring to the educational gains as "phenomenal." Many shared individual stories of youths' successes, including youths who gained credits that were lost due to various placement changes, youths who graduated from high school, and youths who started the program without knowing how to read and who learned to read at the program.

Summary. We were unable to assess the extent to which demonstrable educational gains are evident using quantitative data. However, interviews indicate that many of the youths in REGIONS make educational gains such as credit recovery, promotion to the next grade, and graduation from high school.

59. Any Evidence of Disparate Treatment Based on Race, Ethnicity, or Gender

Nationally, data have shown that youths of color are more likely than White youths to be arrested and subsequently go deeper into the juvenile justice system (e.g., Puzzanchera, 2021; Puzzanchera and Hockenberry, 2013; Sickmund et al., 2021; Sickmund, Sladky, and Kang, 2021). Racial and ethnic disparities in juvenile justice is a complex problem in jurisdictions across the United States (DSG, 2014; Spinney et al., 2018). Nationally, there are also gender disparities in juvenile justice. Boys are more likely to be involved in the juvenile justice system than girls. Many advocates say that because the system was designed for boys, girls' needs are often not met (Anderson et al., 2019; Garcia and Lane, 2010; Goodkind, 2005; Reed, Sharkey, and Wroblewski, 2021). DSG assessed this metric by analyzing youth demographic data and feedback from key stakeholders.

Analysis of Demographics. In REGIONS, there is an expected overrepresentation of males compared with the general Connecticut youth population: 88 percent of the service memos DSG reviewed were for boys; however, boys make up only 49 percent of the total Connecticut youth population ages 10–17 (Puzzanchera, Sladky, and Kang, 2021). REGIONS includes seven residential programs, and girls are referred only to one of them (Journey House, Natchaug Hospital Limited-Secure REGIONS Treatment Program).

Figure 3.16. Race/Ethnicity of REGIONS Youths Compared With Youths in Statewide Population
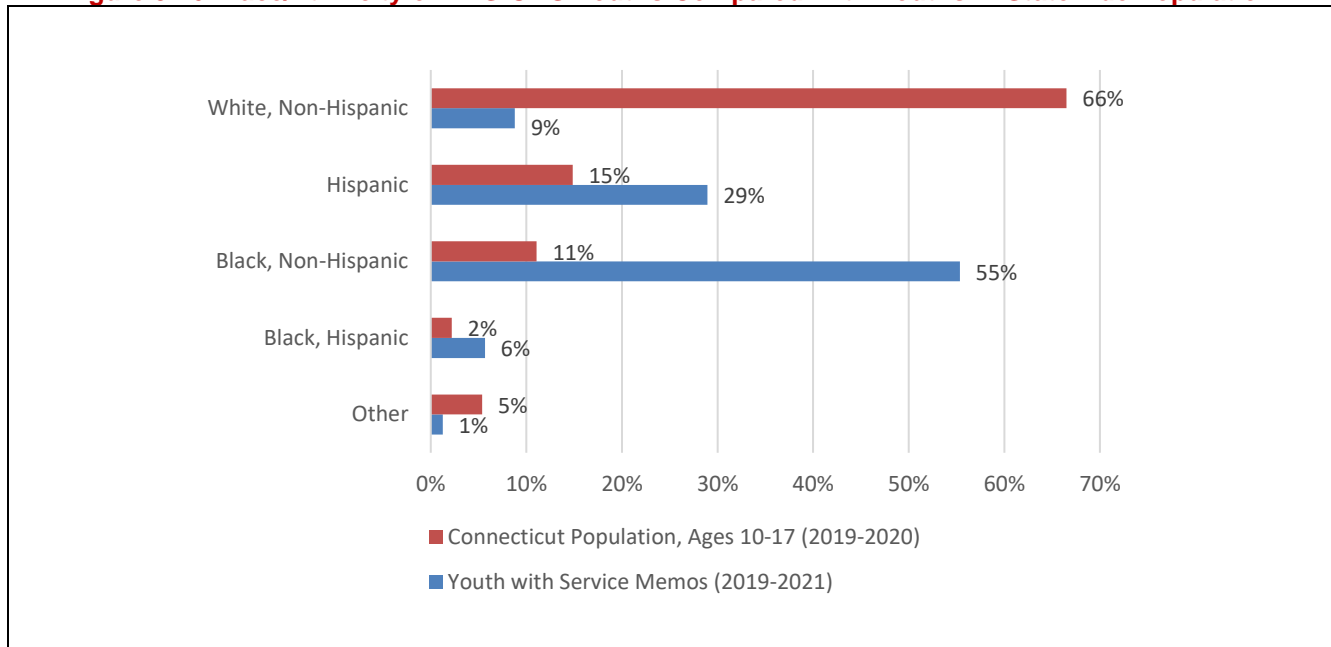
Data source: Service memo audit reports from 2019–2021; Puzzanchera, Sladky, and Kang, 2021. *N* = 161.

In terms of race and ethnicity, although White, non-Hispanic youths make up 66 percent of the total youth population in Connecticut (ages 10–17), they constitute only 9 percent of the REGIONS service memos (see Figure 3.16). Black youths are the most overrepresented group in REGIONS, followed by Hispanic youths: Black non-Hispanic youths make up 11 percent of the Connecticut youth population but 55 percent of the REGIONS service memos; Hispanic youths who are White, Asian, or American Indian represent 15 percent of the Connecticut youth population but 29 percent of the REGIONS service memos.

Residential Treatment Staff Perspective. We asked 50 residential treatment staff, "Have you seen any evidence of disparate treatment based on race, ethnicity, or gender?" While some commented that

youths may have experienced disparate treatment *before* they arrived at the facility, all said that there was no evidence of disparate treatment in their residential program.

Youth Perspective. We asked 12 youths, "In terms of how staff reward and punish the youth in your facility, are there kids that get treated better than other kids?" Eleven of the 12 respondents said the staff treated everyone the same, that there was no favoritism, or that things were fair. Also, in the *2020– 2022 PbS Youth Reentry Survey*, 95 percent of the surveyed youths responded that they felt that their race and cultural heritage were respected, 97 percent shared that their gender identity was respected, 96 percent stated that their gender identity was respected, and 96 percent indicated that their sexual orientation was respected.

Summary. Interviews with residential treatment staff and youths indicate that they perceive the residential program to be fair, without evidence of disparate treatment based on race, ethnicity, or gender. These positive comments from residential treatment staff and youths are notable, especially within a national environment of increasing focus on racial and ethnic disparities. The similarity in the staff members' and youths' responses suggests that they experience the facilities as having organizational cultures of fairness. Similarly, analyses of data from Metric 25 indicate that demographic characteristics, such as gender and race/ethnicity, do not predict placement type within REGIONS. However, it is noteworthy that the multitude of decisions made before a youth is placed in a residential placement has resulted in extreme disproportionality at this deep end of the juvenile justice system, and the disproportionality specifically affects Black and Hispanic youths. A more in-depth analysis of racial, ethnic, and gender disparities within residential treatment programming and decision-making is outside the scope of this study.

60. Presence or Absence of Objective and Subjective Determinants of Treatment Plan Goal Attainment, and a Quality Assurance Process To Gauge Consistency Across Clients and Clinical Teams

To assess this metric, DSG reviewed policies and procedures and conducted interviews with key stakeholders. This metric is divided into two parts. The first part, which addresses determinants of treatment plan goal attainment, references other metrics that cover the same topics. The second part focuses on the quality assurance process.

60a. Determinants of Treatment Plan Goal Attainment

According to JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program), the clinician will facilitate a weekly goal review meeting and a monthly Integrated Treatment Plan (ITP) meeting with the multidisciplinary team (MDT) to discuss each youth's treatment goals, behaviors, progress, and challenges.[22] The clinician will complete a re-assessment of the START: AV after 90 days, and at the time of discharge, to track progress towards treatment goal attainment and discharge. The clinician will confirm through re-assessment that youths have met their individualized treatment goals before discharge from the program. All decisions during meetings related to treatment require a consensus among the MDT members.

As explained in Metric 63, progress toward treatment goals is one of the criteria used to determine readiness for discharge. Clinicians record treatment goals in the youths' ITPs under identified need areas. Need areas are: 1) Mental and Emotional State, 2) Attitudes and Behavior, 3) Substance Use, 4) Social Functioning, 5) Family Functioning, 6) Education/Employment, 7) Self Care, 8) Treatment Amenability/Engagement, and 9) Case Specific Outcome. The ITP includes the goal, the date the goal was initiated, interventions to address the need in the next 30 days, behavioral objectives (measurable steps to determine progress/achievement toward outcomes), and expected outcomes. There is also a

---

[22] See Metric 41 and Metric 44 for more information about the weekly and monthly meetings.

space for guardian, client, and/or stakeholder input. Every 30 days, progress is recorded and discussed in the ITP meeting. Also, progress is discussed in weekly MDT meetings. During these meetings, MDT members discuss the youths' level in the behavior management system and whether the level should change. As mentioned in Metric 42, ability to reach treatment goals is one requirement to reach the top level of the behavior management system. Also, results from reassessments of the START:AV are used as one part of the decision-making process. Stakeholders generally feel that the MDT approach is good and that it is beneficial for each of the team members to have a voice. However, as recommended in Metric 63 the process can be improved by incorporating more objective indicators.

60b. Quality Assurance Process
Continuous Quality Improvement (CQI) is a process that can help juvenile justice organizations demonstrate accountability (Daly et al., 2018; Dedel, 2014; Loeffler–Cobia, Deal, and Rackow, 2012; O'Brien and Watson, 2002). Quality assurance involves systematic measurement of the various aspects of a residential program's operation, comparisons to an objective standard, and modifications of program policy, procedure, and practices when the standard is not met (Dedel, 2014).

An independent CQI team audits REGIONS to ensure high-quality services. According to JBCSSD Policy and Procedure 8.600, the CQI program includes ongoing review of policies, procedures, and practices as well as analysis of data on health and operational care within the detention centers and contracted juvenile residential programs. The CQI program is used to identify healthcare aspects to be monitored, implements and monitors corrective actions when necessary, studies the effectiveness of corrective action plans, and informs policy development and revision. Similar to the Court Clinic CQI team, the REGIONS CQI team submits bids in response to an RFP, and they have a contract that specifies their job responsibilities.

Interviews with CQI auditors and other stakeholders indicate that the CQI team reviews each residential program monthly and produces reports for each program twice per year.[23] The audit forms and processes are guided by several different standards frameworks, including the National Commission on Correctional Health Care (NCCHC) and American Correctional Association (ACA) standards. The process has developed over time as a result of collaboration between the CQI team and JBCSSD.

Given the small number of youths in the residential programs, the auditors are usually able to review files for each of the youths. The reviewed files include the START:AV, Behavior Chain exercise, and Integrated Treatment Plans (ITPs).

The CQI team meets monthly to discuss CQI findings with residential treatment providers. These meetings are a good opportunity to discuss issues and find solutions. One interviewee said:

> These meetings are incredible...I believe in communication and just being able to bounce ideas off each other, and sharing ideas is helpful. Everybody can talk from a wide spectrum of experiences, and it makes things better and more efficient in the facilities and for the kids in our care.

Similar to the Court Clinic CQI process (see Metric 12 and Metric 13), the identification of a problem will generate additional trainings, updates in protocols, changes to audit forms, or additional investigation for process or outcome reports. The auditors also assist in other ways, including by working closely with the DBT specialist and providing informal guidance during visits.

The CQI team gauges consistency across clients and clinical teams using the same audit forms for all programs, and metrics are presented together (see Figure 3.17).

---

[23] Journey House is on a different schedule than the other programs. Their data are reviewed every 2 months, and audits are conducted yearly.

Figure 3.17. Excerpt from Audit Report, July 1, 2021–June 30, 2022

START-AV

Audit Question	BGV	JH	BJDC	HJDC	BGV	CJR	CPA Hmdn	CPA Htfd	JH
	6/21	6/21	2/22	2/22	2/22	2/22	2/22	4/22	6/22
The START:AV is completed in CDCS *Added in 2022*			100%	83%	100%	100%	100%	100%	100%
A clinically appropriate number of Critical Vulnerabilities were identified	100%	100%	100%	100%	100%	100%	100%	100%	100%
A clinically appropriate number of Key Strengths were identified	100%	100%	100%	100%	100%	100%	100%	100%	100%
All Adverse Outcomes are given a Future Risk rating	100%	100%	100%	83%	100%	100%	100%	100%	100%
All moderate and high Adverse Outcomes are given a History rating (*Prior/Recent*)	100%	100%	94%	83%	40%	100%	100%	100%	100%
Within the Comprehensive Rating form, anchors are underlined and/or notes are included that are consistent with/support the clinician's rating of each Item.	0%	100%	100%	83%	20%	100%	100%	81%	100%

Summary. The REGIONS residential program uses several measures, such as behavioral objectives in the ITP and changes in the START:AV, as well as discussions among MDT members to determine treatment plan attainment. This consensus approach is more subjective than objective. The auditors on the CQI team support the residential treatment programs by assisting them in measuring their efforts and identifying where changes need to be made. The auditors are capable and experienced, REGIONS treatment providers are engaged in the process, and the CQI process works very well overall.

61. The Extent to Which Data From the START:AV Is Being Used To Evaluate the Effectiveness of the REGIONS Program Model

According to JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program), the clinician will use the results of the START:AV to guide the development of the treatment plan and track progress towards treatment goal attainment and discharge. The START:AV results should be used to guide evidence-based intervention-planning, facilitate communication among persons involved in the youth's care, and provide a framework and common language for developing and monitoring risk and intervention plans.

Residential Treatment Staff Perspective. To assess whether the START:AV is being used to evaluate the REGION model's effectiveness, DSG asked several questions, including, "How are re-assessments of the START:AV used to augment the treatment process?" "Does any person track results of all START:AV assessments for each youth?" and "Are discharge decisions made based on the final START:AV results?" Twenty individuals responded to these questions, including at least one individual from each of the seven residential programs and three JBCSSD managers, specialists, or supervisors.

Some respondents indicated that the START:AV is a primary driver of decision-making. One interviewee said:

> Initially the START:AV is used to create the treatment plan, which shows vulnerabilities that they might have. And then re-assessments are compared with the initial to see if there have been any changes in their vulnerabilities and then will use that to update/modify the treatment plan for the youth.

Most of the respondents indicated that they look for changes in the START:AV but that these changes

123

may not drive decisions by themselves. One respondent said: "I think it is used. It's a piece of the puzzle. It's not the primary."

A few of the respondents indicated that the START:AV is used to develop the discharge plan (see below). One of the respondents said: "We need to see improvement to move on and discharge." Others mentioned that the START:AV was tracked through the auditing process.

One of the challenges of the START:AV identified by several interviewees is that when the youth is in a secure residential placement, many of the vulnerabilities diminish just because the youth is in a secure placement, and it may seem that the youth is more "ready" to complete treatment than is truly the case. This phenomenon was mentioned specifically in relation to areas such as school and work, substance use, relationships with peers, community, and medication adherence.

File Review. DSG staff reviewed 63 of the discharge plans for youths admitted to REGIONS between April 2021 and December 2022 from six of the seven residential programs. We extracted data from 53 of the discharge plans (10 of the discharge plans were for youths who were AWOL and not much information was available). Eighty-five percent of the discharge summaries specifically mentioned the START:AV and two thirds provided some detail about START:AV results. More than half the discharge summaries (28 out of 53) mentioned progress during treatment related to START:AV results. For example, one of the discharge summaries included the following language:

> Critical risk factors identified via START:AV (initial administration …) and other collateral information included aggression towards peers and staff in a school setting, rule adherence, negative peers, unauthorized absences, impulsive reactions and struggles to manage his emotions. Due to [the child's] fluctuations in milieu behavior while in the program, these risk factors remained critical at both times of START:AV re-administration (XX/XX/2022 and XX/XX/2022).

> Despite these fluctuations in the milieu, [the child] was generally engaged in treatment and built a strong relationship with his first clinician. Treatment focused on learning and practicing coping skills, increasing frustration tolerance and emotion regulation, increasing impulse control, accountability and responsibility for his behaviors, avoiding negative peer interactions, and establishing healthy communication with mother. His ability for insight and interest in learning about DBT skills enabled him to understand negative outcomes of his behavior, such as impulsive actions, quick emotional responses, and the influence of negative peers (football teammates). With support from his clinician, he practiced skills, such as the STOP skill, weighing pros and cons, self-soothing (music), and taking space when frustrated (most helpful). His ability to utilize these skills when triggered by staff or peers was inconsistent, and he often had difficulty taking responsibility for verbal reactivity and disrespect when frustrated, instead externalizing blame.

> Throughout treatment, he had periods where he demonstrated a positive attitude, willingness to accept coaching and positive engagement with staff and peers, and distinct periods where he was generally irritable, struggled to accept responsibility and verbalized frustrations that improving his behavior did not result in positive outcomes for him. Approximately 2 months into treatment, he began psychotropic medication treatment for his attentional difficulties, resulting in increased focus in the classroom and a moderate increase in emotion regulation. His inconsistency was likely a result of continued issues with frustration tolerance and vulnerability to external triggers, such as relational difficulties with his mother and peers, as well as deeper feelings of rejection from his father. Family therapy focused on building communication skills between [the child] and his mother, increasing his mother's understanding of the benefits of positive reinforcement and impact of criticism, and addressing primary behavioral concerns (accepting limits, disrespect and leaving the home without permission).

Although the START:AV results are mentioned in most of the discharge forms, it is clear that these results are not the primary driver of discharge. In many cases, including the one above, the youth's vulnerabilities remained unchanged while in treatment, but discharge was still recommended because of other factors such as engagement in treatment, improvements in the use of DBT skills, and

124

engagement in family therapy.

Summary. It appears that the START:AV is used as one part of the decision-making process, but it is not the driver of this process. As indicated in the example above, when a youth's vulnerabilities remain unchanged while in treatment, discharge may still recommended if other goals are reached. *Since the draft findings and recommendations for this report were presented, JBCSSD shared that they have implemented a quality assurance program for the START:AV and are developing objective behavioral indicators to determine readiness for discharge.*

C. Discharge Planning

Discharge Planning includes 13 metrics related to the REGIONS discharge planning process. These metrics are as follows:

1) Metric 62. Utility and effectiveness of the multidisciplinary team approach in treatment and discharge planning
2) Metric 63. Criteria used to determine readiness for discharge, discharge plan (e.g., step down program, community-based services, in-home services), and the effectiveness of the criteria used
3) Metric 64. Utility and effectiveness of using a consensus approach to treatment plan development and discharge planning
4) Metric 65. Rate of consensus in discharge planning
5) Metric 66. Appropriateness of length of stay
6) Metric 67. Number and percentage of initial Transition Planning Process meetings occurring 60 days prior to discharge
7) Metric 68. Number and percentage of final meetings occurring 30 days prior to discharge
8) Metric 69. Average number of Transition Planning Process meetings occurring prior to discharge
9) Metric 70. Identification of types of post-discharge services that are most common
10) Metric 71. Identification of REGIONS treatment goals that are most likely to require additional work in the community
11) Metric 72. Number and percentage of re-entry packets completed 30 days prior to discharge
12) Metric 73. Identification of post-discharge services that are missing from the discharge service options to meet client needs
13) Metric 74. Level of continuity and consistency in addressing treatment goals throughout the process

62. Utility and Effectiveness of the Multidisciplinary Team Approach in Treatment and Discharge Planning

According to the National Institute of Corrections' *Desktop Guide to Quality Practice for Working with Youth in Confinement*, residential programs should use a collaborative, multidisciplinary planning approach with multidisciplinary team (MDT) members including clinicians and caseworkers; managerial, supervisory, and direct care workers; teachers; medical personnel; mental health and other specialists; and probation and aftercare caseworkers. The guide also states that case planning works best when the individual responsible for implementing the elements of the aftercare plan participates as a member of the planning team throughout the youth's confinement (Griffis and Sloan, 2014). JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program) lays out the processes by which this collaborative, multidisciplinary approach occurs. To assess this metric, DSG interviewed key stakeholders from the Court and residential treatment.

Residential Treatment Staff and Court Perspective. We asked 32 individuals (including 4 JBCSSD administrators, 26 residential treatment staff based at one of the seven residential programs, and 2 attorneys) to rate the utility and effectiveness of the MDT approach in treatment planning, with 1

indicating very low utility and effectiveness and 10 indicating very high utility and effectiveness. Most rated this statement highly, resulting in an average score of 9.0 out of 10 (see Figure 3.18). Half of the respondents rated the utility and effectiveness of the MDT approach in treatment planning as a 10, indicating very high utility and effectiveness. One of the residential treatment providers from a staff-secure program said: "Monthly treatment team meetings are where education, reintegration mentors, probation officers, etc., all share the information we have, plan, and delegate tasks. When we re-group we have proper information." Another residential treatment provider said: "The overall MDT approach helps a lot because it helps the whole team help each other support the client." Finally, another residential treatment providers said:

> The design is a good design. There are always different factors to look at. The education staff looks at education, someone else looks at the legal factors, the mental health specialists look at mental health. We all have a different perspective. The clinicians couldn't do it on their own. We are looking at all sides of it. It also helps because we are human. We may really like a kid, but when we talk about him in a group, we can be more objective. We don't let our emotions drive the decision-making because we hear all the perspectives.

Figure 3.18. Residential Treatment Staff Perspective on the Multidisciplinary Team Approach in Treatment Planning
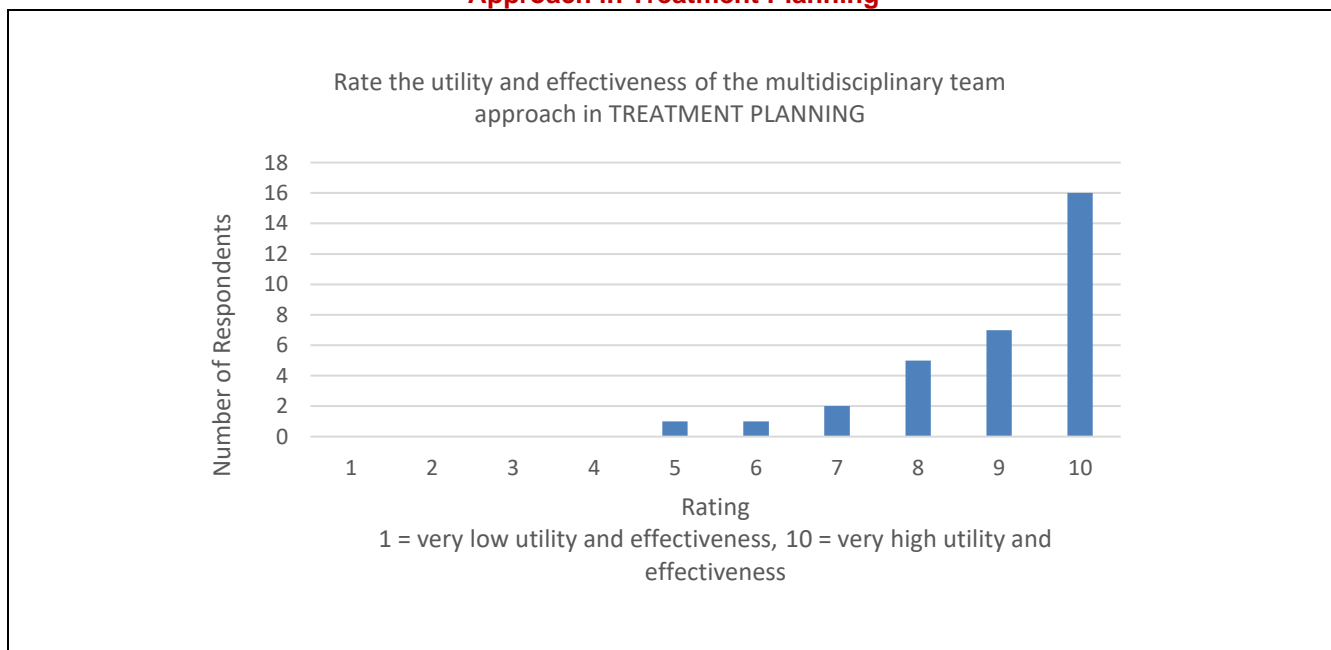
Data source: Residential treatment staff interviews. *N* = 32.

Additionally, we asked 26 interviewees (all JBCSSD administrative staff and residential treatment providers based in one of the seven programs) to rate the utility and effectiveness of the MDT approach for discharge planning (on a scale of 1 to 10, with 1 indicating very low utility and effectiveness and 10 indicating very high utility and effectiveness). Most of the respondents felt that this approach was both useful and effective. For example, one of the residential treatment providers said: "I think this is a good way to determine discharge because you have everyone involved. It takes a while to get everyone to agree." The average score was 8.3 and the range was from 5 to 10.

In the monthly meetings, discharge is typically discussed immediately after the first meeting. One of the residential treatment providers said: "We start to talk about discharge from the second monthly meeting,

even if it's months away. We talk to the PO [probation officer] from the beginning about where s/he sees them at discharge." Another interviewee said: "The whole process is about discharge."

Summary. The multidisciplinary approach to treatment and discharge planning is clearly a strength of the REGIONS program. Several important stakeholders participate, and most interviewees believe the process is going well.

Figure 3.19. Residential Treatment Perspective on the Utility and Effectiveness of the MDT Approach to Discharge Planning
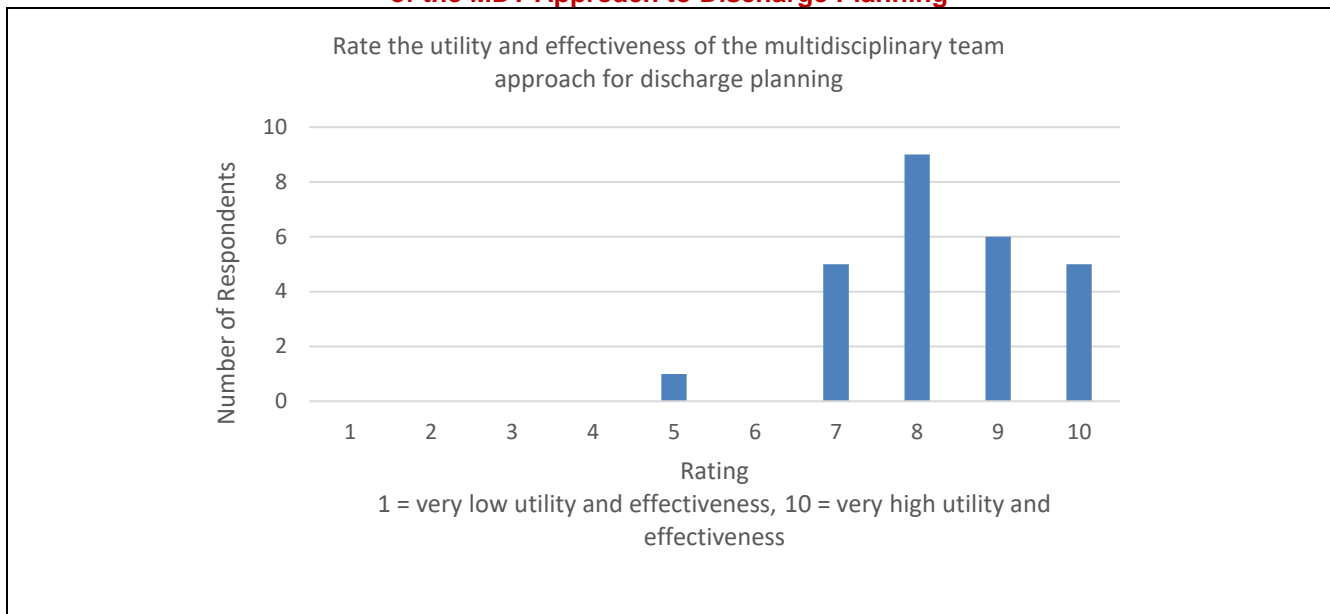
Data source: Residential treatment staff interviews. *N* = 26.

63. Criteria Used To Determine Readiness for Discharge, Discharge Plan, and the Effectiveness of the Criteria Used

JBCSSD Policy and Procedure 8.600 states that the clinician, in consultation with the MDT (multidisciplinary team), will use the most recent START:AV (which is completed 45 days prior to a youth's discharge date) and the REGIONS Recommendation/Discharge Summary form to review a youth's readiness for discharge, which includes, but is not limited to, the review of treatment goals attained and the follow-up services and interventions required to support the youth's success at the next level of care. DSG assessed this metric primarily by analyzing information gathered through key stakeholder interviews.

Perspectives of Residential Treatment Staff, Probation, and Community-Based Providers. During interviews, several different types of stakeholders identified the following criteria that are considered when determining readiness for discharge:

- Progress toward treatment goals.
- Progress toward learning DBT skills.
- Achieving success in the behavior management system, and reaching the highest level (e.g., All-Star, Master).
- Education in the community arranged and in place.
- Housing in the community arranged and in place.

Interviewees indicated that the criteria for determining readiness for discharge are relatively flexible but

are also based on some established and measurable criteria, such as goal achievement, skill attainment and acquisition, and acceptance of feedback and coaching. One of the interviewees said: "As long as they keep it as kind of a data-driven process based on goals, rather than an emotional process, it is helpful towards discharge." Regarding the criteria's flexibility, one of the residential treatment providers from a staff-secure program said: "We look at their levels. We also don't think everyone has to end here at the highest level. If they have reached their milestones, and we feel ready for them to go back home, we base it on that."

Some of the probation officers commented about the difficulties of getting the youths ready for discharge. One of the probation officers said:

> Kids are coming out of so many different facilities. There are so many different variables with making plans and following through. We have providers we are trying to get involved and set up. Some programs, like MST–FIT [Multisystemic Therapy–Family Integrated Transitions], will start when kids are still there so they can get the families to cooperate. There is also a need to get mentors and programs in place and school districts to cooperate. Some kids take a little longer to set up the transition.

The probation officers were also identified by many of the interviewees as the stakeholder group most likely to want to wait a little longer before discharge. One interviewee said:

> Usually the parent wants him home, the attorney who wants him home, and the facility staff wants to free up a bed. They all want the kid out. The P.O. is the only one saying the kids need to stay. We're planning for discharge from day 1, but just because everything is in place in the community, it doesn't mean the kid is ready.

We also asked, "Are there ever times when a client would complete the REGIONS program but not be discharged?" About 30 interviewees responded, mostly from residential programs, but also including probation officers, community-based providers, and JBCSSD administrators. One quarter of the respondents said this never happens. One residential treatment provider said: "I think we advocate for the kids really well. We don't just drag it out to fill a bed. We try to make sure the kid is in the best place." Others mentioned that when going from a secure setting to a step-down program, this usually runs smoothly. In these cases, interviewees shared that discharge is "truly contingent on the youth's progress." Some mentioned that this process was a little slower during the Covid–19 pandemic, but that it is generally not a problem now.

Seventy-five percent of interviewees said that sometimes a youth has completed the REGIONS program but is not discharged, although this happens rarely. When youths do need to stay longer, it is usually because of lack of services secured in the community. Interviewees mentioned that delays to the discharge process may occur when: 1) the parent is not ready to have the child back home, 2) housing is not arranged, 3) a DCF placement was not arranged, 4) there is an order from a judge, or 5) there is a newly discovered mental health need or a mental health crisis that the staff want to get under control before discharge.

One of the reintegration mentors said: "It gets a bit tricky when there is just one thing missing. For example, one kid had school set up but didn't have housing, so that delayed things. This will hold up the discharge process. School and housing are the two most important things." Another interviewee said:

> It can happen. And the reason why is because we have this rule that everyone has to be on the same page. I wouldn't say that it holds the kid for extra months, but sometimes people don't bring their concerns to the table during the monthly meetings, and sometimes someone brings a concern too late. Or maybe something happened, and they don't feel comfortable with the kids going home yet. Then, it's like, "OK, let's give it another 2 weeks and see where he's at then." I think they do a good job of making sure that if

128

the kid needs to leave that he is ready to leave. But sometimes parents aren't ready for the kid to come home or probation's not ready for them to go back to the community, but the team thinks that he would benefit from going home rather than going to a step-down, and we need to figure that out.

We also asked whether youths are ever discharged before they are ready. Fewer interviewees answered this question, but they indicated that this sometimes happens when 1) youths are discharged before services are ready in the community, or 2) youths age out of the system or have set sentences that are complete before they have met their treatment goals or made sufficient progress with their DBT skills. A probation officer commented: "For discharge, I need the home situation, school situation, and the levels completed. But sometimes these things aren't completed, and then they are discharged, too." Another interviewee commented about lack of preparation for the child to go home: "If the family doesn't engage, then they don't get better. Then they go right back home and back to previous behavior."

Youth Perspective. Seventeen youths answered the interview questions, "What do you have to do to complete this program?" and "What do you need to do to go home?" These youths had been in their current residential placement an average of 77 days (about 2.6 months), ranging from 11 days to 240 days. On average, the youths who were interviewed in secure programs had been in their current placement for a greater number of days than the youths in the staff-secure programs (108 days compared with 41 days). Some shared that they had been in other REGIONS placements and had been at non-REGIONS residential placements as well (including Solnit, TRACC program, Rushford, Litchfield CJR, and Hamilton). Most mentioned that they had spent some time in secure detention awaiting their placement. Sixteen of the 17 respondents had at least some idea about how to complete the program and go home, and they all understood that the amount of time they spent in the program depended on their behavior. One response stated: "Don't get in trouble. Work." They mentioned having to move through the behavior management phase system (i.e., Prospect, Rookie, Pro, All-Star), following the rules, and attending treatment.

Summary. Interviews with several stakeholders indicated that discharge decisions are made through group consensus, based on several factors, including progress toward treatment goals, progress toward learning DBT skills, success in the behavior management system, and readiness of education, housing, and other referrals and services in the community. This approach does not rely on a rubric or set of criteria that is clear, objective, or consistently applied across REGIONS programs. When there are disagreements, the team attempts to resolve them. Although changes in strengths and vulnerabilities, as measured by the START:AV, are taken into consideration, they are not a key driver of the discharge decision. It is also the impression of some stakeholders, especially the probation officers, that discharge decisions may be driven more by bed availability than anything else and that some programs are "shorter" than others, indicating that the discharge criteria may vary among the residential programs. Stakeholders generally feel that the MDT approach is good and that it is beneficial for each of the team members to have a voice. However, it can be improved by making the process more objective and less subjective. To best structure the discharge process, clearer definitions are needed of when youths are ready to leave the REGIONS program.

As mentioned in Metric 61, since the draft findings and recommendations for this report were presented, JBCSSD shared that they have implemented a quality assurance program for the START:AV and are developing objective behavioral indicators to determine readiness for discharge.

64. Utility and Effectiveness of Using a Consensus Approach to Treatment Plan Development and Discharge Planning

Assessment of the utility and effectiveness of using a consensus approach to treatment plan development and discharge planning is provided within the assessments of other metrics, such as Metric 41, Metric 62, Metric 63, Metric 65, and Metric 66. There is not much research literature on the effectiveness of using a consensus approach to treatment plan development and discharge planning.

129

65. Rate of Consensus in Discharge Planning

Quantitative data from a state database were not available to assess this metric. Instead, DSG assessed the metric using interviews with key stakeholders.

Court and Residential Treatment Perspectives. About 50 individuals from residential treatment, court, and probation responded to questions about the rate of consensus in discharge planning. Most indicated that there is consensus most of the time. When asked specifically, "How often is there consensus?" many said "always" while others estimated that consensus occurred 90–100 percent of the time (however, one person thought there was consensus 85 percent of the time). In the cases where there are disagreements, respondents shared that these generally relate to the probation officer feeling like the youth is not ready to be in the community while the clinician feels that the youth has met the goals that were set in his treatment plan and should be discharged. When there is no consensus, the multidisciplinary team members discuss each side and try their best to reach consensus.

However, when consensus cannot be reached, the opinion of the clinician is often the final word. One of the probation officers said: "Even if we say we think the kid should stay longer, the REGIONS program wants them out and then they are out." Another interviewee said:

> Yes, there have been times where there has not been consensus. We typically try to get consensus or buy-in or try to see from their point of view. Only a couple of times we have not been able to do this. Usually, it's probation who wants them to stay in the residential program longer. It's more about their risk to public safety. Also, the probation officers know more about what the kid was involved in in the community and what is going on now that may not be safe.

Sometimes, however, probation officers felt that they wanted the youth discharged but the clinician wanted the youth to stay in the program longer. One probation officer said:

> When there are disagreements, often it's when the PO is actually trying to advocate [the clinical team] and the family to have the kid discharged already because he's been there a very long time. And the clinical team at the program feels like, well, his behavior is still not up to par yet he's met his clinical needs. So, it doesn't make sense and we ask, what do you mean? But the kid is just disrespectful. And so, it almost feels, according to the parent, that whenever my kids are disrespectful with staff, they say, well, you're not going home. And so, he's not given a true discharge date. And it's becoming problematic. In those types of disagreements, we just still have to continue to meet, but because they're the clinicians and they're the treatment facility, their opinion matters first. And even with a parent involved, who's advocating for her child to return home and there's referrals already in place for aftercare treatment, the clinicians are still the ones that decided whether he's ready.

Some interviewees also mentioned disagreements with parents about discharge. One of the residential treatment providers said:

> Sometimes it's the parents who disagree that the youth should be discharged, if they don't feel like they can keep them safe or they don't think they can completely control or monitor them. Or they know that certain kids in [the] community will pull them back in. That would make a difference in terms of where they are sent, so that they don't connect with certain friends. Among staff in our program, this is not an issue because we've all been working together. But we can't plan discharge services if we don't know where they're going to go.

Summary. According to feedback gathered through interviews with residential treatment staff, probation officers, and attorneys, there is consensus in discharge planning about 90–100 percent of the time. When there is no consensus, the multidisciplinary team discusses the differences of opinion. Generally, lack of consensus relates to differences of opinion between residential treatment staff and probation

officers. The differences are usually resolved through discussion, but when they are not, the residential treatment program clinician makes the final decision.

66. Appropriateness of Length of Stay

Research on length of stay in correctional interventions suggests programs should not be too short, but also not too long. Lipsey's 1999 meta-analysis of more than 500 studies of interventions for serious juvenile offenders found that institutional programs lasting over 6 months had better effects than programs lasting fewer than 6 months (Lipsey, 1999a). In general, it is recommended that intervention programs last longer than 6 months, but fewer than 12 months (see Andrews and Dowden, 1999; Gendreau, 1996; Lipsey, 1992, 1999b). Several newer studies have also examined the effects of different lengths of stay. For example, analysis of more than 500 juveniles from the Pathways to Desistance study who were sent to institutionalized placements found that for stays between 3 and 13 months, there was "no marginal benefit for retaining a youth in institutional care for longer periods of time" (Loughran et al., 2009). This study also found no difference between public and private facilities. Another study examining therapeutically oriented facilities specifically "failed to find a relationship between length of stay and felony recidivism occurring within one year of release" (Walker and Bishop, 2016).

For the Secure Treatment Program, according to JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program [Attachment A]), a youth's length of stay is roughly 3 to 6 months and is determined by the attainment of treatment goals, not by whether a predetermined amount of time has elapsed.

Dataset. We received length-of-stay data for 174 individuals. The average length of stay was 125 days with a median of 129 and a standard deviation of 75.6. The minimum stay was 0 days, and the maximum stay was 323 days.

Stakeholder Perspective. Residential treatment staff, attorneys, probation officers, and community-based providers had different opinions about the appropriateness of the length of stay. Although some felt that the length of stay was individualized and worked well for most youths, some felt it was too short and others felt it was too long. Some felt that the lack of a clear discharge date at the time of admission was difficult for the youths. Comments included the following:

> Some kids are here 4–6 months, some 9 months. It's not a set length of stay. It's truly contingent on their progress, and it depends on where they are going after this. The length of stay is lengthened and shortened as clinically appropriate.

> If they stay 4–6 months, the outcome is much better than when they stay for less time. That length of time is perfect to get set with aftercare services, build trust, and get treatment.

> I think sometimes it's too long because some of the kids, sometimes they've been gone for like a year. And what I noticed is that during that year, the parent gets so used to the kid not being there, and then when the kid is set to return back home, then the parent doesn't really know how to interact with the kid.

> I think the kids should be here longer. I think 18 months would be better. I think a lot of the young men are discharged too soon. They aren't ready. They don't even know who they are.

> It's not good for kids to be locked up for long periods of time. Sometimes it's really hard to find the sweet spot between benefiting from a program and keeping them there too long. It's really hard to find it. There are kids that are doing really well and then they sabotage themselves because they are afraid or unsure of what's going happen when they're out.

> The length of stay of the youth overall in this facility pretty much hits the mark. Some could benefit from more time with us, but they may not meet criteria for this level of care.

Summary. According to JBCSSD Policy and Procedure 8.600, a youth's length of stay should be "approximately 3 to 6 months, contingent upon attainment of treatment goals and not predetermined 'time.'" CDCS data indicate that the average length of stay was about 4 months. Research on the length of stay in correctional programs reveals that no specific term is optimal. However, research does note two patterns in the relationship between length of stay and recidivism. First, too short of a stay will not produce sustained change in the long term, because not enough time will have been devoted to learning different behaviors. Second, lengthy stays can elicit more criminal justice responses (i.e., more violations of rules and orders) simply as a result of increased surveillance and supervision. Lipsey (1999) undertook a meta-analysis of 83 juvenile institutional programs to understand the characteristics of successful institutional programming. Results indicated that programs lasting 6 months or longer demonstrated more reductions in recidivism compared with institutional programs lasting fewer than 6 months. REGIONS is encouraged to define clearly the attainment of treatment goals. The average length of stay in a REGIONS program is 4 months, which falls short of Lipsey's (1999) recommendations. When determining whether a youth has met treatment goals, REGIONS should use behavioral measurements in addition to clinical observations. For example, youths should be able to *articulate and demonstrate* (i.e., role play) the skills they would use in certain situations. Youths who are high risk should receive more programming (which may result in slightly longer stays) than youths who are at moderate risk to reoffend.

67. Number and Percentage of Initial Transition Planning Process Meetings Occurring 60 Days Prior to Discharge
We assessed this metric by analyzing data from the CDCS database.

Dataset. Of the 354 unique stays in REGIONS, data on initial transition planning process meetings (labeled as case reviews) were available for 92 unique stays. Of these 92 stays for which case review data were available, 36 cases (39.1 percent) had a case review completed within 60 days prior to discharge. For the remaining 56 stays (60.9 percent), the time between a case review and discharge was greater than 60 days. Across all 92 stays, the minimum number of days from a case review to discharge was 8 days and the maximum number of days was 219. The average number of days between a case review and discharge was 88.2, with a median of 92 days and a standard deviation of 55.5 days.

Summary. Data were only available on 26 percent of unique stays. This data shows that 36 cases (39.1 percent) had a case review completed within 60 days prior to discharge. Given that data was missing for a high percentage of cases, DSG recommends that better data entry and auditing procedures be adopted so the process can be better analyzed.

68. Number and Percentage of Final Meetings Occurring 30 Days Prior to Discharge
We assessed this metric by analyzing data from the CDCS database.

Dataset. Of the 354 unique stays in REGIONS, data on initial transition planning process meetings (labeled as "case reviews") were available for 92 unique stays. Of these 92 stays for which case review data were available, 20 cases (21.7 percent) had a final case review completed within 30 days prior to discharge. For the remaining 72 cases (78.3 percent), the time between a final case review and discharge was greater than 30 days. Across all 92 stays, the minimum number of days from a case review to discharge was 8 days and the maximum number of days was 219. The average number of days between a case review and discharge was 88.2, with a median of 92 days and a standard deviation

of 55.5 days.

Summary. Data were only available on 26 percent of unique stays. The data shows that 20 cases (21.7 percent) had a final case review completed within 30 days prior to discharge. As noted in Metric 67, it DSG recommends that better data entry and auditing procedures be adopted so this process can be better analyzed.

69. Average Number of Transition Planning Process Meetings Occurring Prior to Discharge
We assessed this metric by analyzing data from the CDCS database.

Dataset. Of the 354 unique stays in REGIONS, data on initial transition planning process meetings (labeled as case reviews) were available for 92 unique stays. Of these 92 stays where case review data were available, the average number of transition planning process meetings occurring prior to discharge was 3.2, with a median of 3 meetings, and a standard deviation of 1.8. The minimum number of case review sessions noted was 1 with a maximum of 9.

Summary. Data were only available on 26 percent of unique stays. The data indicate that the average number of transition planning process meetings occurring prior to discharge was 3.2. As noted in the assessments of Metric 67 and Metric 68, we recommend that better data entry and auditing procedures be adopted.

70. Identification of Types of Post-Discharge Services That Are Most Common
This metric was assessed by using data from CDCS and reviewing discharge summaries.

Dataset. Of the 354 unique stays in REGIONS, CDCS data were available for 279 unique stays with a discharge. Data demonstrated that 20 percent (55 stays) were discharged to their home (parent/guardian), a foster home, or a group home (see Figure 3.20). No referrals accounted for 42 percent (117 stays) of discharges, and 25 percent (71 stays) absconded before referrals could be made. Roughly 9 percent (24 stays) received a step-down referral to a REGIONS staff-secure facility. The final 4 percent (12 stays) were referred to other services, which included the following: Department of Children and Families (DCF) care facility, detention, independent living, Manson Youth Institute (MYI, part of the Connecticut Department of Correction), another residential/in-patient facility, another REGIONS secure placement, and entries labeled as "other" in CDCS.

Figure 3.20. Post-Discharge Services, Jan. 2019–Dec. 2021
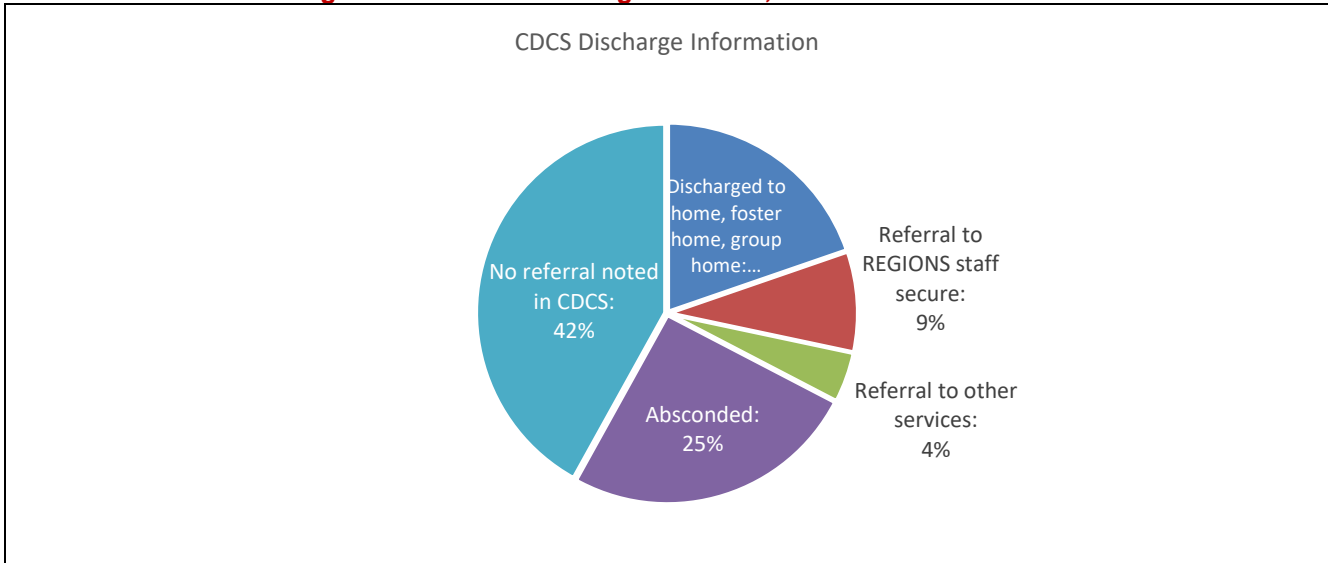
Data source: CDCS. *N* = 279.

File Review. DSG also reviewed 73 discharge summaries for youths admitted to REGIONS between April 15, 2021, and Dec. 31, 2022. Almost half of these 73 discharges were for youths discharged home or somewhere else in the community (some youths discharged to the community moved out of state); one third were for youths discharged to a REGIONS step-down program; and 15 percent were AWOL. Additionally, one of the discharge summaries was for a youth going to MYI and another for a youth going to a non-REGIONS residential program.

Discharge referrals varied by level of security. Of the 45 discharges for males leaving secure placement (i.e., Bridgeport, Hartford, or Hamden), 53 percent were discharged to a REGIONS step-down program, and 42 percent were discharged home.[24] Of the 22 discharges for males leaving a staff-secure placement (e.g., Hartford CPA, Milford BGV), half were discharged home, and half were AWOL.[25] Finally, of the eight discharges for females from Journey House (which were for seven girls), six were for girls discharged home, one was AWOL, and one was referred to a non-REGIONS residential program.

The discharge summaries provided information on several discharge services. The following information is for the 32 youths who were discharged to the community (and did not move out of state).

- **Behavioral health services.** In 94 percent of the cases (30 of the 32), youths were connected with behavioral health services. The most common was MST–FIT (Multisystemic Therapy–Family Integrated Transitions). Other behavioral health services include MST–EA (Multisystemic Therapy–Emerging Adults), individual counseling, family counseling, and a dual-diagnosis program. Service providers included Connecticut Department of Mental Health and Addiction Services, Stokes Counseling Services, Community Mental Health Affiliates, Our Community Counseling, Wellmore Behavioral Health, Connections Counseling, and Connecticut Junior Republic. Two of the 30 youths were placed on a waitlist.

- **Social services and recreation.** In 72 percent of the cases (23 of the 32), youths were connected with social services or recreation opportunities. These options include connections

---

[24] Each of the 45 discharges from secure placements was for a different boy.
[25] These 22 discharges from staff-secure programs were for 21 boys.

with mentors, memberships with the YMCA or Boys & Girls Clubs, connections with sports teams, involvement in arts and crafts programs, and other prosocial activities. Service providers included the Connecticut Violence Intervention Program, Credible Messengers Program, Peace Builders, Connecticut Department of Mental Health and Addiction Services, Manchester Youth Service Bureau, Police Athletic League, Elm Village, Straight Ahead Ministries, and Love146. In nine cases, either information about needs was missing or needs were mentioned but specific services were not named. For example, one discharge summary stated: "He would benefit from a mentor to support him in learning adult life skills as well as connecting to vocation resources. He is interested in cars but is not interested in completing further education in the area of mechanics."

- *Reintegration mentors.* At least 69 percent of the cases (22 of the 32) were assigned a reintegration mentor. Sixteen percent were not assigned a reintegration mentor. In 18 percent of cases, it was unclear whether the youth was assigned a reintegration mentor. Also, in one case, the youth was offered a mentor but refused.

- *Vocational services.* In at least 69 percent of the cases (22 of the 32), youths were connected with vocational services. These opportunities included working with the reintegration mentor for vocational support and assistance in getting a job, referral to community-based organizations for vocational assistance (e.g., Love146, Bridgeport Work Readiness Program), referral to training schools (e.g., New England Tractor Trainer Training School), referral to job placement agencies (e.g., The Workplace), and securing a job (e.g., plumbing, barbering, Popeye's, grocery store). In 6 of the 32 cases, youths were not connected with vocational services. In four cases, it was unclear whether the youth was connected to vocational services or vocational services were not mentioned.

- *Psychiatric services.* In 63 percent of the cases (20 of 32), youths were connected with in-patient, out-patient, and telehealth psychiatric services. Services were set up with several providers, including Connecticut Junior Republic, Community Mental Health Affiliates, Connections Counseling, H.O.P.E. through Healing Wellness Center, Stokes Counseling Services, Straun Health & Wellness, Lifespan Collaborative Services, Wheeler Clinic, LEO Clinic, and Clifford Beers Community Care Center.

- *Family services.* In 56 percent of the cases (18 of 32), family services were described in the discharge summary. The most common service was MST–FIT. Other family services included MST–EA, individual counseling for parents/caregivers, support from the reintegration mentor, and support from education services. In the rest of the cases, either family services were not identified or it was unclear whether the youth was connected to family services. In some of these cases, services were offered but rejected. In other cases, needs were identified, but specific services were not described. For example, one discharge summary stated: "Given his mother's continued medical issues and limited ability for supervision due to those issues, it is recommended that the family receive additional support in structure and supervision of the youth. The family would benefit from continued assistance in their communication patterns and follow-through of expectations (youth keeping mother informed of location at all times)."

- *Substance use services.* In 25 percent of the cases, youths were referred to substance use services, such as the young adult dual-diagnosis program, MST–FIT, MST–EA, and Narcan (Naloxone) prescription.

(For more information about the most common discharge services, see Metric 79 and Metric 80.)

135

Summary. According to CDCS data (entered in 2019, 2020, and 2021), about 20 percent of youths were discharged to their home (parent/guardian), a foster home, or a group home; 9 percent were referred to REGIONS staff-secure programs; and 4 percent were transferred or referred to other services, such as Department of Children and Families placements, Manson Youth Center, and other REGIONS secure programs. Also, about 25 percent of youths absconded before referrals could be made, and there were no referrals in 41.9 percent of discharges. Also, almost half of the 73 discharge summaries from 2022 indicated that youths discharged to home or somewhere else in the community; one third discharged youths to a REGIONS step-down program; and 15 percent of the summaries were for youths who were AWOL. Additionally, one of the discharge summaries was for a youth going to MYI and another for a youth going to a non-REGIONS residential program. Among the 32 youths who were discharged to the community (and did not move out of state), most were referred to behavioral health services (94 percent), social services and recreation (72 percent), vocational services (69 percent), psychiatric services (63 percent), and family services (56 percent). At least 69 percent were assigned REGIONS reintegration mentors, and 25 percent were referred to substance use services. REGIONS should ensure that all discharge referrals are properly entered into the data management system so that this information can be consistently tracked. REGIONS should continue to make community referrals based on the youths' progress in the program and the areas they still need to work on. Because REGIONS targets and admits high-risk youths, they are likely to need aftercare in the community.

71. Identification of REGIONS Treatment Goals That Are Most Likely To Require Additional Work in the Community

Each treatment goal is likely to require additional work in the

> **Among the 32 youths who were discharged to the community (and did not move out of state), most were referred to behavioral health services (94 percent), social services and recreation (72 percent), vocational services (69 percent), psychiatric services (63 percent), and family services (56 percent). At least 69 percent were assigned REGIONS reintegration mentors, and 25 percent were referred to substance use services.**

community after a youth is discharged from a REGIONS facility. A stay in REGIONS is not necessarily sufficient to address most criminogenic needs; this is expected with youths at this level of risk. Interviewees most often mentioned goals related to substance use as those that require special attention once a youth is discharged. Most of the youths had demonstrated at least some risk related to substance use before being placed in REGIONS. However, addressing substance use is not one of the main focuses of the secure programs, and not all youths spend much time in the staff-secure programs. Thus, treatment goals related to substance use are certainly likely to require additional work in the community. In actuality, *all* treatment goals are likely to require additional work in the community after discharge. A continuum of care is necessary to address their treatment goals. Although youths may make progress on one or two treatment goals, follow-up is still needed because it is important to sustain any positive changes the youths made while in the program.

72. Number and Percentage of Re-entry Packets Completed 30 Days Prior to Discharge

JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program) states that at 1 month prior to discharge, the clinician will complete part 1 of the Recommendation/Discharge Summary and send it to the juvenile residential gatekeeper along with the most recent START:AV summary form and the Integrated Treatment Plan. The classification and program officer will gather the required information and send a complete discharge packet to the JBCSSD residential gatekeeper. DSG intended to assess this metric using official data from one of the state databases. However, these data were not available. To get a sense of whether re-entry packets are completed 30 days prior to discharge, we examined the information included in the 75 discharge summaries we received for youths who discharged from REGIONS in 2022.

File Review. Fourteen discharge file reports included both 1) the discharge date, and 2) the date that part 1 of the Discharge Recommendation/Discharge Summary was reviewed and approved by the treatment planning team. These youths were admitted to REGIONS between August 6, 2021, and Oct. 25, 2022. Discharge dates were between Jan. 20, 2022, and Dec. 22, 2022. Most youths were from Journey House (limited-secure) or Waterbury CJR (staff-secure); one was from Hamden CPA (secure) and one was from Hartford (secure). The time between the date of completion of part 1 of the discharge summary and the date of discharge ranged from 1 to 35 calendar days, with an average of 12.2 calendar days and a median of 9 calendar days.

Summary. DSG was unable to assess the number of re-entry packets completed 30 days prior to discharge. However, a review of discharge summaries indicates that the time between the date that discharge summaries were reviewed and approved by the treatment planning team and the discharge date listed in the report was usually less than 30 days.

73. Identification of Post-Discharge Services That Are Missing From the Discharge Service Options To Meet Client Needs

To assess this metric, DSG interviewed key stakeholders with experience working with youths who leave REGIONS and reenter their communities.

Stakeholder Perspective. About 40 interviewees from the Court, residential treatment programs, and community-based programs shared their opinions about the post-discharge services that they wish were available for youths as they discharge from a REGIONS placement. A few parents and guardians were also asked about post-discharge services.

Many felt that there were lots of options for youths and that resources in the community were generally available to meet REGIONS youths' needs. However, others thought that a lot of work remains to be done. One of the interviewees, with decades of experience, said: "They have done an excellent job integrating the DBT stuff into the residential…But then they go home, and they can't connect the two." These respondents were mostly concerned with youths returning to the communities that had encouraged the behaviors which got the youths in trouble in the first place. Another interviewee said:

> We are not tying these kids into alternatives to their negative behaviors. You grew up in this community, and you were engaged with a friend group that was committing all sorts of delinquent offenses. And we've taken you into this program. You've been there for, let's say 6 weeks. And we've given you DBT treatment, we've given you structure, we've stabilized you, we've gotten your education kind of back on track. And now we've put you back into that same environment. Good luck with it! I don't know why anyone is surprised that they are returned to the way they had been behaving prior to it…Every single kid should have a committed mentor that's going into this program, that follows them into the community, that supports them when they're struggling. That role is very often played by a probation officer, but often the probation officer is focused on supervising the youth rather than mentoring.

However, this respondent was interviewed in 2021, and the perspective expressed in the quote above may have changed given the increased availability of reintegration mentors, other mentors, and educational support (see Metric 81). *Today, reintegration mentors are involved from youths' admission to REGIONS until they complete the program, and they continue working with the youths up to 12 months after they return to the community. Also, as the evaluation was being completed, JBCSSD was in the process of issuing an RFP to place reintegration mentors in the Bridgeport and Hartford secure REGIONS programs.*

Others had suggestions for additional services as well as ideas for improving existing services. Most suggestions and ideas were related to education, housing, and vocational opportunities. Interviewees also mentioned needing more support to ensure that the youths and families follow up with aftercare services, extra assistance for youths who are 18 and may be aging out of services, and better connection to psychiatric and substance misuse services.

- *Educational services.* Reconnection to education in the community after leaving a REGIONS placement was a common challenge identified by interviewees. Many of the REGIONS youths struggled at school before their REGIONS placement. Although many of them had a positive educational experience while in placement, including better attendance and credit recovery, the move back to a community school is challenging. The research literature consistently identifies reengagement with education as one of the most difficult challenges for youths leaving residential placement (e.g., Bullis et al., 2002; Farn and Adams, 2016; Kubek et al., 2020; Mathur et al., 2020; Noorman and Brancale, 2023; Wallace, 2012). Much support has been created in Connecticut to address this challenge, and several interventions were initiated while DSG was conducting this process evaluation. (For more information see Metric 57, Metric 77, and Metric 78.)

- *Vocational opportunities.* Securing and retaining vocational training and employment for youths were also identified as a challenge by residential treatment providers, reintegration mentors, and probation officers. Some interviewees felt that existing vocational programs in the community were good, but they may not be suitable for many of the youths leaving REGIONS, given their high levels of risk and need. One interviewee said: "It's certainly a big push of CSSD to have all the kids to be working, but not every kid is ready for that, at least right to start." A sufficient level of available and appropriate services to help with job readiness appears to be missing. One probation officer felt it would be helpful to have a dedicated vocational center for youths leaving REGIONS ("something like Job Corps but in a place with our own staff and run by us"). A community-based services provider made a similar suggestion, saying: "We've tried to get kids into Job Corps. But it never works. Our kids are not ready for that. It would be great to have a living and jobs programs for our kids who have higher needs." Another interviewee commented on the need for more coordination among the different employment programs, which each have different purposes, prerequisites, and levels of support (For more information, see Metric 57, Metric 79, Metric 81.)

- *Housing.* Some interviewees mentioned that a lack of appropriate housing sometimes delays the discharge process. Sometimes this is related to family not being ready to welcome the youth back home or delays in referrals to group homes or other residential programs (For more information, see Metric 63.)

- *Extra support for youths age 18.* There was a sense among many of the interviewees that once a child is 18 years old, "everything changes." One of the community-based providers said: "There is a real underserved population when kids turn 18. They are stuck with the criminals. If we would have EA [Emerging Adults] statewide and if [the] adult system had this, it would be

good. Other than MST–EA [Multisystemic Therapy–Emerging Adults], there isn't much." Others also shared that more MST–EA slots are needed for young adults leaving REGIONS and that sometimes, the individual therapy services were not appropriate for young adults. Finally, some interviewees said that a sense of urgency may be missing for youths to take advantage of all REGIONS has to offer before they turn 18. For example, a reintegration mentor said: "After they are 18, no one cares about them. They don't have that level of one-to-one after that. I tell them to take advantage of everything now." One of the education liaisons said: "I don't know if our students realize that [REGIONS] is a place that's meant to treat, but as soon as they turn 18, they're going to a place that's meant to punish. I don't know that many of them actually realize, 'When I hit 18, this is going to be different.' There's no formal program that talks about that, and I think that would be like very helpful."

- ***Psychiatric services.*** One of the residential treatment providers said: "Psychiatry is so hard to find. It would be nice to have CSSD-contracted psychiatrists." Others mentioned challenges related to getting prescriptions filled after youths left the residential programs. However, other interviewees said that they ensure that youths leaving REGIONS programs have access to their medications once they leave the program. One of the interviewees said: "We don't discharge a kid until we have everything set: school, meds, etcetera." Also, JBCSSD administrators shared that a plan is in place to ensure smooth transition to medication providers.

Finally, some interviewees mentioned that some of the good programs have limited availability, highlighting the Credible Messenger Program and MST–EA in particular. One interviewee said:

> New Haven has enough Tier 5s to fit all the [Credible Messenger] slots. We are trying to reserve them for the highest risk kids who need that one-on-one interaction. At that point, it is a collaboration between the REGIONS staff and the PO to decide which ones would be best for this.

Some also mentioned that a lack of therapists in the community is starting to cause some issues with in-home services, creating wait lists and delays.

However, it is important to note that many services are already available and being accessed. Some of the interviewees felt that there were no gaps in services, except maybe a need for more support to engage in those services. One interviewee said, "I think we have a lot of tools in the community," and another said, "I haven't noticed a gap between services and youth needs." Connecticut's efforts to match youths leaving REGIONS with reintegration mentors, credible messengers, other mentors, probation officers, and other assistance are an important step to ensuring youths are connected to available resources that will support them in engaging with services, avoiding recidivism, and achieving their goals in the community.

Summary. Many resources are available to REGIONS youths in the community. Interviewees identified some challenges in accessing these resources due to waitlists but mostly due to lack of youth engagement. JBCSSD is making important—and continually improving—efforts to match REGIONS youths with reintegration mentors, credible messengers, and other interventions aimed at helping youths access and remain engaged in treatment and other services. Older youths still appear to need more support, mostly related to job readiness and understanding how the justice system treats young people differently after age 18. Communication between parties—including probation officers, community-based providers, schools, reintegration mentors, and others—is currently working well most of the time. Maintaining and improving this communication, especially as new services emerge,[26] will be vital, to ensure that youths remain engaged in the services specified in their discharge plans. Finally,

---

[26] One of the new resources is the pupil services specialist (also known as the transition specialist), who works for the Department of Children and Family's newly created Juvenile Justice Educational Oversight Unit.

JBCSSD should improve communication regarding access to psychiatric services in the community after a youth leaves a REGIONS program. Some community-based providers have encountered youths lacking this generally provided access.

74. Level of Continuity and Consistency in Addressing Treatment Goals Throughout the Process

It is a best practice to develop a treatment plan for youths in residential placement and ensure that this plan guides the youth's treatment throughout the process (Griffis and Sloan, 2014). The plan should include treatment goals and be confidential. Continuity and consistency are important in addressing treatment goals. According to the National Institute of Corrections' *Desktop Guide to Quality Practice for Working with Youth in Confinement*,

> An initial treatment plan is written at the end of the assessment period or at a time required by state regulations, whichever is sooner. These initial treatment plans are then supplemented by case record materials, weekly case notes, educational reports, staff observations, behavior management program records, incident reports, therapy session notes, and other available information. The supplemental information leads to updated plans of care—usually written at set intervals—release plans, and termination or release reports (Griffis and Sloan, 2014).

JBCSSD Policy and Procedure 8.600 (Juvenile Residential Services, REGIONS Secure Treatment Program) provides structure for the development and updating of the initial monthly Integrated Treatment Plan (ITP) as well as the discharge plan. This metric was assessed by analyzing information gathered through interviews and file review.

Residential Treatment Staff Perspective. Twenty residential program staff members from each of the seven residential treatment programs commented on continuity and consistency in addressing treatment goals while youths are in the residential treatment program. Their comments were generally positive. One of the residential treatment staff said: "There's certainly consistency because we're making sure they are meeting their goals weekly by reminding the youth that achieving their treatment goals is how [to] get close to leaving and completing REGIONS." Another interviewee said: "The initial ITP is focused[27], and we make sure to follow-through."

Staff generally felt that the frequent meetings and communication helped to achieve this level of continuity and consistency within the program. Interviewees in the Hartford and Bridgeport secure programs also mentioned the consistent, dedicated staff as contributing to continuity and consistency (compared with the rotating staffing patterns in secure detention). Finally, some interviewees indicated that low turnover in REGIONS programs contributed to continuity and consistency, but this was not the case in each of the programs.

We asked 13 residential treatment staff at each of the seven residential programs to rate the consistency in addressing treatment goals throughout the REGIONS process on a scale of 1 to 10 (with 1 being completely inconsistent and 10 being completely consistent). They all ranked this item an 8 or higher (see Figure 3.21), indicating that they felt REGIONS did a good job in providing continuity and consistency in addressing treatment goals.

---

[27] For more information about the initial ITP meeting, see Metric 41.

**Figure 3.21. Residential Treatment Staff's Perspective on the Level of Continuity
and Consistency in Addressing Treatment Goals Throughout REGIONS**

Rate the consistency in addressing treatment goals throughout the REGIONS process

Rating
1 = completely inconsistent, 10 = completely consistent
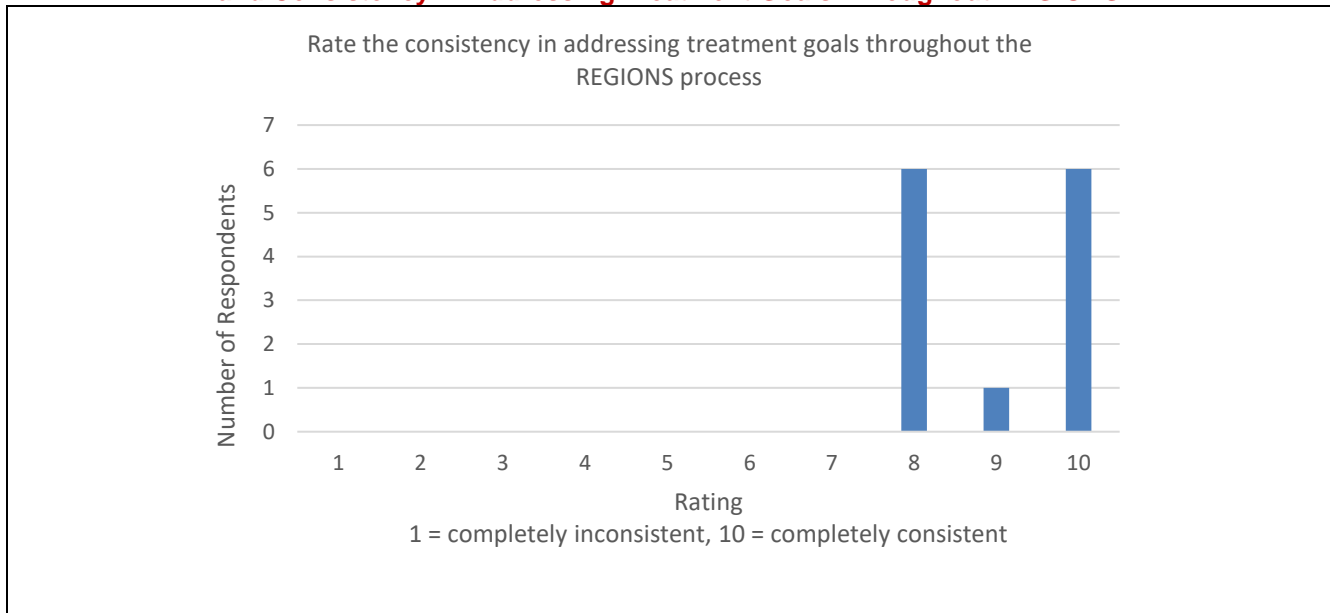
Data source: Residential treatment staff interviews. *N* = 13.

However, when talking about continuity and consistency throughout the whole continuum of care, interviewees were less positive. First, they felt that there was a lack of consistency among the different residential programs. Many interviewees mentioned how each program does things slightly differently. Differences include information sharing, lengths of stay, vocational opportunities, and the education programs. Second, maintaining continuity and consistency after the youth leaves residential placement was frequently identified as a challenge. When talking about addressing mental health and psychiatric needs, one of the reintegration mentors said:

> It's really great while they are in [the residential program]. It's a great team. However, when home, they start to engage less and less. Sometimes they don't want to take their meds or go the appointments. Sometimes they forget their appointments. There is a lot of red tape (referrals that parents sometimes don't want to deal with). They can end up back here [in the residential program] because of this lack of support. It impacts some of the clients a lot if they don't take the meds. They don't have the same restrictions in the community. It's up to probation whether there is a consequence for not doing what they are supposed to do, but probation officers are overwhelmed with a lot of kids.

Another interviewee said: "They have done an excellent job integrating the DBT stuff into the residential programs. But then they go home, they can't connect the two."

File Review. There are many different assessments that are completed throughout the process. This includes the service memo (completed by clinical coordinators in the Court Clinic) and the START:AV and ITP (completed by the clinician after youth arrives at the residential program). Reports that are completed earlier in the process are included in the youths' files for the next assessor to review. For example, when the clinical coordinators complete the service memo, they review the PrediCT (which is completed by the probation officer).

Before arriving at REGIONS, youths will have a service memo completed by the Court Clinic in their referral packet, so the residential treatment clinician is able to review the service memo before completing the ITP. Interviewed residential treatment staff indicated that the service memo is easy to understand and is helpful to them when working with the youths in their care (for more information, see

141

Metric 5). Residential programs also receive other information about the youths at admission, including the PrediCT, to assist with continuity and consistency in addressing treatment goals. The ITP forms provide space to describe the youth's treatment goals. Need areas are identified and prioritized in the initial ITP, and progress is noted every month (in sections called "30–day progress," "60–day progress," etc.). Then, in part 1 of the Recommendation/Discharge Summary, background information and progress toward treatment goals are described. This information is used to develop the discharge recommendations.

Summary. The REGIONS program appears to have a high level of continuity and consistency in addressing treatment goals while youths are in the residential programs. Regular documentation of treatment needs is achieved through the monthly ITPs. Strong policies and procedures related to staff meetings and other communication enhance continuity and consistency. Progress toward treatment goals is incorporated in the discharge summary. However, interviewees commented that maintaining continuity and consistency after discharge was more challenging (for more information about the transition back to the community, see Chapter 4. Re-entry and Probation). and that there are substantial differences among the seven residential programs. Nevertheless, the continuity and consistency within each of the residential programs is a strength of REGIONS.

D. Recommendations

REGIONS programs have many strengths. Youths and staff feel heard. Programs have high quality Integrated Treatment Plan (ITP) meetings and weekly team meetings. Court staff, residential treatment staff, and youths felt strongly that these meetings were appropriate, focused, and useful.

Some recommendations are below.

1) The REGIONS program's intake process functions as designed. In nearly 100 percent of cases, youths received intake screening at or before admission to a REGIONS facility. The program's intake instruments are appropriate. To ensure application of the risk, need, and responsivity principles, DSG recommends that REGIONS use the assessment results from the PrediCT (if targeting general recidivism) or the SAVRY (if targeting violence) to ensure that only high- or moderate-risk youths are admitted to the program. We also recommend that the criminogenic needs assessed by the PrediCT and SAVRY are reflected in the ITP to ensure that the ITP targets those specific criminogenic needs. Finally, since the REGIONS model is concerned with addressing trauma, results from the STRESS assessment should be used to identify the youths who need these services. Those not identified by means of the STRESS as having a trauma need should not be targeted for trauma services.

2) The data demonstrate that the REGIONS program is identifying youths who are at high risk for recidivating and have many behavioral needs. This identification of appropriate youths is important for programming. A program can only achieve desired results when it administers interventions for the correct target population. We recommend that REGIONS continue to admit high-risk youths. Furthermore, REGIONS should take note of the assessed need areas of the youths who are admitted. Achieving reductions in unwanted behaviors (anger, violence, substance use, etc.) in the long term requires that these needs be targeted with an evidence-based intervention. If youths have needs that are not being addressed in the program and these needs are contributing to their propensity for future criminal involvement, then the program will have limited impact. REGIONS should either 1) extend programming to target these needs, 2) redefine who is eligible for programming, or 3) develop consistent referrals to outside programming that address untargeted (or under-targeted) needs.

3) In connection with recommendation 2, if REGIONS begins prioritizing substance use as a treatment

target, DSG recommend that a substance-misuse specific assessment tool be employed. Currently, REGIONS does use the CRAFFT at intake. REGIONS should use the results of the CRAFFT to identify youths who have substance misuse as a targeted criminogenic need. Interviews and observations indicated that many youths had such needs. However, staff often felt that these needs are minor compared with other criminogenic needs, and thus the former often do not receive much attention in REGIONS. And yet, substance use needs are correlated with many others. For example, youths often use substances and are supported in their use by peers, they have attitudes and values that support substance use, and their substance use impacts their school behaviors and attendance. This observation should be balanced with the practical notion that interventions (especially when the average length of a youth's stay is 4 months) cannot be expected to fix all needs. Thus, if REGIONS were to choose to redefine who is eligible for programming (i.e., screen out youths with severe substance use in addition to other criminogenic needs), the program should adopt a substance-misuse screening instrument to identify those who present with high substance use needs. This report provided recommendations on a number of such tools that could be adopted.

4) The REGIONS program should use empirical tools to assess motivation, because motivation is a responsivity target for the program. The incorporation of a motivation tool will allow for standardized, consistent measurement of a youth's level of motivation. Tools include the Adolescent Treatment Motivation Questionnaire (Roest et al., 2016), Motivation for Treatment Questionnaire (Van Binsbergen, 2003; Van der Stouwe et al., 2018), and the Readiness to Change Questionnaire (Rollnick, Heather, and Bell, 1992; Van der Helm et al., 2014). Examples of free, validated tools that assess motivation include the University of Rhode Island Change Assessment (URICA) and the Texas Christian University Client Evaluation of Self at Treatment (TCU CEST).

5) Once a youth is in the REGIONS program, dialectical behavioral therapy (DBT) is the modality used to target criminogenic needs. The recommendations below relate to DBT delivery.

    a) DBT delivery should be standardized. The curriculum should provide a set number of lessons, which include topics, exercises, and homework. The lessons should be clear for both those facilitating and those participating in DBT. Standardizing the delivery of DBT will allow for more consistency in delivery within and across REGIONS programs. The program can be standardized by purchasing an already-developed DBT curriculum, or REGIONS can continue to develop its own in collaboration with their DBT consultant. However, as DBT was not developed for juvenile populations (or justice populations), care should be taken to make sure that any curriculum developed in-house focuses on a young population.

    b) REGIONS has done an excellent job of admitting high-risk youths into the program *(risk principle)*. And recommendations have been made on how to improve adherence to the *need principle* (targeting treatment towards assessed criminogenic needs) and *responsivity principle* (focusing on behavioral modalities to achieve change and identifying individual barriers to treatment). In addition to these three evidence-based principles, a fourth principle is necessary to promote behavioral change and program success—*fidelity.* Evidence-based practices can only have their intended impact when they have fidelity to the model. Having a standardized DBT curriculum will allow REGIONS to monitor youths' adherence to DBT. Fidelity should be monitored to ensure that lessons and topics are adhered to, homework is being provided and reviewed, and role plays are being administered properly.

    c) DBT skills provide value by teaching new, healthy ways to avoid or cope with difficult situations. REGIONS youths lack these valuable skills, so teaching them is vital for promoting long-term behavioral change. Learning new concepts can occur through discussion and reading, but

143

learning new behaviors is best promoted through practice. If REGIONS wishes to change participants' behaviors, they need to practice the new behaviors. Role plays are how a youth practices a new behavior, and, like any new behaviors, a great deal of practice is needed to become proficient. Thus, the development of a standardized DBT curriculum should emphasize role-playing. Role playing should be a constant, repeating component of the DBT curriculum. Youths should role play daily, in group sessions, in one-on-one sessions, and while on the unit.

i)   In groups, the facilitator should set up role plays as follows: 1) introduce the skill to the youths and explain how it can be helpful (i.e., sell the skill); 2) discuss each step of the skill individually, explaining why the step is important to the skill and describing how the step is performed; 3) set up a situation in which the skill can be used, and role play the skill for all youths to watch. During this role play, assign the youths different parts of the skill to watch for and tell them that they will need to explain whether and how the facilitator did this part of the skill; 4) after the youths provide feedback on how the facilitator did, ask two youths to role play for the group and assign youths who are not in the role play steps of the skill to observe and provide feedback on (this ensures that all youths pay attention throughout the role plays); 5) give every youth a turn role playing before the end of the group session.

ii)   Role plays should be set up in a controlled manner so that the focus is on the practicing of the skills not on "acting." Role plays are not opportunities to act goofy or crazy. Situations should be selected that are relevant to the youths and allow them to practice a new skill in an unthreatening (easy) manner. Youths should not be expected to become masters of skills until they have had ample opportunities to practice the skills. Role plays should have little resistance. For example, if the situation is that a youth is asked by a peer to help him steal a car, the STOP (**S**top, **T**ake a step back, **O**bserve, and **P**roceed mindfully) skill can be role played. At the end of the skill, the youth may choose to say: "Instead of stealing a car, I'm going to stay home and play video games." The other youth role-playing should agree with this solution. While this outcome may seem unrealistic, the point of early role-plays is not realism—it is getting used to the skill and performing the steps properly.

iii) Role plays can be made more difficult once youths have had ample opportunity to practice the new skills and are comfortable with the steps of the skill. A more difficult role play is one in which the youth may go through all the steps and then receive pushback. For example, if the youth says, "Instead of stealing a car, I'm going to stay home and play video games," the co-actor may say something like, "You aren't going to stay here and do that. You are going to come and help me." The youth must now deal with a new situation—the rejection of the "I'm going to stay home" solution—and decide how to proceed. Known as advanced practice, this type of situation is more difficult to navigate and requires more problem solving. REGIONS could incorporate advanced practice into later sessions of its DBT curriculum, but having open groups would make this difficult. REGIONS should consider adding an advanced practice group that would be separate from the group learning the basic DBT curriculum, and that youths would attend once they are comfortable with DBT skills.

iv)   Role plays should be used on the unit. If a youth is struggling to make good decisions, staff can set up role plays to deal with those situations. For example, if a youth is arguing with another juvenile, staff should separate the youths and allow for a cooling off period. Then staff can say: "You know that behavior is not tolerated. You also know that if you break unit rules there are consequences, and I know that you have been working to avoid getting into trouble. I also know that you have learned skills in DBT to help you deal with situations like the one you were just in. What skill could you have used to get out of that situation? Let's practice that skill now." The more times youths practice new behaviors and apply them in

144

different situations, the more likely they are to replicate those behaviors.

In the situation above, it is important to engage in the role play when the youth has calmed down. New skills are difficult to replicate when emotions run high. Therefore, the role play should wait until the youth is ready, which could be 5 minutes or 5 hours.

When teaching role plays in this manner, it is also important to frame the role play as a learning opportunity, not as a punishment. In other words, the role play should not be introduced as: "You broke unit rules so now you have to role play." This approach frames the role play as a negative thing. Instead, the role play should be framed as an answer to problems. If a youth breaks a rule on the unit, the proper sanction should be administered. After the sanction has occurred and time has elapsed, then a role play can be administered as a future solution to the problem. For example: "You know that you cannot yell and threaten other kids. Because you did this, you had your privileges removed for 24 hours. There isn't anything we can do about it now, but there is a way for us to avoid this in the future. I don't want to see you get in more trouble, and I bet you would prefer it if you didn't lose privileges you like. So, I want to practice how we can deal with that situation in the future so you can avoid getting into trouble in the future."

    v)   All REGIONS staff (regardless of title) should know when and how DBT skills are applied and should know how to demonstrate DBT skills, teach them, provide corrective feedback, and initiate role plays, because there will be more opportunities to correct behaviors and practice new behaviors outside of group time. REGIONS is encouraged to set up staff support meetings for DBT. Staff can ask questions, troubleshoot their approaches, share strategies, and practice setting up role plays. These staff support meetings will help staff learn, promote consistency, and increase fidelity.

d)   Ultimately, role-plays should focus on behaviors in the community rather than unit behaviors. Unit situations (e.g., not following REGIONS rules) are acceptable to role play and it may be necessary to concentrate on them in the beginning; however, a focus on unit behaviors emphasizes compliance in the short term and does not necessarily translate to long-term behavior changes. Therefore, the role plays should relate to situations that youths are most likely to encounter when they leave REGIONS. They should practice dealing with the behaviors that will get them in trouble when they leave. The youths should understand how they can use these skills in their post–REGIONS lives.

    i)   Upon completion of a role play using a community situation that is relevant to the youths, staff should always ask, "Do you think that you would use this skill in this situation when you leave?" In other words, staff should seek feedback from the youths on whether they view the solution as viable. If the youths were to say "no" (i.e., they do not think they would actually use the skill in the situation), staff should ask the youths why not and listen to their reasons. Then staff can problem-solve with the youths to identify a different skill that would be more appropriate. The purpose of this discussion is not to force youths to adopt the staff's viewpoint. If the youths truly believe they cannot use the skill in that situation, the staff need to work with the youths to find a different solution to the problem. Framing discussions in this way promotes problem-solving (i.e., thinking how different skills can be applied in different situations).

6) Currently, there is no body of research to guide dosage recommendations for juveniles in the criminal justice system. There is strong evidence supporting the risk principle. A review of data suggests that REGIONS does adhere to the risk principle: those who are assessed as high risk with

the PrediCT/SAVRY are targeted for referral to REGIONS. However, once in REGIONS, youths who are high risk should receive more intervention (i.e., more structured services targeting assessed criminogenic needs) than youths who are assessed as moderate risk. Moderate-risk youths are still appropriate for REGIONS, but they may need less time in programming. REGIONS should follow the risk principle by tracking the risk level of youths admitted to the program. REGIONS should ensure that clinical interventions consistently use a structured approach (e.g., target a criminogenic need, teach a skill in a concrete manner, have everyone role-play the skill, give homework). REGIONS should work to have more (and consistent) role-playing of all skills that are taught. Non-clinical interventions, or interventions that do not target criminogenic needs, should not count toward dosage. These activities provide structure and keep youths busy, so they have value—but they should still not be regarded as long-term behavior change interventions.

7) REGIONS is encouraged to develop a fidelity monitoring system. The data provided for the REGIONS evaluation suggest that data entry is sporadic. This issue is partly due to ongoing changes in data collection (i.e., new data fields being added during the course of the evaluation). However, the issue is also due to the amount of data entry required and lack of monitoring as to who is responsible for entering what information. REGIONS is encouraged to develop a committee composed of REGIONS staff to review all the data required for monitoring the youths in REGIONS programs. The committee should discuss 1) what, if any, data fields are missing and should be added; 2) what data fields are required but staff feel are unnecessary and should be removed; and 3) what system barriers are hindering appropriate data entry. Some aspects of data collection are necessary because they are required by the state system. However, additional data should always be collected as part of the program's CQI (consistent quality improvement) process. The committee should evaluate 1) whether particular data are required to be documented, and 2) whether the collected data will be reviewed consistently to assess program performance and evaluate the program. If the answer to both questions is "no," a discussion on the viability of collecting these data should be had. Auditing procedures should be adopted to ensure that the level of missing data is greatly reduced.

8) REGIONS should be applauded for its efforts to engage parents/guardians in the programming process—a task that can be difficult in the juvenile justice system. Although parents/guardians are included throughout the REGIONS process, the program is encouraged to augment families' involvement so that they are also part of the milieu. The main behavioral component of the REGIONS DBT programming is the teaching of skills. DSG recommends that families be aware of the skills being taught, of what those skills look like (e.g., they can learn the acronyms or steps that make up each skill), when the skills should be used, and how to reinforce the use of the skills. These topics can be introduced during meetings with parents/guardians. If the program expects youths to replicate these skills in the community, members of the community (i.e., parents/guardians) need to understand what the skills look like, how to reinforce the skills, and how to continue teaching the skills so the youths sustain them.

9) The residential treatment programs should be commended for having the appropriate staffing structure and levels, which many jurisdictions nationally lack. Another positive feature is the consistent, dedicated staff in the treatment programs. Both staff and youths repeatedly noted that having consistent, dedicated staff is an asset. Even within the detention center buildings, REGIONS staff appear to be given the freedom to run their program as a proper treatment program, rather than as just another pod in a large facility. However, many staff also expressed a desire to receive more DBT training. Availability of training has increased in the past year. DSG recommends that more training be offered since it will also strengthen the implementation fidelity of DBT and its

146

application to achieve long-term behavior changes.

10) The REGIONS program has done well at credit recovery and in trying to meet the educational needs of the youths, especially given the challenge of helping many youths who have different needs. We recommend that education liaisons be invited to all the monthly ITP meetings, and that their attendance be required at the discharge meetings.

11) REGIONS also has made great efforts in addressing the youths' vocational needs. Although the private programs tend to have facilities and opportunities more conducive to meeting vocational needs, the state-run programs have also taken steps to buttress vocational programming. DSG recommends that REGIONS secure facilities continue to work on opportunities for vocational training. Increasing opportunities for vocational training could be accomplished, for example, through jobs in the detention center, jobs on the unit, or role-playing jobs on the unit.

12) REGIONS is encouraged to examine the usefulness of the existing forms, especially the REGOINS Recommendation/Discharge Summary form and the Probation Case Plan form. The discharge forms for youths returning to the community are often detailed and helpful to future service providers. However, it is unclear how useful these discharge forms are for the youths going to step-down programs, because most of the recommendations on the forms reviewed for the process evaluation are relatively broad and vague.

13) Many of the interviewees still miss the previous system, especially the CJTS (Connecticut Juvenile Training School). They mostly miss the central location, the grounds, the sports programs, the vocational opportunities, the cafeteria, the medical unit, the dirt bikes, the staffing structure, the education, and the "beautiful building." Many of the interviewees also commented that the facilities used in the two state-run programs (Bridgeport and Hartford secure) were insufficient to best serve youth. At the same time, they acknowledged that many components of the system were better in the REGIONS approach. The improvements included the option of going to a step-down program (rather than being sent directly back to the community), the MDT (multidisciplinary team) process, group decision-making and the consensus approach to treatment and discharge, and the quality of the residential treatment clinicians. Also, many probation officers thought that keeping the youths under the probation umbrella throughout their time in REGIONS was a positive change (as compared with the youth leaving probation and then becoming part of the parole system). Finally, many of the interviewees felt that the Hamden CPA model worked well and wished that youths had the same opportunities in each of the residential programs. REGIONS may want to create more opportunities for communication and discussion related to these changes, especially with probation officers and other community-based stakeholders working with REGIONS youths. More opportunities for the various stakeholders to discuss these changes may be helpful in creating more buy-in and in building, sustaining, and improving communication among stakeholders and partnerships to best serve REGIONS youths.

Chapter 4. Re-entry and Probation

Two of the most critical components of promoting success for young people placed in residential facilities in the justice system are 1) adhering to good transition and re-entry planning, and 2) applying a re-entry framework to programming. Re-entry planning and services work best when they are comprehensive, integrated, and coordinated. Research emphasizes the importance of providing a seamless transition from institutional settings to community settings, with clear communication among the different agencies and individuals involved in the re-entry process (Burrell and Moeser, 2014; Platt et al., 2015).

Seven metrics in the process evaluation relate to REGIONS re-entry and probation:

1) Metric 75. Extent to which the final START:AV is integrated with the Juvenile Probation Case Plan to establish treatment and services for the transition to the community
2) Metric 76. Identification of the roles that the juvenile probation officer, reintegration mentor, mentor, and case and education coordinator, as applicable, play in this process, including how well service delivery is coordinated
3) Metric 77. Number and percentage of clients who are connected with their home school prior to discharge
4) Metric 78. Number and percentage of clients who make school visits prior to discharge
5) Metric 79. Number and percentage of clients who are connected with vocational services, training, or a job prior to discharge
6) Metric 80. Number and percentage of clients who are connected with community-based and/or in-home services prior to discharge
7) Metric 81. Number and percentage of clients who stay connected until the termination of their period of probation supervision

Throughout this chapter, there is some information included from discharge summaries. To maintain confidentiality, all names and other identifying information have been removed or replaced by "XXXX"; or "the client" has been substituted for the youth's name.

75. Extent to Which the Final START:AV Is Integrated With the Juvenile Probation Case Plan To Establish Treatment and Services for the Transition to the Community
This metric was assessed by reviewing files and examining findings from interviews.

Probation Officer Perspective. The interviewed probation officers, probation officer supervisors, and probation leadership shared that probation officers do not regularly receive the final START:AV to review while they are case planning. Most did not know what the START:AV is. However, probation officers do attend the Integrated Treatment Plan (ITP) meetings where START:AV results are sometimes discussed, so it is likely that, at least on occasion, some of the information captured in the START:AV reports is shared with probation officers and incorporated into the juvenile probation case plan.

Table 4.1. Comparing Information in Final START:AV With Information From Probation Case Plan

START:AV		Probation Case Plan			
Case #	Vulnerabilities and Strengths^	Critical Risk Domains*	Formulation and Analysis	Raise the Grade	Supervision Plan
1	Vulnerabilities Impulse control Coping Substance use Peers Material resources Community Strengths Conduct Attitudes Insight Plans	Antisocial peers* *Mental health* *Family distress*	Placed at CJR REGIONS after adjudicated on weapons poss. and theft of a firearm. Was with peers when arrested (as previous arrests). When in the community, struggled with mental health management, substance, and school engagement.	Enrolled in adult education while in REGIONS. Feels it's important to get his diploma and is considering acquiring a trade afterwards.	Important to support him in maintaining his mental health, which includes taking his medication consistently. It will also be important for him to maintain engagement with adult education. Probation will also assist and support his effort in obtaining employment, which could reduce his opportunities to get involved in negative activities with peers.
2	Vulnerabilities School and work Rule adherence Impulse control Emotional state Peers Strengths Recreation Social skills Caregivers/ adults	Academic disengagement* Callousness Antisocial Peers* Impulsive/ Oppositional Substance use*	He has always struggled with obeying house rules, negative peer association, non-compliance with treatment, and school disengagement, which intensified during Covid–19. He will benefit from a short-term residential placement to address and provide him with coping skills.	Records indicate that he has not met achievement levels in core subjects for the past 2 years. He will benefit from a thorough review of his academic records to ensure his current educational plan is addressing possible learning gaps.	The treatment focus will be geared toward decision-making, academic engagement, and peer association. He currently needs assistance to improve himself, which the recommendation is a referral to a short-term residential placement such as AMIR.
3	Vulnerabilities Substance use Coping Emotional state Peer social support Peers Material resources Strengths Social skills Adult social support	Academic disengagement* Family distress Anger & aggression* Impulsive/ oppositional* Callousness Antisocial peers	He has struggled with a chaotic and unstable home life. The exposure to severe domestic violence may be a factor in his aggressive behaviors. He also suddenly lost his father. Although he has received many services in and out of the community and was being supervised by the probation department, he continued to display criminal behavior in the community.	He should continue to work with CJR to address his academic performance while in placement.	Ensure his trauma issues are addressed as well as his compulsivity and decision-making. Also, that he get re-engaged in school and put on a path to graduate.

^ START:AV vulnerabilities in the table are either recorded as "high" (among options of low, medium, high) or identified as "critical."

* Probation case plan-targeted risk domains are identified with an asterisk; all targeted risk domains are identified as "critical risk domains" in the probation case plans, except those in italics, which were not identified as critical but *were* identified as targeted.

File Review. DSG requested files from a representative sample of 40 youths (for more information on our approach, see Appendix A). We received 15 files that included both the final START:AV and the juvenile probation case plan. Although we know that probation officers do not normally review the START:AV documents for the youths in their caseloads, we reviewed the case plans to identify whether START:AV results aligned with the case plans. As discussed in other metrics, the START:AV includes information about vulnerabilities and strengths (rated as high, moderate, or low) as well as the history and future risk of adverse outcomes. Also, according to JBCSSD Policy and Procedure 7.25 (Juvenile Services, Juvenile Probation Supervision Services), the juvenile probation case plan is a document created by a juvenile probation officer in collaboration with a youth and the youth's family to address identified risk/needs; strengthen protective factors; and articulate goals, activities, interventions, and expectations throughout the young person's period of probation/supervision. Table 4.1 provides information from 3 of the 15 files.

There does seem to be an overlap in the identification of vulnerabilities, especially in the identification of antisocial peers. For example, in case #1 in Table 4.1, impulse control, coping, substance use, peers, material resources, and community are all listed as high-level vulnerabilities (in a scale that includes low, medium, high) or identified as critical items. Similarly, in the formulation and analysis in the probation case plan, peers, substance use, community, and mental health management are identified as areas of risk. One difference between the two tools is that school engagement is identified as an area of need in the probation case plan but not in the final START:AV. It is common for youths to be more engaged in school while in residential placement than in the community, so this difference is to be expected. Substance use is also identified inconsistently.

Although there is some overlap between the START:AV and the probation case plans, most of the supervision plans in the probation case plans were short and not very specific. Examples are provided below.

- Attend all groups, and services provided by CJR REGIONS
- Abide by probation orders. Participate in all substance abuse treatment. Community interventions: therapy (substance abuse program through Yale, recommended and referred by REGIONS).
- There is no recommendation for mental health services and the focus will be to engage on pro-social activities in an effort to stay busy and avoid negative peers.
- Will focus on school attendance and completion of schoolwork.
- Ensure his trauma issues are addressed as well as his compulsivity and decision-making. Also, that he gets re-engaged in school and put on a path to graduate.
- Been involved with IICAPS since he was discharged from REGIONS. Unfortunately, he has also picked up new charges. The officer will continue to work with him on staying engaged in treatment and making better choices.
- While in placement supervision will focus on encouraging and counseling the youth to engage in treatment and set reasonable goals for discharge.
- While at the REGIONS placement, he will participate in therapy. After release, he is expected to participate in the counseling/therapy recommended by REGIONS clinician.
- Supervision focus: To provide him with the opportunity to process how his actions affect others. Community intervention: Therapy (currently working with the LYNC [Linking Youth to Natural Communities] program. Meets with the LYNC program once a week and has been consistent in doing so).
- The focus will be for him to reengage in his academics and to participate and successfully complete therapy. Immediately, this officer wants him to continue his stay at REGIONS Bridgeport and to be able to successfully transfer to a program or step-down (whichever is needed)

Some of the supervision plans were more detailed. Examples are provided below.

- PO will re-connect him with NHFA to assist with job search. PO will also facilitate a meeting with NHBOE

150

to get him re-enrolled in school and to identify services to assist him with obtaining academic success. PO will also attempt to assist with employment search as well as exploring pro-social activities that he may be interested in.

- Supervision focus: To support her as she transitions from residential setting to therapeutic foster home, keep her connected with activities and pro socials in effort to avoid future delinquent behavior. Contracted services: REGIONS reintegration mentor from Hartford Healthcare. Community intervention: mentoring (youth is connected with a reintegration mentor through Journey House); vocational employment (actively looking for gainful employment and has interview with Chick Fil A); vocational employment (DCF to connect youth with cosmetology program at a local hair salon); school (youth is attending alternative education high school at ANCHOR program); school (youth is attending Joshua Center for school).
- Important to support client in maintaining his mental health which includes taking his medication consistently. It will also be important for him to maintain engagement with adult education. Probation will also assist and support his effort in obtaining employment which could reduce his opportunities to get involved in negative activities with peers.
- Supervision focus: This officer will continue working on positive rapport building with the youth and helping her plan for her next steps post-graduation in December and her coming up on aging out of DCF foster care. Community intervention: Currently working at an elderly home for the summer.
- The plan is to get her engaged in treatment (MDFT), to get her engaged in school again, and to help her lessen, if not stop altogether, her substance abuse.

Summary. Probation officers do not regularly review the START:AV results. However, probation officers do attend ITP meetings where information about START:AV results might be discussed. They also play a role in developing the discharge plan during ITP meetings. Some of the information in the START:AV is similar to the information in the probation case plans. However, the information from the START:AV is not fully integrated or used to establish treatment and services in the community. JBCSSD should discuss the benefits of sharing the START:AV with probation officers and whether they would like to make this standard practice.

76. Identification of the Roles That the Juvenile Probation Officer, Reintegration Mentor, Mentor, and Case & Education Coordinator, as Applicable, Play In this Process, Including How Well Service Delivery Is Coordinated

It is important for the various stakeholders engaged in re-entry planning and service delivery to work together in a coordinated manner. As previously mentioned ideally, there should be a seamless transition from residential programs to community settings, with clear communication among the different agencies and individuals involved in the re-entry process (Burrell and Moeser, 2014; Platt et al., 2015). In many systems, this coordination can be challenging. Often, coordination is initiated and maintained by individuals who make the effort to reach out, rather than by systems and processes that ensure this coordination systematically meets the youth's needs. In REGIONS, several different stakeholders and decision-makers are involved in the re-entry process. To assess this metric, we analyzed data from key stakeholder interviews.

Role of Reintegration Mentors. The reintegration mentors' role is a critical one. Interviewees from all three components of REGIONS—including Court staff, residential treatment staff, community-based providers, and parents/guardians—mentioned that it was important for youths leaving residential placement to have a mentor or another individual assigned to look out for them. These individuals work closely with youths to help them access and engage in services, attend school, have someone to talk to, and advocate for them. Reintegration mentors are involved starting from the youths' admission to REGIONS and continue working with them up to 12 months after they return to the community. Although probation officers fulfill these roles some of the time, the reintegration mentor position aims to do this more fully and with more of an emphasis on being a mentor than on ensuring compliance with conditions of probation.

The REGIONS reintegration mentors interviewed for this report varied widely in terms of experience. Some were brand new at the time of the interview while others had been working with justice system-involved youths for more than 20 years. Reintegration mentors are employed at the private facilities only (and not at Bridgeport and Hartford REGIONS secure programs). We asked 14 reintegration mentors (4 in July 2021, 4 in July 2022, 6 in May 2023) to describe their role in REGIONS. They mentioned several tasks related to serving the youths in the residential program, before discharge, during discharge planning, and after discharge. They talked about acting somewhat like caseworkers, attending to needs as they come up. One of the reintegration mentors said:

> The majority of kids have gotten jobs. We stay with them. We get them clothes, shoes, help with birth certificates, take them to the DMV, things like that. Sometimes it takes the parents a while to open up to us. We build relationships with them, too. We offer a lot. I like to try to see our kids twice per week in person when they are in the community. We are also part of the floor here [in the residential program]. We document everything. We have our own files. We enter data on our contacts with the kids into CDCS. Even on the weekends, I call them. If you lose contact with them, they know you're not interested, and they won't talk to you anymore. We don't let that happen.

Most of the interviewees mentioned the following tasks that were part of the reintegration mentor's role:

- *Attending MDT meetings.*
- *Identifying and assessing community resources.*
- *Facilitating home passes.*
- *Assessing family needs.*
- *Individualizing services.* Some of the interviewees mentioned that they get to know the youths as individuals to best arrange services and opportunities for them. They talked about the importance of the intake session and meeting with the youth regularly. One of the interviewees said: "I do research. After I speak to the kid about his interests, I do research to assist or be useful for when he discharges. For example, one of our kids is good at basketball so we connected him with the coach so he can a play for school team."
- *Collaborating with clinicians.* Reintegration mentors collaborate with many decision-makers and stakeholders. They collaborate with clinicians to ensure the youths understand their treatment goals before discharge and when they are back in the community.
- *Keeping in touch with probation.*
- *Making sure that the transition back to the community is successful and that they are meeting their goals.* Several of the reintegration mentors mentioned having three key goals for their youths: 1) high school diploma, 2) a job, and 3) staying out of the adult system. Youths also have their own individual goals.
- *Facilitating groups in the residential program.* More than half of the reintegration mentors also said that they facilitated groups.

Reintegration mentors also mentioned some challenges regarding their roles, including lack of safety in the community, maintaining a good perspective when working with youths who have multiple challenges, and building and maintaining relationships with community-based partners. One of the reintegration mentors said: "It's tough not to get jaded. Sometimes you get so excited, and then later you see them in jail. But I do enjoy what I'm doing, especially when we see a kid succeed." Another reintegration mentor said: "It is dangerous for us in the community. We sometimes have to go into shady neighborhoods." Some reintegration mentors also mentioned that their voices were not considered as much as the clinician's voices when discussing discharge options for youths still in residential placement.

An additional challenge mentioned by other interviewees was the lack of consistency among reintegration mentors, which may be related to the high turnover rate in some programs. Although two of the reintegration mentors had a lot of experience, this position has had more turnover than many of the other positions, especially compared with the probation officers. The lack of experience was also reflected in responses that indicated preferences for working with classification and program officers rather than reintegration mentors due to the former having "more longevity and more experience because they are state employees." Also, some interviewees commented that they did not think younger women should be assigned as reintegration mentors to older boys.

Despite the identified challenges, all interviewed reintegration mentors appeared dedicated to the youths and their jobs. One of the reintegration mentors said: "I like my job. I like being able to work with the kids in a greater capacity and help them at discharge." And the role of the reintegration mentor has been strengthened and clarified over time. One of the reintegration mentors said: "When we started, they should have laid out more about what our jobs are supposed to be. We had job descriptions, but there are lots of other things we didn't know we had to do. They should make the requirements of the position more clear so we know exactly what we should be doing."

Role of Probation Officers. Our interviews produced a range of responses related to the role of probation officers with REGIONS youths. Some responded that they were mostly focused on ensuring that youths maintain compliance with their conditions of probation, while others indicated that the probation officers play a larger role in the community, coordinating services, building relationships with the youths and their families, and acting more like a mentor or advocate. For example, one of the attorneys said:

> Unfortunately, a lot of the probation officers' mentality is, 'I'm going to supervise you. I'm going to put in graduated sanctions, and if you mess up, then I'm going to violate you.' That has zero value to helping these kids out. You know, it's just ridiculous that people think that's what a probation officer should be doing. Probation officers should be your strongest ally and should be out there fighting for you. They should be doing whatever they can to make sure you succeed. And although some probation officers think that way, I think many of them do not.

However, interviews with probation officers provided a more positive view of their role. Some of the interviewees, acknowledging the challenge of youths working with many different services providers after discharge, were proactive in ensuring that service delivery was coordinated. One probation officer said: "For some kids, I set up my own provider meeting because kids have so many services and people involved."

Some of the challenges that probation officers shared during interviews included having to understand and respond to the processes and procedures of each of the different REGIONS programs. When asked, "How does the overall MDT approach address discharge?" one of the probation officers answered:

> It depends. Kids are coming out of so many different facilities. There are so many different variables with making plans and following through. We have providers we are trying to get involved and set up. Some programs (like MST–FIT) will start when kids are still there so they can get the families to cooperate. Other times we need to get mentors and programs in place. We need the school district to cooperate. Some take a little longer to set up the transition.

Some of the probation officers felt that the REGIONS programs had unrealistic expectations for the probation officer's role. One of them said:

> When we're transitioning our kids into step-down, I'm having trouble engaging the parents to do the intake

153

paperwork. I need to do this to transition him, but this takes a long time. [The REGIONS program] just sends me the paperwork and says I need to get this paperwork done with the parents before he can go. This is not okay because it's not my program, and I don't think this should be my role. This is a bad way of starting a working relationship. It's on probation to go over it. It's all legal documents. They are having the families go to the facilities. It's not appropriate that POs do this paperwork. We are not guardians. We should not be responsible for any of this intake paperwork.

Some of the other probation officers shared similar frustrations. One of them said: "We literally do everything for everyone. They can get their own releases signed. We've become the administrative assistants to CCs and REGIONS programs." Some felt that it was too much to ask to work with youths in residential programs as well as youths in the community. One shared: "Working with kids in the community and kids in REGIONS is too much. It would be easier to do the planning for REGIONS kids if I didn't have community kids." Finally, some of the probation officers felt that they were too often used as "the heavy." One of the probation officers said: "Sometimes in the meetings, they will say, 'the PO says you can't go home.' But we're supposed to be a team."

Role of Case & Education Coordinators. Only a few of the interviewees discussed the role of the case and education coordinator during re-entry. However, those who did share information said that the case and education coordinator plays a role when it comes to the youth's education needs and credits, and making sure the youth is in the proper grade level. Additionally, they file any new special education forms with the school, if not already completed. Essentially, the case and education coordinator helps bridge the gap between the education needs that were identified and addressed in the REGIONS education program and the services that may be needed when the youth is back at school in the community. If the school has questions once the youth has returned to the community, the case and education coordinator can still provide assistance (within 3 months of discharge).

A job positing for a case and education coordinator position posted in 2022 stated:

> This position establishes and maintains local educational connections and assists families with empowerment, especially around educational advocacy. They obtain educational records, identify needs, and assist the clinician in facilitating team meetings and help to establish long term meaningful and supportive connections with the community (Salary.com, 2022).

Essential functions related to re-entry include the following: coordinating provider meetings, treatment plan review meetings, and discharge meetings; coordinating educational services, obtaining educational and health records, arranging transportation, and attending school-based meetings; assisting the youth and family with school reintegration; supporting vocational planning and secondary options; maintaining regular and open communication with the youth's probation officer; and assisting the family with arranging after-care services.

Role of Education Liaisons. The education liaisons play an important role in reengaging youths with their home schools after they leave REGIONS. Unlike the pupil service specialists (described below), the education liaisons were already employed by school districts when they were assigned the education liaison role in addition to their other job responsibilities. As of July 2022, there were 20 education liaison positions in 20 different school districts across the state (Connecticut State Department of Education, 2022). The purpose of this position is to "facilitate student transitions between public schools and the Connecticut juvenile justice system, including the timely transfer of records of justice-involved students to and from juvenile justice agencies and facilities" (2022). The education liaisons also assist with the transition of youths to and from Department of Children and Family (DCF) placements and Department of Correction (DOC) placements. They are charged with ensuring that students returning to their districts from juvenile justice system custody are immediately enrolled in school. They are also responsible for complying with several other requirements in the Connecticut

General Statutes, including communication with the residential program sending youth back to school, transfer of relevant education records, and student receipt of appropriate credit for schoolwork completed while in juvenile justice custody.

The education liaison initiative was established quickly without sufficient communication about the role to other stakeholders. One of the probation officers said: "Education liaison just crept up on us. No one told us about them." However, over time, this role has been clarified and has been helpful.

Role of Pupil Services Specialists. To comply with Public Act 21–174, DCF began the process of hiring pupil services specialists (also called transition specialists) while this REGIONS process evaluation was being conducted. We did not interview any of the pupil services specialists, but we reviewed job descriptions for the position of pupil services specialist. The job descriptions include responsibilities such as: 1) working to collaborate with receiving schools, youth-serving agencies, employers, and other community supports to manage successful transition; 2) advocating for student's academic, social, and emotional well-being; 3) communicating with re-entry coordinators and students' networks of supports; and 4) tracking educational credits. (For more information, see Metric 77.)

Coordination of Service Delivery. Many individuals work with youths after they leave a REGIONS facility: reintegration mentors; probation officers; education liaisons; pupil service specialists; community-based behavioral health, psychiatric, medical, and other service providers; community-based vocational service providers; school staff; families; and in many cases, DCF workers. Coordination of services can be challenging and even overwhelming, given all the different individuals involved.

An important aspect of coordination is understanding each other's roles. By the second and third rounds of the interviews DSG conducted in July 2022 and May 2023, interviewees seemed to have a good understanding of everyone's roles during re-entry. One of the reintegration mentors said: "The POs make sure they are following the conditions of probation. We help them get to their appointments. The POs are responsible to see if they are committing another crime. We help with the employment, state ID, parents, etc." Comments improved from the first site visit in July 2021 to the second and third interviews in July 2022 and May 2023.

There were many positive comments about coordination of service delivery during and after discharge. For example, one of the interviewees said:

> Probation has a good relationship, especially with the reintegration mentors. They're required to give them reports on what they're doing, and of course, the contracted programs are required to give reports on what they're doing, including progress and areas of concern.

There were many challenges as well, including the following:

- Several of the interviewees who have more years of experience felt that the old model of using parole officers was better than the current REGIONS re-entry model.
- Others felt that the policies, procedures, and guidelines related to discharge and re-entry are "tweaked too much." One of the reintegration mentors said: "There are changes every week, and we revisit things too much. It should be more concrete."
- Some of the reintegration mentors shared that it was difficult to navigate through all the different goals for the youth. They said that although there is only one treatment plan (which is developed by the clinicians), each department has their own individual goals for the kid and there is a lot of back-and-forth.
- Many of the reintegration mentors and probation officers felt that better communication and

155

collaboration were needed among all the decision-makers and stakeholders working with the same youths.

- A few of the reintegration mentors felt it would be helpful for the clinicians to spend more time in the community to better understand the realities that the youths face after discharge.

- Finally, many of the probation officers and community-based providers felt that there were too many differences between the residential programs. For example, when asked about the criteria for determining when youths can go home, one of the probation officers said: "It depends on the program. [This program] will do whatever they want. [That program] will go with what the probation officer says. When you don't agree with [this program], they will bring a whole lot of people into the meeting that agree with them."

Also, one of the education liaisons said:

> I can't tell you how many times a student will get to their senior year, first semester, and they're not ready to graduate because they don't have enough credits. And they'll say to me, "I took that class already." And I go back and realize they were in detention for 3 months. We didn't get the transcript. Now I'm not blaming the facilities. I don't even know if we asked for the transcript. But I know for a fact that many of my kids have lost credits because there was no communication between the sending and the receiving schools. And they are going to school in detention and they're doing well, but then we don't give them credit for it because we're either not aware of it or we didn't ask for the transcript. And that bothers me because for some of these kids, high school graduation is a huge thing, and it's as far as they're going to get.

The new education liaison and pupil specialist roles, and many of the new policies and procedures, aim to prevent this lack of communication and coordination, and most of the interviewees were positive that things were moving in the right direction. The REGIONS re-entry policies, procedures, and practices are still being developed and are at the beginning stage of implementation. There are many positive pieces in place that may take just a little longer to come together to provide REGIONS youths with a seamless transition from a residential program to the community.

Summary. Juvenile probation officers, reintegration mentors, case and education coordinators, education liaisons, pupil services specialists, and other community-based providers all play an important role in the re-entry process. Ensuring sufficient communication and collaboration among partners to best serve the youths can be challenging. Service delivery and service delivery coordination during re-entry appear to have improved since the start of REGIONS. Later interviews (2022 and 2023) produced more positive comments than earlier interviews (2021) related to service delivery and coordination. However, levels of service delivery coordination vary across the state, with most of the interviewees identifying great partners as well as partners that were not as helpful. Improved coordination and regular oversight by JBCSSD of the re-entry process, including greater clarity about the roles of the various stakeholders and decision-makers are recommended.

77. Number and Percentage of Clients Who Are Connected With Their Home School Before Discharge

As mentioned in Metric 57, youths in the juvenile justice system are at higher risk of educational failure than youths in the general population, and meeting their educational needs is important (DSG, 2019a; Foley, 2001; Sedlak and Bruce, 2010). Low levels of personal, educational, vocational, or financial achievement are one of the eight major risk/need factors for criminal conduct (Latessa, Listwan, and Koetzle, 2015). Youths who achieve higher levels of education while in the juvenile justice system are more likely to experience positive outcomes in the community once released (Blomberg et al., 2011; Cavendish, 2014).

The State of Connecticut has several policies designed to enhance communication and coordination

regarding REGIONS youths' educational services, including policies related specifically to youths leaving REGIONS and returning to their home public school district. For example:

> In accordance with Connecticut Public Act 18–31, each public school district with a student enrollment of at least 6,000 is required to designate a Juvenile Justice Liaison/Re-entry Coordinator to facilitate student transitions between public schools and the Connecticut juvenile justice system, including the timely transfer of records of justice-involved students to and from juvenile justice agencies and facilities.

The juvenile justice liaisons/re-entry coordinators are tasked with assisting schools, the Department of Children and Families (DCF), JBCSSD, and any other relevant schools or educational service providers to ensure that:

- Students are immediately enrolled in public school upon their return from justice system custody, pursuant to Connecticut General Statutes (C.G.S.) Section 10–186(e);
- Not later than ten days after the date of enrollment, the school district provides written notification of such enrollment to the appropriate juvenile justice system facility, pursuant to C.G.S. Section 10–220(h);
- Not later than ten days after the receipt of the notification of enrollment in the school district, the justice system facility transfers all relevant education records to the appropriate public school, pursuant to C.G.S. Section 10–220(h);
- Not later than thirty days after receiving the students' educational records from the justice system facility, students receive appropriate credit for schoolwork completed while in justice system custody, pursuant to C.G.S. Section 10–220(h) [Connecticut State Department of Education, 2022].

Additionally, while this process evaluation was being conducted, Connecticut passed Public Act 21–174, which included a section that required DCF, with help from an implementation team, to develop an operational plan for an education unit within DCF to educate children who are incarcerated. To comply with this Act, DCF began the process of hiring a dozen pupil service specialists (Caffrey, 2022). Pupil services specialist job listings were posted in 2023 (Jobapscloud.com, 2023). Job descriptions for these positions indicated that applicants need a master's degree and experience in the field. The pupil service specialist's responsibilities include the following:

- Pupil Service Specialist works to collaborate with receiving schools, youth serving agencies, employers, and other community supports to plan and manage successful transition. Inclusive of all agencies (juvenile justice, probation, school).
- Advocate for students' academic, social and emotional well-being, as well as support student's efforts to find employment, post-graduate options and beyond. The PSS is also responsible for communicating with re-entry coordinators, and student's network of supports.
- Track educational credits of youth while in and out of home placement and document the success of placements following youths' re-entry into their communities through strategic goal setting and progress monitoring.

Many changes are currently in process related to overseeing educational services and ensuring that youths are connected with their home schools prior to discharge. This metric was assessed by reviewing state policies and by gathering and analyzing information from discharge summaries and key stakeholder interviews. Quantitative information was not available through state databases.

File Review. DSG researchers requested discharge summaries from 2022. We received 73 discharge summaries from six of the seven residential programs[28] that were completed for youths admitted to REGIONS between April 2021 and December 2022. Thirty-two of these summaries were for youths being discharged to home or somewhere else in the community (i.e., not to another REGIONS residential program, to Manson Youth Institution, or out of state).

---

[28] Discharge summaries from Boys & Girls Village were unavailable.

Of the 32 youths who discharged home or to the community, 3 had already graduated. Discharge summaries indicated that 28 of the 29 youths who had not already graduated were connected to an educational institution at discharge. Only 1 of the 29 did not have clear information on a connection to a specific school. That youth's discharge summary included the following remarks:

> Education advocate to support completion of high school and exploring options for continued education. Probation also put in a referral for an educational advocate to help support client and his mother in determining the best path for finishing his high school education and explore secondary options.

It was unclear how many youths are going back to their home schools compared with how many are going to new schools. However, some of them certainly are returning to their home schools. Below are examples of text from the discharge summaries indicating that youths are going back to their original schools.[29]

- Youth will be **returning** to XXXX School. He was able to engage in this program in the past and earn many credits. It will be imperative that youth receive adequate educational support to address his learning difficulties.
- Youth participated in a **re-entry** meeting for XXXX High School on XX/XX/2022. CJR staff coordinated a zoom meeting with the principal and staff in order to prepare youth for his **return** to school on XX/XX/2022.
- Youth was offered supportive placements through both XXXX and XXXX High School's XXXX program, however, he has refused both. He will be **returning** to mainstream XXXX High School classes. He will benefit from school- based supports in order to assist him with the transition to mainstream classes.
- Youth will **return** to XXXX School in Waterbury on XX/XX/2022. She is considered an 11th grade student.
- Enrolled in XXXX High School will **return** to school on XX/XX/22. He will complete his High School education at XXXX High School with 1:1 mentoring.
- He will be **re-enrolled** to XXXX High School and is scheduled to meet with the principal, on XX/XX/2022 by 9am.

Youths were enrolled in several different types of schools in a variety of programs, including regular education enrollment in neighborhood public schools, special education programs within neighborhood public schools, alternative schools, magnet schools, adult education programs, and independent schools specializing in social, emotional, behavioral, and mental health issues, and/or learning issues.

Three of the discharge summaries specifically mentioned youths having an "educational advocate." The educational advocate roles written into the discharge summaries included attending school re-entry meetings, assisting with gathering credits earned while in detention or in other residential placements, and advocating "to support completion of high school and exploring options for continued education."

Perspectives of Reintegration Mentors, Probation Offices, and Community-based Providers. Interviewees acknowledged both the importance of youths transitioning back to school after REGIONS and the challenges related to reintegrating to school in their home communities. One of the probation officers said:

> A lot of young kids finally find success when they are in staff secure and in one of those schools. Some kids from Bridgeport were good to remain in the staff-secure school. I would love the option where someone can facilitate the transition better back to their home schools. It's really hard, and sometimes there are safety concerns.

---

[29] Personal names, school names, and other identifying information have been removed or replaced.

Some interviewees shared that schools vary in their ability to reengage students effectively after time away at a REGIONS program, but almost all felt that the process is never easy. A probation officer said:

> The school piece is a concern. The school is behind in receiving information and will sometimes put kids back in places they don't need to be. It is never a smooth transition. There are always issues and barriers.

Most interviewees agreed that the transition needs to be very well organized between many of the partners (e.g., residential treatment staff, probation, schools) to best support the youth leaving a REGIONS program.

Youth Perspective. A focus group conducted by the Juvenile Justice Policy and Oversight Committee asked youths in REGIONS several questions about re-entry. The participants made several points about rejoining the community and reengaging in school. They mentioned two main needs related to school during re-entry: 1) being active in school, and 2) having transportation to and from school. They identified two gaps in services: 1) having school during the summer, and 2) needing additional support to ensure that they actually go to school.

Summary. According to discharge summaries for youths discharged from REGIONS in 2022, 97 percent of youths who discharged to the community and had not already graduated from high school were connected to a school before discharge. Several initiatives are in place to support youths' transition from residential placement to their school in the community.

78. Number and Percentage of Clients Who Make School Visits Before Discharge

DSG assessed this metric using information from youth files and from key stakeholder interviews. We reviewed the discharge summaries of youth returning to their home communities (i.e., not to another REGIONS residential program, to Manson Youth Institution, or out of state).

Dataset. The CDCS dataset did not include any information on whether youths completed school visits before discharge.

File Review. Of the 32 discharge summaries of youths returning to their home communities (see Metric 77 for more information about this data), 8 indicated that the youth visited the school in person before discharge, met with school staff remotely, or planned to visit before discharge. In 3 cases, it was clear that no school visit took place, and in 18 cases, no information was available about whether a school visit occurred (see Figure 4.1). In three cases, the youth had already graduated so a school visit was unnecessary. Seven of the eight files indicating a school site visit took place were from staff-secure programs, while one was from a secure program. Examples of text from the discharge summaries referring to a school visit (in person or virtual) are below.

- [The child] attended his re-entry meeting with the XXXX Board of education on XX/XX/2022. He will be re-enrolled to XXXX High School and is scheduled to meet with the principal, XXXX, on XX/XX/2022 by 9 am. [The child] also completed his XXXX interview on XX/XX/2022.
- [The child] will attend 10th grade at XXX High School, an alternative school in XXXX. She has attended school here previously and has several positive connections to staff. She completed her admission paperwork and intake with the school on XX/XX/2022 with her father.
- [The child] is a special education student who last attended XXXX High School as a 10th grader. A placement PPT was held at CJR on XX/XX/2022. [The child] was re-connected to his Educational Advocate XXXX (XXX.XXX.XXXX) during his time at CJR. [The child] will attend XXXX High School upon his discharge. [The child] and his family completed their re-entry meeting with Mr. XXXX from XXXX Public Schools on XX/XX/2022 via zoom. The education advocate was present for the client's re-entry meeting with XXXX from XXXX Public Schools on XX/XX/2022.

Figure 4.1. Percent of Clients Who Made School Visits Prior to Discharge, 2021–2022
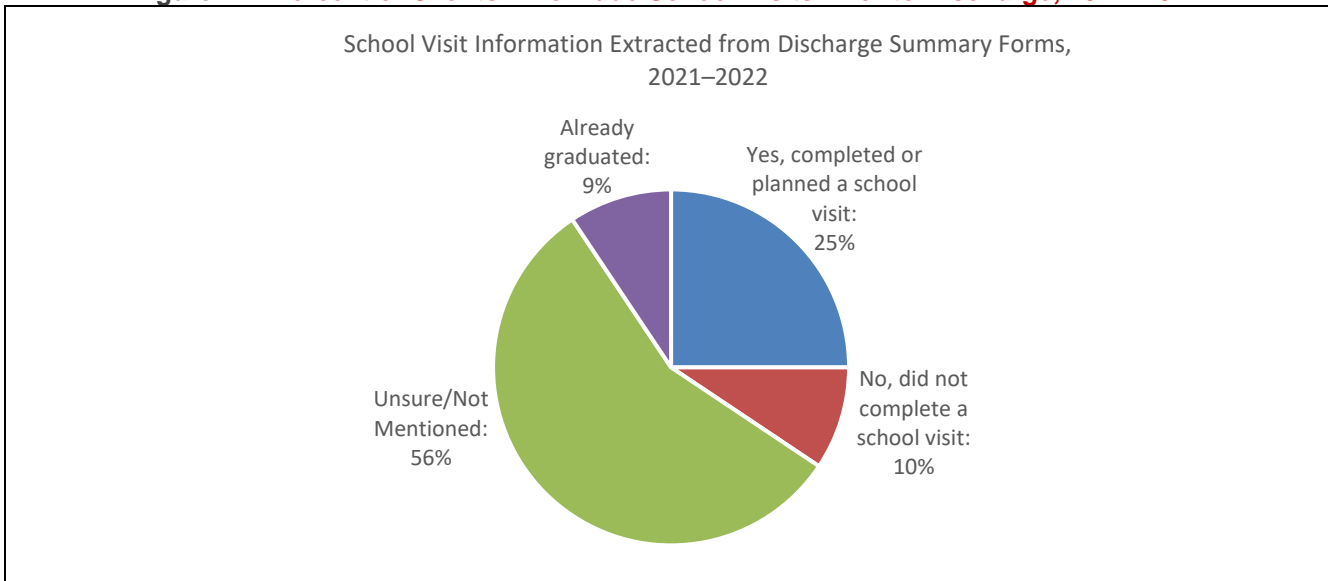
School Visit Information Extracted from Discharge Summary Forms, 2021–2022

Already graduated: 9%

Yes, completed or planned a school visit: 25%

No, did not complete a school visit: 10%

Unsure/Not Mentioned: 56%

Data source: 2022 discharge summaries. Includes six REGIONS programs (excludes Milford Boys & Girls Village). *N* = 32.

Stakeholder Perspective. DSG asked interviewees whether youths completed a school visit before discharge, and, if so, how often this occurred. Seventeen stakeholders responded, including residential treatment providers and reintegration mentors from each of the seven residential programs, and education liaisons from Bridgeport Public Schools, Hartford Public Schools, and Stamford Public Schools. Some interviewees said school visits always happen, while others said visits rarely happen. Some commented that in the secure programs, youths are not permitted to leave for in-person school visits, but such visits do occur for youths in staff-secure programs. Others said that a school visit is more likely if a youth is going to a new, specialized school out of the district, and a school visit is unlikely if the youth is returning to the school that they attended before being admitted to REGIONS. The children of all seven parents/guardians interviewed were in secure programs and only three youths were discharged from REGIONS at the time of the interviews. Out of the seven parents/guardians interviewed, only one reported attending a school visit before discharge. They discussed having a strained relationship with the school system they visited because of the school system's inefficiency and inconsistency. (For more information, see Metric 77.)

Summary. School visits occur for at least some of the youths before they are discharged from REGIONS. Also, the visits seem to happen more for youths leaving staff-secure programs than for youths leaving secure programs. However, it is unclear how often the school visits occur. If JBCSSD would like to track these data, a simple check box on the discharge form for indicating whether an in-person or virtual school visit took place would be helpful.

79. Number and Percentage of Clients Who Are Connected With Vocational Services, Training or a Job Before Discharge

DSG initially planned to assess this metric using quantitative data from one of the state databases, but the data was not available. Instead, DSG assessed this metric by reviewing discharge summaries.

File Review. We received 73 discharge summaries from six of the seven residential programs[30], completed for youths admitted to REGIONS between April 2021 and December 2022. Thirty-two of these summaries were for youths being discharged to home or to another location in the community (i.e., not to another REGIONS residential program, to Manson Youth Institution, or

---

[30] Discharge summaries from the Boys & Girls Village were unavailable.

out of state). In 69 percent of the cases, the discharge summaries mention connecting youth to vocational support or services (see

Figure 4.2). Examples of relevant text from the discharge summaries are below.

- [The child] will continue to work with his reintegration mentors to obtain part-time employment. He has previously identified Walmart and Subway as viable options.
- [The child] is connected to a job placement agency called XXXX that will assist with job training and placement opportunities. His intake was completed on XX/XX/2022 and his worker is _____ (name, email, and phone number were included in the form).
- [The child] will continue to work with his reintegration mentor on obtaining his permit/ID and completing job applications.

Figure 4.2. Percent of Discharge Summaries Indicating the Youth Was Connected With Vocational Services or Training
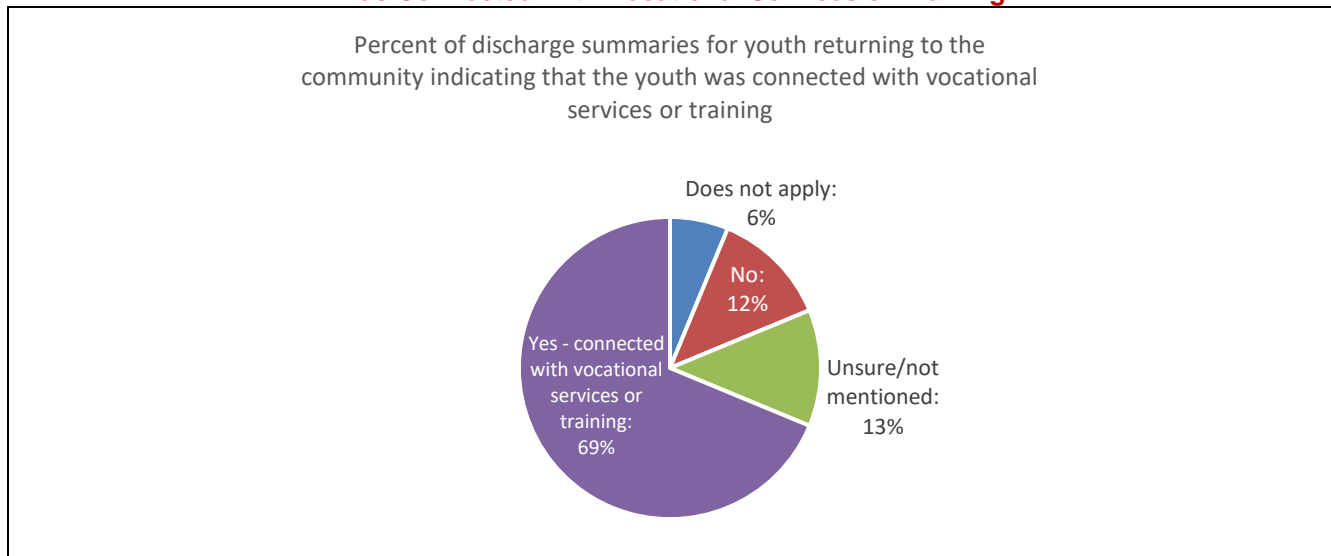
Percent of discharge summaries for youth returning to the community indicating that the youth was connected with vocational services or training

Does not apply: 6%
No: 12%
Unsure/not mentioned: 13%
Yes - connected with vocational services or training: 69%

Data source: 2022 discharge summaries. Includes six REGIONS programs (excludes Milford Boys & Girls Village). *N* = 32.

Also, in 5 of the 32 cases (16 percent), the youth had already obtained a job before leaving the facility. In one case, the youth had applied for a job, but had not yet received the job offer. In another case, the question of whether a connection had been made to vocational services, training, or a job did not apply because the youth was too young for a job. In the remainder of the cases, the youth either had not obtained a job at the time of discharge or the issue of a job was not mentioned (25 cases). Below are excerpts from two discharge summaries describing promising job prospects.

- [The youth] is interested in both the plumbing and barbering vocations. He has an appointment on 12/29 at 5 pm to meet a barber for a potential apprenticeship that he was connected to via CTVIP. He also completed the registration for a Tech Training Program offered at XXXX in plumbing. This program is from 1/18-5/11, Tuesday, Wednesday, and Thursdays from 2:30-5:30. [The youth] provided mom's contact information in his application. He created a résumé and Indeed account and applied to several jobs including: Chic-fil-A, Five Guys, Costco, a janitorial position, 2 positions through Chartwell at Quinnipiac University, and McDonalds. He received notification through Indeed that Five Guys would be reaching out to him for an interview. He will need his driver's license to move forward with plumbing apprenticeships. He has his permit test appointment scheduled for 1/5 and will be enrolled in Driver's education.
- While in the REGIONS program, [the youth] applied for and interviewed for part-time employment at Popeye's Restaurant in Hamden, CT. He got the job and will begin once he provides documentation. He was also connected to X, the Hamden Program Coordinator at CT Intervention. She will maintain contact with [the youth] and connect him to a mentor who is employed as a plumber. [Contact information was provided in the discharge summary.]

Summary. According to the 32 discharge summaries completed for youths admitted to REGIONS between April 15, 2021, and Dec. 31, 2022, and who were discharged to the community, at least 69 percent of the youths were connected with vocational services or training and at least 16 percent had already obtained a job when they were discharged.

80. Number and Percentage of Clients Who Are Connected With Community-Based and/or In-Home Services Before Discharge

DSG initially planned to assess this metric using quantitative data from one of the state databases, but the data was not available. Instead, we assessed this metric by reviewing discharge summaries and conducting key stakeholder interviews. This section summarizes information about substance use services, family services, psychiatric services, behavioral health services, medical services, and other services listed in the discharge summaries. When the information is not provided elsewhere in this report, we include findings from interviews with key stakeholders. Some of this information is also presented in Metric 70.

File Review. Similar to Metric 77, Metric 78, and Metric 79, DSG assessed the 32 discharge summaries from 2022 for youths being discharged to home or somewhere else in the community (excluding youths going to a REGIONS step-down program and youths moving out of state).

S*UBSTANCE* U*SE* S*ERVICES.* The Discharge Summary form contains a subsection in part 2 titled "Substance Use" for describing substance use needs, and each of the 32 discharge summaries included information in that subsection. In about one third of the discharge summaries, the clinician indicated that substance use services were not needed (See Figure 4.3). For example,

> Clinician is not recommending a specific substance use treatment at this time but has provided information for the local mental health authority in XXXX. Clinician advised mom to call XXXX in New Haven (XXX) XXX-XXXX if there is a need for mental health or substance use concerns.

In one quarter of the cases, substance use needs were identified, and youths were connected with services. Some recommendations were quite specific while others were more general. For example:

> The client's substance use may be addressed in clinical services he receives through MST–FIT.

> The client will attend the XXXX program 4 days a week 4 hours per day for 6 weeks. His intake will be on XX/XX/XXXX @ 930 am on MyChart.

Finally, in 41 percent of the files, a substance use need was identified, but the text in the discharge summary did not clearly state whether a connection was made to specific services. For example:

> Client will benefit from ongoing therapeutic support in managing triggers for substance use in the community. Client would benefit from ongoing support in utilizing adaptive coping and skills to manage substance use urges in the community.

In these cases, it is possible that a connection to specific services was made, although the connection was not described in the discharge summaries.

162

Figure 4.3. Clients Connected With Substance Use Services at Discharge, 2022
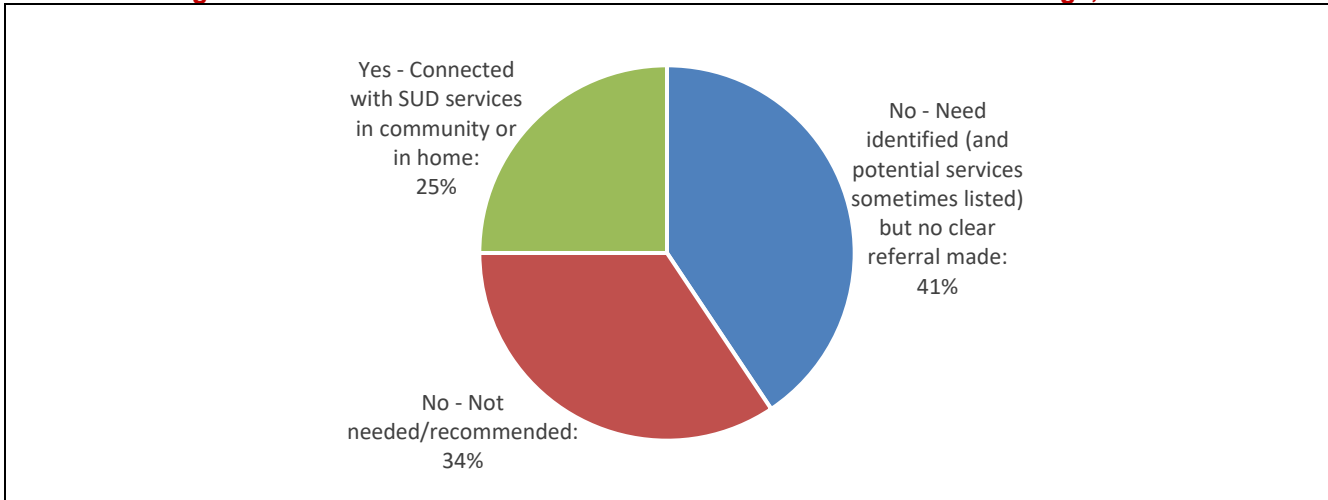
Yes - Connected with SUD services in community or in home: 25%

No - Need identified (and potential services sometimes listed) but no clear referral made: 41%

No - Not needed/recommended: 34%

Data source: 2022 discharge summaries. Includes six REGIONS programs (excludes Milford Boys & Girls Village). *N* = 32. SUD = Substance use disorder.

FAMILY SERVICES. Each of the 32 discharge summaries provided information about family services. In more than half of the discharge summaries (18 of the 32), it was clear that the youth was connected with family services (see Figure 4.4). In 6 of the 32 cases (16 percent) family services were not recommended because they were not needed. These youths were between 17 and 19 years old. Below are sample entries. Finally, in 8 of the 32 cases (32 percent), it was unclear whether there was a connection to family services or there was no information about family services.

Figure 4.4. Clients Who Are Connected With Family Services at Discharge, 2022
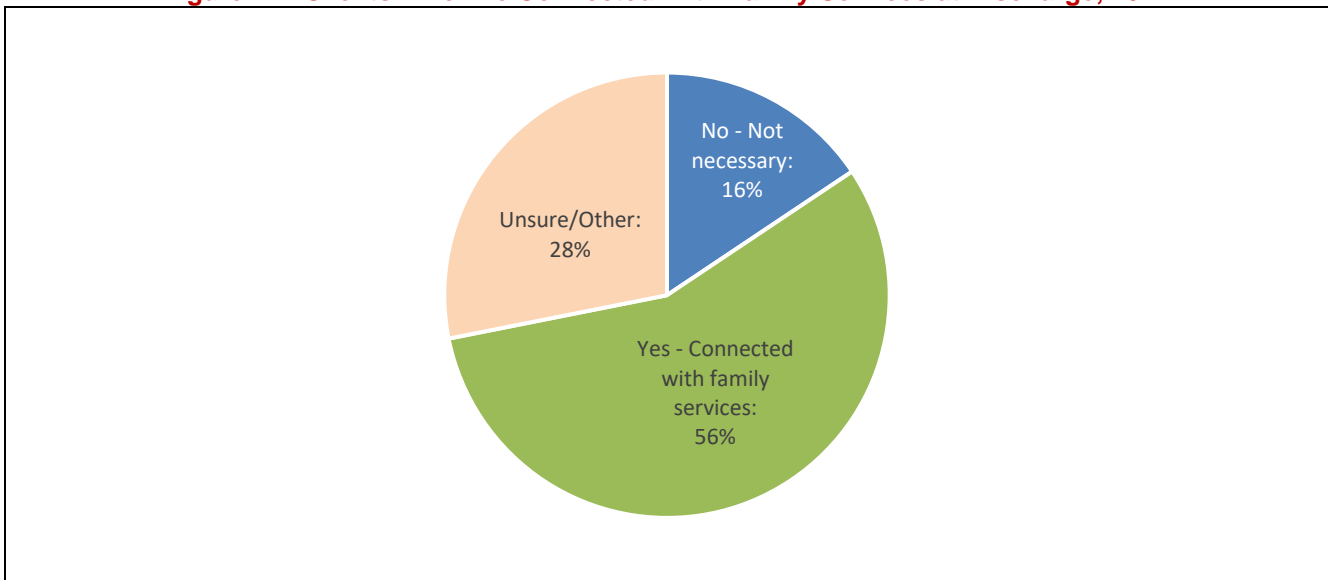
No - Not necessary: 16%

Unsure/Other: 28%

Yes - Connected with family services: 56%

Data source: 2022 discharge summaries. Includes six REGIONS programs (excludes Milford Boys & Girls Village). *N* = 32.

REINTEGRATION MENTORS AND OTHER MENTORS. Twenty-two of the 32 discharge files (69 percent) noted that a REGIONS reintegration mentor will work with the youth after discharge. Many of the files included the name of the reintegration mentor, contact information, and how often the reintegration mentor planned to meet with the youth. Of the 10 youths not assigned reintegration mentors, 8 were already connected with a mentor in the community, a credible messenger, or a community-based program that has access to mentors. Additionally, 5 of the 22 youths with reintegration mentors had additional mentors assigned (e.g., through Connecticut Violence Intervention Program, V.E.T.T.S. Mentoring

163

Program, Straight Ahead Ministries, Credible Messengers Program).

BEHAVIORAL HEALTH SERVICES. Most of the discharge summaries included information about connections to behavioral health services (see Figure 4.5). Eighty-eight percent of the summaries clearly indicated that the youth was connected to specific behavioral health services, and 6 percent stated that the youth was a waitlist for services. Service providers included Community Mental Health Affiliates–Waterbury, LMFT (therapy with Licensed Marriage and Family Therapist), Love146, Multisystemic Therapy for Emerging Adults (MST–EA), Multisystemic Therapy–Family Integrated Transitions (MST–FIT), Our Community Counseling, Stokes Counseling Services, Wellmore Behavioral Health, and the young adult dual diagnosis program.

PSYCHIATRIC SERVICES. In most of the cases (63 percent), the discharge summaries indicated that youth were connected with psychiatric services (see Figure 4.5). Specific service locations that were mentioned included Brook House, Clifford Beers Community Care Center, Community Health Center of Meriden, Community Mental Health Affiliates–Waterbury, CJR's MST–FIT program, Connections Counseling, H.O.P.E. through Healing Wellness Center, Journey House, LEO clinic, Lifespan Collaborative Services, Stokes Counseling Services, Straun Health & Wellness, and Wheeler Clinic/Family Health & Wellness Center–Waterbury. Other discharge summaries mentioned the name and contact information of individual providers.

Figure 4.5. Clients Who Are Connected With Behavioral and Psychiatric Services at Discharge, 2022
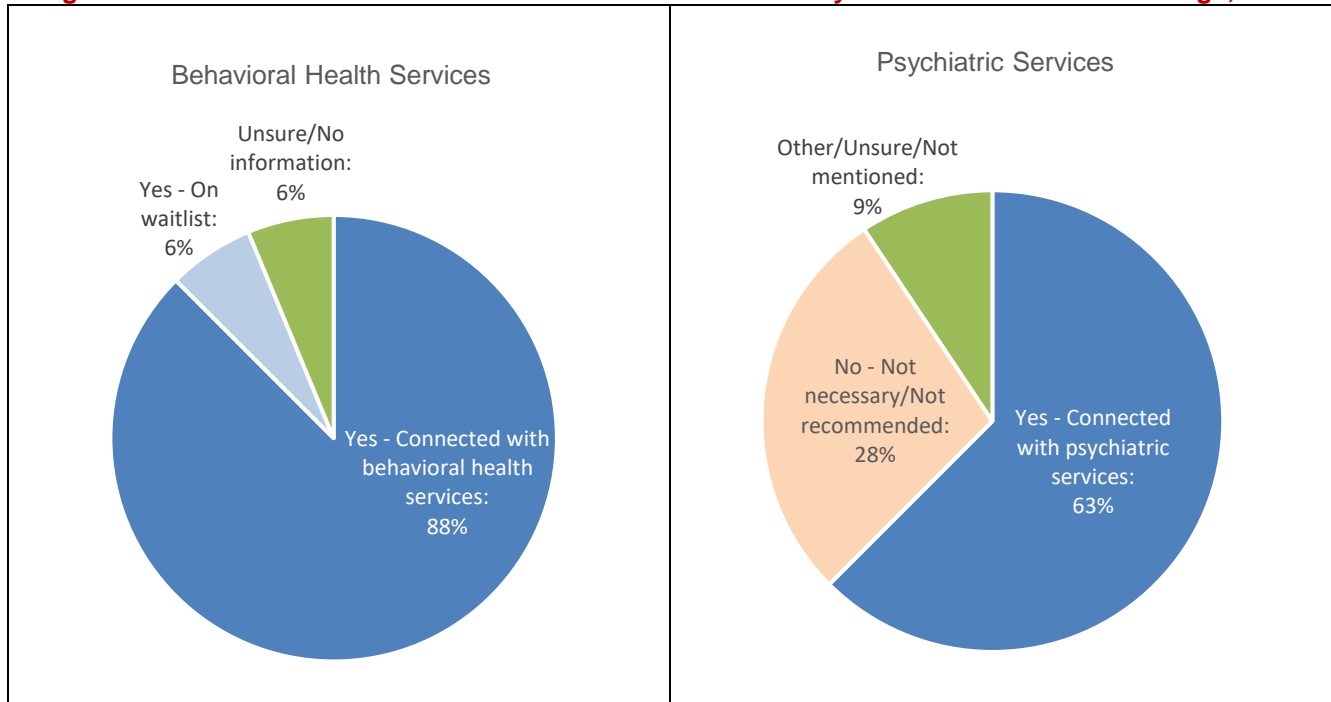
Data source: 2022 discharge summaries. Includes six REGIONS programs (excludes Milford Boys & Girls Village). *N* = 32.

In 9 of the 32 cases (28 percent), psychiatric services were not recommended by the clinician. In the other three cases, it was unclear whether psychiatric services were arranged or the summary indicated that the family denied psychiatric services.

OTHER SERVICES. Several other services were noted in the discharge summaries. For example, every discharge summary made some mention of a connection to medical services in the community. In almost half of the discharge summaries (15 of the 32) the details about this connection were in the

164

discharge summary itself, and in the others, a note was included stating, "See medical transition summary," indicating that the details were provided elsewhere. Also, in 11 of the 15 discharge summaries with medical information, the primary care provider's name and contact information were given. In 23 of the 32 discharge summaries, additional social services were listed, including connections to Boys & Girls Clubs, a father initiative program, Manchester Youth Service Bureau, Connecticut Violence Intervention Program (VIP), Street Safe Program, sports teams, Waterbury Youth Services, YMCAs, DMHAS YAS (Connecticut Department of Mental Health and Addiction Services–Young Adult Services), Police Athletic League, and LOVE146.

Summary. All 32 youths who discharged to the community in 2022 (and did not move out of state) were connected to medical services in the community, and most were referred to behavioral health services (94 percent), social services and recreation (72 percent), psychiatric services (63 percent), and family services (56 percent). Also, 94 percent were connected with a REGIONS reintegration mentor, a mentor in the community, a credible messenger, or a community-based program that has access to mentors. Finally, 25 percent were referred to substance use services.

81. Number and Percentage of Clients Who Stay Connected Until the Termination of Their Period of Probation Supervision

DSG did not receive quantitative data from the state databases that could indicate the number or percentage of clients who stay connected to services until the termination of their probation supervision. Juvenile Probation Services recently added data items in CMIS that track attendance and engagement, so this kind of analysis will be possible in the future. Through interviews with key stakeholders, we were able to gather some information to assess this metric, especially regarding staying connected to education, probation, and reintegration mentors.

Connection to Probation Officers Until Termination of Probation. Probation officers generally felt that youths were "very connected" to their assigned probation officers until termination of their period of probation supervision. Interviewees mentioned that they met with the youths, their families, and the schools on a weekly basis, and that the amount of contact was based on their treatment plans. One interviewee said: "If they don't stay connected to something, we'll find another service to make sure they're in something. Connection is a big piece. They are usually in Tiers 4 or 5 [in the PrediCT tool], so we see them weekly." When asked how well youths stay connected to services until the termination of probation, a probation officer said: "They are required to attend the services. For the most part they stay connected."

Connection to Education Until Termination of Probation. In previous sections we discuss connections to school coordinated at discharge (see Metric 77 and Metric 78). After the initial challenge of connecting youths to school in the community, ensuring youths stay connected is an additional challenge. Some of the interviewees worried about a lack of enforcement of school attendance. One of the interviewees said: "Over the years, I've just seen probation have less and less teeth."

Another interviewee said:

> They were doing good when they were in detention [and REGIONS] because they had no choice but to go. Now they came out, they're good for two weeks and then they fall off. You call probation, they say, "Listen, we can't really do anything about it." Or they will say, "Next time we're in court next month we'll let the judge know and then nothing really happens." Okay. And then the kid starts failing.

All acknowledged that connection to education until termination of probation is a challenge for youths who do not graduate before leaving a REGIONS program.

Connection to Reintegration Mentors Until Termination of Probation. Interviews with key stakeholders indicate that connection to reintegration mentors until the termination of the youth's period of probation has improved over time. Most of the interviews related to re-entry occurred in the second half of DSG's data gathering for the process evaluation. However, in some of the earlier interviewees, we discussed re-entry topics. The earlier interviews had a more negative tone than the later interviews. The earlier interviewees sometimes mentioned they were "surprised" that there was not a better plan for re-entry. They indicated that the reintegration mentors sometimes did not follow up enough with their clients, and that the earlier model (with Department of Children and Families) was better for the re-entry component than the new REGIONS model. One of the Court interviewees said this was "a huge change that needs to be made." However, by the time DSG conducted the second half of the interviews, more reintegration mentors had been hired, and comments about reintegration mentors improved. For example, at our first site visit to Hamden CPA in July 2021, there were no reintegration mentors. However, at our site visit to Hamden CPA in May 2023, Hamden CPA had four reintegration mentors and one family support specialist to support youths after discharge. Also, as DSG was developing the findings and recommendations for this report, JBCSSD reported that they were issuing an RFP for reintegration mentors at the Bridgeport REGIONS Secure and Hartford REGIONS Secure programs. (For more information, see Metric 76.)

Connection to Employment Programs Until Termination of Probation. Interviewees shared that many of the youths who have jobs at discharge do not have the skills yet to stay employed, which results in losing the job before termination of probation. Much of this job loss is due to a lack of job readiness and "soft skills." One of the interviewees said: "The majority of them are not making it through their first week on the job, just from things like not showing up, inappropriate language, not calling when they are going to be late, and those kind of things." This same interviewee also stated: "We're realizing now as we're getting kids placements that they really need those soft skills first; a lot of these kids are not quite job ready yet." (For more information see Metric 73 and Metric 79.)

Summary. Information gathered through interviews with probation officers, reintegration mentors and other residential treatment staff, and community-based providers suggests that most youths stay connected to their probation officers and that, by 2022 and 2023, most youths who are assigned reintegration mentors remain connected to them. Interviews also reveal that it is difficult for youths to attend school regularly and achieve academic success after re-entry. Finally, youths who are connected to a job at discharge often struggle to stay connected to it until the termination of probation. However, the interview findings cannot be confirmed with quantitative data at this time. Juvenile Probation Services recently added data items in CMIS that track attendance and engagement, so this kind of quantitative analysis will be possible in the future.

Recommendations

Best practices indicate that youths should receive intensive intervention while in residential placement, during their transition to the community, and when they are under community supervision. There should also be a coordinated and collaborative plan to ensure that this transition addresses the youths' unique needs (DSG, 2017).

In July 2022, JBCSSD conducted a focus group of REGIONS youths, at the request of the Juvenile Justice Policy and Oversight Committee (JJPOC) Re-Entry Subgroup, to obtain feedback from youths on barriers to re-entry, needs and experiences, and gaps in services. The youths indicated that their top four needs were 1) positive influences in their lives while in the community, 2) financial help, 3) vocational development and support, and 4) assistance with transportation. Interviews with key stakeholders and a review of discharge summaries indicate that REGIONS has several options for addressing each of these needs.

Some recommendations are below.

1) Implement a mechanism to ensure that good communication between partners is supported. Many stakeholders and decision-makers have established good communication with partners. However, this good communication is not yet achieved systematically; rather, it tends to be based on individuals and personalities. REGIONS should identify where communication and partnership are working best and share the best practices with other sites.

2) As the pupil service specialists begin working with REGIONS youths, ensure that efficient and effective communication is established and maintained as soon as possible.

3) Since over half of the youths in REGIONS placements are age 16 or older, it is important to begin preparing them for employment, which can be a complicated and difficult task. Discharge summaries show that two thirds of youths returning to the community either had jobs or were connected with vocational support services. However, there are challenges associated with vocational planning for justice system-involved youths. One issue raised by staff was the lack of available and appropriate services to help with job readiness, including helping youth learn the interpersonal skills required to get and maintain employment. Several interviewees shared that youths often are unable to keep the jobs they have at discharge, owing to a lack of job readiness skills. JBSSCD should explore opportunities to identify or develop job readiness training programs that specifically target justice system-involved youths. In addition to enhancing job readiness opportunities, it is important to improve the offerings available to and support provided to youths who are turning 18 or are not returning home upon release.

4) Mentoring is an essential tool to help youths successfully return to the community, and results indicate that youths leaving REGIONS programs are routinely paired with mentors either from the reintegration mentor program or from other mentoring programs. Some challenges were raised during interviews with mentors, including uneven levels of experience among mentors, concerns for personal safety in the community, feelings of not being an equal partner in discharge planning, and turnover among mentor staff, which affects consistency. We recommend that JBCSSD provide additional support to reintegration mentors in an effort to reduce turnover; provide mentors new to working with justice system-involved youths with training on how to effectively work with this population; and review the discharge planning process to be more inclusive of mentors' input.

5) The use of the START:AV as a planning tool for transitioning youths from REGIONS back to probation is inconsistent. Currently, probation officers do not regularly have access to START:AV results unless they happen to be discussed at an ITP meeting. Although there is some overlap between START:AV results and probation case plans, if JBCSSD would like probation treatment planning to more closely align with findings from the final START:AV, a system should be developed to ensure that probation staff receive a copy of the START:AV at the beginning of the case planning process.

6) We were unable to assess many of the metrics in this section by using official quantitative data that would permit us to calculate the number and percentage of clients who: a) are connected with their home school, b) make schools visits, c) are connected with vocational services, and d) are connected with community-based and/or in-home services prior to discharge. As an alternative, we conducted a one-time review of a small number of casefiles to try to respond to these metrics. If JBCSSD desires to systematically track specific re-entry data for all discharges going forward, DSG recommends that specific information be identified and entered into CDCS or another management information system on a regular basis.

Chapter 5. Outcome Evaluation

Outcome studies evaluate the impact of an intervention on a group exposed to the intervention relative to a group who was not exposed to the intervention. Our outcome evaluation analyses used coarsened exact matching (CEM) to compare REGIONS youths with similar youths who were placed on probation supervision during the same period of observation but did not attend REGIONS. (For more information about the methodology, see Appendix D.)

Results

The outcome analyses began with an inspection of REGIONS data. As noted in Appendix D, there were 170 eligible cases. Table 5.1 depicts the demographic information for all eligible REGIONS youths. The typical REGIONS youth was male (85.3 percent) and Black (57.6 percent). Less than half of REGIONS youths were Hispanic/Latino (41.2 percent). The average age of the sample was 15.8 years, with a median age of 16.

Table 5.1 also shows that the most common PrediCT risk level was Tier V (48.8 percent), the next most common was Tier IV (37.1 percent). This demonstrates that REGIONS is following the risk principle, with only 6.5 percent of the sample assessed as Tier III or lower. Finally, the most common start year for this sample was 2019 (46.5 percent), followed by 2020 (23.5 percent).

The outcome under investigation is recidivism. Recidivism was defined in multiple ways for this project. First, *new arrests for misdemeanors and felonies* was examined at 1 and 2 years after completion of the REGIONS program). Second, *a new detention stay for any misdemeanor or felony* was examined at 1 and 2 years after program completion. Third, *new adjudications for misdemeanors and felonies* was examined at 1 and 2 years after program completion. Controlling for time at risk is important for outcome evaluations

Table 5.1. REGIONS Demographics

Variable		*N*	%
Gender	Male	145	85.3
	Female	25	14.7
Race	Black	98	57.6
	White	64	37.6
	Unknown	8	4.7
Ethnicity	Not Hispanic/Latino	82	48.2
	Hispanic/Latino	70	41.2
	Unknown	18	10.6
Age	13	3	1.8
	14	17	10
	15	38	22.4
	16	50	29.4
	17	48	28.2
	18	5	2.9
	Missing	9	5.3
Risk	Tier II	2	1.2
	Tier III	9	5.3
	Tier IV	63	37.1
	Tier V	83	48.8
	Missing	13	7.6
Start Year	2018	34	20
	2019	79	46.5
	2020	40	23.5
	2021	17	10

examining recidivism such as the REGIONS evaluation: youths in REGIONS are placed in secure and staff-secure facilities that prevent access to opportunities to commit crime in the community, whereas probationers have community access and opportunities to recidivate. As a result, recidivism was evaluated for REGIONS youths upon the completion of the REGIONS program, and probationers' recidivism was evaluated following the start of their supervision. Thus, for 1-year measures, all youths have exactly 1 full year evaluated, and 2-year measures allow for 2 full years to be evaluated. Each of the above measures was dichotomized (i.e., 0=no recidivism, 1=recidivism).

Table 5.2 examines recidivism for the entire REGIONS sample. Roughly 77 percent of REGIONS youths had a new arrest within 1 year for a misdemeanor or felony. After 2 years, just over 88 percent

of REGIONS youths had a new arrest. The proportion drops when looking at new detention stays. Specifically, 50 percent of REGIONS youths had a new detention stay within 1 year. This number increased minimally to just below 53 percent at 2 years, which suggests that new detention stays are most likely within the first year. Finally, the strictest measure of recidivism evaluated is any new misdemeanor or felony adjudication. After 1 year, only 18 percent of REGIONS youths had a new adjudication. Two years after completing REGIONS, only 32 percent of REGIONS youths had a new adjudication.

Table 5.2. REGIONS Recidivism, 2018–2021

Variable		Yes		No	
		N	%	*N*	%
New Arrest	One Year	131	77.1	39	22.9
	Two Year	150	88.2	20	11.8
New Detention Stay	One Year	85	50	85	50
	Two Year	90	52.9	80	47.1
New Adjudication	One Year	31	18.2	139	81.8
	Two Year	55	32.4	115	67.6

N = 170.

Table 5.3 further examines 2-year recidivism measures for REGIONS youths by program start year. This table shows whether there are large differences across start years, since REGIONS was operated and implemented during differing impacts of the Covid–19 pandemic. As illustrated, the proportion of recidivism was fairly consistent across program years. Roughly 94 percent of youths starting in 2018, 2019, and 2021 were rearrested within 2 years. This proportion was lower in 2019, with 81 percent of youths starting in that year rearrested within 2 years. A similar pattern was found looking at new detention stays. The highest proportions of new detention stays were in 2018 and 2021 (58.8 percent), with a slightly lower proportion in 2020 (52.5 percent), and the lowest proportion in 2019 (49.4 percent). Finally, the highest proportion of new adjudications was in 2018 (44.1 percent), followed by 2020 (37.5 percent). Again, 2019 had the lowest proportion of new adjudications within 2 years (24.1 percent). Table 5.4 depicts similar patterns for all three measures of recidivism at 2 years by program location.

Table 5.3. Number and Percent of REGIONS Youths Who Recidivated After Two Years, by Type and Year

Variable	2018 (*N*=34)		2019 (*N*=79)		2020 (*N*=40)		2021 (*N*=17)	
	N	%	*N*	%	*N*	%	*N*	%
New Arrest	32	94.1	64	81.0	38	95.0	16	94.1
New Detention Stay	20	58.8	39	49.4	21	52.5	10	58.8
New Adjudication	15	44.1	19	24.1	15	37.5	6	35.3

Table 5.4. REGIONS Recidivism at Two Years by Type and Residential Location

Residential Location	2-Yr. New Arrest		2-Yr. New Detention		2-Yr. New Adjud.	
	N	%	N	%	N	%
Journey House (*N*=25)	20	80	8	32	2	8
Bridgeport (*N*=37)	32	86.5	22	59.5	14	37.8
Hamden (*N*=3)	3	100	2	66.7	2	66.7
Hartford, Secure (*N*=42)	38	90.5	24	57.1	16	38.1
Hartford, Staff Secure (*N*=6)	6	100	4	66.7	2	33.3
Milford (*N*=31)	29	93.5	19	61.3	12	38.7
Waterbury (*N*=26)	22	84.6	11	42.3	7	26.9

Table 5.5. Demographic Information by Sample for Matching Process

Variable		Control Group		REGIONS		Test	
		N	%	N	%		
Gender	Male	245	87.8	101	87.8	χ^2= 0.000	*p*=0.997
	Female	34	12.2	14	12.2		
Race	Black	154	55.2	68	59.1	χ^2= 0.737	*p*=0.692
	White	117	41.9	43	37.4		
	Unknown	8	2.9	4	3.5		
Ethnicity	Not Hispanic/Latino	140	50.2	54	47	χ^2= 0.509	*p*=0.775
	Hispanic/Latino	115	41.2	49	42.6		
	Unknown	24	8.6	12	10.4		
Age	13	11	3.9	3	2.6	*t*=-3.291	*p*<0.001
	14	44	15.8	12	10.4		
	15	104	37.3	30	26.1		
	16	77	27.6	38	33		
	17	43	15.4	32	27.8		
Risk	Tier II	1	0.4	1	0.9	χ^2= 48.253	*p*<0.001
	Tier III	65	23.3	8	7		
	Tier IV	165	59.1	49	42.6		
	Tier V	48	17.2	57	49.6		

The next step in the outcome evaluation is to compare the recidivism of youths in REGIONS with a similar group of youths who did not attend REGIONS. As discussed above, this comparison was accomplished through post-hoc matching. The matching process is depicted in Table 5.5. CEM was used to match REGIONS youths with probation youths on gender, race, ethnicity, age, and risk level. The ensuing CEM process resulted in a match of 115 REGIONS youths to 279 probation youths. There were similar proportions in group composition across variables and groups despite different sample sizes across groups, which reflects the balancing process of CEM. The test column statistics also demonstrate the success of the matching process. For example, there were 101 males in the REGIONs sample and 245 males in the probation sample; however, each of these numbers represents the same proportion (87.8 percent) across samples. The result is a non-significant chi-square test statistic, indicating there are no differences in gender across treatment and control groups. The same pattern was noted for race and ethnicity, as both of these showed no statistically significant differences across groups. There were statistically significant differences for age and risk level. As indicated, the control group members are slightly, but to a statistically meaningful degree, younger than REGIONS participants. Furthermore, REGIONS youths include significantly more individuals who are assessed at a higher risk level than comparison group participants. The inability to balance age and risk is indicative of the REGIONS program—it is selecting older, riskier youths.

This finding illustrates three important considerations: first, it indicates that the REGIONS program is successful at identifying and selecting the riskiest youths (i.e., there were not enough high-risk youths on probation to match to the high-risk youths in REGIONS). Second, the REGIONS program generally admits older youths (i.e., there were not enough older youths on probation to match to older youths in REGIONS). Third, due to the statistically significant difference across groups for the age and risk level variables, multivariate logistic regression analyses were conducted to control for these differences.

Table 5.6. Recidivism Measures for Matched REGIONS Sample

Recidivism Measure		Yes		No	
		N	%	*N*	%
New Arrest	One Year	88	76.5	27	23.5
	Two Year	102	88.7	13	11.3
New Detention Stay	One Year	65	56.5	50	43.5
	Two Year	69	60	46	40
New Adjudication	One Year	23	20	92	80
	Two Year	34	29.6	81	70.4

N = 115.

Table 5.6 provides information on measures of recidivism for REGIONS youths. Just over 76 percent of REGIONS youths were arrested within 1 year of completing REGIONS. This figure increases to 88.7 percent 2 years after completing REGIONS programming. Regarding a new admission to detention, 56.5 percent of REGIONS youths had a new detention stay 1 year after completing REGIONS. Interestingly, this number increases only slightly to 60 percent (going from 65 youths with a detention stay after 1 year to only 69 youths with a detention stay after 2 years). For the most restricted definition of recidivism, new adjudications, the number decreases even more. One year after completing REGIONS, 20 percent of REGIONS youths had a new adjudication. This proportion rose to 34 percent 2 years after completing REGIONS.

Table 5.7 provides information on all measures of recidivism for both REGIONS youths and the matched comparison group of probationers. REGIONS youths were statistically significantly more likely to have a new arrest 1 year after completing REGIONS compared with probationers (76.5 percent vs. 44.8

percent). This difference was maintained after 2 years, as 88.7 percent of the sample of REGIONS youths had a new arrest compared with 69.9 percent of the comparison group. Of note is the difference across proportions in the 2 years. After 1 year, there was a 31.7 percent difference (76.5 percent – 44.8 percent), but this was reduced by nearly half to 18.8 percent (88.7 percent – 69.9 percent) after 2 years. Thus, while REGIONS youths were significantly more likely to experience a new arrest, the proportion increase from 1 to 2 years was much less for REGIONS youths than for comparison group youths.

Comparing REGIONS with probation in terms of a new stay in detention yields similar results. Table 5.7 shows that 56.5 percent of REGIONS youths had a new detention stay within 1 year of completing REGIONS, compared with 30.5 percent of probationers. After 2 years, 60 percent of REGIONS youths had a new detention stay compared with 39.8 percent of probationers. Both measures were statistically significant.

Table 5.7. Recidivism Measures by Group Status

Recidivism Measure		Comparison		REGIONS		Test
		N	%	N	%	
New Arrest, 1 Year	No	154	55.2	27	23.5	χ^2=32.989
	Yes	125	44.8	88	76.5	p<.001
New Arrest, 2 Year	No	84	30.1	13	11.3	χ^2=15.514
	Yes	195	69.9	102	88.7	p<.001
New Detention, 1 Year	No	194	69.5	50	43.5	χ^2=23.449
	Yes	85	30.5	65	56.5	p<.001
New Detention, 2 Year	No	168	60.2	46	40	χ^2=13.411
	Yes	111	39.8	69	60	p<.001
New Adjudication, 1 Year	No	238	85.3	92	80	χ^2=1.684
	Yes	41	14.7	23	20	p=.194
New Adjudication, 2 Year	No	211	75.6	81	70.4	χ^2=1.114
	Yes	68	24.4	34	29.6	p=.285

Table 5.7 also evaluates new adjudications. Within 1 year of completing REGIONS, 20 percent of youths had a new adjudication, whereas 14.7 percent of the comparison group had a new adjudication. This difference was not statistically significant, indicating that there was no difference between REGIONS and comparison group youths in the likelihood of a new adjudication within 1 year. This same finding was present at 2 years, as 29.6 percent of REGIONS youths had a new adjudication within 2 years compared with 24.4 percent of probationers. Although REGIONS youths were more likely to have a new arrest and a new detention stay, analyses of the strictest definition of recidivism indicated no difference between the two groups.

To further elucidate the results above, Table 5.7, Table 5.8, and Table 5.9 evaluate the offense categories and levels for new arrests, new detention stays, and new adjudications, respectively. Table 5.7 evaluates arrest offense categories for all new arrests after 2 years. The REGIONS group had a slightly higher percentage of youths being arrested for assaults and weapons-related offenses.[31] Regardless, these differences across categories were not statistically significant. Inspection of the level of offense (misdemeanor vs. felony) suggests that REGIONS youths were statistically significantly more

---

[31] Weapons-related offenses included: Carrying a pistol without a permit, carrying a dangerous weapon, stealing a firearm, criminal possession of a firearm, illegal possession of a weapon in a motor vehicle, stealing a firearm, possession of a weapon on school grounds, and illegal possession of a large capacity magazine.

likely to be arrested for a felony offense compared with probationers (91.2 percent vs. 79.0 percent respectively). Thus, the data suggest that, in general, REGIONS youths are not more likely to be re-arrested for any specific offense but are more likely to be arrested for an offense that is classified as a felony.

Table 5.8 provides information on the offense categories and offense levels for new detention stays. Statistical analysis indicated a statistically significant difference across offense categories. The finding suggests that youths on probation were more likely to have a new detention stay for robbery, assault, and larceny, whereas REGIONS youths were more likely to have a stay for an escape from custody. However, this finding should be interpreted with caution, as the low cell values for some categories can lead to unstable estimates. The level of offense was also significant; however, results suggest that probationers were more likely to have a new detention stay for felony-level offenses compared with REGIONS youths (81.1 percent vs. 68.1 percent).

Table 5.8. Offense Categories and Levels for Two-Year New Detention Stays

	Variable	Comparison		REGIONS		Test
		N	*%*	*N*	*%*	
Offense Category	Assaults	24	21.6	10	14.5	χ2=31.022
	Burglary	3	2.7	4	5.8	*p*=.001
	Robbery	12	10.8	4	5.8	
	Sex Offenses	1	0.9	1	1.4	
	Weapons-related	8	7.2	8	11.6	
	Drug-related	2	1.8	1	1.4	
	Larceny	48	43.2	22	31.9	
	Public Order	9	8.1	3	4.3	
	Escape from Custody	1	0.9	16	23.2	
	Other	3	2.7	0	0	
Level	Misdemeanor	21	18.9	22	31.9	χ2=3.934
	Felony	90	81.1	47	68.1	*p*=.047

Table 5.9 depicts information on offense categories and levels for new adjudications after 2 years. Although a larger proportion of REGIONS youths had a new adjudication for a weapons charge and a larger proportion of probationers had a new adjudication for larceny and public order offenses, data show no statistically significant differences across categories. Further, there was no statistical difference in new adjudication offense level, implying that REGIONS youths were no more or less likely to be adjudicated for more serious offenses compared with a matched sample of probationers.

Table 5.9. Offense Categories and Levels for Two-Year New Adjudications

Variable		Comparison		REGIONS		Test
		N	*%*	*N*	*%*	
Offense Category	Assaults	4	5.9	5	14.7	χ2=13.121
	Burglary	3	4.4	2	5.9	*p*=.108
	Robbery	6	8.8	3	8.8	
	Sex Offenses	1	1.5	0	0	
	Weapons-related	8	11.8	6	17.6	
	Drug-related	2	2.9	0	0	
	Larceny	35	51.5	14	41.2	
	Public Order	9	13.2	1	2.9	
	Escapes/Viol. Orders	0	0	3	8.8	
Level	Misdemeanor	15	22.1	3	8.8	χ2=2.732
	Felony	53	77.9	31	91.2	*p*=.098

The analysis now turns to logistic regression. Logistic regression is used to control for multiple variables at the same time. This analysis is also necessary to inspect the impact of age and risk, as these variables differed across groups after CEM. Table 5.10 provides the results of three logistic regression models.[32] Model 1 evaluates the relationship between predictor variables and new arrests at 2 years, model 2 evaluates a new detention stay within 2 years, and model 3 evaluates a new adjudication within 2 years.

In model 1, no racial categories were statistically significant, implying that there were no differences between Black youths and White youths, or Black youths and youths with an unknown race, in their likelihood of being arrested within 2 years. This same finding was true for ethnicity. The variables of gender, age, risk level, and group status did demonstrate statistically significant relationships. Girls were less likely than boys to be rearrested within 2 years. The column labeled Exp(B) can be interpreted as an odds ratio. Thus, for gender, the odds ratio of .485 suggests that girls were 51.5 percent less likely than boys to be rearrested within 2 years.

The analysis also indicates that age was significantly and inversely related to rearrest; older youths were less likely to be rearrested than younger youths. Specifically, every increase of 1 year corresponded to a reduction in the odds of being arrested by 31.7 percent. Risk (as measured by the PrediCT) was also a significant predictor of rearrest. Specifically, Tier IV youths were 1.9 times more likely to be rearrested within 2 years compared with youths assessed as Tier III, and Tier V youths were 2.7 times more likely to be rearrested within 2 years compared with Tier III youths. After controlling for gender, race, ethnicity, age, and risk level, group status remained a statistically significant predictor of rearrest. Specifically, REGIONS youths were 3.5 times more likely to be rearrested than youths in the probation sample.

---

[32] Two cases were removed from the sample for logistic regression analysis. These cases (one from REGIONS and one from probation) were assessed as Tier II on the PrediCT. Since categorical variables in logistic regression compare one category with only one other category, having only two cases produces unstable estimates. Models that include the two cases did impact the results presented in Table 5.10.

Table 5.10. Logistic Regression on Three Outcome Measures

Variable	Model 1: Arrests				Model 2: Detentions				Model 3: Adjudications			
	B	S.E.	Sig.	Exp(B)	B	S.E.	Sig.	Exp(B)	B	S.E.	Sig.	Exp(B)
Female	-0.723	0.364	0.047	0.485*	-1.054	0.415	0.011	0.348*	-2.525	1.030	0.014	0.080*
Race (Black)												
White	-0.593	0.370	0.109	0.552	-1.012	0.354	0.004	0.363*	-1.003	0.404	0.013	0.367*
Unknown	-0.740	0.815	0.364	0.477	0.367	0.745	0.623	1.443	0.030	0.749	0.968	1.031
Ethnicity (not H/L)												
Hispanic/Latino	0.569	0.392	0.147	1.766	0.555	0.365	0.128	1.742	0.374	0.404	0.355	1.453
Unknown	0.234	0.500	0.639	1.264	0.742	0.423	0.079	2.101	0.456	0.400	0.255	1.578
Age	-0.381	0.128	0.003	0.683*	-0.746	0.124	0.001	0.474*	-0.519	0.127	0.001	0.595*
Risk (Tier III)												
Tier IV	0.643	0.326	0.048	1.902*	0.361	0.333	0.278	1.435	0.072	0.375	0.849	1.074
Tier V	0.995	0.427	0.020	2.705*	0.676	0.390	0.083	1.966	0.588	0.412	0.153	1.801
REGIONS	1.277	0.358	0.001	3.585*	1.105	0.280	0.001	3.019*	0.273	0.293	0.351	1.314

Model 2 uses the same independent predictors but evaluates their impact on a new detention stay within 2 years. Gender remains a statistically significant predictor, with girls having 65.2 percent reduced odds of experiencing a new detention stay within 2 years than boys. Ethnicity was unrelated to new detention stays, as was risk level. Youths whose race was unknown did not differ when compared with Black youths in their likelihood of a new detention stay, but White youths were statistically significantly less likely (reduced odds of 63.7 percent) than Black youths to have a new detention stay within 2 years.

As with model 1, age was a statistically significant negative predictor—each year a youth's odds of a new detention stay decreases by 31.7 percent. Interestingly, risk was not a significant predictor in this model. There were no statistically significant differences between Tier III and Tier IV or Tier III and Tier V youths in their odds of experiencing a new detention stay within 2 years. Finally, REGIONS youths were more likely than probationers to have a new detention stay. Specifically, REGIONS youths were three times as likely to have a new detention stay within 2 years. This finding was statistically significant.

Model 3 of Table 5.10 evaluates the relationship between predictor variables and new adjudications within 2 years. Ethnicity and risk did not demonstrate statistically significant relationships with new adjudications. Race was statistically significantly different between Black and White youths but not between Black and Unknown youths. White youths' odds of a new adjudication within 2 years were reduced by 63.3 percent compared with Black youths. Gender remained statistically significant, as girls' odds of a new adjudication were lowered by 92 percent. Age also remained in a statistically significant negative relationship with new adjudications. A 1-year increase in age was associated with a 40.5 percent reduction in the odds of a new adjudication. Finally—and of note—there was no statistically significant difference across groups. Specifically, REGIONS youths were not different from their matched probationers in the likelihood of a new adjudication.

We then conducted survival analyses. The purpose of these analyses is to inspect the time until the recidivism event occurred across groups in a way that is not limited in time (i.e., goes beyond the 2-year investigations above). The three figures below visually display the differences across time and group to recidivate. Figure 5.1 shows the hazard function from a Cox Regression time series analysis of new arrests. Hazard functions plot the different times to an event (recidivism) for all cases by group.

175

The hazard function provides insights into the likelihood of experiencing the event at different points in time. The decrease in lines over time reflects cases "falling out" or experiencing the event. The separation between the group lines denotes different hazard rates at different time points. As shown in Figure 5.1, REGIONS youths separate from probationers quickly and consistently for the entirety of the time series. This finding supports findings from the above bivariate and multivariate analyses.

A similar pattern is noted in Figure 5.2, which depicts the hazard function for new detention stays. Again, REGIONS youths are more likely to experience a new detention stay in a shorter period of time relative to probationers, which confirms the findings above. Finally, Figure 5.3 presents the hazard function for new adjudications. The lines depicting the cumulative hazard ratio for each group remain very close until around 200 days, and then slowly separate until roughly 350 days. After 350 days, the lines again come closer together before separating again around 600 days. This pattern of results shows little difference in the beginning and middle between the groups, a pattern similar to the above analyses.

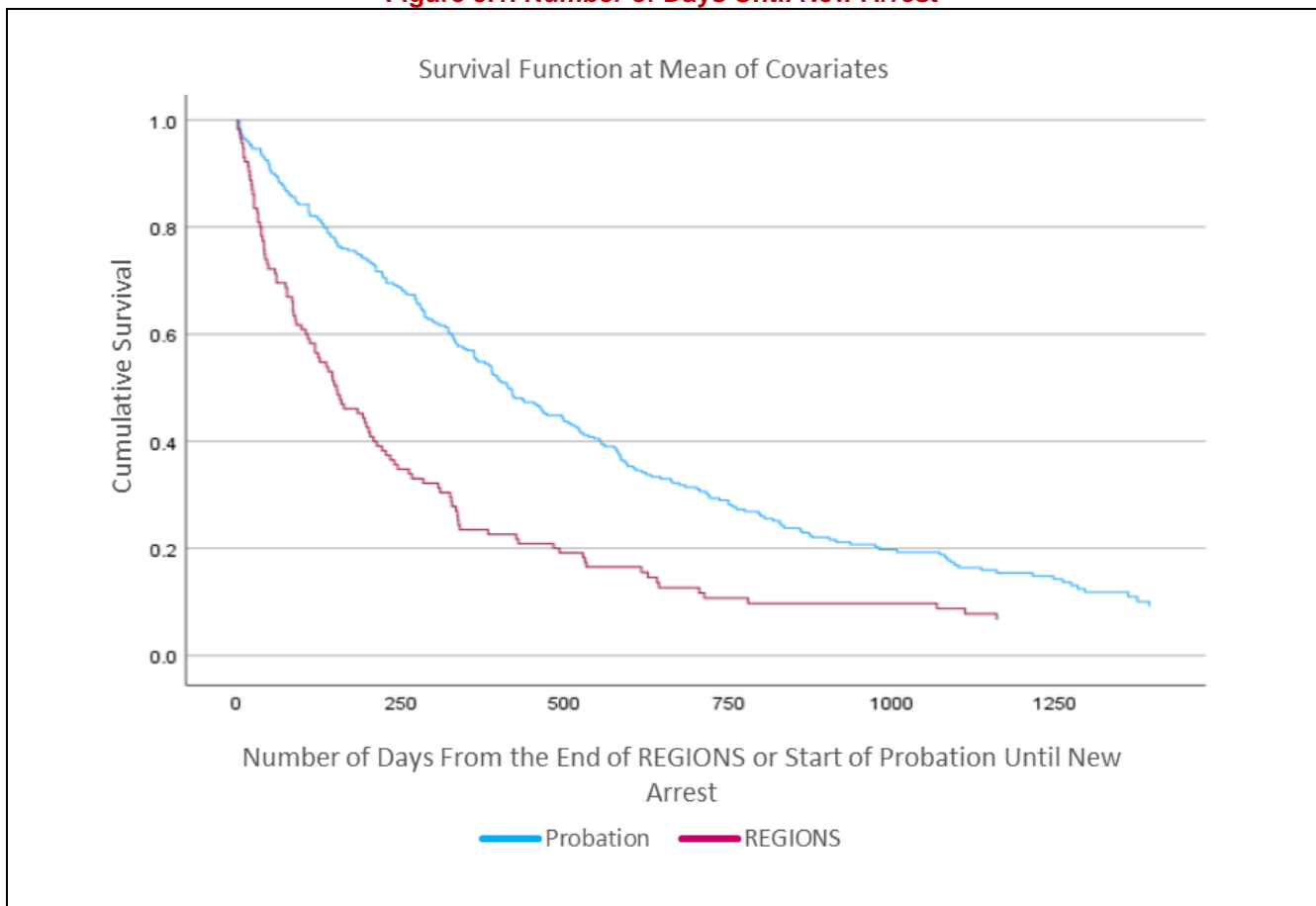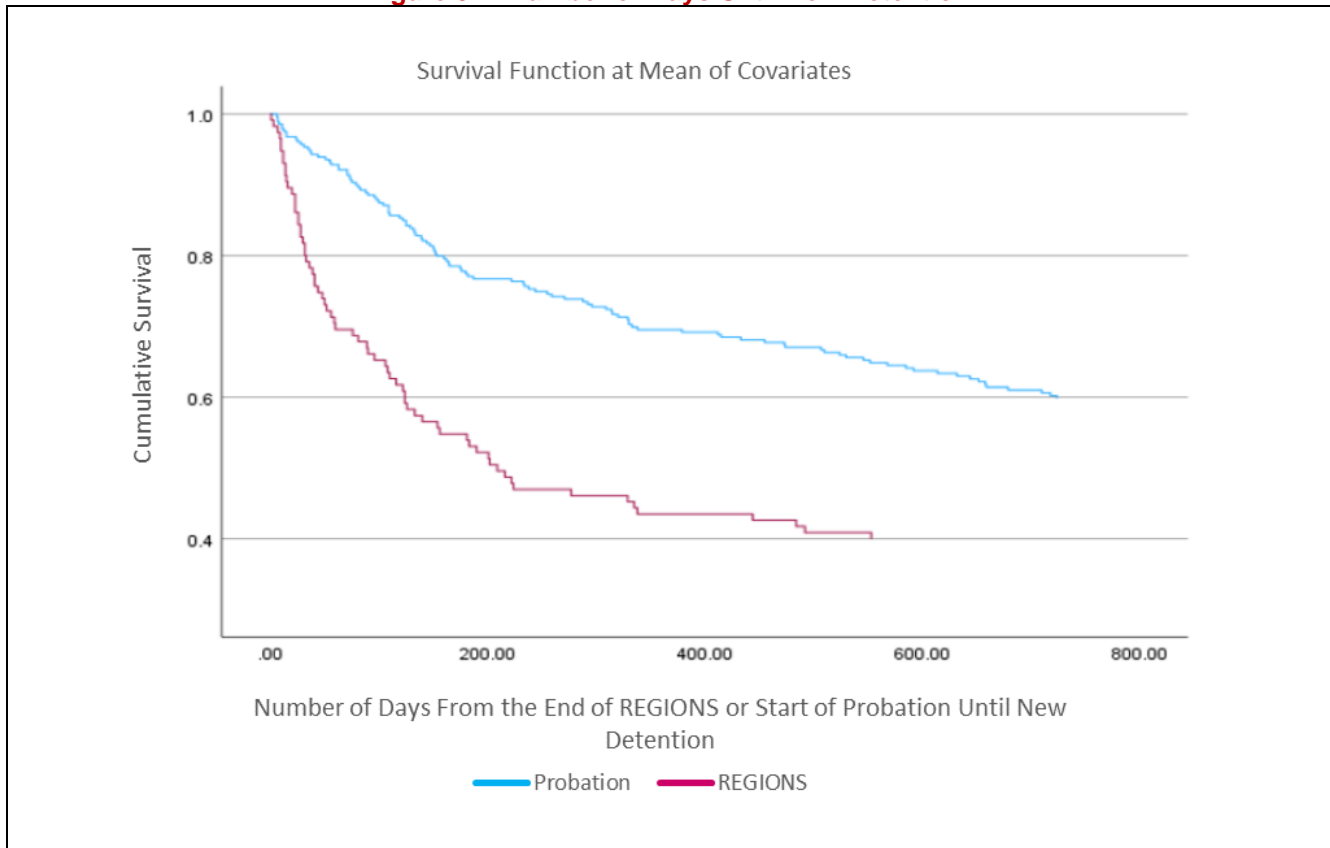**Figure 5.1. Number of Days Until New Arrest**

**Figure 5.2. Number of Days Until New Detention**

Discussion

Study Limitations. Outcome studies are useful for evaluating the impact a program has on an outcome of interest, but they are not without their limitations. First, although outcome studies can demonstrate the presence or absence of an impact, they will not reveal why the impact does or does not occur. Results suggested REGIONS youths were more likely to be rearrested and have a new detention stay within 2 years relative to a matched comparison of youths who were not in REGIONS. Results also showed that when evaluating the new adjudications within 2 years, there were no differences across groups. The outcome study is not able to elaborate beyond showing the presence or absence of differences. The detailed process evaluation can provide context for findings from the outcome evaluation.

Second, outcome studies are preferable when a program has reached a stable state of operation, as implementation and fidelity are critical issues that can impact the delivery of a program (Rossi, Lipsey, and Freeman, 2003). Said differently, outcome studies are preferable for programs that have reached some level of maturity. REGIONS is a relatively new program that was still being established when it was disrupted by the Covid–19 pandemic (i.e., implementation and components of training were delayed). Owing to the impact of Covid and the delays in training and implementation, this outcome evaluation took place during a time when REGIONS had not yet matured as a program.

Missing data is a third limitation of the outcome evaluation and was also noted as a limitation in the process evaluation. Missing data is a symptom of REGIONS establishing itself while data collection processes and management were changing during the evaluation time period. These changes impacted

Figure 5.3. Number of Days until New Adjudication
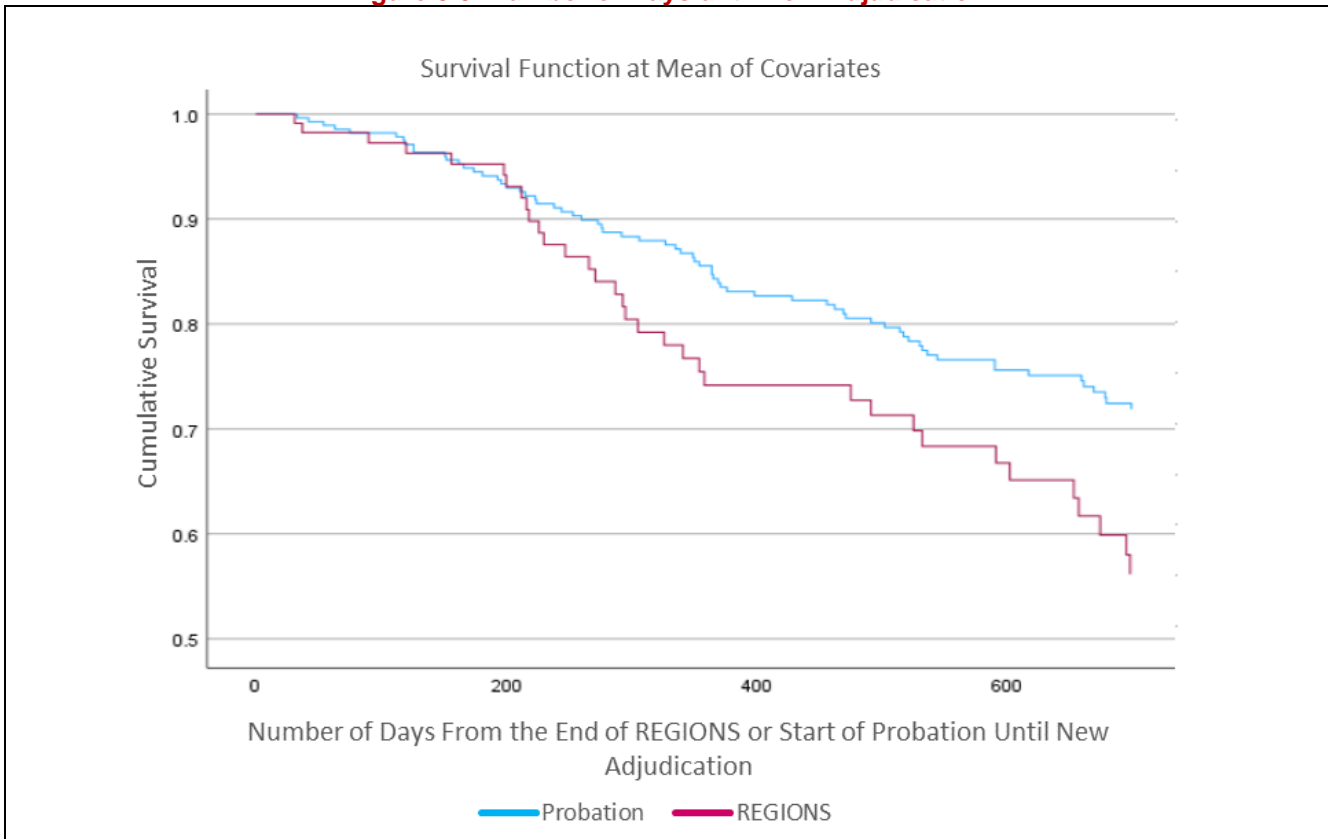
the evaluation study in two specific ways. First, only outcome data on recidivism were consistently available for both groups. It is possible that REGIONS is having impacts on other outcomes of interest (e.g., educational, vocational, home life); however, data were not consistently available across groups and thus could not be evaluated reliably. Second, a common limitation of outcome studies is the ability to control for unmeasured/unknown confounding variables (i.e., variables that exert an independent effect on the outcome of interest). Said differently, if variables are not measured and statistically controlled for, a study cannot fully understand their impact. The study was able to minimize this limitation through matching and logistic regression analyses; however, it is unknown if other variables impact the outcome that were not controlled for in the analyses.

As noted above, a matching process was used to develop the comparison group. Coarsened exact matching (CEM) was the process used. As previously discussed, a randomized controlled trial was not a viable option for the current study. Although exact matching on a case-to-case basis is preferable, it was not possible owing to the lack of probation cases available relative to the number of REGIONS cases. This limitation is a function of the program population. REGIONS is targeting the riskiest youths for treatment, and the remaining probation pool had fewer youths who were at high risk and of similar age. Therefore, despite the fact that the outcome study controlled for risk by means of matching and multivariate statistical analysis, the nature of the targeted REGIONS population needs to be taken into account when considering the findings of the outcome evaluation.

Findings. The outcome evaluation used CEM to match 279 youths on probation to 115 youths in REGIONS from 2018–2021. Examination of the matching process revealed that youths were successfully matched on gender, race, and ethnicity, but there were still significant differences in age and risk level across groups. As noted above, the differences are a reflection of the REGIONS targeted

178

population, as the REGIONS sample had more Tier V youths and older youths compared with probation youths. These two variables were further controlled in the multivariate logistic regression analyses.

New arrests, new detention stays, and new adjudications within 1 and 2 years were evaluated. Results demonstrated that REGIONS youths were significantly more likely to have a new arrest and new detention stay within 1 and 2 years. However, for the stricter measure of recidivism—new adjudications—there were no differences across groups. Thus, youths who are in REGIONS are not any more or less likely to have a new adjudication at 1 or 2 years. Examination of offense categories for new arrests found no differences between arrest categories across the two groups. Thus, even though REGIONS youths are more likely to be arrested, they are not more likely to be arrested for any specific offense category. Examination of offense categories for new detention stays revealed that probation youths were more likely to have a new detention stay within 2 years for robbery, assault, and larceny. Further, probationers were more likely than REGIONS youths to have a new detention stay for a felony. Taken together, these findings suggest that REGIONS youths are more likely to have a new detention stay, but this detention stay is more likely to be for a misdemeanor. Whereas probation youths are less likely to have a new detention stay than REGIONS youths, probation youths are more likely to have a felony stay for robbery, assault, and larceny. Examination of new adjudication data did not reveal any significant differences. Taken with the above findings, this lack of significant differences suggests that REGIONS youths are no more or less likely to have a new adjudication and that adjudication is not more serious than for probation youths.

Multivariate logistic regression models were created for the three outcomes of interest. Gender was a significant predictor across all three models, as girls were at reduced odds than boys of having a new arrest (51.5 percent reduction), a new detention stay (65.2 percent reduction), and a new adjudication (92 percent reduction). This finding is consistent with the extant literature. Race was not a significant predictor of rearrest but was significant for new detention and new adjudications. Specifically, White youths were at reduced odds compared with Black youths (63.7 percent and 63.3 percent, respectively). There were no significant differences between Black youths and youths whose race was unknown. Ethnicity was not a statistically meaningful variable for any of the models. Risk, however, was a significant predictor for rearrest but not for detention (although Tier V youths approached significance in the detention model) or adjudications. Tier IV youths were 1.9 times more likely than Tier III youths to experience a new arrest within 2 years, and Tier V youths were 2.7 times more likely than Tier III youths to have a new arrest within 2 years. As youths increase in age, they have reduced odds of being rearrested, having a new detention stay, and having a new adjudication. Finally, confirming bivariate findings, group status was a significant predictor across two models—REGIONS youths were more likely than probationers to have a new arrest and a new detention stay. REGIONS youths were not more or less likely than probationers to have a new adjudication.

As noted above, outcome evaluations focus on detecting a difference across treatment conditions and have limited ability to explain findings. Results of the outcome study suggest that the REGIONS program is not producing reductions in recidivism events. These findings are partially due to the nature of juvenile justice—the system limits its use of interventions so that only youths with serious offenses are placed in intensive programs like REGIONS, and youths with less serious offenses are placed on probation. While this practice is admirable and aligns with evidence-based practice recommendations, it creates difficulties for developing outcome studies. Therefore, recommendations to improve REGIONS programming should be drawn from the REGIONS process evaluation. For example, research on correctional programs illustrates the importance of treatment in creating long-term behavioral change and reducing recidivism. The reader is encouraged to review the process evaluation recommendations concerning increasing fidelity to evidence-based treatment practices.

References

Agudelo, Sandra Villalobos. 2013. *The Impact of Family Visitation on Incarcerated Youths' Behavior and School Performance*. Issue brief. New York N.Y.: Vera Institute of Justice.

Anderson, Valerie R.; Kayla M. Hoskins; and Laura L. Rubino. 2019. "Defining Gender-responsive Services in a Juvenile Court Setting." *Women & Criminal Justice* 29(6):338–354.

Andrews, Don A.; James Bonta; and Robert D. Hoge. 1990. "Classification for Effective Rehabilitation: Rediscovering Psychology." *Criminal Justice and Behavior* 17(1):19–52.

Andrews, Don A.; James Bonta; and J. Stephen Wormith. 2006. "The Research Past and Near Future of Risk and/or Need Assessment." *Crime and Delinquency* 52(5):7–27.

Andrews, Don A., and Craig Dowden. 1999. "A Meta-Analytic Investigation into Effective Correctional Intervention for Female Offenders." *Forum on Corrections Research* 11(2):18–21.

Archer, Robert P.; David E. Elkins; Richard W. Handel; Elise C. Simonds-Bisbee; and David R. Spiegel. 2010. Validity of the Massachusetts Youth Screening Instrument–2 (MAYSI–2) Scales in Juvenile Justice Settings. *Journal of Personality Assessment* 92(4):337–348.

Barnes–Lee, A.R. 2020. "Development of Protective Factors for Reducing Juvenile Reoffending: A Strengths-Based Approach to Risk Assessment." *Criminal Justice and Behavior* 47(11):1371–89.

Barnoski, R.P. 2002. *Washington State's Implementation of Functional Family Therapy for Juvenile Offenders: Preliminary Findings*. Washington State Institute for Public Policy.

Basto-Pereira, Miguel, and David P. Farrington. 2022. "Developmental Predictors of Offending and Persistence in Crime: A Systematic Review of Meta-analyses." *Aggression and Violent Behavior* 65(2):101761.

Beard, Jaden. 2023, January 27. "Staffing Crisis at Juvenile Justice Facilities: Low Retention Rates, Overcrowding." *Spartan Newsroom. Capital New Service.* Michigan State University School of Journalism.

Beltrani, Amanda. 2022, August 23. "Juvenile General Violence Risk Assessments. The Business of Practice." *Concept.* Palo Alto University. Retrieved on May 22, 2023, from https://concept.paloaltou.edu/resources/business-of-practice-blog/juvenile-general-violence-risk

Bishka A. 2010. Learning Styles Fray: Brilliant or Batty? *Performance Improvement* 49(10): 9–13.

Blomberg, Thomas G., William D. Bales, Richard A. Berk, Karen Mann, and Alex R. Piquero. 2011. "Incarceration, Education and Transition From Delinquency." *Journal of Criminal Justice* 39(4):355–365.

Bonta, James, and D.A. Andrews. 2007. "Risk–Need–Responsivity Model for Offender Assessment and Rehabilitation." *Rehabilitation* 6(1):1–22.

Borseth, Jenna L. 2021. "Needing More Guidance: Adherence to Offender Needs in Case Plan Objectives." *Corrections: Policy, Practice and Research*. In print: https://doi.org/10.1080/23774657.2021.2011804

Borseth, Jenna L.; Andrew J. Myer; and Matthew D. Makarios. 2021. "Superficial Adherence to EBP: An Example of Low Fidelity to the RNR Model Using a Halfway House." *Corrections: Policy, Practice and Research*. In print: https://doi.org/10.1080/23774657.2021.1886888

Bullis, Michael; Paul Yovanoff; Gina Mueller; and Emily Havel. 2002. "Life on the 'Outs'—Examination of the Facility-to-Community Transition of Incarcerated Youth." *Exceptional Children* 69(1):7–22.

Burrell, Joyce, and Jim Moeser. 2014. "Ch. 18 Transition Planning and Reentry." In *Desktop Guide to Quality Practice for Working with Youth in Confinement.* National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. https://info.nicic.gov/dtg/node/17

Caffrey, Jane. 2022, November 2. "New DCF Unit Working to Improve Educational for Kids in Juvenile Justice Facilities." *NBC Connecticut*. Accessed on June 12, 2023. https://www.nbcconnecticut.com/news/local/new-dcf-unit-working-to-improve-education-for-kids-in-juvenile-justice-facilities/2907068/

Caldwell, Roslyn M.; Noelle Lefforge; N. Clayton Silver; and Jenna Silverman. 2004. "Adjudicated Mexican American Adolescents: The Effects of Familial Emotional Support on Self-Esteem,

Emotional Well-being, and Delinquency." *The American Journal of Family Therapy* 32(1):55–69.

Cavendish, W. 2014. "Academic Attainment During Commitment and Postrelease Education-related Outcomes of Juvenile Justice-involved Youth with and Without Disabilities." *Journal of Emotional and Behavioral Disorders* 22(1):41–52.

Clark, Pam. 2014. "Ch. 4 Developing and Maintaining a Professional Workforce." In *Desktop Guide to Quality Practice for Working with Youth in Confinement.* National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. https://info.nicic.gov/dtg/node/12

Connecticut State Department of Education. July 2022. *Connecticut Juvenile Justice System Liaisons/Reentry Coordinators.* Hartford, Conn.

Cuevas, Joshua. 2015. "Is Learning Styles-Based Instruction Effective? A Comprehensive Analysis of Recent Research on Learning Styles." *Theory and Research in Education* 13(3):308–33.

Curry, Susan J.; Edward H. Wagner; and Louis C. Grothaus. 1991. "Evaluation of Intrinsic and Extrinsic Motivation Interventions with a Self-Help Smoking Cessation Program." *Journal of Consulting and Clinical Psychology* 59:318–24.

De Beuf, Tamara L. 2023. "Introducing the START: AV in Secure Youth Care: Illustration of a Structured Risk Assessment Implementation Process." *International Journal of Forensic Mental Health* 1–17.

De Beuf, Tamara L.F.; Vivienne de Vogel; and Corine de Ruiter. 2020. "Adherence to Structured Risk Assessment Guidelines: Development and Preliminary Evaluation of an Adherence Scale for the START: AV." *Journal of Forensic Psychology Research and Practice* 20(5):413–435.

Deci, Edward L., and Richard M. Ryan. 1985. "Cognitive Evaluation Theory." In *Intrinsic Motivation and Self-Determination in Human Behavior.* Boston, Mass.: Springer.

Dedel, Kelly. 2014. "Ch. 17 Quality Assurance." In *Desktop Guide to Quality Practice for Working with Youth in Confinement.* National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. https://info.nicic.gov/dtg/node/5

Desmarais, Sarah L.; Brian G. Sellers; Jodi L. Viljoen; Keith R. Cruise; Tonia L. Nicholls; and Joel A. Dvoskin. 2012. "Pilot Implementation and Preliminary Evaluation of START: AV Assessments in Secure Juvenile Correctional Facilities." *International Journal of Forensic Mental Health* 11(3):150–164.

Development Services Group, Inc. 2014. "Disproportionate Minority Contact." In *The Model Programs Guide.* Literature review. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention. https://www.ojjdp.gov/mpg/litreviews/Disproportionate_Minority_Contact.pdf

[DSG]. Development Services Group, Inc. 2015. "Protective Factors for Delinquency." In *The Model Programs Guide.* Literature review. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention. https://www.ojjdp.gov/mpg/litreviews/Protective%20Factors.pdf

[DSG]. Development Services Group, Inc. 2017. "Juvenile Reentry." In *The Model Programs Guide.* Literature review. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention. https://www.ojjdp.gov/mpg/litreviews/Aftercare.pdf

[DSG]. Development Services Group, Inc. 2018. "Family Engagement in Juvenile Justice." In *The Model Programs Guide.* Literature review. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention. https://www.ojjdp.gov/mpg/litreviews/FamilyEngagement-in-Juvenile-Justice.pdf

[DSG]. Development Services Group, Inc. 2019a. "Education for Youth Under Formal Supervision of the Juvenile Justice System." In *The Model Programs Guide.* Literature review. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention. https://www.ojjdp.gov/mpg/litreviews/Education-for-Youth-in-the-Juvenile-Justice-System.pdf

[DSG]. Development Services Group, Inc. 2019b. "Juvenile Residential Programs." In *The Model Programs Guide.* Literature review. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention. https://www.ojjdp.gov/mpg/litreviews/Residential.pdf

DiClemente, Carlo C.; Lori E. Bellino; and Tara M. Neavins. 1999. "Motivation for Change and Alcoholism Treatment." *Alcohol Research and Health* 23:86–92.

Dowden, Craig, and D.A. Andrews. 2004. "The Importance of Staff Practice in Delivering Effective

Correctional Treatment: A Meta-Analytic Review of Core Correctional Practice." *International Journal of Offender Therapy and Comparative Criminology* 48(2):203–14.

Duriez, Stephanie A.; Carrie Sullivan; Edward J. Latessa; and Lori Bursman Lovins. 2017. "The Evolution of Correctional Program Assessment in the Age of Evidence-Based Practices." *Corrections: Policy, Practice, and Research* 3(2):1–18.

Evans-Chase, Michelle. 2013. "Internet-based Mindfulness Meditation and Self-regulation: A Randomized Trial with Juvenile Justice-Involved Youth." *Journal of Juvenile Justice* 3(1):63–79.

Farabee, David, Michael Prendergast, Jerome Cartier, Harry Wexler, Kevin Knight, and M. Douglas Anglin. 1999. "Barriers to Implementing Effective Correctional Drug Treatment Programs." *Prison Journal* 79(2):150–62.

Farn, Amber, and Jill Adams. 2016. *Education and Interagency Collaboration: A Lifeline for Justice Involved Youth*. Washington, DC: Center for Juvenile Justice Reform, Georgetown University McCourt School of Public Policy.

Farringer, Alison J.; Stephanie A. Duriez; Sarah M. Manchak; and Carrie C. Sullivan. 2021. "Adherence to 'What Works:' Examining Trends Across 14 Years of Correctional Program Assessment." *Corrections: Policy, Practice, and Research* 6(4):269–87.

Farrington, Davip P., and Brandon Welsh. 2003. "Family-based Prevention of Offending: A Meta-analysis." *The Australian and New Zealand Journal of Criminology* 36(2):127–151.

Fritzon, Katarina; Sarah Miller; Danielle Bargh; Kerrilee Hollows; Allana Osborne; and Anna Howlett. 2021. "Understanding the Relationships Between Trauma and Criminogenic Risk Using the Risk–Need–Responsivity Model." *Journal of Aggression, Maltreatment, and Trauma* 30(3):294–323.

Foley, R.M. 2001. "Academic Characteristics of Incarcerated Youth and Correctional Education Programs." *Journal of Emotional and Behavioral Disorders* 9(4):248–259.

Fox, Andrew M.; Dlan Miksicek; Sarah Veele; and Beth Rogers. 2020. "An Evaluation of Dialectical Behavior Therapy for Juveniles in Secure Residential Facilities." *Journal of Offender Rehabilitation*, 59(8):478–502.

Gagnon, J.C., and Barber, B. 2010. "Characteristics of and Services Provided to Youth in Secure Care Facilities." *Behavioral Disorders* 36(1):7–19.

Garcia, C.A., and Lane, J. 2010. "Looking in the Rearview Mirror: What Incarcerated Women Think Girls Need from the System." *Feminist Criminology* 5:227–243.

Gendreau, Paul. 1996. "The Principles of Effective Interventions with Offenders." In A.T. Harland (ed.). *Choosing Correctional Options that Work: Defining the Demand and Evaluating the Supply.* Washington, D.C.: Sage.

Gendreau, Paul, and D.A. Andrews. 1994. *The Correctional Program Assessment Inventory*. St. John, New Brunswick: University of New Brunswick and Carleton University.

Gendreau, Paul; Claire Goggin; and Paula Smith. 1999. "The Forgotten Issue in Effective Correctional Treatment: Program Implementation." *International Journal of Offender Therapy and Comparative Criminology* 43(2):180–87.

Gibson, Polly Y.; Prachi Agarwala; Kiel J. Opperman; Adam Horwitz; and Cheryl A. King. 2016. "Columbia-Suicide Severity Rating Scale: Predictive Validity with Adolescent Psychiatric Emergency Patients." *Pediatric Emergency Care* 31(2):88–94.

Gogus A, and Gunes H. 2011. "Learning Styles and Effective Learning Habits of University Students: A Case from Turkey." *College Student Journal* 45(3):586–600.

Goodkind, Sara. 2005. "Gender-Specific Services in the Juvenile Justice System: A Critical Examination." *Affilia* 20(1):52–70.

Grasso, Damion J.; Julia W. Felton; and Kathryn Reid-Quiñones. 2015. "The Structured Trauma-related Experiences and Symptoms Screener (STRESS) Development and Preliminary Psychometrics." *Child Maltreatment* 20(3):214–220.

Griffis, Nelson, and Jennifer Sloan. 2014. "Ch. 15 Service and Treatment Plans." in *Desktop Guide to Quality Practice for Working with Youth in Confinement.* National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. https://info.nicic.gov/dtg/node/20

Haktanir, Abdulkadir, and Karisse A. Calleder. 2020. "Meta-analysis of Dialectical Behavior Therapy (DBT) for Treating Substance Use." *Research on Education and Psychology*, 4(Special Issue):74–87.

Hannah–Moffat, Kelly. 2005. "Criminogenic Needs and the Transformative Risk Subject." *Punishment and Society* 7(1):29–51.

Himelstein, Sam; Arthur Hastings; Shauna Shapiro; and Myrtle Heery. 2012. "Mindfulness Training for Self-regulation and Stress with Incarcerated Youth: A Pilot Study." *Probation Journal* 59(2):151–165.

Hoeve, Machteld; Judith Semon Dubas; Veroni I. Eichelsheim; Peter H. van der Laan; Wilma Smeenk; and Jan R. M. Gerris. 2009. "The Relationship Between Parenting and Delinquency: A Meta-analysis." *Journal of Abnormal Child Psychology* 37(6): 749–75.

Holman, Barry, and Jason Ziedenberg. 2006. *The Dangers of Detention*. Washington, DC: Justice Policy Institute.

Jobapscloud.com. 2023. "Pupil Services Specialist (12 Month) (35 Hour)." Job posting. Annapolis, Maryland. https://www.jobapscloud.com/CT/sup/bulpreview.asp?R1=230120&R2=6659T4&R3=001, February 9.

Joe, George W.; Danica Kalling Knight; Jennifer E. Becan; and Patrick M. Flynn. 2014. "Recovery Among Adolescents: Models for Posttreatment Gains in Drug Abuse Treatments." *Journal of Substance Abuse Treatment* 46:362–73.

Kentucky Tonight. 2023, January 23. "Kentucky's Juvenile Justice System." https://ket.org/program/kentucky-tonight/kentuckys-juvenile-justice-system/

Klodnick, Vanessa V.; Brenda Kissane; Rebecca P. Johnson; Candy Malina; Allison Ewing; and Marc A. Fagan. "Adapting Dialectical Behavior Therapy for Young Adults Diagnosed with Serious Mental Health Conditions in Residential Care: A Feasibility Study." *Residential Treatment for Children and Youth* 38(3):269–288.

Knight, Danica K.; George W. Joe; Jennifer E. Becan; Rachel D. Crawley; Sarah E. Theisen; and Patrick M. Flynn. 2019. "Effectiveness of an Intervention for Improving Intrinsic Motivation Among Adolescent Males in a Secure Substance Use Treatment Setting." *Criminal Justice and Behavior* 46(1):101–14.

Knight, John R.; Lon Sherritt; Lydia A. Shrier; Sion Kim Harris; and Grace Chang. 2002. "Validity of the CRAFFT Substance Abuse Screening Test Among Adolescent Clinic Patients." *Archives of Pediatrics & Adolescent Medicine* 156(6)607–614.

Kolb, David A. 1984. *Experiential Learning*. Englewood Cliffs, NJ: Prentice Hall.

Kolb, David A. 1985. *Learning Style Inventory*, *revised ed.* Boston, MA: Hay Group, Hay Resources Direct.

Kruh, Ivan; Kathleen Kemp; and Cynthia Palmisano. 2021. "Clinical Coordinator REGIONS Evaluation Reports: Continuous Quality Improvement Audits Final Report—2020–2021."

Kruh, Ivan; Kathleen Kemp; and Cynthia Palmisano. 2022. "Clinical Coordinator PWP Evaluation Reports: Continuous Quality Improvement Audits, FINAL REPORT–2021-22."

Kubek, Julia Behen; Carly Tindall-Biggins; Kelsie Reed; Lauren E. Carr; and Pamela A. Fenning. 2020. "A Systematic Literature Review of School Reentry Practices Among Youth Impacted by Juvenile Justice." *Children and Youth Services Review* 110: 104773.

Latessa, Edward J.; Shelley J. Listwan; and Deborah Koetzle. 2015. *What Works (and Doesn't) in Reducing Recidivism*. New York, N.Y.: Routledge.

Legault, Lisa. 2016. "Intrinsic and Extrinsic Motivation." *Encyclopedia of Personality and Individual Differences.*

Liddell, Wayne, and Pam Clark. 2014. "Ch. 10 Effective Programs and Services." In *Desktop Guide to Quality Practice for Working with Youth in Confinement.* National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. https://info.nicic.gov/dtg/node/16

Linehan, Marsha M., and Chelsey R. Wilks. 2015. "The Course and Evolution of Dialectical Behavior

Therapy." *The American Journal of Psychotherapy* 69(2):97–110.

Lipsey, Mark W. 1992. "Juvenile Delinquency Treatment: A Meta-Analytic Inquiry into the Variable of Effects." In T.D. Cook, H. Cooper, D.S. Corday, H. Hartmann, L.V. Hedges, and R.J. Light (eds.). *Meta-Analysis for Explanation: A Casebook.* New York, N.Y.: Russell Sage.

Lipsey, Mark W. 1999a. "Can Intervention Rehabilitate Serious Delinquents?" *Annals of the American Academy of Political and Social Science* 564(1):142–66.

Lipsey, Mark W. 1999b. "Can Rehabilitative Programs Reduce the Recidivism of Juvenile Offenders? An Inquiry into the Effectiveness of Practical Programs." *Virginia Journal of Social Policy and the Law* 6:611–641.

Lipsey, Mark W., James C. Howell, Marion R. Kelly, G. Chapman, and Darin Carver. 2010. *Improving the Effectiveness of Juvenile Justice Programs*. Washington D.C.: Center for Juvenile Justice Reform at Georgetown University.

Livengood, Pual, and Matt Howerton. 2022, July 8. "Texas Juvenile Detention Facilities Halting Youth Intake due to 'Critical Staffing Shortage.'"

Loeffker-Cobia, Jenniger; Teri Deal; and Anne Rackow. 2012. Continuous Quality Improvement Guide for Juvenile Justice Organizations. Pittsburgh, PA.

Loughran, T.A.; Mulvey, E.P.; Schubert, C.A.; Fagan, J.; Piquero, A.R.; and Losoya, S. H. 2009. "Estimating a Dose-response Relationship Between Length of Stay and Future Recidivism in Serious Juvenile Offenders." *Criminology* 47(3):699–740.

Lovett, Kim Godfrey, and Brian O'Neal. 2020. *Family Data Snapshot.* Braintree, Mass.: PbS Learning Institute.

Lowenkamp, Christopher T., and Edward J. Latessa. 2002. "*Evaluation of Ohio's Community-based Correctional Facilities and Halfway House Programs: Final Report.*" Cincinnati, OH: University of Cincinnati, Center for Criminal Justice Research, Division of Criminal Justice.

Lowenkamp, Christopher T., and Edward J. Latessa. 2004. "Understanding the Risk Principle: How and Why Correctional Interventions Can Harm Low-Risk Offenders." *Topics in Community Corrections* 3–8.

Lowenkamp, Christopher T., and Edward J. Latessa. 2005. "*Evaluation of Ohio's RECLAIM funded Programs, Community Corrections Facilities, and DYS Facilities.*" Cincinnati, OH: University of Cincinnati, Center for Criminal Justice Research, Division of Criminal Justice.

Lowenkamp, Christopher T.; Edward J. Latessa; and Paula Smith. 2006. "Does Correctional Program Quality Really Matter? The Impact of Adhering to the Principles of Effective Intervention." *Federal Probation* 5(3):201–20.

Lyons, Kelan. 2022. "Staffing Shortages at North Carolina Juvenile Detention Centers: So Bad That, 'If You Show Up to Work Today, You Get a Bonus.'" Raleigh, North Carolina. https://ncnewsline.com/2022/12/14/staffing-shortages-at-ncs-juvenile-detention-centers-reaches-crisis-levels/, December 14.

Magura, Stephen; Graham Staines; Nicole Kosanke; Andrew Rosenblum; Jeffrey Foote; Alexander DeLuca; and Priti Bali. 2003. "Predictive Validity of the ASAM Patient Placement Criteria for Naturalistically Matched Versus Mismatched Alcoholism Patients." *American Journal of Addictions* 12(5):386–97.

Makarios, Matthew D.; Lori Lovins; Edward J. Latessa; and Paula Smith. 2016. "Staff Quality and Treatment Effectiveness: An Examination of the Relationship Between Staff Factors and the Effectiveness of Correctional Programs." *Justice Quarterly* 33(2):348–67.

Makarios, Matthew D.; Kimberly Gentry Sperber; and Edward J. Latessa. 2014. "Treatment Dosage and the Risk Principle: An Extension and Refinement." *Journal of Offender Rehabilitation* 53(5):334–350.

Maldonado, Ana I., and Christopher M. Murphy. 2021. "Readiness to Change as a Predictor of Treatment Engagement and Outcome for Partner Violent Men." *Journal of Interpersonal Violence* 36(7/8):3041–64.

Mathur, Sarup R.; Heather Griller Clark; Rebecca I. Hartzell; Leslie LaCroix; and Terrence S. McTier Jr.

2020. "What Youth with Special Needs in Juvenile Justice say About Reentry: Listening to Their Voice." *Youth & Society* 52(8):1501–1522.

McDonald, Brendan R., and Robert D. Morgan. 2013. "Enhancing Homework Compliance in Correctional Psychotherapy." *Criminal Justice and Behavior* 40(7):814–28.

Mikytuck, Alyssa, and Jennifer Woolard. 2020. *Increased Family Visitation Leads to Fewer Incidents and Less Staff Fear.* Research Brief. Braintree, Mass.: PbS Learning Institute.

Mikytuck, Alyssa; Jennifer L. Woolard; and Michael Umpierre. 2019. "Improving Engagement, Empowerment, and Support in Juvenile Corrections through Research. *Translational Issues in Psychological Services* 5(2):182–192.

Miller, Rudy. 2022, July 21. "Controversy Over Staffing Crisis at Northampton County Juvenile Justice Center." https://www.lehighvalleylive.com/news/2022/07/controversy-over-staffing-crisis-at-northampton-county-juvenile-justice-center.html

Monahan, Kathryn C.; Asha Goldweber; and Elizabeth Cauffman. 2011. "The Effects of Visitation on Incarcerated Juvenile Offenders: How Contact with the Outside Impacts Adjustment on the Inside." *Law and Human Behavior* 35(2):143–51.

Morgan, Robert D., and David B. Flora. 2002. "Group Psychotherapy with Incarcerated Offenders: A Research Synthesis." *Group Dynamics: Theory, Research, and Practice* 6(3):203–18.

Mulvey, Edward P., and Anne-Marie R. Iselin. 2008. "Improving Professional Judgments of Risk and Amenability in Juvenile Justice." *The Future of Children/Center for the Future of Children, the David and Lucile Packard Foundation* 18(2):35–57.

National Research Council. 2013. *Reforming Juvenile Justice: A Developmental Approach.* Washington, D.C.: The National Academies Press.

Nicotera, Nicole, and Erica Viggiano. 2021. "A Pilot Study of a Trauma-Informed Yoga and Mindfulness Intervention With Young Women Incarcerated in the Juvenile Justice System." *Journal of Addictions & Offender Counseling* 42(2):80–96.

Norman, Rosana E.; Munkhtsetseg Byambaa; Rumna De, Alexander Butchart; James Scott; and Theo Vos. 2012. "The Long-Term Health Consequences of Child Physical Abuse, Emotional Abuse, and Neglect: A Systematic Review and Meta-Analysis." *PLOS Medicine* 9(11): e1001349

Noorman, Kaylee and Julie Brancale. 2023. "Barriers to School Reentry: Perceptions of School Reentry Among Detained and Committed Youth." *Youth Violence and Juvenile Justice* 21(3), 175-194.

O'brien, Mary, and Peter Watson. 2002. *A Framework for Quality Assurance in Child Welfare.* Portland, Maine: National Child Welfare Resource Center for Organizational Improvement.

Osher, Trina W.; Barbara Huff; Greta D. Colombi; and M. Amelga. 2012. *Facility Toolkit for Engaging Families in Their Child's Education at a Juvenile Justice Facility.* Washington, D.C.: National Evaluation and Technical Assistance Center for the Education of Children and Youth Who Are Neglected, Delinquent, or At Risk.

Osher, Trina W., and Pat Hunt. 2002. Involving Families of Youth Who Are in Contact with the Juvenile Justice System. Research Brief. New York: N.Y.: National Center for Mental Health and Juvenile Justice.

Panos, Patrick T.; John W. Jackson; Omar Hasan; and Angelea Panos. 2014. "Meta-analysis and Systematic Review Assessing the Efficacy of Dialectical Behavior Therapy (DBT)." *Research on Social Work Practice*, 24(2): 213-223.

Pashler, Harold; Mark McDaniel; Doug Rohrer, and Robert Bjork. 2008. "Learning Styles: Concepts and Evidence." *Psychological Science in the Public Interest* 9(3):105–119.

Pennell, Joan; Carol Shapiro; and Carol Spigner. 2011. *Safety, Fairness, Stability: Repositioning Juvenile Justice and Child Welfare to Engage Families and Communities.* Washington, D.C.: Georgetown University Center for Juvenile Justice Reform.

Person, Elise. 2023, March 13. "A Staffing Shortage in PA Juvenile Justice System is Creating a Public Safety Crisis." https://local21news.com/news/facing-the-future/a-staffing-shortage-in-pa-juvenile-justice-system-is-creating-a-public-safety-crisis

Platt, John S.; Paul D. Bohac; and Wanda Wade. 2015. "The Challenges in Providing Needed Transition

Programming to Juvenile Offenders." *Journal of Correctional Education* 66(1): 4–20.

Puzzanchera, Charles; Anthony Sladky; and Wei Kang. 2020. "Easy Access to Juvenile Populations: 1990–2019." Online: https://www.ojjdp.gov/ojstatbb/ezapop/

Puzzanchera, Charles. 2021, May. Juvenile arrests, 2019. *Juvenile Justice Statistics.* Bulletin. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

Puzzanchera, Charles, and Sarah Hockenberry. 2013. *National Disproportionate Minority Contact Daok.* Washington, D.C.: National Center for Juvenile Justice, Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice. http://www.ojjdp.gov/ojstatbb/dmcdb/

Reed, Lauren; Jill Sharkey; and Althea Wroblewski. 2021. "Elevating the Voices of Girls in Custody for Improved Treatment and Systemic Change in the Juvenile Justice System." *American Journal of Community Psychology* 67:50–63.

Riener C., and D. Willingham. 2010. "The Myth of Learning Styles." *Change* 42(5):32–35.

Roest, J.J.; G.H.P. Van der Helm; and G.J.J.M. Stams. 2016. "The Relation Between Therapeutic Alliance and Treatment Motivation in Residential Youth Care: A Cross-Lagged Panel Analysis." *Child and Adolescent Social Work Journal* 33(5):455–68.

Rollnick, Stephen; Nick Heather; and Alison Bell. 1992. "Negotiating Behaviour Change in Medical Settings: The Development of Brief Motivational Interviewing." *Journal of Mental Health* 1(1):25–37.

Rossi, Peter H.; Mark W. Lipsey; and Howard E. Freeman. 2003. *Evaluation: A Systematic Approach, 7th Ed.* Thousand Oaks, CA: Sage.

Salary.com. 2022. "Case and Education Coordinator | REGIONS." Job posting. Waltham, Massachusetts. https://www.salary.com/job/boys-and-girls-village-inc/case-and-education-coordinator-regions/j202208030526223241831, September 26.

Schwalbe, Craig S., and Maschi, Tina. 2010. "Patterns of Contact and Cooperation Between Juvenile Probation Officers and Parents of Youthful Offenders." *Journal of Offender Rehabilitation* 49(6): 398-416.

Sedlak, A.J., and Bruce, C. 2010. Youth's Characteristics and Backgrounds: Findings from the Survey of Youth in Residential Placement. *OJJDP's Juvenile Justice Bulletin*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Sedlak, A.J., and McPherson, K.S. 2010. Youth's Needs and Services: Findings from the Survey of Youth in Residential Placement. *OJJDP's Juvenile Justice Bulletin*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Shanahan, Ryan, and Margaret diZerega. 2016. *Identifying, Engaging, and Empowering Families: A Charge for Juvenile Justice Agencies.* Washington, D.C.: Center for Juvenile Justice Reform, McCourt School of Public Policy, Georgetown University.

Shanahan, Ryan, and Sandra Villalobos Agudelo. 2012. *Families and Partners: Supporting Incarcerated Youth in Ohio.* Research Brief. New York N.Y.: Vera Institute of Justice.

Sickmund, Melissa; Anthony Sladky; Charles Puzzanchera; and Wei Kang. 2021. *Easy Access to the Census of Juveniles in Residential Placement.* Online. Available: https://www.ojjdp.gov/ojstatbb/ezacjrp/

Sickmund, Melissa, Anthony Sladky, and Wei Kang. 2021. *Easy Access to Juvenile Court Statistics: 1985–2019.* Online: https://www.ojjdp.gov/ojstatbb/ezajcs/

Singh, Jay P.; Sarah L. Desmarais; Brian G. Sellers; Tatiana Hylton; Melissa Tirotti; and Richard A. Van Dorn. 2014. "From Risk Assessment to Risk Management: Matching Interventions to Adolescent Offenders' Strengths and Vulnerabilities." *Children and Youth Services Review* 47:1–9.

Smith, Paula, and Myrinda Schweitzer. 2012. "The Therapeutic Prison." *Journal of Contemporary Criminal Justice* 28(1):7–22.

Sperber, Kimberly Gentry, and Christopher T. Lowenkamp. 2017. "Dosage Is More Than Just Counting Program Hours: The Importance of Role-Playing in Treatment Outcomes." *Journal of Offender Rehabilitation* 56(7):433–51.

186

Sperber, Kimberly Gentry; Edward J. Latessa; and Matthew D. Makarios. 2013a. "Establishing a Risk-Dosage Research Agenda: Implications for Policy and Practice." *Justice Research and Policy* 15(1):123–41.

Sperber, Kimberly Gentry; Edward J. Latessa; and Matthew D. Makarios. 2013b. "Examining the Interaction between Level of Risk and Dosage of Treatment." *Criminal Justice and Behavior* 40(3):338–48.

Spinney, Elizabeth; Marcia Cohen; William Feyerherm; Rachel Stephenson; Martha Yeide; and Tayler Shreve. 2018. "Disproportionate Minority Contact in the US Juvenile Justice System: A Review of the DMC Literature, 2001–2014, Part I." *Journal of Crime and Justice* 41(5):573–95.

Stallvik, Marianne; David R. Gastriend; and Hans M. Nordahl. 2015. "Matching Patients with Substance Use Disorder to Optimal Level of Care with the ASAM Criteria Software." *Journal of Substance Use* 20(6):389–98.

Stice, Eric; Jennifer Ragan; and Patrick Randall. 2004. "Prospective Relations Between Social Support and Depression: Differential Direction of Effects for Parent and Peer Support?" *Journal of Abnormal Psychology* 113(1):155.

Swift, Tim. 2022, September 27. "Report: Low Staffing at City Juvenile Jail has led to 'Dangerous,' 'Chaotic' Conditions. https://foxbaltimore.com/news/local/report-low-staffing-at-baltimore-juvenile-jail-has-led-dangerous-chaotic-conditions

Tab, Kip. 2022, December, 30. "Serious Staffing Shortages Plague Juvenile Justice." *The Outer Banks Voice*. Retrieved from https://www.outerbanksvoice.com/2022/12/30/serious-staffing-shortages-plague-juvenile-justice/

Taylor, C.J. 2016. "The Family's Role in the Reintegration of Formerly Incarcerated Individuals: The Direct Effects of Emotional Support." *The Prison Journal* 79(3):331–354.

Taxman, Faye S. 2014. "Second Generation of RNR: The Importance of Systemic Responsivity in Expanding Core Principles of Responsivity." *Federal Probation*, 78(2):79–91.

The Council of State Governments Justice Center. 2023. *Creative Solutions and Opportunities to Address the National Juvenile Justice System Staffing Crisis*. Webinar. https://www.youtube.com/watch?v=DzmV1ytwarA

Tomlinson, Monica F. 2018. "A Theoretical and Empirical Review of Dialectical Behavior Therapy Within Forensic Psychiatric and Correctional Settings Worldwide." *International Journal of Forensic Mental Health* 17(1):72–95.

Van Binsbergen, M.H. 2003. *Treatment Motivation in a Dutch Youth Prison (Du)*. Antwerpen/ Apeldoorn, Belgium: Garant.

Van der Helm, G.H.P.; I.B. Wissink; T. De Jongh; and G.J.J.M. Stams. 2013. "Measuring Treatment Motivation in Secure Juvenile Facilities." *International Journal of Offender Therapy and Comparative Criminology* 57(8):996–1008.

Van der Helm, Peer; Lotte Beunk, Geert–Jan Stams; and Peter van der Laan. 2014. "The Relationship Between Detention Length, Living Group Climate, Coping, and Treatment Motivation Among Juvenile Delinquents in a Youth Correctional Facility." *Prison Journal* 94(2):260–75.

Van der Stouwe, Trudy; Jessica J. Asscher; Machteld Hoeve; Peter H. van der Laan; and Geert Jan JM Stams. 2018. "The Influence of Treatment Motivation on Outcomes of Social Skills Training for Juvenile Delinquents." *International Journal of Offender Therapy and Comparative Criminology* 62(1):108–28.

Vanderbilt–Adriance, Ella, and Daniel Shaw. 2008. "Protective Factors and the Development of Resilience in the Context of Neighborhood Disadvantage." *Journal of Abnormal Child Psychology* 36(6):887–901.

Viljoen, Jodi L.; Melissa R. Jonnson; Dana M. Cochrane; Lee M. Vargen; and Gina M. Vincent. 2019. "Impact of Risk Assessment Instruments on Rates of Pretrial Detention, Postconviction Placements, and Release: A Systematic Review and Meta-Analysis." *Law and Human Behavior* 43(5):397–420.

Viljoen, Jodi L.; Jennifer L. Beneteau; Erik Gulbransen; Etta Brodersen; Sarah L. Desmarais; Tonia L. Nicholls; and Keith R. Cruise. 2012a. "Assessment of Multiple Risk Outcomes, Strengths, and

Change With the START: AV: A Short-Term Prospective Study With Adolescent Offenders." *International Journal of Forensic Mental Health* 11(3):165–180.

Viljoen, Jodi L.; Keith R. Cruise; Tonia L. Nicholls; Sarah L. Desmarais; and Christopher D. Webster. 2012b. "Taking Stock and Taking Steps: The Case for an Adolescent Version of the Short-term Assessment of Risk and Treatability." *International Journal of Forensic Mental Health* 11(3):135–149.

Vincent, Gina M.; John Chapman; and Nathan E. Cook. 2011. "Risk-needs Assessment in Juvenile Justice: Predictive Validity of the SAVRY, Racial Differences, and the Contribution of Needs Factors." *Criminal Justice and Behavior* 38(1):42–62.

Vincent, Gina M.; Laura S. Guy; and Thomas Grisso. 2012. *Risk Assessment in Juvenile Justice: A Guidebook for Implementation.* New York, N.Y.: Models for Change.
http://modelsforchange.net/publications/346

Wallace, Paige. 2012. "Juvenile Justice and Education: Identifying Leverage Points and Recommending Reform for Reentry in Washington, DC." *Georgetown Journal on Poverty Law & Policy* 19:159–79.

Weinberger, Emily C.; Keith R. Cruise; Evan E. Auguste; and John K. Samuels. 2023. "The Structured Trauma-Related Experiences and Symptoms Screener (STRESS): Assessing Factor Structure and Clinical Utility in a Juvenile Justice Sample." *Psychological Trauma: Theory, Research, Practice, and Policy* 15(Suppl 1):S143–S153.

Winters, Drew E., and Emily Beerbower. 2017. "Mindfulness and Meditation as an Adjunctive Treatment for Adolescents Involved in the Juvenile Justice System: Is Repairing the Brain and Nervous System Possible?" *Social Work in Health Care* 56(7):615–635.

Winters, Ken C. 1992. "Development of an Adolescent Alcohol and Other Drug Abuse Screening Scale: Personal Experience Screening Questionnaire." *Addictive Behaviors* 17(5):479–490.

Winters, Ken C., and Yifrah Kaminer. 2008. "Screening and Assessing Adolescent Substance Use Disorders in Clinical Populations." *Journal of the American Academy of Child and Adolescent Psychiatry* 47(7):740–744.

Wolff, K.T.; Limoncelli, K.E.; and Baglivio, M.T. 2022. "The Effect of Program Staffing Difficulties on Changes in Dynamic Risk and Reoffending Among Juvenile Offenders in Residential Placement." *Justice Quarterly* 39(3):525–552.

Yang, Yang; Kevin Knight; George W. Joe; Grace A. Rowan–Szal; Wayne E.K. Lehman; and Patrick M. Flynn. 2013. "The Influence of Client Risks and Treatment Engagement on Recidivism." *Journal of Offender Rehabilitation* 52:544–64.

Young, Brae, and Jillian J. Turanovic. 2022. "What About the Kids? Examining the Visitation-Recidivism Relationship Among Incarcerated Juveniles." *Youth & Society* 54(7):1126–1149.

Zacharis N.Z. 2011. "The Effect of Learning Style on Preference for Web-based Courses and Learning Outcomes." *British Journal of Educational Technology* 42(5):790–800.