



**FROM TRAUMA TO TRAGEDY:  
CONNECTICUT GIRLS IN ADULT PRISON**

***A BRIEFING PAPER BY THE OFFICE OF THE CHILD ADVOCATE***

***July 2008***

## EXECUTIVE SUMMARY

Girls in Connecticut are in serious trouble.

For nearly a decade, starting with the investigation of the suicide of Tabatha B. at the Long Lane School, the Office of the Child Advocate (OCA) and numerous other state entities and advocates have urged the Governor and the Department of Children and Families (DCF) to proactively plan, implement, and oversee a continuum of services for girls in Connecticut. This call to action is reinforced by national research that supports gender-responsive practice in the areas of child welfare, mental health and juvenile justice.<sup>1</sup>

Many, including their families, DCF, the Departments of Education (DOE) and Correction (DOC), the Judicial Branch, and the Legislature, shoulder the responsibility for the well-being of girls in Connecticut. Yet, as the state's lead children's agency with a nearly one billion-dollar budget, DCF has foremost obligation to act. Most of the programs serving girls in Connecticut are licensed and funded by DCF. In many instances, DCF is their parent.

Despite substantial state dollars expended on evaluations, provider contracts, and additional DCF staff, Connecticut still lacks a continuum of services for girls. None of the DCF supported programs serving girls have met the expectations set forth in numerous reports by oversight agencies and DCF's own consultants. Despite repeated calls for early intervention and prevention, the most tangible evidence of attention to the needs of girls exits at the deep-end of the service spectrum as DCF plans to build an eighteen to twenty bed, short-stay secure facility for delinquent girls. At the same time, DCF's continued failure after nearly two decades under the Juan F. consent decree to comply with the most fundamental outcome measures of treatment planning and meeting the needs of children places all girls at substantial risk for poor outcomes.<sup>2</sup>

Yet, the stakes are exceedingly high. Nearly every girl involved with DCF has experienced abuse and neglect. Most have experienced poverty, violence in their homes and community, and multiple disruptions from their families, school and residential placements. These experiences make it very difficult for most to develop relationships with consistent, caring adults. It also poses great risk to their emotional, mental health and behavioral development.

For too many girls in Connecticut, the years of unmet needs, inadequate treatment planning, and lack of gender responsive services creates a pathway toward the juvenile and adult criminal justice systems. In the last year, 571 girls age fifteen and younger have spent time in a Connecticut juvenile detention center. Over the past two years, nearly 250 girls between age fifteen and eighteen spent part of their adolescence at York Correctional Institution (YCI), Connecticut's only prison for adult women. Unlike the Manson Youth Institution (MYI) for boys who are in the adult criminal justice system, Connecticut lacks a separate facility for girls. All girls involved in the adult criminal system, regardless of the severity of their crime, are incarcerated at YCI where they are housed on the maximum-security unit in close sight and sound proximity to adult women serving the most extensive sentences for the most serious crimes.

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<sup>1</sup> Gender responsive practice refers to systems and services that apply research and knowledge about the development, socialization, risks, strengths and needs of girls and boys to all aspects of system and service design and implementation. See Bloom, B., Owen, B., and Covington, S. (2003) *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders*, National Institute of Corrections, Washington, D.C. See also Child Welfare League of America at <http://www.cwla.org/programs/ngi/ngiabout.htm>

<sup>2</sup> See Juan F. Court Monitor's Office, *Juan F. v. Rell Exit Plan Quarterly Report: January 1, 2008-March 31, 2008 H-89-859 (AFIN)*(June 16, 2008).

In December 2005, the OCA initiated a multifaceted strategy to better understand the needs and experiences of the girls at YCI. OCA's broad statutory authority to provide independent oversight of all state-funded services to children allows us to review information that crosses all domains of the child's life. Informed by a "full picture" of a child, we can identify barriers to appropriate care and serve as a catalyst for collaboration among state agencies, providers and individuals on a behalf of a child. Our analysis of state-funded services for girls and the conditions of confinement at YCI benefits from our broad access to information and vast experience with case reviews, facility oversight, program monitoring, and investigations related to all children involved with DCF and other state-funded entities.

For more than a decade, OCA has documented a chronic and consistent pattern of deficiencies in leadership, program planning, service delivery and oversight at every level of DCF. The Child Advocate has partnered with the Attorney General to investigate and calculate the immense costs to children and taxpayers when DCF fails to provide appropriate and timely services. Recent reports by the Legislative Program Review and Investigations Committee and the Juan F. Court Monitor offer corroborating evidence of systemic problems. At the time of this writing, DCF faces a new federal court order to meet the most basic needs of children in its care – permanent homes in family settings and dental, medical, and mental health care. The settlement agreement was announced the same day that the DCF Commissioner described the investigative work in the case of a DCF worker charged with the death of an infant who was placed in her home as "substandard and unacceptable." Current investigations by the Child Advocate and Attorney General are uncovering redundant systemic problems at DCF related to several facilities licensed, funded and contacted by DCF, voluntary mental health services for children and inadequate planning for young adults transitioning from the child welfare and juvenile justice systems.

This Briefing Paper finds that DCF demonstrates substantially similar and troubling patterns in planning and responding to the needs of girls:

- On September 26<sup>th</sup>, 1998, 15-year-old Tabatha B. was found hanging in her room at Long Lane School, then the only secure facility for adjudicated children in Connecticut. Despite extensive knowledge of serious problems at Long Lane, DCF left girls at the facility for five years until closing its doors in 2003. While Tabatha B.'s untimely death was the catalyst for building Connecticut Juvenile Training School for Boys, Connecticut did not begin to address the needs for girls until 2004.
- In May 2004, the Connecticut legislature mandated that DCF prepare a plan for community-based services designed to prevent incarceration of court-involved girls.
- One year later, in February 2005, DCF responded with a 110-page report that found an "urgent compelling need" for DCF to establish a continuum of gender-specific services for girls and strategies to ensure effective program oversight and evaluation.
- In December 2005, a DCF consultant issued a report that identified a need for a system of services for girls and increased staff competencies in gender specific, strengths based, trauma informed, culturally competent, and relationship-driven philosophy and strategies. It suggested that DCF answer two core questions before building a new secure facility for girls: (1) why are current secure programs for girls not sufficiently serving girls and (2) are there ways to add secure capacity to current programs?

- During 2005, DCF created the new management position of Director of Girls' Services with no staff and minimal program direction and authority.
- In 2006, DCF funded a consultant to assess residential programming for girls in Connecticut who found inadequate services and "system practices that appear to result in ineffective interventions and a continually revolving door." The consultant urged DCF to infuse gender responsiveness at every system decision point and require system level quality assurance for gender specific programming.
- In November 2006, a record number of adolescent girls were incarcerated at YCI. Most had current and past involvement with DCF and had spent significant years of their childhood at many of the girls' programs examined by DCF and its consultants.
- Throughout 2006 and 2008, OCA met with DCF and testified before the legislature to spotlight the lack of girls' services. OCA met repeatedly with leadership at DCF and DOC to share grave concerns about the conditions of confinement at YCI and the inadequate social work practice and services to prevent incarceration and ensure timely and safe release.
- In June 2008, OCA learned that the DCF Commissioner had assigned lead responsibility for girls' services to its Bureau of Juvenile Justice. The primary focus of this work is the creation of an 18 -bed secure facility to house temporarily girls who are adjudicated delinquent. To date, DCF has not provided a public response regarding the findings and recommendations related to girls in several reports or answered the questions posed by its own consultant as a prerequisite to building a secure girls' facility.
- In June 2008, Stepping Stone, one of the programs assessed by the DCF consultants, reported the arrest of thirteen girls. Six of these girls were sent to YCI by the adult criminal court.
- **In June and July 2008, YCI reported its highest census of girls in two years.** While the average census has been 22 girls, a June roster reported 38 girls and a July roster reported 37 girls. Two of the girls admitted in July 2008 were under age 16.

### SUMMARY OF SYSTEMIC FINDINGS

During the past two years, OCA staff conducted weekly site visits at YCI, monitored case conferences, and met extensively with DCF and DOC leadership and staff. We reviewed all relevant DCF and DOC policy and the Memoranda of Understanding (MOU). We convened and participated in multi-agency stakeholder workgroups. We reviewed DCF case records for girls incarcerated at YCI, attended DCF case conferences, and tracked significant events and critical incidents at facilities serving girls. We facilitated and observed weekly case conferences held at YCI and reviewed DOC disciplinary and medical records for the girls. We gathered information from the girls themselves, meeting with them in their cells and at the YCI school. We conducted site visits and interviews at juvenile detention centers, residential treatment facilities and community-based programs serving girls.

While this Briefing Paper focuses on girls, many of the following findings and recommendations apply as urgently to boys in Connecticut. OCA believes that reform to infuse and monitor trauma and gender informed practice across state agencies promotes better outcomes for all children. The following systemic findings relate to OCA's review of the needs and pathways of the girls who ultimately experienced incarceration at YCI:

- In the five years since the closing of Long Lane School, Connecticut still lacks a broad continuum of services for girls.
- Many of the programs and group homes licensed and funded by DCF struggle to meet the needs of girls at-risk to enter the juvenile and adult justice systems.
- The lack of community-based programs and services for pre-adolescent and adolescent girls places them at increased risk for residential care, incarceration and/or extended pre-trial stays at YCI.
- DCF had substantial involvement from early childhood in the lives of the vast majority of girls at YCI.
- Many girls had excessive truancy from school and schools often responded to behaviors in schools by contacting law enforcement.
- Girls who were pregnant and who had a history of running away from home and treatment experienced increased risk for incarceration.
- A preliminary review suggests that non-white; Hispanic and African American girls are disproportionately represented in detention centers and at YCI.
- With respect to the girls incarcerated at YCI, DCF specifically has failed to:
  - Ensure that DCF caseworkers and social workers advocate on behalf of the girls to avoid unnecessary residential placement, juvenile detention and incarceration.
  - Share information about struggling DCF licensed and funded programs with the court and other decision makers to increase understanding about the experiences and behaviors of girls.
  - Comply with DCF Policy related to incarcerated youth involved with DCF.
  - Comply with the DCF-DOC MOU related to girls incarcerated at YCI.
  - Lead efforts to monitor and address whether the conditions of confinement for the girls at YCI are safe and adequate to meet their needs.
  - Coordinate and collaborate across its Bureaus to share information necessary to assess and address the needs of individual girls.
  - Monitor that DCF workers provide coordinated, child-specific, and timely discharge for girls at YCI.

### **SUMMARY OF FINDINGS OF TARGETED CASE REVIEWS**

The following findings are based on OCA's review of DCF LINK case records, weekly DCF-DOC rosters developed by DCF, DOC disciplinary reports and medical records, and participation in case conferences for the 49 girls under age 18 who were incarcerated at YCI from February through April 2008:

- More than 90% of the girls had either current or historical involvement with DCF.
- Nearly half of the girls had a current open case with DCF.
- In more than one-third of the open cases, DCF was legal guardian or statutory parent.
- Among the open DCF cases, 91% were accused only at the time of incarceration; 9% of the girls were sentenced at the time of incarceration; and 17% received sentences during the two-month targeted review period.
- Among the open DCF cases, 43% had bond amounts less than \$5000; 17% had bond amounts less than \$2500. (DCF would need to pay ten percent of the bond amount to secure a girl's release from YCI).
- Among the open DCF cases, 30% had more than one admission to YCI in the past year.
- Two girls had open cases with DCF as the *subject* of a DCF investigation because they were mothers of infant children.
- Eight (16%) of the 49 girls had at least one pregnancy. Three of these girls were parenting infant children prior to incarceration. All but two had significant DCF placement history.
- Half of the girls with closed DCF cases had their cases closed one year prior to incarceration.
- More than 20% of the girls with closed DCF cases had experienced more than one admission to YCI in the past year.
- A significant number of girls with both open and closed cases had experienced at least one placement at Klingberg Family Center, Touchstone and Stepping Stone – residential treatment programs viewed as leaders in gender responsive programming and services.
- Seven girls (30%) with open DCF cases had experienced placement at Klingberg, Touchstone and Stepping Stone residential programs in the past year.
- During incarceration, many girls were confined to quarters and had co-occurring loss of commissary, recreation, visits and phone contacts for several weeks.
- Two point-in-time audits of DOC medical and mental health files for girls with open cases found no copies of a DCF treatment plan or any clinical evaluation completed by the girl's prior residential treatment program or primary clinician.

### **RECOMMENDATIONS AND NEXT STEPS**

As the lead state agency for prevention, child protection, children's mental health, and juvenile justice, DCF is obligated to stem the pipeline to prison for all girls. As the legal guardian and statutory parent for many girls at YCI, DCF must act as a responsible and caring parent to understand and respond to their needs, obtain support and services to divert them from prison. When a girl is sent to YCI, DCF must lead efforts to monitor her safety and well-being during

incarceration and plan for her successful return to the community. DCF policy and the Memoranda of Understanding between DCF and DOC reinforce these expectations.

At the same time, the implementation of the following recommendations requires leadership at every level of government and throughout Connecticut's communities. Despite its broad statutory mandates, the Child Advocate lacks enforcement authority over state agencies. While OCA will continue its oversight, legislative and other advocacy efforts, we call on the Governor, Legislators, and advocates to urge DCF, and all agencies with responsibility for well being of children, to establish a coordinated and meaningful response to the needs of Connecticut's girls. Citizens must also voice their expectation that state dollars are spent responsibly to provide all girls with the opportunity to become safe, strong, and successful adult women.

1. DCF must produce an action plan to create a continuum of services for girls informed by the findings and recommendations in existing reports. The plan should have specific time frames and embed responsibility for implementation throughout the agency.
2. The DCF Bureau of Continuous Quality Improvement must collect, analyze and report information related to the demographics, needs, service gaps, and pathways for girls involved with DCF. These reports should be generated monthly and provide a basis for proactive planning and response.
3. DCF must conduct a quarterly review of available placements and barriers to services to girls with serious and persistent mental health needs.
4. DCF must demonstrate how its Foster Care Plan addresses the unique needs of girls.
5. DCF licensed girls' programs must undergo a current evaluation and receive ongoing oversight. Monitoring of these activities by DCF must be transparent.
6. DCF should revise its Structured Decision-Making tool to include risk factors for involvement in the juvenile and adult criminal justice systems. These risk factors should be reassessed prior to approval for case closure.
7. DCF must develop a single, comprehensive assessment and planning tool for girls that is based on gender responsive and trauma informed best practices. This tool should follow a girl throughout her involvement with DCF, be part of the DCF LINK case record, and shared as appropriate with agencies and providers.
8. DCF must develop and maintain a mechanism to identify and track pregnant and parenting girls and boys in the care of the DCF and its licensed facilities to proactively plan for programs and reduce the risks for incarceration.
9. DCF must immediately evaluate compliance across every DCF Bureau with its policies and the DOC-DCF MOU related to incarcerated youth.
10. DCF must conduct an audit of social work practice by Area Office staff related to the girls at YCI. Areas for review should include use of trauma informed, gender responsive, and adolescent best practices, frequency and quality of visitation, quality of reports to the adult criminal court and probation, and collaboration and information-sharing with the DCF Liaison, DOC clinical and custody staff at YCI, and probation.

11. DCF must conduct an audit of LINK case records of all girls currently at YCI to ensure that information is up-to-date and accurate to facilitate alternative placements, the provision of services during incarceration, and re-entry planning and supports.
12. All Connecticut state agencies with responsibility for children, including the Departments of Education, Developmental Disabilities and Mental Health and Addiction Services, must commit resources and staff to understand and address the needs of girls at-risk. To facilitate these efforts, the Legislature and Governor should request written action plans for collaborative strategies by state agencies on behalf of girls in Connecticut.

With the urging and support of OCA, the DOC has embarked on several initiatives to identify, understand and respond to the needs of all girls at YCI. **Despite these critical reforms, YCI remains a maximum-security prison for adult women that cannot meet the unique needs of adolescent girls. Girls in Connecticut require an alternative to YCI.** The existence of MYI as a separate DOC facility for adolescent boys raises concerns about parity for incarcerated girls. Additionally, in January 2010, Connecticut law will raise the age of juvenile jurisdiction and girls who are sixteen and seventeen years old will no longer automatically enter the adult juvenile justice system. Yet, even under the new law, girls who are charged with certain crimes may be transferred from the juvenile to adult criminal justice system. These girls will comprise an even smaller minority among the 1400 adult women at YCI, placing them at greater risk for isolation, physical harm, and limited access to needed services and programs. The following recommendations are made to the DOC given its jurisdiction over the care and custody of girls in adult prisons and with the expectation that DCF will provide support to related DOC efforts:

1. The DCF and DOC must immediately partner to actualize the DOC-DCF MOU related to incarcerated youth.
2. DOC must convene a planning group with leadership from the DCF, UCONN Correctional Managed Health Care, the Departments of Education, Mental Health and Addiction Services and Developmental Disabilities, the Judicial Branch, the Legislature, and juvenile justice advocates, to recommend alternatives to YCI for girls who must be incarcerated in the adult system. The “SHE-MAWGY” should continue to provide guidance to DOC and serve as a forum to share information about girls at YCI.
3. DOC must document its current reform efforts at YCI to facilitate ongoing oversight and future policy direction.
4. DOC must audit the availability and access to programming and transitional supervision for girls at YCI to assess parity with the boys at MYI.
5. DOC must audit its compliance with education laws for girls at YCI.
6. DOC must move forward to develop, implement, and monitor gender-responsive, adolescent appropriate, and trauma informed discipline for girls currently at YCI.



## Introduction

### ***A System of Care for Connecticut's Girls***

For nearly a decade, starting with the investigation of the suicide of Tabitha B. at the Long Lane School in 1998 and the subsequent closing of the facility in 2003, to the present-day record numbers of girls with substantial involvement with the Department of Children and Families (DCF) incarcerated at York Correctional Institution (YCI), Connecticut's only prison for adult women, the Office of the Child Advocate (OCA) and numerous others have urged DCF to proactively plan, implement and oversee a broad spectrum of services to girls in the State of Connecticut. Despite cumulative evidence of the need to create systems and services premised on the philosophy that gender matters, Connecticut's lead child welfare, children's mental health, juvenile justice, and prevention agency has failed to provide leadership on behalf of girls.

As early as 1999, the Judicial Branch, through its Court Support Services Division (CSSD), published a comprehensive profile of court-involved girls in Connecticut with recommendations for continued system improvements. In July 2001, the Connecticut General Assembly passed a statute that required any juvenile justice-serving agency to provide services that are gender-specific. (Public Act 01-181) In 2003, following the closure of Long Lane School, the OCA, along with the Court Monitors for the Juan F. and Emily J. cases,<sup>3</sup> advocated that DCF plan for trauma-informed and gender-responsive programming for girls involved with child welfare and juvenile justice services. In May 2004, the Connecticut legislature mandated that DCF prepare a plan for community-based services designed to prevent incarceration of court-involved girls. One year later, in February 2005, DCF responded with a 110-page report that found an "urgent compelling need" for DCF to establish a continuum of gender-specific services for girls and strategies to ensure effective program oversight and evaluation.

Between 2005 and 2006, DCF hired consultants to analyze Connecticut's system for girls and assess residential programming for girls at three DCF licensed facilities: Natchaug Hospital, Stepping Stone, and Touchstone. Both consultants found pockets of strengths and serious systemic and programmatic deficiencies.

- Dr. Marty Beyer, Ph.D. identified a need for system of services for girls and increased staff competencies in gender specific, strengths based, trauma informed, culturally competent, and relationship-driven philosophy and strategies. Her report recommended that DCF answer two core questions before building a new secure facility for girls: (1) why are current secure programs for girls such as Natchaug, Stepping Stone and Riverview Hospital not sufficiently serving girls and (2) are there ways to add secure capacity to current programs?<sup>4</sup>
- The "Girls Programs Inquiry Project" found that the "programs revealed not only inadequate services for girls, but system practices that appear to result in ineffective interventions and a continually revolving door." The consultants recommended infusing gender responsiveness at every system decision point that impact females' movement through DCF and requiring system level quality assurance for gender specific programming.<sup>5</sup>

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<sup>3</sup> Juan F. is a federal class action reform lawsuit brought against the state on behalf of the children in and at-risk to enter state custody. The Emily J. lawsuit sought to improve medical, mental health and educational services for girls and boys involved with Connecticut's child welfare in juvenile detention.

<sup>4</sup> Beyer, M. *A System of Services for Girls in Connecticut*, December 15, 2005. (On file at OCA).

<sup>5</sup> Benedict, A., *Connecticut Department of Children and Families Girls Programs Inquiry Project: Findings and Recommended Action Steps*, February 23, 2006. (On file at OCA).

During this period, DCF created the new management position of Director of Girls' Services with no staff and minimal program direction and authority. At the same time, efforts to "Raise the Age" of juvenile jurisdiction in Connecticut made public the substantial gap in community-based programs and services for sixteen and seventeen year old girls and boys. By November 2006, a record number of adolescent girls regardless of the severity of their crime were incarcerated at YCI. For example, the majority of girls at YCI are charged with violations of probation orders due to excessive truancy from school, running away from their residential treatment placements, and fighting and aggressive behaviors while receiving mental health treatment at residential programs and hospitals. Some girls were involved in robberies and the sale of illegal substances. Most of these girls had current and past involvement with DCF resulting from abuse and neglect by their families and had spent significant years of their childhood at many of the girls' programs licensed, funded, and ultimately examined by DCF and its consultants.

By January 2007, OCA had met with leadership at both DCF and DOC to share grave concerns about the troubling conditions of confinement for the girls incarcerated at YCI. OCA also had met with DCF and testified before the legislature regarding the lack of services for girls. In June 2008, OCA learned that the DCF Commissioner had assigned lead responsibility for girls' services to its Bureau of Juvenile Justice. The primary focus of this work is the design and implementation of an eighteen to twenty-bed, short-stay secure facility to house girls who are adjudicated delinquent. DCF projects that the facility will be completed by mid-2010 at the cost of \$11 million.

OCA also learned that the DCF Director of Girls' Services, who still lacked staff, would be relocated to the Bureau of Juvenile Services from the Bureau of Behavioral Health. While the Deputy Commissioner and Bureau Chief for Juvenile Services have expressed a strong commitment to developing community capacity to serve adjudicated girls, it remains unclear how their efforts will be integrated and supported by DCF's bureaus responsible for child welfare, behavioral and mental health, adolescent transitional services, and continuous quality improvement. Plans related to DCF's collaboration with other state agencies with responsibility to provide services to girls including the Department of Developmental Services (DDS), the Department of Mental Health and Addiction Services (DMHAS), the Department of Education (DOE), and the Department of Public Health (DPH) also remain undefined. At the time of this writing, DCF has not answered the two core questions posed by its consultant as a prerequisite to building a secure girls' facility.

***In the five years since the closing of Long Lane, Connecticut still lacks a broad continuum of services for girls.*** OCA's recent facility investigations indicate that while well intentioned, none of the DCF supported programs serving girls have met the expectations for girls programs set forth in reports by a myriad of DCF consultants and innumerable DCF trainings. Many of these programs have voiced serious concerns about their capacity to serve the girls in their care and too often "feed" girls to the juvenile and adult criminal justice systems. OCA's extensive review of DCF case records reveals a pervasive pattern of focus and reaction to girls' behaviors without an understanding of the impact of traumatic experiences (e.g. abuse, neglect, early sexual activity, exposure to violence), adolescent development, and unmet mental health and educational needs, substance abuse, and poverty.

This Briefing Paper also spotlights one of the most tragic consequences of inadequate services for girls in Connecticut. Since the OCA began its review at YCI in December 2006, nearly 250 Connecticut girls have been spent part of their adolescence in a maximum-security adult prison. Yet, any exploration of how adolescent girls find their way to adult prison must include a review of the capacity of Connecticut's lead children's agency to engage, assess and respond to all children and

families. Echoing several existing reports, this Briefing Paper finds substantial gaps in DCF's capacity to promote social work practice and develop an infrastructure necessary to support the well-being of girls and prevent tragic outcomes such as incarceration in adult prison. In the past, and again today, DCF possesses the awareness of the problems, yet fails to initiate timely and decisive action, provide ongoing oversight, and enforce change. Many definitions of gender specific services exist in the literature and in mission statements of programs for girls in Connecticut and nationwide.<sup>6</sup> All of these definitions, however, are premised on the belief that gender does matter.

***Gender-responsive systems and services purposefully apply research and knowledge about the development, socialization, risks, strengths and needs of girls and boys to all aspects of system and service design and implementation.***

### ***Adolescents in Adult Prisons***

OCA's review of the girls at YCI is based on a premise unequivocally supported by nationally recognized research in the fields of child development and health, child welfare, and the juvenile and criminal justice: ***Adolescents are children and children do not belong in adult facilities.***

Adult prisons adhere to adult standards of care and programming. The core protections of the federal Juvenile Justice and Delinquency Prevention Act do not apply to youth sentenced as adults and incarcerated in adult prisons. As a result, the programs, services and disciplinary standards in adult prisons neither reflect nor respond to the unique developmental needs of adolescents. Not surprisingly, the vast research on adolescent development, juvenile and criminal justice, and child well being makes clear that incarcerating adolescents in adult correctional facilities places them at great risk.<sup>7</sup>

- Adolescents in adult prisons are five times more likely to be sexually assaulted and fifty percent more likely to be attacked with a weapon than adolescents in a juvenile facility.
- The suicide rate for juveniles housed in adult facilities is eight times the rate for adolescents in juvenile detention facilities.
- Extensive research affirms that incarcerating adolescents in adult facilities increases the likelihood that they will re-offend more quickly, more often, and with more serious offenses than youth in the juvenile system.

Advances in brain research confirms that adolescent do not have the same decision-making and organizational capacities as adults.<sup>8</sup> Nationally, policymakers are applying brain research to planning for child welfare, children's mental health and juvenile and criminal justice systems.

- Adolescents are more likely to engage in risk taking and impulsive behaviors and less able to consider the long-term consequences of their actions.

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<sup>6</sup> See note 1.

<sup>7</sup> See reports at <http://www.juvjustice.org/> and Campaign for Youth Justice, *Jailing Juveniles: The Dangers of Incarcerating Youth in Adult Jails in America* (2007) at [http://www.campaignforyouthjustice.org/national\\_reports.html](http://www.campaignforyouthjustice.org/national_reports.html)

<sup>8</sup> For an overview of adolescent brain research see <http://www.pbs.org/wgbh/pages/frontline/shows/teenbrain/> and Rebecca L. McNamce, *An Overview of the Science of Brain Development*, University of Pittsburgh, May 2006.

- Research also suggests that when children live in chaotic environments, the part of the brain that regulates emotion rather than reasoning is more likely to be activated.

If adult prisons cannot meet the needs of the typical adolescent, they are particularly ill equipped to understand and meet the needs of adolescents with serious and persistent mental health issues and developmental disabilities.<sup>9</sup>

- 50-75% of adolescents involved in the criminal justice system have mental health needs.
- Nearly 80% have learning disabilities and the vast majority is eligible for special education services.
- A disproportionate number of adolescents in the juvenile and criminal justice facilities have with prior involvement with the child welfare system, highlighting the high need for trauma-informed mental and behavioral health assessments and services.
- Studies have found significant differences in the therapeutic service environments found in juvenile correctional facilities and adult prisons.

Girls and boys share many economic, familial, and education risk factors for involvement in the child welfare and juvenile and adult justice systems. Yet, girls respond to these risk factors in different ways and may be exposed to them to different extents as compared to their male peers. Additionally, girls also have unique needs and experiences. These differences require gender specific assessment tools, programs and staff training.<sup>10</sup>

- Girls and young women are sexually abused before age 18 almost three times more often than boys.
- Girls in the juvenile justice and adult criminal systems have been found to have higher rates of substance abuse and addiction than their male counterparts.
- Teen pregnancy and parenthood is a primary risk factor for girls.
- The majority of girls are arrested and involved in the juvenile and adult criminal justice systems for less serious offenses than boys.
- Girls arrested for more serious offenses are often involved with crimes linked to relationships such as carrying and selling drugs for friends, family member and partners, and assaults and gang activity to protect loved ones.

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<sup>9</sup> See note 7 and Gaarder, E. & Belknap, J., *Little Women: Girls in Adult Prison*, Women & Criminal Justice, Vol. 15 (2) (2004).

<sup>10</sup> See Gaarder & Belknap at note 9 and Gaarder, E. & Belknap, J., *Tenuous Borders: Girls Transferred to Adult Court*, Criminology, Vol. 40 (3) (2002). See also OJJDP, Girls Study Group findings at <http://ojjdp.ncjrs.org/Programs/ProgSummary.asp?pi=42&ti=5&si=19&kw=&strItem=&strSingleItem=&topic&PreviousPage=SearchResults#Overview>

While research on the experiences of adolescent girls incarcerated in adult prisons has been limited, the few studies have found that girls in adult prison face dire risks to their health, safety, and well-being.<sup>11</sup>

### ***Connecticut Adolescents in Adult Prisons***

Currently, the State of Connecticut is one of three states that automatically transfer all 16 and 17 year olds to adult criminal court regardless of the charges. Children age 14 and 15 who are charged with a Class A or B felony are automatically transferred to adult criminal court and those charged with Class C or D felony *may* be transferred to the adult criminal court on a motion by the juvenile prosecutor and order of a Juvenile Matters judge.

In response to national research and public support, in 2007 Connecticut passed legislation that becomes effective in January 2010 to raise the age of juvenile jurisdiction to age seventeen. Despite this reform, Connecticut will still incarcerate some adolescents in its adult prison facilities. Sixteen and seventeen year olds with motor vehicle infractions and violations and with Class A and B felonies will still be legally considered adults. Prosecutorial discretion will be allowable in all felony cases. There will be no change in 2010 in the Connecticut transfer laws for 14 and 15 year olds.

Currently, Connecticut girls accused and sentenced under the jurisdiction of the adult criminal court, and regardless of the severity of their offense, are incarcerated at YCI. YCI has a capacity for approximately 1,400 adult women. The majority of the girls are housed in the prison's maximum-security area for adult women who are serving the most extensive sentences for the most significant crimes, including the murder of children. The girls reside separately from the women on a lower tier (hallway) in single or double cells. Each 5x8 cell has a metal bunk bed, a writing surface, an open toilet and a small sink. The cell doors are locked when closed and have one narrow window. Sounds from the adult women's hallways can be heard from the girls' common area that has two plastic chairs, a small table bolted to floor, and a bookshelf filled with a few tattered paperbacks. The tier has two showers with plastic curtains. Girls must use an intercom and buzzer to communicate with the DOC correctional officers who are stationed up a flight of stairs. A maximum-security adult tier is located directly above the girls. Adult women inmates with responsibilities for cleaning and laundry have been permitted on the girls' tier.

Girls with acute mental health needs may be housed temporarily on the Mental Health Unit that also serves adult women. Girls who receive disciplinary sanctions or who are suspected of having gang affiliation may be housed in a separate building where they are placed in single-person cells adjacent to cells occupied by adult women. The cells contain a mattress and toilet. The girls take all their meals in their cells, are secluded by themselves in the cell for up to 23 out of 24 hours each day, and handcuffed and shackled when they do leave the cell.

Boys under the jurisdiction of the adult criminal court are incarcerated at Manson Youth Institution (MYI) in Cheshire, Connecticut. All inmates at MYI are boys under age 21. Boys also may be housed in specific units related to their security risk and mental health, medical and substance abuse needs.

Education programming at both YCI and MYI is available to youth through the DOC Unified School District (USD) #1, which operates in a separate building at each facility. A comprehensive Adult Basic Education (ABE) program serves as the foundation for all program offerings. This mandated program includes the ABE, General Education Diploma (GED) preparation, and special education services. DOC policy permits students under age 18 to attend school for five hours each day. At YCI adult inmates and the girls may attend classes together. Girls on the mental health and

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<sup>11</sup> See Gaarder & Belknap at notes 9 and 10.

restrictive housing units can receive tutoring in their cells for one to two hours per day and depending on teacher availability. Girls who have completed their GED may apply for certificate programs. Until a slot becomes availability, girls may spend school hours isolated on the tier with minimal programming.

Since 1997, the DOC has contracted with the University of Connecticut Correctional Managed Health Care Program (CMHC) to provide medical, dental and mental health and pharmacy services to all inmates including youth incarcerated at YCI and MYI. Prior to 2007, YCI lacked mental health practitioners with an expertise in adolescent development and treatment.

### OCA Review at YCI

#### ***OCA Involvement at YCI***

Over the past several years, OCA has advocated on behalf of children incarcerated at Connecticut's adult prisons. We have collaborated with DCF and the Child Welfare League of America to conduct child fatality reviews related to incidents at Manson Youth Institution (MYI). We have advocated that individual children receive needed services and supports. We have observed court hearings and reviewed DCF case records to understand the effectiveness of DCF advocacy and social work in recommending alternative placements to YCI and expediting discharge plans. We have provided technical assistance to child protection attorneys and public defenders on behalf on adolescents in adult court. OCA staff has conducted site visits and facility reviews to programs reporting significant events and critical incidents that result in the arrests of girls. We are active participants in the Multi-Agency Working Group on Youth (MAWGY) to review policies and practices as they relate to youthful offenders.

In December 2006, as part of our work with the Connecticut legislature's Juvenile Justice Planning and Implementation Committee, the OCA conducted informal focus groups and interviews with the boys incarcerated at MYI and the girls incarcerated at YCI. We asked about the person who had the greatest impact on their life, what programs and services they and their family needed, what services they would need when they returned to their communities, and what services would best help them transition from Manson and York. These interviews took place not in the prison visiting rooms, but in their classrooms, housing tiers and the cells.

While we found deficient living conditions and inadequate programming and supports at MYI, we were particularly troubled by the experiences of the girls at YCI. We discovered that the girls were completely isolated in their cells on the maximum-security side of the prison as part of an effort to maintain sight and sound separation from the adult women. Youthful offenders (age 16 and 17) left their cells only for meals, school, and during one hour each day to recreate on the tier, make phone calls and shower. The girls required escorts to and from the chow hall and school. They often missed school due to frequent facility lockdowns, lack of available escorts, and an inadequate pool of substitute teachers. Juvenile offenders (age 15 or younger) were placed together in a single cell for nearly 23 hours each day. They did not attend school and took all meals in their cell. They were permitted to recreate only with one another for one hour each day.

Unlike the boys at MYI, the girls did not receive snacks between designated meal times or outdoor, large muscle group recreation. Unlike the common areas in the tiers for the adult women, the girls' tier had empty bookshelves. OCA observed peeling paint and mold on the walls in the girls' cells and throughout the facility. One of the two showers on the girls' tier was broken and had no curtain. Our daytime visits often found the majority of the girls sleeping.

Most girls reported unmet medical and mental health needs since arriving at YCI. Several did not have their prescription glasses and had not received medication that they were taking prior to

incarceration. They showed us infected cuts from attempts at self piercing and cutting. Others requested our assistance with medical attention for gynecological needs. Many expressed wanting to speak with a mental health clinician because they felt scared, angry, and desperate.

Girls informed us that they lacked access to commissary items due to disciplinary sanctions and insufficient commissary accounts. Many complained that they did not have enough money in their commissary accounts to purchase extra underwear, socks, shampoo, writing materials and snacks. Most did not attend YCI programs due to DOC concerns about co-mingling with the general population and competition for available program slots with 1400 adult women.

Some girls were segregated in the Restrictive Housing Unit and spent their days alone in their cells, did not attend school and received only one hour outside their cell daily. They reported taunting from the neighboring adult women through the cell vents. The girls we interviewed were brought to us in wrist and ankle shackles and presented as unkempt and very distressed. A handful of girls were housed in the mental health unit. They were restricted to their rooms to avoid contact with the adult population and did not attend school.

At the end of our visit, two girls asked to speak with us privately in their cell. We learned that one of the girls had a stillbirth the week before in the cell toilet. The girls – both of who had contact with DCF two years prior to incarceration -- expressed feeling traumatized by this experience and reported receiving no follow-up from either DOC or DCF staff. The girl who had given birth was still experiencing heavy bleeding. Neither had been able to contact her family members during this experience.

Most of the girls lacked access to adults with the authority and obligation to advocate on their behalf. The majority of girls reported no visits with their public defenders. Nearly all the girls who had involvement with DCF reported limited to no contact with their DCF worker, child protection attorney or guardian ad litem during incarceration. None of the girls could recall meeting or knowing the role of the DCF Liaison at YCI. Many girls did not communicate with family because of DOC rules that require to the girls to make collect calls to family. They are unable to make collect calls to cell phones and some of their families lack the financial means to accept collect calls. Most had no visits due to family transportation difficulties, confusion about the paperwork needed to approve and plan visits, and limited family supports. At least two girls reported that their mother, grandmother and other female family members were also incarcerated during their stay at YCI.

### ***The OCA Response***

After the initial site visits, OCA immediately informed both DOC and DCF about our observations and concerns related to the girls at YCI. In January 2007, OCA met with the DCF Assistant Commissioner and Bureau Chief of Prevention and External Affairs to present our findings, make recommendations related to DCF policy, and suggest that DCF convene stakeholders to develop a collaborative plan to understand and respond to the needs of the girls at YCI. OCA expressed concerns about the pathways to adult prison for the girls and the need for DCF to implement the recommendations in the DCF girls' reports. OCA also shared our concerns about the lack of leadership by DCF staff in the Area Offices and Ombudsman Unit in sounding an alarm about the dire conditions for the girls.

One month later, in February 2007, OCA met with the DOC Director of Programs and Treatment and the YCI Warden. We discussed concerns and recommended enhancements to DOC policies and practices in a number of areas: operations, programs, mental health and medical care access, inter-agency collaboration, and re-entry services. After receiving limited follow-up from DCF, in March 2007, OCA shared our recommendation for a girls-focused stakeholder group with the DOC Director. During this time, OCA also met with staff from the DOC Health and Addition Services

and CMHC to share our concerns about the girls' access to medical and mental health services at YCI. The recommendations and relationships developed through this work became part of several ongoing workgroups and initiatives at DOC and CMHC in which OCA was actively involved. In addition, the OCA held information-sharing and strategy meetings with both the Director of Juvenile Delinquency from the Office of the Chief Public Defender and the Chief Child Protection Attorney. At this time, OCA has not evaluated the quality of legal representation for children dually involved in the child welfare and the juvenile and adult justice systems. Yet, several citizens concerns and review of DCF case records have alerted OCA to concerns. As a first step, the OCA has recommended that the Chief Child Protection Attorney partner with DCF to ensure that she is alerted when a child who has an assigned child protection attorney and/or guardian ad litem enters MYI or YCI. OCA also provides ongoing technical assistance to attorneys on behalf of girls at YCI.

### ***The DOC Response***

The DOC responded to OCA's concerns in several ways. After the initial meeting in February 2007, the DOC Director recommended an increased emphasis on the experiences of girls at the next meeting of the MultiAgency Working Group for Youth (MAWGY). In April 2007, the DOC Director convened the first "SHE-MAWGY" meeting to focus on the girls at YCI. Since the initial meeting, SHE-MAWGY has met approximately every two months and included representatives from, OCA, DOC Central Office, YCI leadership, custody, program, and education staff, CMHC leadership and clinicians, DCF Bureau Chiefs of Prevention and External Affairs and Juvenile Services, DCF-DOC Liaison staff, community providers, CSSD, and the Office of the Public Defender. The group shares information and recommendations regarding the YCI facility and program enhancements related to the girls. The DOC Director chairs and provides direction for SHE-MAWGY.

During May 2007, OCA was invited to meet with the new warden at YCI to discuss our authority and role related to the girls at YCI. The warden appointed the deputy warden to work closely with OCA to implement strategies recommended by the OCA and the SHE-MAWGY stakeholders. By August 2007, at OCA's suggestion and with OCA support, the YCI warden and deputy warden convened the first Team Meeting related to the adolescent girls at YCI (known as the Juvenile Offenders/Youthful Offenders or JO/YOs).<sup>12</sup> The meetings include DOC custody, education, and program and health care staff. The DCF Liaison attends during discussions of DCF committed girls. Initially, the meetings provided a forum to build relationships among DOC staff working with the girls and ensure that the needs of the girls were identified and met. Over time, the group began to function as a team to identify, assess, and respond to systemic and individual issues related to the girls. The team now meets weekly. During the first three meetings each month, girls are invited or may request to meet with the team for the first hour. The last meeting of each month is reserved to discuss and respond to administrative problems and the effectiveness of the weekly team process.

In addition, the DOC Central Office provided funding to designated staff at YCI to receive Girls Circle Training, a research based gender specific model that trains facilitators to lead groups that increase girls' self-sufficiency, body image and improve relationships to address risky behaviors. The federal Office of Juvenile Justice and Delinquency Prevention endorses the program.

In January 2008, OCA was approached by the DOC Director to provide recommendations for additional review related to the girls at YCI. OCA suggested an audit of the DOC-DCF MOU for discharge planning of youth at MYI and YCI and developing a pilot at YCI to explore alternative disciplinary sanctions for the JO/YOs at YCI. Between January and March 2008, at the request of the DOC Director, a review team from DOC Central Office, YCI, MYI and the DCF Liaisons to

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<sup>12</sup> Juvenile Offenders refers to youth age 15 and younger in the adult criminal justice system and youthful offenders refers to youth age 16 and 17 in the criminal justice system.



DOC met to review the MOU and make recommendations for next steps. In May 2008, the SHE-MAWGY group agreed to pursue a pilot to design, implement and evaluate alternative disciplinary sanctions for the girls at YCI. The leadership at DOC and CMHC also has convened a multiagency group to explore and recommend alternative behavior management strategies for MYI and YCI.

### ***The DCF Response***

At the first meeting with OCA in January 2007, the DCF Assistant Commissioner acknowledged the need to better understand and respond to the experiences of the girls and agreed to convene a small stakeholder group to plan next steps. In June 2007, DCF experienced turnover in its executive leadership and the Assistant Commissioner left DCF shortly thereafter. The stakeholder meeting was not convened by DCF. Instead, the DOC Director convened the first SHE-MAWGY. One month later, in July 2007, as DOC commenced its weekly YCI Team meetings, OCA met for the first time with the newly appointed DCF Deputy Commissioner and shared our ongoing concerns about the needs of girls involved with DCF and our work at YCI. In October 2007, OCA requested a second meeting with the Deputy Commissioner and the Bureau Chief of External Affairs and Prevention to share observations related to the girls at YCI, concerns about DCF meeting the scope of DCF policy and the DOC-DCF MOU and the integration of all DCF resources in planning and addressing the needs of the girls at YCI. OCA also requested that DCF move toward better documentation in the DCF case records of the work done on behalf of the girls at YCI by the Ombudsman Liaison and Area Office staff. At the close of the meeting, DCF informed OCA about its efforts to develop an Action Plan related to the adolescents at YCI and MYI. At the time of this writing, OCA has not formally received any follow-up report or action plan.

DCF's involvement at the SHE-MAWGY meetings and the JO/YO team meetings has not included representation from Bureaus of Child Welfare, Behavioral Health and Medicine or Adolescent and Transitional Services. While management and direct staff from DOC and CMHC Central Office staff attends the SHE-MAWGY meetings, only the Bureau Chief of Prevention and External Affairs and his DOC Liaison staff have represented DCF. The Director of Girls Services and the Bureau Chief of Juvenile Services have attended some of the SHE-MAWGY meetings.

The DCF Liaison to YCI attends the JO/YO meetings only during the time that the group discusses girls who are committed to DCF. Despite requests from the team that DCF area office workers assigned to the girls attend the meetings or that the DCF Liaison consult on cases where girls have an open case, but are not committed to DCF, DCF has not provided any additional resources to the girls at YCI at the weekly meetings.

From January 2008 to the present, the DCF Commissioner, the Chief of Staff, Deputy Commissioner, Bureau Chief of Child Welfare, and the Ombudsman Unit staff have received ongoing concerns and inquiries from OCA related to the girls at YCI. To date, DCF has not convened a meeting with OCA to respond.

### **OCA Methodology**

OCA's extensive experience and knowledge from more than a decade of case reviews, facility oversight, program monitoring, and investigations related to children informed greatly our examination of the pathways experienced by girls and the conditions of confinement for girls at YCI. During the past two years, OCA staff conducted weekly site visits at YCI, monitored case conferences, and met extensively with DCF and DOC leadership and staff. We revisited the myriad of reports and recommendations related to girls in Connecticut. We reviewed all relevant DCF and DOC policy and the Memoranda of Understanding. We convened and participated in multi-agency stakeholder workgroups. We reviewed DCF case records for girls incarcerated at YCI, attended DCF case conferences, and tracked significant events and critical incidents at facilities serving girls.

We facilitated and observed weekly case conferences held at YCI and reviewed DOC disciplinary and medical records for the girls. We gathered information from the girls themselves, meeting with them in their cells and at the YCI school. We conducted site visits and interviews at juvenile detention centers, residential treatment facilities and community-based programs serving girls.

Currently, DCF tracks the weekly admission of girls to YCI to record the name, case number, bail amount and type of case (i.e. open, closed, committed, volunteer, in-home, out-of-home). The DCF Liaison to DOC uses this information to notify DCF workers by email of a client's admission to YCI and to request that the worker forward appropriate information to the DOC. OCA has been reviewing the DOC and DCF rosters of girls admitted to YCI and conducting some case reviews since January 2006. Most recently, we reviewed LINK case records for the girls on DCF roster sheets during a two-month period from February 21, 2008 through April 30, 2008. To our knowledge, DCF has not completed a similar analysis.

### **OCA Findings and Analysis**

#### ***DCF Policy***

In 2007, DCF issued a revised policy, *36-95-1 Working With DOC Involved Youth/Children*. The policy guides DCF staff in their efforts to support and plan for children who are incarcerated at a DOC facility and involved with DCF defined by having an open case due to voluntary services, DCF investigation, and DCF status as legal guardian or statutory parent. Under the policy, DCF staff is required to assist the planning, services and monitoring of these children incarcerated at a DOC facility. The policy rationale states clearly that:

*Children and youth may lack appropriate family support and have no outside contact. The DCF Area Office social worker or parole staff may be child/youth's only source of support and information. Therefore, it is important that the DCF social worker or parole staff fully understand the circumstances leading to the child/youth's arrest, their legal status and the importance of maintaining regular contact.*

DCF policy specifies duties for follow-up and discharge by designated DCF staff. The policy identifies a "DCF Ombudsman," a DCF employee assigned to and working within a DOC facility who is designated as a point person between DOC and DCF. In addition, DCF policy requires that the DCF worker or parole services work on behalf of children at DOC facilities. Within DCF, the Ombudsman Unit is located within the Bureau of Prevention and External Affairs under the supervision of the Bureau Chief who reports to a Deputy Commissioner who also oversees the Bureaus of Juvenile Justice Services and Adolescent and Transition Services. The DCF Ombudsman Unit receives and investigates inquiries and complaints relating to Department services in an effort to bring about a resolution for the best interests of children. The distinct Bureaus of Child Welfare, Behavioral Health, and Continuous Quality Improvement report directly to the Chief of Staff. The 15 Area Offices are located under the Bureau of Child Welfare. The DCF Girls Services Unit sits under the Bureau of Behavioral Health and Medicine.

DCF policy requires the Ombudsman to facilitate, invite, and attend an "Initial Planning Conference" for youth within 45 days of DOC placement. Invitees should include appropriate DCF staff, service providers, family members and the child's attorney. For those children with significant mental health, addiction or cognitive limitations, the Ombudsman may invite DCF Central Office staff as well as staff from the Connecticut Department of Mental Health and Addiction Services (DMHAS) and the Department of Developmental Disabilities Services (DDS). The Ombudsman must document conference results and recommendations and forward to the DCF worker and all other attendees.

- In practice, the DCF staff designated to work with DOC is known as the DCF Liaison

rather than “Ombudsman.” There is no evidence in DCF case records or from OCA’s site observations at YCI that the DCF Liaison to YCI facilitates an initial planning meeting. No documentation of the 45-day timeframe was found. In some case records, OCA found a formulaic email from the DCF Liaison to the DCF worker for the child that included notice of the child’s admission to YCI and a request for pertinent information, records, and signed releases to facilitate planning by the DOC staff.

The DCF worker must make reasonable efforts prior to any court hearing to develop an appropriate discharge plan, attend all court hearings and appropriately advocate for the youth without jeopardizing the youth’s legal status or safety of the community. In addition, the DCF worker must collaborate with the youth’s DOC primary clinician and the DCF Ombudsman to make timely referrals to appropriate community resources prior to discharge from the DOC to promote a successful transition and continuity of care. The policy states that a “DOC Designee Social Worker” will develop a plan to fill the youth’s medication prescriptions at the time of discharge. This assigned DCF staff is not defined under the policy.

- The case records reflect a pattern of reactive rather than proactive casework by the DCF workers. In many instances, as evidenced by the case record and reported to OCA by girls’ public defenders and judges, the DCF worker failed to appear at court with a meaningful discharge plan. OCA reviewed some case files where the worker documented a plan to request the court to remand a girl to YCI until an alternative placement could be found. In addition, case records and reports from other court participants reveal that DCF workers often presented a similar picture of the girls to the court, focusing on girls’ aggressive behaviors, noncompliance with family or program rules, and incidents of running away. Some information provided to the court was inaccurate and others appeared to be cut and pasted from dated case records. OCA found limited examples where the DCF workers advocated that a girls’ behavior be understood in the context of her mental health needs or trauma history. No evidence in the case record was found demonstrating that DCF workers were sharing information about struggling programs from which the girls were sent to YCI. OCA’s finding was reinforced by the findings of DOC-DCF MOU audit team referenced in the next section.
- OCA’s review of the DCF case record, DOC medical and mental health records, and interviews with the DOC and CMHC staff found limited contact between the DCF worker and the DOC primary clinician for a girl. In the few instances where some reference was made in the case record, the DCF worker appeared to request evaluations from the DOC clinician rather than share information from clinicians who had prior and longer-term knowledge of the girl. In one case, the DCF worker requested that the DOC clinician perform an IQ and cognitive capacity exam on a girl who had spent years in DCF care at Lake Grove, a DCF licensed facility expressly for children with cognitive disabilities and now closed due to chronic problems.

DCF policy does not allow DCF to post bond for any child. Instead, DCF requests DOC to provide notification if any other party seeks to post bond for the child for those children under commitment, custody, and guardianship or for whom DCF is the statutory parent. The policy requires that DCF to complete an assessment to determine whether release is appropriate. Determining factors include whether release from prison would be in the child’s best interest or pose a threat to others and the community. The policy does not specify an objective assessment tool nor what DCF bureau or staff will complete this assessment.

- OCA's review of case records found no documentation of a review of bond request or an objective assessment of whether release was appropriate. Most often, case records revealed that the DCF worker presented the court with a list of behaviors by girls without providing a context such as underlying mental illness, developmental disabilities, or a chaotic residential program that lacked the capacity to meet the needs of girls.

If DCF determines that a child is ready for release, DCF policy requires the development of an appropriate discharge plan, including alternative placement. The plan is presented to the criminal court and the assigned DCF worker has responsibility to advocate that it be accepted as an alternative to incarceration and bail. If the child does not have a court date scheduled within a reasonable period of time, the DCF worker must work with DCF legal staff and the child's public defender to develop a strategy to bring the plan to the attention of the court.

- OCA's review of the case records and concerns received by attorneys, judges, and probation officers found that DCF workers often did not have a plan for alternative placement. In many cases, alternative placements were sought based on bed availability rather than best fit. Perhaps most disturbing were case records that documented that DCF workers made a request to the judge to remand a girl back to YCI due to lack of an alternative placement.

Where DCF determines that a child is not ready for release from adult prison, DCF policy requires continued efforts to provide services during incarceration including arranging family visits, commissary payment, and regular visits and contact with the DCF worker and/or parole staff. DCF policy requires face-to-face contact within 5 working days of admission to a DOC facility and ongoing face-to-face contact once per month with more frequent visits to the extent possible. The policy explicitly states that attending court with the youth should not substitute for the monthly visits.

- Some case records document that a DCF worker facilitated transportation of a girl's family member to court and less frequently to YCI. The case records indicate that most contact between the girls and their DCF worker occurred before or after court appearances. OCA found no case records that indicated awareness or monitoring of the required 5-day face-to-face contact.

The policy also designates DCF staff to facilitate information sharing about youth incarcerated at DOC and involved with DCF. The Ombudsman has responsibility to identify and immediately share information regarding any discrepancies in the DOC and DCF electronic files and notifies the DCF worker of any change to the youth's status relating to mental health and non-life threatening conditions by the next business day. The DCF worker must provide the Ombudsman with current and historical information about the youth as soon as possible and inform the youth's legal guardian of who to contact at the DOC for information about the youth.

- Through discussions with DCF and the DOC-DCF MOA audit OCA learned that the DCF Liaison sends an email notification a girl's admission to YCI to the DCF Area Office and requests that the DCF workers then send a summary of the girl's case back to the DCF Liaison to be shared with staff at YCI. The DCF case files do not indicate when and what information is sent to the DCF Liaison from the area office. OCA's review of DOC medical files for the girls found only one file that contained an email with some information from DCF to YCI medical staff.

The Ombudsman must attend the “DOC Health Services/Custody review meeting” to obtain information about youth and share this information with the Area Office worker.

- Prior to the development of the YCI Team meeting, it is unclear what, if any, meeting occurred regularly to share information about the girls between DCF and DOC. Currently, the DCF Liaison to DOC attends only those Team meetings and clinical meetings on the YCI mental health unit that pertain to girls who are committed to DCF. DOC staff leads both of these meetings. OCA has observed that the DCF Liaison to YCI shares limited information about individual girls at the Team meetings. OCA also has not found enough evidence that DCF consistently shares case specific information about the girls between the DCF Liaison to YCI and the DCF workers in the area offices.

DCF policy allows an open DCF case to be closed during incarceration after ensuring that DOC is aware of and addressing any treatment needs of the child. For children involved with DCF Voluntary Services, the case will be kept open until sentencing. For children with DCF as their legal guardian or statutory parent, the case will be kept open where the child is sentenced to serve three years or less and the child is likely to require DCF services upon discharge from the DOC facility. The DCF Ombudsman can initiate a referral based on identified concern or need through the DCF Hotline. The Hotline will assess whether the case should be accepted.

- OCA’s case review found that many girls with open cases for child protection investigation at the time of admission to YCI had their cases closed after admission. DCF case records document the reason for closing as child being out of the home. Although, girls often have very short stays at YCI, the case closing summaries reviewed by OCA did not reflect a safety plan to be triggered by the girl’s release from YCI. DOC staff has reported concerns about girls who were released with questionable family supports. In one case that required OCA’s intervention, a girl with an open and long-standing DCF case was released with the plan to have her mother, who had a documented pattern of unreliability, pick her up at a courthouse in the early morning hours. DCF made alternative arrangements only after several emails and phone calls by both OCA and the DOC JO/YO team.

#### ***Other DCF Policy Relevant to Girls at YCI***

In addition to the specific policy on working with incarcerated youth, DCF has policies related to notification to parents and attorneys when a child experience change in placement, frequency of visitation by DCF workers, and treatment plan development and monitoring. OCA’s review of case records found minimal documentation related to notification and treatment planning revision based on a girl’s admission to YCI. Documentation often focused on court appointments and difficulties in finding an available bed when discharge became imminent. In addition, OCA’s review of the case and court records did not find enough evidence that policies related to matching children to appropriate placements in families, group homes and residential facilities based on individualized needs were consistently applied to girls who needed alternative placements to YCI and girls ready for discharge from YCI. Bed availability appeared to be the most influential factor in choosing placements for the girls at YCI.

#### ***DCF-DOC Memoranda of Understanding (MOU)***

Since 2005, the DCF and DOC have entered into MOUs relevant to the girls incarcerated at YCI. The first MOU, “Location of Department of Children and Families (DCF) Staff in York Correctional Facility” was executed in December 2005. This MOU outlines the purpose and duties of out-posting two part-time DCF workers at YCI. Under the MOU, the DCF workers receive supervision within the Bureau of Continuous Quality Improvement with local supervision provided

by a Correctional Counselor Supervisor from DOC. The DCF workers would be expected to have four separate, but related responsibilities:

- Serving as a case manager for adolescent girls between the ages of 16 and 21 who are eligible for DCF services.
- Providing appropriate referrals, treatment planning and service coordination for women with children who are currently in DCF care.
- Developing and maintaining a database pertaining to women who are DCF clients at YCI and facilitate communication between staff at YCI and DCF Area Office social workers.
- Serving as the custodian of DCF records while DOC staff processes records.

In May 2006, DCF and DOC executed a second MOU, “Discharge Protocol for Youth,” applicable to both MYI and YCI to develop and implement individualized discharge planning for youth in the custody or guardianship of DOC or who are DCF involved and have significant mental health needs. The MOU states that the purpose of the DOC-DCF collaboration is to ensure that youth who are able to remain in their community with appropriate resources or who require a higher level of psychiatric care do not remain in the correctional system for an extended period of time.

At the suggestion of OCA, a MOU audit team was convened in January 2008 to understand how the MOU is implemented at YCI and MYI. In May 2008, the audit team submitted a draft report with findings and recommendations to the DOC and DCF Commissioners.

While the draft report categorizes most components of the MOU as meeting partial compliance, the commentary section indicates that most aspects of the MOU could not be audited at all due to lack of documentation and communication by and between DOC and DCF. The audit team found that several activities under the MOU have never occurred and that other activities could not be verified. As such, OCA finds that the audit exercise reveals that DOC and DCF are in substantial noncompliance with the existing MOU. OCA’s observations at the JO/YO Team meetings, DOC CMHC clinical team meetings for girls on the YCI mental health unit, and case review provides further evidence of substantial noncompliance with the MOU’s sections on information-sharing, treatment planning, and discharge planning. Specific findings include:

- Lack of clear documentation or communication regarding the medical and mental health needs for youth involved with DCF between the DOC and DCF.
- Lack of clear documentation or communication regarding discharge planning for youth involved with DCF between the DOC and DCF.
- No protocol exists to ensure and document information-sharing activities related to assessment, treatment and discharge planning for children as envisioned in the MOU.
- The initial planning conference for youth under the guardianship and/or custody of DCF as envisioned in the MOU does not occur at YCI. Audit team representatives from DCF reported that these meetings are occurring at the Area Offices but OCA found no documentation of these meetings in LINK and the audit team representatives from DOC had never received information related to such meetings.
- Although the DCF Liaison to YCI reports obtaining releases of information to appropriately provide DOC with a child’s current and historical information, the team could not document that this was occurring routinely or determine where such information was filed.
- Adherence to the Confidentiality requirements under the MOU and Connecticut statute was difficult to verify.

The audit team made several recommendations to the DCF and DOC Commissioners including:

- Develop policies and procedures that clearly delineate responsibility and monitor implementation of activities for DCF, DOC and CMHC staff envisioned under the MOU.
- Recognize the different challenges for implementation of the MOU at MYI with a population of nearly 400 youth and YCI with a census of less than 40 youth.
- Unify the existing MOUs between DCF, DOC and DMHAS.
- Revise MOU to assist youth who are at-risk and ready for release, but not DCF-involved.
- Document the results of case conferences occurring at the JO/YO team meetings occurring at YCI and place minutes in a youth's file at DCF and DOC.
- Implement a weekly case conference model at MYI.
- Implement mechanisms to ensure and monitor that DCF Area Office workers have a more active role on behalf of incarcerated youth as envisioned by the MOU.
- Assign a DCF Liaison to MYI and YCI that have responsibility exclusively for JO/YOs.

At the time of this writing, OCA has not received notice of any further activities related to the audit team review and recommendations. In its own case reviews for the girls at YCI, OCA found no designated place or form in the DCF LINK case record or the DOC medical and mental health files that specifically documented the activities delineated in the MOU. Some DCF case records referenced that the DCF Liaison at YCI had notified the DCF worker about a girl's incarceration and made a request for a case summary for DOC. The few summaries found and reviewed by OCA were written by the DCF worker and contained incomplete and inaccurate information, medical and mental health diagnoses cut and pasted from other sections of the DCF case record, and a listing of the girls' aggressive behaviors rather than their strengths and needs.

#### ***Targeted Review of DOC Medical/Mental Health Records***

In March 14, 2008, OCA shared concerns with DCF Central Office and DCF AREA OFFICE staff about the lack of documentation about the mental health needs or cognitive status in the medical/mental health record at YCI for a girl who had been a former resident at now defunct Lake Grove residential treatment facility who was now pregnant and incarcerated at YCI. It appeared that the DOC clinician completed an evaluation based on the youth's self-report and the DOC clinician's observations. OCA shared with DCF its observations regarding delays in forwarding and the absence of pertinent medical and mental health records of youth at YCI. DOC and CMHC staff informed OCA and the DCF Liaison that the lack of information sharing about the historical needs and experiences of individual girls created a barrier to their appropriate and expedient transition and permanency planning. OCA also raised these concerns on several occasions with DCF. On March 19th, OCA reviewed 12 medical/mental health records at YCI. Of these 12, five were committed to DCF and four were closed cases. Of 12, only four had emails from the DCF Liaison to YCI or from the DCF worker to the DCF Liaison. One was found in the record of a closed case and three found in a DCF committed case. OCA found no DCF treatment plans and no clinical evaluations completed by a clinical professional in the files. OCA shared these findings with the DCF Bureau Chief of Prevention and External Affairs.

Following OCA's review, the DCF Liaison to DOC Program Supervisor and the DCF Liaison to YCI subsequently convened a meeting with the Deputy Warden at YCI and the CMHC psychologist designated to work with the JO/YOs to develop protocol to share existing medical and mental health information for individual girls. The protocol requires the DCF Liaison to YCI to request historical and current information from the child's DCF worker. If the youth has previously been in congregate care and there are evaluations available, the worker is required to obtain and fax the evaluations to the mental health unit at YCI. The DCF Liaison to YCI will provide pertinent information to the DOC mental health staff and review the status of requests for information with

the mental health staff during the YCI weekly JO/YO meetings. No reference was made regarding the information sharing and planning activities outlined in the MOU.

***OCA Targeted Case Review (February 21, 2008 - April 30, 2008)***

From January 2006 to April 2008, nearly 250 girls have been newly admitted to YCI. The weekly roster for JO/YOs at YCI was an average census of 22 girls. According to a DOC sampling completed in 2006 of 20 girls at YCI, the average length of stay for an accused, pretrial YO was 59 days. The average length of stay for a sentenced girl was approximately 193 days.<sup>13</sup>

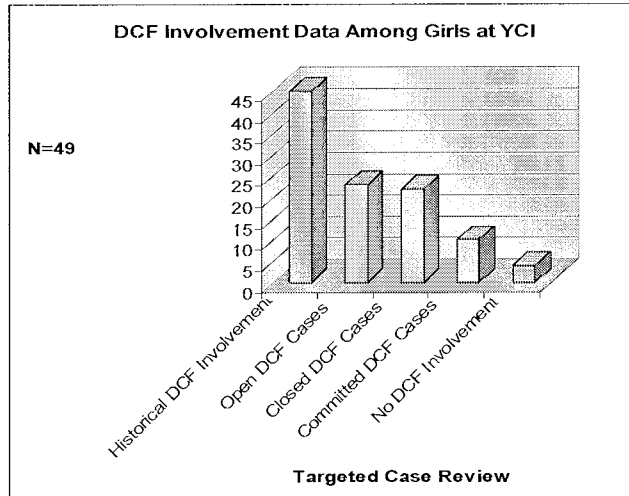
OCA reviewed DCF case records and DOC records related to the girls incarcerated at YCI during February 21 through April 30, 2008. Of the 49 girls incarcerated during this period, OCA made the following findings:

- Nearly half (47%) of the girls had a current open case with DCF.
- In nearly half (43%) of the open cases, the girl was committed to DCF. In these cases, girls may be given court orders that allow DCF to place them if they are not doing well with court-ordered expectations. In some cases, such as delinquency and FWSN commitments, the girl's parent maintains guardianship. In other committed cases, such as committed abuse /neglect or uncared for cases, DCF acts as the legal guardian or parent for the girl.
- DCF was the legal guardian or statutory parent in more than one-third of the open cases.
- The vast majority of the girls had significant mental health needs and histories of trauma due to physical and emotional abuse and neglect, sexual abuse, exposure to violence, and multiple placements.
- Approximately half (45%) of the girls had a closed case with DCF.
- 92% of the incarcerated girls had either current or historical involvement with DCF.
- Four girls (8%) had no current or historical involvement with DCF.
- A preliminary review suggests that the vast majority of the girls identify as non-white, Hispanic and African American.

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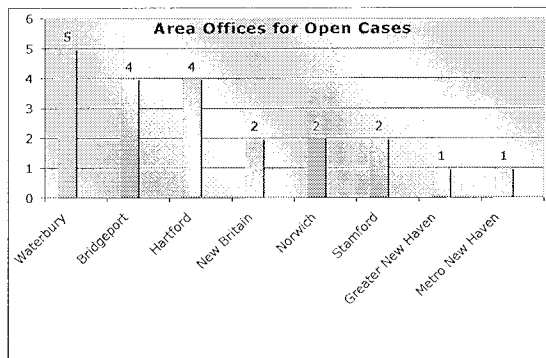
<sup>13</sup> Presented by DOC Commissioner Teresa Lantz at the Connecticut Juvenile Jurisdiction Implementation Committee (2006) (On file at OCA).



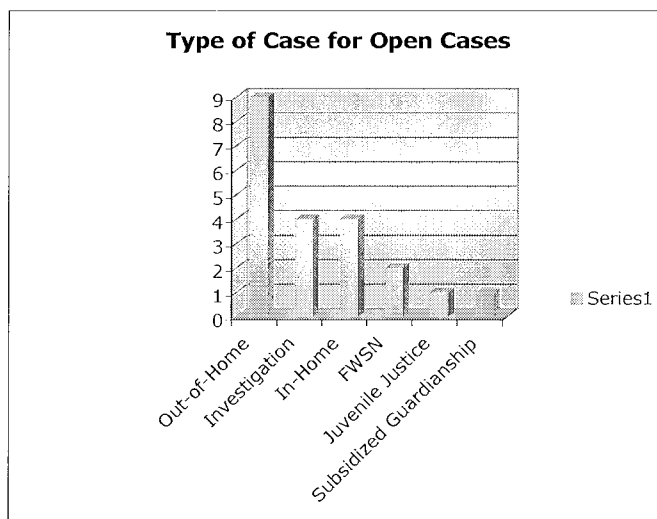


**OCA Review of Open Cases (n=23)**

- Among the open cases, 91% of the girls were unsentenced.
- The majority of the unsentenced girls had bond amounts less than \$2000. This would have required that DCF or a guardian to provide \$200 or less for the girl's release.
- One-third of the girls with open cases had more than one incarceration at YCI in the past year.

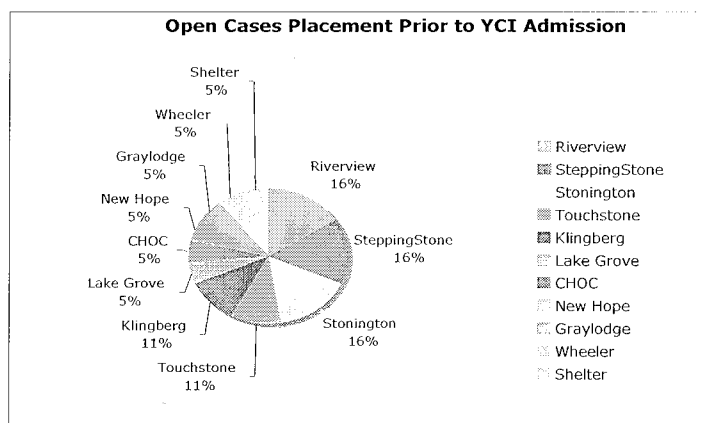


- The majority of the open cases were out-of-home cases, indicating the need for foster care placement or residential treatment.



(N=21 because the two remaining cases are designated as Parole and Subsidized Guardianship only)

- One-third of the girls in the open cases experienced placement at Klingberg, Touchstone and Stepping Stone in the past year – DCF licensed residential treatment programs and purported leaders in gender responsive programming and services.
- Five of the open cases were arrested at their residential placement and sent directly to YCI. Two girls were sent from Klingberg, two from Stepping Stone, and one from Touchstone.
- The vast majority had experienced placement at one or more residential treatment programs in Connecticut.



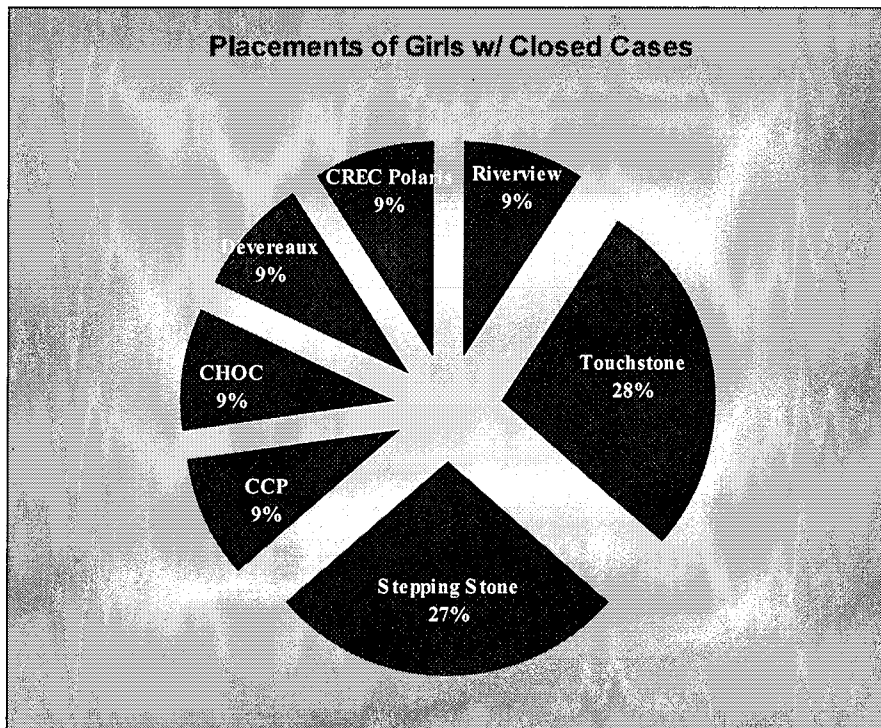
### **OCA Review of the Closed Cases (n=22)**

OCA was particularly concerned about the girls who had closed cases with DCF because these girls were not eligible for oversight and services from either the DCF AREA OFFICE WORKER or from the DCF Liaison to YCI. The DCF YCI roster tracks only whether a case is open or closed. OCA reviewed available LINK case records to obtain reasons for case closure and the date of closure. Our concerns were heightened by the discovery that half of the 22 closed cases were closed within one year prior (2007-2008) to the current placement at YCI and a third had been closed within

two years prior (2005-2006) to the current placement at YCI. The remaining 18% had been closed before 2005.

- Prior to closure, 45% of the cases had been open for one to two years and 41% had been open for more than five years.
- Only one case was found to be open less than one year prior to closing.
- Five girls (23%) with closed DCF cases had more than one admission to YCI in the past year.
- Fifteen girls were accused/pretrial and seven girls were sentenced.
- Prior to case closure, many girls had experienced excessive truancy or expulsion from school and experience with juvenile detention.

OCA also relied on LINK case records to review DCF activity prior to case closure and the placement histories of the girls during DCF involvement. The LINK case records often did not provide easily identifiable information related to the whereabouts of the girls in the year prior to incarceration at YCI. Under the LINK Placement History icon, OCA was able to obtain whether girls had a history of placement at a residential facility or foster care home. Among the closed cases, girls had a history of placement at the following residential treatment facilities: Riverview Hospital, Steppingstone, Touchstone, Connecticut Children’s Place (CCP), Children’s Home Of Cromwell (CHOC), Devereaux, Capital Region Education Council (CREC) Polaris.



### ***Disciplinary Sanctions Review***

While at YCI, several of the girls with both open and closed DCF cases received significant disciplinary sanctions from DOC staff, which resulted in periods of confinement to quarters and loss of recreation, commissary, phone, and visits. Given the relative short-stays for girls at YCI, and the fact that most girls were presentenced, sentences of 15 days confined to quarters or months without phone privileges often amounted to isolation throughout their stay. During the two-month period of the targeted case review, four girls with open cases and seven girls with closed DCF cases received disciplinary sanctions.

#### ***Examples of Disciplinary Sanctions***

Girl One: (Open DCF case) Two weeks Confined to Quarters followed by ten days Loss of Recreation for disobeying a direct order to stop insulting language and return to cell.

Girl Two: (Open DCF case) Three months Loss of Phone contacts for disobeying a direct order to return to cell.

Girl Three: (Open DCF case) Two consecutive 15 days of Confined to Quarters for being Out of Place in another girl's cell.

OCA has expressed concerns to DOC that disciplinary sanctions often fail to reflect the developmental, cognitive, and mental health capacity of the girls. Very often, the girls are unclear about the rules, react impulsively in an environment that has minimal tolerance for rule-breaking, and have extreme emotional and behavioral reactions triggered by post traumatic stress disorders. Information about disciplinary tickets also can negatively impact court decisions related to discharge and jeopardize placements with community providers upon release from YCI. At the time of this writing, in response to OCA concerns and the JO/YO team meetings, YCI leadership and custody staff are developing and piloting alternative disciplinary approaches and behavioral management for the girls. Examples include creating a better understanding of girls' mental health and behavioral needs through collaboration with the CMHC clinical team and allowing girls to complete consequences, including confinement to quarters, on the girls' tier. In addition, CMHC and DOC have convened a working group to explore adolescent and gender specific behavioral management strategies. The Supervising DCF Liaison to DOC represents DCF at this group. OCA's review of case records did not find consistent evidence that the DCF Liaison to YCI or the DCF workers had knowledge of the disciplinary process for girls at YCI or the impact of sanctions experienced by individual girls. While some DCF case records indicated awareness that a girl had received sanctions, notes by the DCF workers related only to concerns that the sanction might make it more difficult to secure a specific placement for the girls upon discharge from YCI. OCA did not find evidence in the case record related to inquires from DCF workers about to the well-being of the girls who were confined to quarters or who received segregation sanctions. We also did not find evidence that the DCF workers advocated on behalf of girls with mental health issues who received sanctions related to behaviors that may have been triggered by their mental health diagnoses.

### ***Review of Pregnancy and Parenting Among Girls at YCI***

OCA is particularly concerned about pregnant and parenting girls at YCI. National research reveals that pregnancy and parenting during incarceration poses increased risks to the permanency, well-being and safety of the mother and baby and can extend prison stays due to the lack of community-based maternity placements. Girls involved with DCF are at particular risk for adolescent pregnancy. The Child Welfare League of America reports pregnancy among youth in foster care is two and a half times higher than in the general youth population. Among girls involved in the Connecticut juvenile

justice system, it is estimated that 10-15% have been pregnant or are parenting. OCA made the following findings at YCI:

- Of the total number of incarcerated girls at YCI since 2006, at least 10% are known to have been pregnant or parenting during their incarceration.
- Of the girls reviewed in the OCA targeted case review, 16% (n=8) have experienced at least one pregnancy.
- Three of the eight girls in the targeted case review are parenting infant children.
- All but two of the cases of pregnant and parenting incarcerated girls in the targeted case review have significant DCF placement histories.

While the DCF Liaison to YCI spends significant time with adult women at the facility who have children involved with DCF, she has not been able to devote specific time and resources for pregnant and parenting JO/YOs. Currently, DCF does not identify and track pregnant and parenting girls and boys in the care of the DCF and its licensed facilities.

### ***Facilities Review***

A significant number of the girls at YCI spent time at the residential programs licensed and funded by DCF and the subject of review by several DCF consultants. OCA's review found that these programs continue to struggle to understand and meet the needs of girls, and in many cases, "feed" girls to the juvenile and adult justice systems. Connecticut expends substantial dollars to sustain these programs: the daily rate in FY06 was \$389.51 at Stepping Stone; \$288.12 at Touchstone; \$225.93 at Klingberg (FY07) and \$2,369 at Riverview Hospital. Klingberg also operates 15 beds for girls in its group homes at a cost of \$949,078 per year. As a comparison, in FY2006, the daily cost of incarceration at YCI was \$101.85.

The Third Quarter (January – March 2008) report by the Monitor at Riverview Hospital expressed concern about children with pending criminal charges admitted to Riverview Hospital and quickly transitioned from Riverview Hospital to YCI.<sup>14</sup> During this period, which coincides with the period of targeted review for this report, two girls experienced troubling shuffling between Riverview Hospital and YCI. OCA observed that Riverview Hospital and DCF staff was unable to adequately understand and address the behaviors of the girls as manifestations of their mental health needs. OCA also observed a serious need for Riverview Hospital to meet with the administrators and clinicians at YCI to clarify the relationship between the two facilities, increase understanding of the roles of both Riverview Hospital and YCI in the care of youth with complex needs, and discuss barriers to ensuring appropriate transitions between Riverview and YCI. The following is one case observed by OCA involving Riverview Hospital that highlights the need to better manage the care, treatment and discharge planning of girls with serious mental health issues and court involvement:

- Y. was hospitalized after attempting to hang herself at the Touchstone residential facility. During this time, she made another significant suicide attempt and was referred to Riverview Hospital for long-term care. As a toddler, Y. was placed by DCF with her grandmother. Her mother was a heroin addict, her father died when she was ten years old, and she had been raped on three occasions. She has been diagnosed with Depressive Disorder, PTSD, and Bipolar Disorder. While waiting for a bed at Riverview Hospital, she assaulted another patient, was arrested, and subsequently sent to YCI. At YCI, the mental health team, and at the advice of

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<sup>14</sup> *Riverview Monitoring Report*, Fourth Quarter, April – June 2008. (On file at OCA).

her lawyer and guardian ad litem, advocated for her admission to Riverview for voluntary treatment of her depression and PTSD. After a 21-day stay, Riverview Hospital sent a letter of noncompliance to DCF detailing Y.'s aggressive behaviors and lack of cooperation with treatment and requested her discharge back to YCI. Riverview Hospital also documented that Y. wished to retract her voluntary admission. After reviewing her behaviors, the judge remanded her to YCI and she was placed on the mental health unit. Three days after her return, Y. attempted suicide. Despite OCA's advocacy and repeated requests for assistance from the YCI clinical director, DCF did not convene a case conference until thirteen days after Y.'s re-entry to YCI.

During the period of OCA's review of YCI, OCA also received and responded to calls from concerned professionals and parents. We also monitored and raised concerns about the number of significant events and critical incident reports from DCF generated at the facilities that had been reviewed by the DCF consultants for girls' programming including Klingberg, Stepping Stone and Touchstone.

- Throughout 2007 and 2008, OCA conducted site visits at Klingberg and convened several meetings with Klingberg and DCF management to discuss concerns about the chaotic environment on the girls' unit, inadequate care and supervision by direct care staff, and a substantial escalation in the number of significant events and arrests for girls. For example, during March 2008, two girls were arrested and sent directly to YCI and two weeks later, six residents from the girls unit (under age 16) were criminally charged and sent to juvenile court.
- In April 2008, OCA became aware of a DCF hotline report by Touchstone staff related to the arrests of two fifteen-year-old girls and requested a programmatic update from DCF. The DCF case record documents that Touchstone staff raised concerns about the program's ability to maintain the girls at the program and requested assistance with the girls' behavioral and mental health needs. The case record also documented that the hotline worker made the recommendation that the staff involve the police. Three days later, the DCF Director of Girls Services visited the program and sent an email to the DCF Bureau Chief of External Affairs stating, "the program remains unstable, but working on a plan."
  - OCA requested a written description of concerns and the corrective action plan from DCF. Three weeks later, OCA received a document that identified areas for improvement with no time frames or oversight action steps for DCF. OCA requested documentation of specific oversight activities and site visits by DCF. DCF informed OCA that there was no formal documentation of the site visits and oversight plan other than email correspondence among involved DCF staff.
  - At the same time, OCA discovered that DCF quality assurance staff made a quarterly site visit to Touchstone shortly after the above hotline report to meet the new program director and follow-up with concerns about the cleanliness and disrepair of the physical plant. In addition, DCF had convened several meetings with the parent organization, NAFI, to discuss clinical programming concerns at both Touchstone and Stepping Stone.
- In June 2008, Stepping Stone, one of the programs assessed by the DCF consultants, reported the arrest of thirteen girls. Six of these girls were sent to YCI by the adult criminal court. At a June 2008, MAWGY meeting, DCF stated that it was aware that the program was undergoing significant staff turnover and retraining.

- In July 2008, OCA met with the leadership from NAFI, the parent organization for Touchstone and Stepping Stone, to discuss program concerns, the high number of arrests of girls at Steppingstone, and the plans for remedy. The leadership shared with OCA its own concerns about the girls and reiterated their commitment to program improvement.

OCA's findings indicate that several programs are struggling to meet the complex needs of the girls and that front-line staff often respond to girls' behaviors by involving 911 rather than providing gender responsive, trauma informed, and clinically-based interventions. The case files and incident reports reviewed by OCA often characterized girls' behaviors as aggressive and noncompliant rather than being rooted in underlying mental illness or triggered by inadequate treatment environment. Once law enforcement became involved, the girls experienced increased risk for arrest and involvement with the adult court. Many girls were arrested for violating court orders of probation to behave at their programs or not run away from the program. In court, all too often girls' behaviors were the primary focus for decision-making and DCF workers did not provide the court with information about the problems at the programs as a context for some of the behaviors. OCA has convened several meetings with DCF to specifically discuss concerns about the chaotic environments at these programs and the need for increased support and oversight by DCF.

### **RECOMMENDATIONS AND NEXT STEPS**

OCA finds that DCF, as the state's lead children's agency, falls short in meeting its responsibility to lead efforts to ensure permanency, safety, and well-being of girls in Connecticut. However, the implementation of the following recommendations requires leadership at every level of government and throughout Connecticut's communities. Despite its broad statutory mandates, the Child Advocate lacks enforcement authority over state agencies. While OCA will continue its legislative and other advocacy efforts, we call on the Governor, Legislators, and advocates to urge DCF, and all agencies with responsibility for well being of children, to establish a coordinated and meaningful response to the needs of Connecticut's girls. Citizens must also voice their expectation that state dollars are spent responsibly to provide all girls with the opportunity to become safe, strong, and successful adult women.

1. DCF must produce an action plan to create a continuum of services for girls informed by the findings and recommendations in existing reports. The plan should have specific time frames and embed responsibility for implementation throughout the agency.
2. The DCF Bureau of Continuous Quality Improvement must collect, analyze and report information related to the demographics, needs, service gaps, and pathways for girls involved with DCF. These reports should be generated monthly and provide a basis for proactive planning and response.
3. DCF must conduct a quarterly review of available placements and barriers to services to girls with serious and persistent mental health needs.
4. DCF must demonstrate how its Foster Care Plan addresses the unique needs of girls.
5. DCF licensed girls' programs must undergo a current evaluation and receive ongoing oversight. Monitoring of these activities by DCF must be transparent.

6. DCF should revise its Structured Decision-Making tool to include risk factors for involvement in the juvenile and adult criminal justice systems. These risk factors should be reassessed prior to approval for case closure.
7. DCF must develop a single, comprehensive assessment and planning tool for girls that is based on gender responsive and trauma informed best practices. This tool should follow a girl throughout her involvement with DCF, be part of the DCF LINK case record, and shared as appropriate with agencies and providers.
8. DCF must develop and maintain a mechanism to identify and track pregnant and parenting girls and boys in the care of the DCF and its licensed facilities to proactively plan for programs and reduce the risks for incarceration.
9. DCF must immediately evaluate compliance across every DCF Bureau with its policies related to incarcerated youth and with the DOC-DCF MOU.
10. DCF must conduct an audit of social work practice by Area Office staff related to the girls at YCI. Areas for review should include use of trauma informed, gender responsive, and adolescent best practices, frequency and quality of visitation, quality of reports to the adult criminal court and probation, and collaboration and information-sharing with the DCF Liaison, DOC clinical and custody staff at YCI, and probation.
11. DCF must conduct an audit of LINK case records of all girls currently at YCI to ensure that information is up-to-date and accurate to facilitate alternative placements, the provision of services during incarceration, and re-entry planning and supports.
12. All Connecticut state agencies with responsibility for children, including the Departments of Education, Developmental Disabilities and Mental Health and Addiction Services, must commit resources and staff to understand and address the needs of girls at-risk.

With the urging and support of OCA, the DOC has embarked on several initiatives to identify, understand and respond to the needs of all girls at YCI. **Despite these critical reforms, YCI remains a maximum-security prison for adult women that cannot meet the unique needs of adolescent girls. Girls in Connecticut require an alternative to YCI.** The existence of MYI as a separate DOC facility for adolescent boys raises concerns about parity for incarcerated girls. Additionally, in January 2010, Connecticut law will raise the age of juvenile jurisdiction and girls who are sixteen and seventeen years old will no longer automatically enter the adult juvenile justice system. Yet, even under the new law, girls who are charged with certain crimes may be transferred from the juvenile to adult criminal justice system. These girls will comprise an even smaller minority among the 1400 adult women at YCI, placing them at greater risk for isolation, physical harm, and limited access to needed services and programs. The following recommendations are made to the DOC given its jurisdiction over the care and custody of girls in adult prisons and with the expectation that DCF will provide support to related DOC efforts:

1. The DCF and DOC must immediately partner to actualize the DOC-DCF Memoranda of Understanding for incarcerated youth.
2. DOC must convene a planning group with leadership from DCF, UCONN Correctional Managed Health Care, DOE, the Departments of Mental Health and Addiction Services and Developmental Disabilities, the Judicial Branch, the Legislature, and juvenile justice advocates, to recommend alternatives to YCI for girls who must be incarcerated in the adult system. The SHE-MAWGY should continue to provide guidance to DOC and serve as a forum to share information about the needs of girls currently incarcerated at YCI.



3. DOC must document its current reform efforts at YCI to facilitate ongoing oversight and future policy direction.
4. DOC must audit the availability and access to programming and transitional supervision for girls at YCI to assess parity with the boys at MYI.
5. DOC must audit its compliance with education laws for girls at YCI.
6. DOC must hasten its efforts to develop, implement, and monitor a gender-responsive, adolescent appropriate, and trauma informed discipline program for girls at YCI.