NCYOJ
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National Center for Youth Opportunity and Justice

Mental Health Training
for Juvenile Justice

Participant Manual

Mental Health Training for Juvenile Justice

Fourth Edition

Disclaimer

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National Center for Youth Opportunity and Justice

About the NCYOJ

Established in 2001, the National Center for Youth Opportunity and Justice (NCYOJ)[1] at Policy Research, Inc. (PRI) assists the field with advancing policy and practice to ensure the well-being of children and youth in contact with the juvenile justice system who are experiencing mental and substance use disorders. The NCYOJ supports systems and practice improvements by collaborating with communities to build capacity across service delivery systems; conducting applied research and evaluation; communicating emergent and best practices to policymakers and practitioners; guiding and informing policy at the national, state, and local level; and elevating the voices and perspectives of youth and families.

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[1] Between September 2001 and October 2018, the NCYOJ operated as the National Center for Mental Health and Juvenile Justice.

Acknowledgements

The NCYOJ would like to acknowledge the following individuals for their efforts to maintain and update, evaluate, and support dissemination of the curriculum, now in its fourth edition.

Karli Keator, MPH, Director, National Center for Youth Opportunity and Justice

Aly Feye, Training Coordinator, National Center for Youth Opportunity and Justice

Stephen Phillippi, Ph.D., LCSW, Louisiana State University Health Science Center

Special Thanks To

The NCYOJ would like to acknowledge the following individuals for their assistance with developing the original curriculum.

Julie Biehl, J.D., Child and Family Justice Center, Northwestern University School of Law

John Chapman, Ph.D., Connecticut Judicial Branch

Erin Espinosa, Ph.D., Texas Juvenile Probation Commission

Debra Ferguson, Ph.D., Illinois Department of Human Services/Division of Mental Health

Catherine Foley Geib, MPA, Connecticut Judicial Branch

Gene Griffin, Ph.D., J.D., Northwestern University, Feinberg School of Medicine

Pamela Gulley, Ph.D., Ohio Department of Youth Services

Holly Hills, Ph.D., Florida Mental Health Institute, University of South Florida

Antoinette Kavanaugh, Ph.D., Northwestern University School of Law

Tracy Levins, Ph.D., Prevention and Early Intervention Services, Texas Juvenile Justice Department

Stephen Phillippi, Ph.D., LCSW, Louisiana State University Health Science Center

Kathleen Skowyra, Associate Director (former), National Center for Youth Opportunity and Justice

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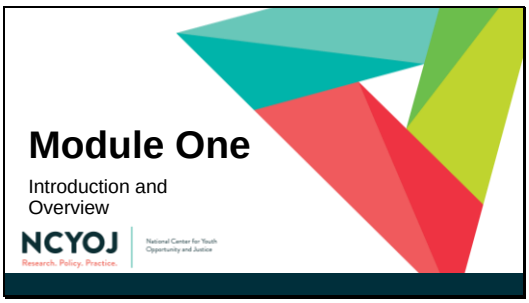

Module Objectives

- Describe goals of the MHTC-JJ
- List the different units of the course
- Why MHTC-JJ?

Training Goals

- Increase understanding of youth with mental and substance use disorders in the juvenile justice system
- Increase familiarity with issues of adolescent development and how they impact youth behavior
- Understand the important role of families
- Increase knowledge of effective, evidence-based interventions
- Improve job safety and reduce job-related stress

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Overview of the Day

- Adolescent Development
- Child Trauma
- Adolescent Behavioral Health
- The Family Experience
- Working with Youth – What You Can Do
- Effective Interventions
- Taking Care of You

Activity

Free Association

Purpose of the Exercises

- You and your role in the juvenile justice system
  - Importance and challenges of what you do
  - What you can do to increase safety and get better outcomes
- Universal aspects of adolescence
  - What teenagers are like
  - How teenagers relate
  - How we are all alike
- Understand the impact of childhood trauma, and mental and substance use disorders on behavior

Youth are different than adults

Recent Supreme Court cases, citing new research on brain development, have established that youth should be treated differently than adults.

- Roper v. Simmons (2005)
- Graham v. Florida (2010)
- Miller v. Alabama (2012)

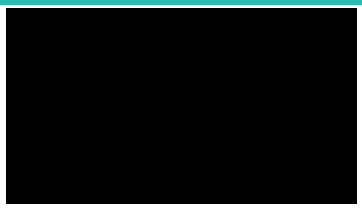
Youth may do terrible things, but they are less culpable than adults.

Throughout the training, consider the following

- Each of the topics in the context of your job
- Development in the context of your experience with teenagers (e.g., you as a teen, your kids or relatives)
- Impact of childhood trauma, mental illness and substance use on typical adolescent development
- Further stress of juvenile justice involvement

The Family Experience

Opportunity for Change



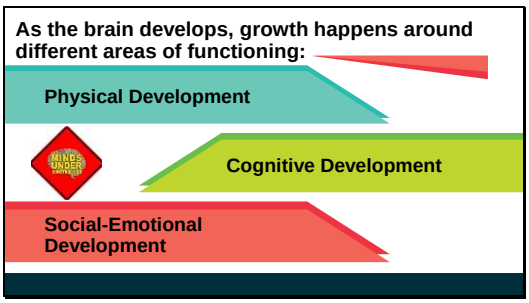
Getting Started

- What challenges do you face in understanding or assisting youth in coping with their symptoms?
- What changes would **YOU** like to see happen for these youth?
- What are **YOU** hoping to get from the training today?

Module Objectives

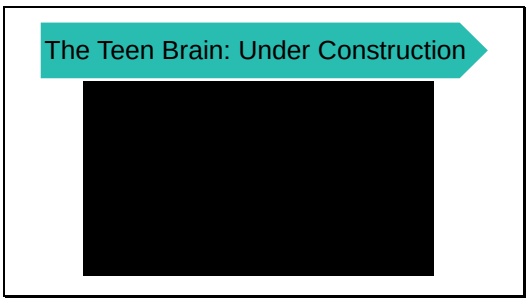
- Explain basic brain development in adolescents
- Describe the impact of brain research on the law
- Discuss adolescent risk-taking and impulsive behavior

- A new engine and a lot of horsepower **(physical)**
- A brake system that won't work completely for several years **(cognitive)**
- A sensitive gas pedal that can go from 0-60 mph in seconds **(emotional)**
- A group of friends to share the racetrack and influence driving **(social)**



Activity

Candid Camera



Brain Basics – Development

Physical

A message comes into a brain cell. The cell does its work and sends the message on to other brain cells.

Brain Basics – Plasticity

Physical

- For some aspects of brain development, **timing is critical**. Important abilities will be lost or diminished if they don't develop at the right time.
- Childhood experiences impact how the brain develops.
- Negative early childhood experiences can result in developmental delays.

Brain Basics – Plasticity

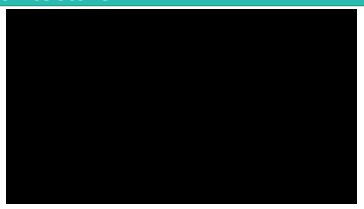
Experiences cause changes in the brain, for better or worse.

- This is why we practice behaviors – the more we repeat things, the stronger the brain connections become.
- A single, powerful experience can affect our brain for life.
- Repeated smaller experiences can also change our brain.

There is always hope that youth can improve with new, positive experiences…

Physical

Experiences Build Brain Architecture



Physical

"*Brain development continues long after childhood and well into early adulthood. In fact, scientists now believe that adolescence may be as important in brain development as the first three years of life*"

(Steinberg, 2008)

Physical

Don't confuse physical development with cognitive or emotional development.

Although teenagers start to look like adults, they are still limited by their cognitive development.

What is Cognitive Development?

Cognitive

It refers to the way in which individuals learn and think about the environment around them.

Cognitive Development

Cognitive

The part of the brain that develops last during adolescence is the **prefrontal lobe**, which controls some important functions:

- Weighing pleasure & reward
- Susceptibility to peer pressure
- Self-control
- Complicated decision-making

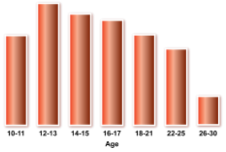
Cognitive

What are some of the types of thinking that will change between adolescence and adulthood?

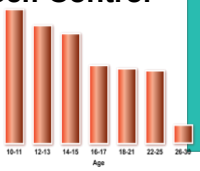
- Self-control
- Short-sightedness
- Susceptibility to peer pressure

Self Control

Cognitive



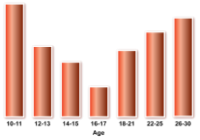
Sensation-Seeking Declines With Age



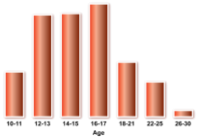
Impulsivity Declines With Age

Risky Behavior

Cognitive



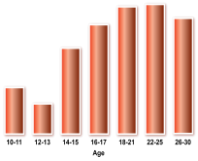
Preferences for Risk Peaks in Mid-adolescence



Risk Perception Declines and then Increases after Mid-adolescence

Shortsightedness

Cognitive



Older Individuals Are More Willing to Delay Gratification

- Youth focus more on gains and less on loss.
- Youth focus more on what they will get right now and less on what might happen in the future.

What is Emotional Development?

Emotional

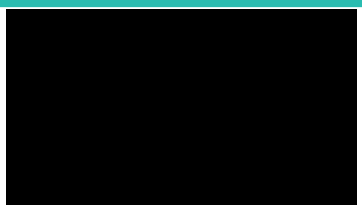
The process of establishing a sense of identity in the context of relating to others and learning to cope with stress and manage emotions.

During adolescence, girls and boys go through significant physical and emotional development. The rate of development varies widely.

Emotional

Social

Peer Influence and Adolescent Behavior



Susceptibility to Peer Influence

Social

At a time when youth most need adult guidance to mediate some of their impulsive, shortsighted behavior, they are simultaneously moving away from adult influence and control.

Mid-adolescence is a time of **high sensation seeking** and still **developing self-control**, which can lead to **short-sightedness** and **risky behaviors**.

Because the brains of teenagers are not yet fully developed, some of their **behaviors** may result from immaturity.

If a four-year-old child doesn't follow signs posted on a bus, do we hold him/her responsible? No, because we realize he/she is not yet capable of reading.

Recall your own teenage behavior.

- Did you do anything that could have gotten you stopped by the police?
- Would you deal with that same situation differently now as an adult?

Module Three

Child Trauma

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Module Objectives

- Define trauma: **E**vents, **E**xperiences, **E**ffects
- Review prevalence of trauma among youth involved with the juvenile justice system
- Describe the impact of childhood trauma on youth development, behavior, and delinquency
- Discuss trauma-informed responses

Concept of Trauma

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

Activity

Traumatic **E**vents

- Actual or extreme threat of physical or psychological harm
- Severe, life-threatening neglect

Traumatic Experiences

- May be life-threatening
- Overwhelming
- Vary between people
- Vary over time
- Be a single incident
- Or chronic incidents

Most people can get through adverse experiences without developing trauma symptoms. Resilience and protective factors contribute to this.

It's About Perspective

Trauma Effects

- Nightmares
- Flashbacks
- "Fight or flight"
- Disassociation
- Cutting
- Avoidance behaviors
- Exaggerated negative beliefs about the world

A Common Theme for Child Systems

In a longitudinal general population study of 9- to 16-year-old youth, 25% had experienced at least one traumatic event in the past three months.

At least 75% of children in the juvenile justice system have experienced traumatic victimization.

As many as 50% of these youth may have symptoms of trauma.

93% of children in detention reported exposure to adverse effects (e.g., accidents, physical and sexual abuse, neglect, community violence)

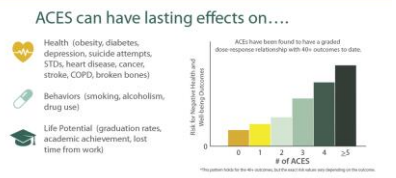
Trauma and Family

Trauma can be an intergenerational issue that affects all family members.

Adverse Childhood Experiences Study (ACES)

- Examined adults who, in childhood, experienced
  - physical abuse and neglect
  - emotional abuse and neglect
  - sexual abuse
- Or grew up in a household with
  - an alcohol or drug user
  - an incarcerated household member
  - someone who was chronically depressed, suicidal, institutionalized, or mentally ill
  - domestic violence

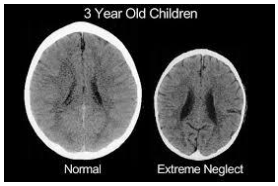
Lasting Effects



Trauma's Impact on the Brain

- Disruptors of normal neural development can include
  - Failure to expose youth to appropriate experiences at the critical times (neglect) and
  - Overwhelming the brain's alarm system (abuse)

Disrupted Brain Development – Childhood Neglect



Trauma and Alarm

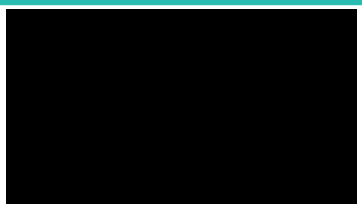
- The alarm system is a survival mechanism.
- Extreme or frequent threats can damage the alarm system.
- With trauma, the alarm system is too easily triggered and too slow to shut down.

Traumatic Response Styles

- Fight
- Flight
- Freeze
  - Non-responsive
  - Self-mutilation
  - Passing Out

After experiencing trauma, youth may …

Trauma Effects and Resiliency



Recovery

- Resilience - Not everyone exposed to adverse experiences is traumatized.
- Recovery - Brains respond to repeated stimuli (use-dependent development).
- Even as adults, brains are capable of learning and changing.

Recovery – What Can Adults Do?

Any adult can help a traumatized adolescent by being aware of the youth's current environment and the four "Ss"

- **S**afety
- **S**upportive Adult Relationships
- **S**elf-regulating
- **S**trengths

Safety is essential…

- From a trauma perspective, youth act out when they feel threatened. Therefore, helping youth feel safe should reduce the acting out and improve safety.

Support

- You don't have to be therapist to be therapeutic.
- Each interaction presents an opportunity…
  - To build skills
  - To foster a helping relationship

Self-regulating

Teach Calming Skills
- Recognizing physical signs of escalation
- Incorporating relaxation techniques

Teach Coping Skills
- Using verbal rather than behavioral responses
- Seeking adult support

Strengths

- Build strengths and resilience
- Work with natural talents and interests
  - Sports, music, drawing, cooking
- May include spiritual beliefs and cultural identity

Module Four

Adolescent Behavioral Health

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Module Objectives

- Understand the prevalence of mental and substance use disorders within the juvenile justice population
- Identify signs of and symptoms associated with these conditions
- Discuss warning signs for suicidal and self-injurious behavior

Activity

Symptom Matching

A mental disorder is characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior.

Mental Disorders Defined

Depending on the exact nature of the mental disorder,

- judgment and behavior can be significantly impaired;
- functioning at home, at school, and at work can be adversely impacted;
- disturbances will be episodic, rather than continuous; and
- there can be long periods of healthy functioning.

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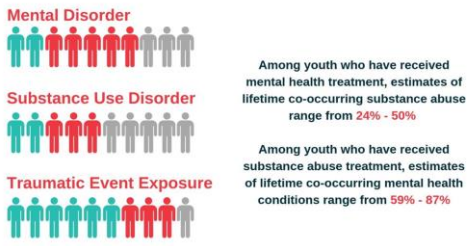
In juvenile justice, you will encounter youth who have these conditions.



Among youth who have received mental health treatment, estimates of lifetime co-occurring substance abuse range from 24% - 50%

Among youth who have received substance abuse treatment, estimates of lifetime co-occurring mental health conditions range from 59% - 87%

Each disorder is characterized by basic signs and symptoms.

There is a process for identification and diagnosis.

Anxiety Disorders

Primary emotional symptoms are fear and anxiety in response to specific phobias, as well as fear and anxiety prompted by the following:

- Panic Disorder
- Generalized Anxiety Disorder
- Separation Anxiety Disorder

Prevalence within the juvenile justice population is estimated to be 34.4%.

Panic Disorder

- Recurrent, brief attacks of intense fear absent any real danger
- Accompanied by physical symptoms such as palpitations, sweating, nausea, and dizziness

Generalized Anxiety Disorder

- Excessive anxiety or worry
- Restlessness
- Difficulty concentrating, muscle tension, and sleep disturbance

Separation Anxiety Disorder

Excessive and age-inappropriate anxiety concerning separation from individuals to whom the youth is attached

Disruptive Behavior Disorders

- Conduct Disorder
- Oppositional Defiant Disorder
- Attention Deficit Hyperactivity Disorder

Prevalence within the juvenile justice population is approximately 46.5%.

Conduct Disorder

Characterized by a persistent pattern of behavior which violates the basic rights of others:

- aggression toward people or animals
- destruction of property
- lying and theft
- bullying or intimidation
- initiation of physical fights

Oppositional Defiant Disorder

- Involves a persistent pattern of hostile and defiant behavior:
  - arguing with adults
  - defying rules/requests
  - blaming others
  - being easily annoyed
  - being angry
  - being spiteful and vindictive

Attention-Deficit/Hyperactivity Disorder

- Types
  - ✓Inattention (difficulties in sustaining attention, listening, following instructions, attending to details)
  - ✓Hyperactivity/impulsivity (constant squirming or fidgeting, difficulty in playing quietly, talking excessively)

- **Major Depressive Disorder**
- **Disruptive Mood Dysregulation Disorder**
- **Bipolar Disorder**

Prevalence within the juvenile justice population is approximately 46.5%.

Major Depressive Disorder

- Sad or irritable mood
- Change in sleep or appetite
- Loss of interest in previous activities
- Low energy
- Poor concentration
- Thoughts of death/suicide

Disruptive Mood Dysregulation Disorder

- Severe, recurrent temper outbursts
- A persistently irritable or angry mood between temper outbursts

Bipolar Disorder

- Characterized by extreme mood swings between depression and mania/hypomania.
- Mania
  - ✓Inflated self-esteem
  - ✓Rapid speech
  - ✓Decreased need for sleep
  - ✓Grandiosity
  - ✓Distractibility
- Can present in childhood, especially when there is a strong family history of the disorder.

Neurodevelopmental Disorders

- Intellectual Disabilities
- Communication Disorders
- Autism Spectrum Disorder

Prevalence within the juvenile justice population is approximately 46.5%.

Intellectual Disabilities

- Impaired intellectual functioning (including reasoning, problem solving, judgment, and learning from experience)
- Adaptive impairment (including independent living, social, and communication skills)

Communication Disorders

- Include deficits in speech, language, and nonverbal communications
- Must take into account cultural background, including growing up in a household where English is not the primary language
- May result in youth having difficulty understanding basic instructions from staff

Autism Spectrum Disorders

- Persistent deficits in social communication and social interaction across multiple contexts
- Restricted, repetitive patterns of behavior, interests, or activities
- Symptoms must be present in the early developmental period (but may be masked by learned strategies in later life)
- Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning

Substance-Related Disorders

Substance-related disorders involve a pattern of substance use leading to significant impairment and distress:

- Craving the substance
- Taking the substance in larger amounts or over a longer period than intended
- Making unsuccessful attempts to reduce substance use
- Experiencing recurring interpersonal problems

Prevalence within the juvenile justice population is approximately 46.2%.

Switching Gears

Juvenile Suicide

Juvenile Suicide

General Youth Population

- Suicide is the second leading cause of death among youth ages 10-18
- One in 13 high school students attempt suicide

Justice-Involved Youth

- Have an increased risk for suicide
- Suicide is the leading cause of death for youth in confinement
- Youth in residential facilities have nearly 3x the suicide rate of peers in the general youth population

Suicide Risk Factors for Youth in the Juvenile Justice System

- History of mental or substance use disorder
- Involvement in special education
- Legal/disciplinary problems
- Prior disciplinary action
- Prior offenses
- Referral to juvenile court
- Placement in room confinement

- Unusual or sudden changes in personality, behavior or mood
- Talking about wanting to die
- Withdrawal from friends, family or usual activities
- Expressions of hopelessness or feeling trapped
- Actively securing access to lethal means

Periods of High Risk for Suicide in Juvenile Justice

- Although youth can become suicidal at any point during confinement, the following periods are considered times of high risk:
  - during initial admission
  - upon return to the facility from court after adjudication
  - upon return to the facility after sentencing
  - following receipt of bad news
  - after suffering any type of humiliation or rejection
  - during confinement in isolation or segregation
  - following a prolonged stay in the facility

What can ***staff*** do to prevent juvenile suicide?

- Take any written, spoken, or other communication of suicide seriously.
- If you think someone is at risk, do not be afraid to ask if that person if considering suicide. This will not cause suicide.
- Communicate any suspicion that a youth is thinking about suicide to a mental health professional or supervisor immediately.
- Stay with the youth. Do NOT leave a suicidal youth alone while you get help.

What can juvenile justice systems do to prevent juvenile suicide?

- Provide routine suicide prevention training for all staff.
- Conduct a standardized intake screening for suicide risk using a valid and reliable tool for youth, with suicide risk assessment conducted by a qualified mental health professional.
- Develop protocols that provide shared information about suicide risk.
- Institute varying levels of supervision.

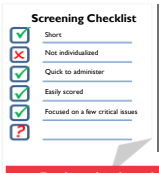
(continued on next slide)

- Provide a safe physical environment.
- Establish emergency response protocol.
- Institute a notification system for suicides or suicide attempts through the chain of command.
- Create a critical incident stress debriefing protocol, as well as a death review, for all staff and youth.

Given the high prevalence of mental and substance use disorders, and suicide, among justice-involved youth,

How are these conditions identified?
How do we determine individual treatment and needs?

Identification Begins with Screening



- The goal is to identify youth
  - in crisis – needing immediate intervention
  - as possibly having a disorder
- Screening results indicate the need for
  - crisis intervention
  - follow-up assessment

Designed to be administered by non-mental health professionals.

What is a mental health assessment?

- individualized
- more detailed evaluation of a youth after a screening
- may use "in-depth" interviews, rating scales, verbal and non-verbal tasks, self-report measures, and interviews with family members
- focus on a wide range of clinical issues
- administered and interpreted by persons with advanced mental health training

Screenings are recommended for

- prevention and diversion programs
- probation intake
- detention centers
- reception into juvenile corrections

Assessments may be conducted for

- trial
- sentencing
- comprehensive treatment planning
- transition from institutional custody
- institutional treatment planning

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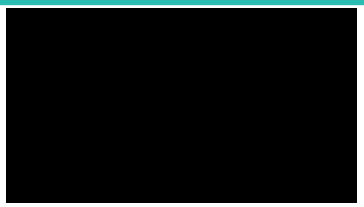
Summing It Up: Consider Other Factors

Not all "misbehaviors" are signs of a mental disorder

Other factors to consider include the following:

- Normal adolescence is a time of risk-taking behaviors.
- Deviant behaviors that go beyond normal risk-taking can be illegal without also being a sign of mental illness.
- Behaviors that appear unusual to our culture might be appropriate in another culture.

Childhood Is Not a Mental Disorder



Activity

Where do you stand?

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Where do you stand?

Youth repeatedly involved in juvenile justice are beyond rehabilitation, and are unlikely to become productive citizens.

All youth in the juvenile justice system need mental health treatment.

Families and communities are essential components of positive youth development.

A youth's family is his or her best support system.

Incarcerated youth should be provided with the supports necessary to enable them to return to their biological families once they are released.

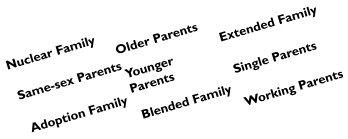
If a youth is upset or agitated, it is best to wait until he or she is calm before attempting to intervene.

I have a tremendous impact on whether a youth achieves his or her rehabilitative goals.

Module Objectives

- Be aware of the experience of living with and caring for a child or youth with a behavioral health condition
- Describe the importance of positive family engagement in the juvenile justice system
- Explain the challenges experiences by families involved in the juvenile justice system
- Create meaningful opportunities to engage families and promote partnerships

Let's Talk About Families



Activity

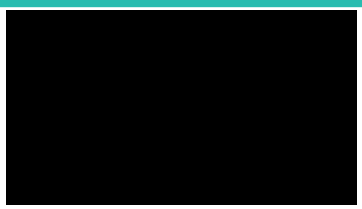
Family Stressors

Family

Think about the family of a youth experiencing a behavioral health condition involved with the juvenile justice system:

- What are they thinking?
- What are they feeling?
- What if the youth has a mental illness?
- What questions might the family have?
- What concerns might arise?

Role of the Family I



Supporting Materials

Hand-Out: Help Wanted

Person willing to be on call 24 hours a day, 7 days a week, with no vacation, personal days, or holidays.

There is no salary, bonus plan, or 401K Plan. There is no supervisor or on-the-job training and no yearly holiday party.

You must be emotionally involved with the person you are going to work for, and be willing to work until you are exhausted. You must be a self-starter and entrepreneur.

You must also be willing to learn the job by trial and error. The person you are going to care for will frequently not be able to express any appreciation and may even be abusive to you at times.

If you are interested in this position, please apply immediately.

(Scherma, G.A. (2000). How to get organized as a caregiver. *Loss, Grief and Care*, *8*(3/4), 127-133.)

Mental Health Diagnosis: Impact on the Family

- The diagnosis of childhood mental illness has an impact on the entire family.
- Accepting that a child (or sibling) has a mental illness can be difficult.
- When parents find out that their child has been diagnosed with a mental illness, they may go through a grief process.

Influencing Factors on the Effect of a Child's Behavioral Health Diagnosis on the Family

- Family's social-support system
- Family's previous experience with/history of mental and substance use disorders
- Family's coping patterns and resources
- Access to and quality of health care
- Financial status – access to resources
- Nature of symptoms

Juvenile Justice: Impact on the Family

- Entry into the juvenile justice system can be confusing and frightening for the youth and his/her family.
- The entire family may experience fear, helplessness, anxiety, and relief.
- This is especially true if the youth has a mental illness, substance use disorder, or history of traumatic experiences.

Why is family engagement important?

- Shared information and planning increases the likelihood that families follow through with service plans.
- Families learn more effective skills for responding to challenging situations involving their children.
- Positive youth development increases the likelihood that a youth successfully re-enters his/her home, school, or community.
- Families offer expertise, partnership, and advocacy.

Families as Experts

Families have information that can be invaluable to your work with the youth.

- History (school, medical, mental health, substance abuse, trauma)
- Treatment
- Strengths

- Relationships
- Triggers
- Motivators
- De-escalators
- Community

Characteristics of Family Engagement

- Treating families with dignity and respect.
- Peer-to-peer support.
- Collaboration and partnerships between service professionals and family members.
- Meaningful communication across all involved parties.
- Sustained familial engagement.

Indicators of High Engagement

- The family's rate of attendance at appointments is high.
- The family follows through with interventions.
- The family completes assignments and tasks.
- Youth and family members are fully present and involved.
- Family members are actively involved in decisions and make progress toward treatment goals.

Indicators of Low Engagement

- Scheduling appointments is difficult.
- Appointments are missed.
- Intervention plans are not followed.
- Goals of the family contain little substance.
- Treatment progress is very uneven.
- Family members conceal information about important issues.

Factors Influencing Family Dropout

- Failure to address practical barriers (e.g., transportation, child care)
- Lack of belief by the family that counseling will help
- Poor relationship with the caseworker

Challenges for Families

- Loss of power
- Family mental illness, substance use, or trauma
- Cultural and ethnic barriers
- Mutual mistrust between families and the juvenile justice system
- Multiple and often competing demand
- Financial limitations

Supporting Materials

Checklist for Parent-Professional Collaboration

- ✓ Have I put myself in the parent's place and mentally reversed roles to consider how I would feel as the parent of a child with an emotional disability?
- ✓ Do I see the child/adolescent in more than one dimension, looking beyond the diagnosis or disability?
- ✓ Am I able to keep in mind the child/adolescent is a person whom the parent loves?
- ✓ Do I really believe that parents are equal to me as a professional and, in fact, are experts on their child?
- ✓ Do I consistently value the comments and insights of parents and make use of their reservoir of knowledge about the child's total needs and activities?
- ✓ Do I judge the child/adolescent in terms of his or her progress and communicate hope to the parents by doing so?
- ✓ Do I listen to parents, communicating with words, eye contact, and posture that I respect and value their insights?
- ✓ Do I ask questions of parents, listen to their answers, and respond to them?
- ✓ Do I work to create an environment in which parents are comfortable enough to speak and interact?
- ✓ Am I informed about the individual child's case before the appointment or group session, placing equal value on the parent's time with my own time?
- ✓ Do I treat each parent I come in contact with as an adult who can understand a subject of vital concern?
- ✓ Do I speak plainly, avoiding the jargon of medicine, sociology, psychology, or social work?
- ✓ Do I make a consistent effort to consider the child as part of a family, consulting parents about the important people in the child's life and how their attitudes and reaction affect the child?
- ✓ Do I distinguish between fact and opinion when I discuss a child's problems and potential with a parent?
- ✓ Do I make every effort to steer parents toward solutions and resources, providing both written and oral evaluations and explanations as well as brochures about potential services, other supportive arrangements, and financial aid?
- ✓ Do I tell each family about other families in similar situations, recognizing parents as a major source of support and information and, at the same time, respecting their right to confidentiality?

- ✓ At the request of parents, am I an active part of their information and referral network, expending time and energy to provide functional contacts to points in the service system and to parent support networks? Do I see as my goal for interactions with parents the mutual understanding of a problem so that we can take action as a team to alleviate the problem?
- ✓ Do I express hope to parents through my attitude and my words, avoiding absolutes like “always” and “never”?
- ✓ Do I actively involve the parents of each child in the establishment of a plan of action or treatment and continually review, evaluate, and revise the plan with the parents?
- ✓ Do I make appointments and provide services at times and in places which are convenient for the family?
- ✓ Do I obtain and share information from other appropriate professionals to insure that services are not duplicated and that families do not expend unnecessary energy searching for providers and services?

This article is used with permission from Portland State University, Research and Training Center on Family Support and Children's Mental Health, Portland State University, Portland, Oregon. Questions for this checklist were stimulated by the following article: Rosemary Alexander and Patricia Tompkins-McGill. (1987). Notes to the Experts from the Parent of a Handicapped Child. Social Work, 32(4).

Actions of Juvenile Justice Professionals that May Negatively Impact a Family

- Pressuring the family
- Engaging in power struggles with the family
- Blaming the youth's behavior on the parents or caregiver
- Failing to identify barriers to caregiver follow-through
- Failing to facilitate contact with family

For Families with Low Engagement

- Be aware of the barriers and follow through with families to help them overcome the barriers.
- Examine your own attitude about the family.
  - ✓Have you had inappropriate expectations?
  - ✓Have you been overly controlling?
  - ✓Have you given up on the family?

What do ALL families want?

- Dignity, respect, and honesty
- A positive focus and hope for the future
- Cultural competence
- Flexible scheduling
- High-quality interventions

What can YOU do to support families?

Listen in an active, non-judgmental way

Provide information and answer questions

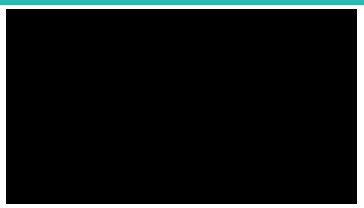
Identify potential resources and encourage continued engagement

Provide reassurance and emphasize strengths

What can systems do to support families?

- Provide qualified translators.
- Hold family events at the facility or in the community.
- Help establish peer support groups for families.
- Recruit family members to serve on planning and advisory groups or be peer specialists

Role of the Family II

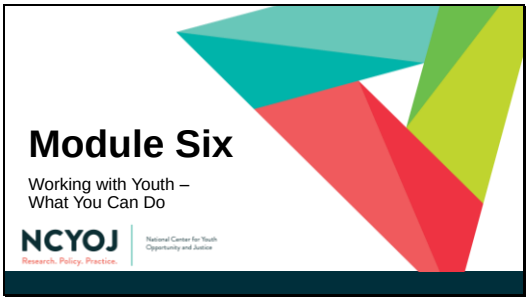


Remember…

- One strategy will not work for all families.
- Some strategies can be implemented by direct care staff.
- Other strategies go beyond anything that any one staff person could do and are aimed at the systems level.

Moving Forward with Family Engagement

- Where are you in your readiness to engage families?
- Is there something you will do differently or want to change?
- Where is your organization's readiness?



Module Objectives

- Describe the various types of de-escalation techniques you can use when youth are in crisis
- Positively interact with youth and families to achieve the best possible outcomes
- Apply this knowledge to make job safer and less stressful

Many youth in juvenile justice…

- don't think before they act.
  - don't assess risk accurately
  - are highly impulsive
- don't relate well with others.
  - misinterpret social cues
  - overreact to (real or perceived) slights
- struggle with learning.
  - have poor problem-solving skills
  - have difficulty incorporating new information

Youth in Juvenile Justice

- Many youth in juvenile justice struggle with issues relating to mental illness, substance use, and trauma.
  - These issues are in addition to the behavioral, interpersonal, and learning problems typical of many justice-involved youth.
  - Therefore, they will need even more support, guidance, and role-modeling from adults.

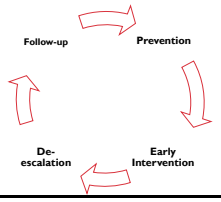
What can you do to help youth . . .

- . . . learn to think before acting?
- . . . develop positive relationships?
- . . . learn from their mistakes?

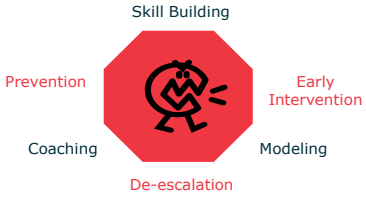
Remember…

- Brain development is based on what is experienced.
  - Adolescence can be a time of positive experiences.
- Adults can help teenagers develop strengths:
  - calming and self-regulation skills
  - assertiveness rather than aggression
  - problem-solving skills

Key Interventions



Keys to Successful Crisis Management



Crisis Prevention

- Is an on-going activity
- You are in the best position to spot a potential crisis and de-escalate the situation BEFORE it turns dangerous
- Expecting youth to make the best choice in the heat of the moment is not a good approach

Remember!

- You don't have to be a therapist to be therapeutic.
- Each interaction presents an opportunity to
  - model adaptive behaviors,
  - build skills, and
  - foster a helping relationship.
- Further developing some skills you already have can help you intervene more successfully

Take Action Early

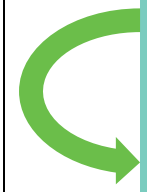
- Being PROactive rather than REactive can go a long way toward keeping the environment safe for staff and youth.
- The best time to intervene in a crisis is before it starts.
- Be alert to early warning signs.
  - What things signal a budding crisis?
  - What cues are present in the environment?
  - What sorts of behaviors might precede a crisis?

Know the Youth

- What pushes his/her buttons?
- What helps him/her calm down?
- Are there events, interactions, or situations that usually lead to conflict?

Optimize the Environment

- Ensure that youth are safe from other youth, mistreatment by staff, and hurting themselves.
- Set and post clear and simple rules.
- Provide structure.
  - Set schedules and keep to them.
  - Announce changes to schedules when they occur.
  - Establish a bedtime procedure that allows time to calm down and check in before lights out.



Response Tips

- Be consistent.
- Set limits appropriately.
  - No violence.
  - No yelling.
  - No retaliation: separate out your anger.
- Praise and reward youth for positive behavior, including recovery.
- Model appropriate coping, anger management, and problem-solving behaviors.

Anger Management Skills for Youth

- TAKE A TIME OUT
  - Safety Stop
  - Separation
  - Recognition
    - ✓Recognize physical reactions (examples: rapid heartbeat, tightness in chest, feeling hot or flushed)
    - ✓Recognize behavioral reactions (examples: pacing, clenching fists, raising voice, staring)
  - (Reilly et al., 2002)

Anger Management Skills for Youth

- CALM SELF
  - Slow and deep breathing
    - ✓It is physically impossible to be both agitated and relaxed at the same time.
    - ✓Breathing exercise
    - ✓Progressive muscle relaxation exercise
  - Humor
  - Music
  - Recalling positive images
  - Seeking supportive relationships
  - (Reilly et al., 2002)

Anger Management Skills for Youth

- PROBLEM SOLVING SKILLS FOR YOUTH
  - Clearly define the problem.
  - Compile a list of options.
  - Narrow down the options.
  - Choose an option.
  - Implement the option.
  - Examine the outcome.
  - (Reilly et al., 2002)

Activity

Incident Reports

Supporting Materials

Vignettes: Incident Report

When Kathy came back from the dining area after dinner, she was mad at Ms. Smith because Kathy wasn't picked for chores. As Kathy entered her room, she began hitting her fist against her hand and saying, "Bring that bitch back here." She kept saying this, even after she was told this was inappropriate language. When she was informed that she was being given 36-hours isolation for threatening a staff member, Kathy stood up on her bed and began yelling at Ms. Smith, "You bitch, come in here. Stop backing up, bitch. I'll beat your ass." Kathy was taken down, cuffed, and shackled. She did walk to segregation on her own. At the 6:45 check, Kathy was informed that the staff member would return to shower Kathy later. Kathy responded by telling the staff member to get out and to leave her alone.

Optional Vignettes

This morning, room searches were conducted. When staff searched Jenny's room, several forbidden items were found. Jenny had 11 dirty/used feminine pads, 3 decks of cards, 4 books, 3 magazines, and 4 pairs of underwear all under her mattress. This is a major infraction and after staff discussion, it was decided that Jenny would receive 36-hours isolation for contraband due to several of the items having the potential of being used as a weapon. After her 36 hours were up, Jenny was returned to the regular unit schedule with no follow-up discussion or mental health referral. [Note: One of the authors followed up with the reporting officer, who acknowledged that he was "grossed out and angry" when he pulled the used feminine pads out from under the mattress and that was why he gave Jenny 36-hours isolation.]

Joe had been out for recreation until 7:45 p.m. before asking staff to make a phone call. He received an answer from his grandmother, but she asked him to call back in a few minutes because she was on another call. Joe moped around the living area until 8:15, knowing that his recreation time ended at 8:25 p.m. He asked to make his phone call again. Reporter did allow him to attempt to call and was going to give Joe the entire 15 minutes for the call, but Joe got no answer. He then asked to try once more. The reporter attempted to call again, but got no answer. Right at 8:25 p.m., Joe's grandmother called and asked to speak to Joe. The reporter informed her that Joe had no remaining incoming calls and that his recreation time was over now, so he could not return the call. Joe's grandmother said rather rudely, "Well, I thought he had until 9:30 p.m." The recreation schedule was explained to her. She hung up on the reporter. When Joe returned to his room, he slammed his door and then began screaming and pounding on his door. He continued to pound. When Mr. Smith went to talk to Joe, Joe made the comment, "Anyone opens my door will get bruised." This was considered a threat toward staff since staff members are the only ones capable of opening his door. Joe also tore a strip of his sheet off and had it wrapped around his hand. He willingly walked to segregation without assistance. Joe accepted the 36-hour lock-up consequences without further problems.

Crisis De-escalation

Crisis Intervention De-escalation

De-escalation resolves a crisis through problem-solving rather than by force and helps to re-establish equilibrium faster.

De-escalation

- Consult the youth's treatment plan, if there is one.
- Get the youth's attention.
- Gain the youth's cooperation.
  - ✓What does the youth really want?
  - ✓What is the youth really responding to (disrespect vs. mental health vs. trauma reaction)?

- Be aware of your own feelings.
  - ✓Some youth just want to push others' buttons, getting them to react emotionally.
- Be aware of your own posture, voice, and tone.
- Remove the audience.
  - ✓Provide the youth with an opportunity for a face-saving resolution.

Nonverbal Communication

- Body language
  - ❑Open, non-confrontational stance
  - ❑Arms uncrossed
- Physical proximity
  - ❑Express engagement and interest
  - ❑Avoid invading personal space
- Facial expressions
- Eye contact

Volume, Speed, and Tone

The same phrase can communicate totally different meanings depending on
- volume,
- tone, and
- speed.

Examples
- Who left this book here?
- May I help you?
- Have a nice day!

Slow Down

- Youth are impulsive and often fail to think before they act.
- Simply slowing things down can be an effective intervention. It provides youth an opportunity to
  - talk about their feelings,
  - think through options, and
  - weigh consequences.
- Stop, talk, wait, and then act.

Sssshhhhhhhh!

- Talk softly.
  - If you talk softly, the other person will often automatically lower his/her voice.
- Speak calmly.
  - Soothing versus confrontational words
- Provide reassurance.
- Keep instructions clear and simple.

Active Listening

- A powerful skill that can be developed and enhanced
- Active listening is hearing with engagement, empathy, and understanding
- Listening is often the key to a successful intervention

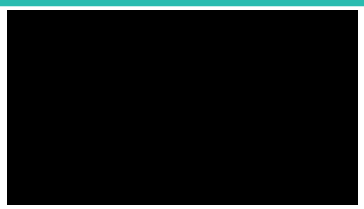
Features of Active Listening

- Ask open-ended questions.
- Pose clarifying questions.
- Use “I” messages.
- Repeat back what you are hearing.
- Label feelings.
- Focus on the positive.

Barriers to Active Listening

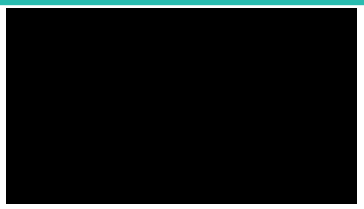
- Arguing
- Criticizing
- Pacifying
- Jumping to Conclusion
- Labeling
- Derailing
- Ordering
- Asking Why

Reenactment I



Reenactment II

Reenactment III



Reenactment IV

When a Crisis Escalates

Unfortunately, some incidents will still escalate to a crisis

- Safety is the primary concern
- Follow departmental or institutional policies regarding progressive levels of intervention, as well as physical and mechanical restraint

Crisis Follow-up: Learning New Skills

- Youth are not going to learn new behaviors in the middle of the crisis
- They may learn from their mistakes after they have calmed down
- Otherwise, they may keep repeating the same violent, unsuccessful behaviors

The Calm After the Storm

- Reflect on the event
- Ask open-ended questions
- Avoid power struggles
- Acknowledge mistakes
- Identify alternatives
- Express caring and offer support
- Reward the youth for doing something right

- Express caring.
- Offer support.
- Catch youth doing something right.
- Work with the treatment team to modify the treatment plan.

Communication

Teach

Calming skills
- Recognizing physical signs of escalation
- Incorporating relaxation techniques

Coping skills
- Using verbal rather than behavioral responses
- Seeking adult support

Problem-solving skills
- Alternating responses

Promote Strengths

- Build strengths and resilience.
- Work with natural talents and interests.
  - sports, music, drawing, cooking, writing
- Strengths can include spiritual beliefs and cultural identity.

Activity

Case Description

Supporting Materials

Vignette: Case Description

Antonio is a Hispanic male who is 16 years of age. He has been on probation supervision for the past three years. His mother speaks Spanish only. He has five siblings, with two still residing in the home. Over the last three years, Antonio has been in and out of detention multiple times. While on supervision, he has also received several positive urinalysis tests for marijuana and admits to frequent alcohol use. Several months ago, Antonio was charged with an Assault, Second Degree. According to the police report, Antonio was at home when his 13-year-old sister returned home from school. She reported that she was playing with a pin cushion used for sewing. Then, without provocation or notice, Antonio flew across the room and held a pair of scissors to his sister's neck. Another family member called 911. Antonio then retreated to his bedroom, where the police later arrested him. Antonio told the arresting officer that his sister was doing voodoo on him and that he could feel the pins going into him. Antonio also reported that there are bugs crawling across his room. He had drawn several crosses on his bedroom walls and is seen sleeping with a picture of the Virgin Mary on his chest. Antonio was psychiatrically hospitalized three times within the next two months. He was started on psychotropic medications. Antonio's mother reported to the probation counselor recently that Antonio had been seen by their church priest. He had something bad inside of him that needed to come out. She reported that this visit has helped him. His mother continues to ask the probation counselor if Antonio can just be seen by their priest and stop taking the medication.

Optional Vignettes

Jamie is a 15-year-old female. She has been a State-dependent youth since she was five years old. She has had multiple caseworkers and has been in countless placements. Most recently, Jamie has been placed at a group home for girls. This group home placement is two hours away from her local community, due to a lack of placement options. She often becomes assaultive or runs away from this placement. The last time she ran away, she went to a larger metropolitan area. She reportedly engaged in heavy substance use and prostitution. Her mother is a long-term substance abuser who often does not show up for scheduled visits. Jamie continues to tell her caseworker and probation counselor that she just wants to live with her mother. Jamie often becomes verbally aggressive towards her caseworker, probation counselor, and caregivers. She has not been in school for any consistent amount of time over the last two years, due to her refusal to remain in placements. She also has not been able to receive consistent mental health or substance abuse services due to her run-away behavior. She has been prescribed medication for bipolar disorder in the past. Recently, Jamie has lost some weight and appears to be in poor physical health. She has a hopeless attitude about her future and is uninterested in making changes.

Brianna is a 15-year-old female. She has just recently come onto probation supervision. She has missed two probation appointments so far, with no phone call. The probation counselor has attempted to contact her several times by phone,

without success. Her mother works long hours and is unavailable while on shift. The probation counselor has stopped by the home, but was unable to get an answer at the door. The windows are covered and the home appears dark inside. When the probation counselor stops by the second time, a sibling lets her into the home, but tells the counselor Brianna is sleeping. The probation counselor is able to rouse Brianna, who was sleeping on the couch. Brianna reports that she had just forgotten about her appointments. She also admits that she has not been attending school. She states she has been too tired to get up on time and also feels she is behind anyway, so there's no point in going. She presents with a lack of energy when she does exit her room. She has to be strongly encouraged to shower. She also often refuses to eat meals. The judge had ordered Brianna to serve on a work crew as part of her sentence. However, she has not shown up this week.

Key Components of Crisis Management
- Prevention
- Early intervention
- De-escalation
- Follow-up

Crisis Management Strategies for Staff
- Skill building with youth
- Coaching and guiding
- Modeling behavior

Module Objectives

- Discuss why it is important that youth involved in the juvenile justice system have access to treatment
- Describe recent innovations in treatment, including the application of evidence-based practices
- Discuss special issues concerning treatment and psychopharmacological interventions

What should the goals of effective treatment be for youth in the juvenile justice system?

Your Perspective

Empirical Perspective

Some of the items researchers look at include

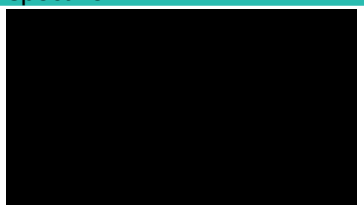
- decreased mental health symptoms and substance use;
- reduced recidivism and reduced illegal activities;
- decreased out-of-home placements; and
- increased competencies.
  - increased school attendance and/or grades
  - increased quality of family interactions

Evidence-Based Practices

Interventions proven to be effective and that are…

- standardized treatments that result in improved outcomes
  - outcomes are replicated in a variety of studies with different types of youth
- based in a thorough understanding of adolescent development
- flexible enough to be incorporated into a program serving youth and their families
- increasingly being mandated by states

Intervention & Treatment: A Youth's Perspective I



Types of EBPs

Family- & Community Based Models

Psychosocial Therapies

Psychopharmacological interventions

- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- Multidimensional Treatment Foster Care (MTFC)

Examples of EBPs to Address Multiple Needs of Juvenile Justice-Involved Youth

Multisystemic Therapy

Key Elements

- MST views the youth as embedded in interconnected systems.
- Therapist is available to the family 24/7.
- Therapist works extensively with the youth's caregivers.

Indicators of Effectiveness

- Reduction in recidivism
- Decreased mental health problems
- Improved family functioning

Functional Family Therapy

Key Elements

- Short-term, family focused
- Three phases
  - Engagement and Motivation
  - Behavior Change
  - Generalization

Indicators of Effectiveness

- Reduced recidivism
- Reduced sibling high-risk behaviors

Multidimensional Treatment Foster Care

Key Elements

- Youth is placed in a foster care setting for 6-9 months.
- Foster care setting provides…
  - close supervision,
  - fair, consistent, and predictable behavior management.
- Youth receives services.

Indicators of Effectiveness

- Fewer days of out-of-home placement
- Increased school attendance
- Reduced recidivism

Examples of EBPs to Address Substance Abuse

- Brief Strategic Family Therapy (BSFT)
- Multisystemic Therapy (MST)
- Cannabis Youth Treatment (CYT)

Examples of EBPs to Address Trauma

- Trauma-Focused Cognitive Behavior Therapy (TF-CBT)
- Trauma Affect Regulation: A Guide for Education and Therapy (TARGET)
- Trauma Recovery and Empowerment Model (TREM)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

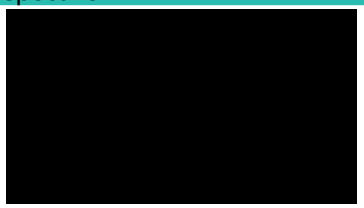
Psychopharmacological Interventions

- Medication is aimed at symptom reduction.
- For most, this **should not** be the first line of treatment.
- Often, this is most effective if used along with an EBP.

Critical Issues in Treatment

- Address co-occurring disorders
- Trauma-focused treatments
- Gender-specific considerations
- Culturally sensitive interventions

Intervention & Treatment: A Youth's Perspective



Are evidence-based practices really cost effective?

Examples of Benefits of Selected Programs for Juvenile Justice Youth

Program Name	Chance benefits will exceed costs	Cost Savings (benefits-costs)
Functional Family Therapy for youth on probation	96%	$25,484
Functional Family Therapy for youth in state institutions	96%	$36,767
Cognitive Behavioral Therapy	95%	$14,722
Scared Straight	2%	($10,865)
Intensive Supervision (Probation)	0%	($10,208)

(Washington State Institute for Public Policy, December 2017)

- Does your agency utilize EBPs? If so, which ones?
- If your agency did use EBPs, how might they impact your…
  - work culture?
  - ability to do your job?
  - satisfaction with your job?
- What do you think prevents your agency from utilizing EBPs?

Module Eight

Taking Care of You

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Module Objectives

- Identify physical, emotional, personal, and workplace indicators of stress
- Define vicarious trauma and how it applies to juvenile justice staff
- Engage in strategies for self-care at work and at home

Can you recall a recent stressful experience that you had with a youth while at work?

Has there ever been a time when you needed to. . .

. . . feel safer?
. . . take a timeout?
. . . switch assignments?
. . . call a supervisor for assistance?
. . . call mental health staff for assistance?

Physical
- Headaches, stomach aches, lethargy, constipation

Emotional
- Anger, sadness, anxiety, depression

Personal
- Self-isolation, cynicism, mood swings, irritability

Workplace
- Avoidance of certain people, tardiness, lack of motivation

Indicators of Stress

Vicarious Trauma

- Conditions that are known to affect people who work in the helping professions
- Sometimes referred to as compassion fatigue
- Defined as "emotional residue of exposure that counselors have from working with people, as they hear their trauma stories and become witness to the pain, fear, and terror that trauma survivors have endured"

Red Flags for Vicarious Trauma

People experiencing vicarious trauma may have problems with the following:

- Emotion regulation
- Self-worth
- Decision-making
- Managing boundaries
- Relationships
- Physical health (aches and pains, illnesses, accidents)
- Emotional detachment

Working with Youth Can Be Stressful!

- Difficult jobs
- Teenagers who push limits and buttons
- Staff are only human

What is Self-Care?

Paying attention to ***your*** needs

- Emotional
- Physical
- Recreational
- Relational
- Spiritual

Self-Care Strategies

- Emotional
  - See friends, cry, laugh, praise yourself, use humor
- Physical
  - Get regular sleep, proper and balanced nutrition, and exercise
- Relational
  - Spend time with people you care about
- Recreational
  - Travel, start or engage in a hobby or relaxing activity, spend quiet time
- Spiritual
  - Pray, seek guidance from clergy

Self-Care at Work

Juvenile justice systems can support staff by offering:

- Training
- Supervision
- De-briefings after stressful incidents
  - What happened?
  - How did we respond?
  - Could we have done anything differently? Would it have changed the outcome for the better?
- Employee assistance and counseling
- Staff recognition and appreciation opportunities


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