Dispositional Planning and Advocacy August 30, 2023

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3 things typically guide my interaction.

- Client focused
- Strengths based
- Committed to remaining in the community.

- Client focused means
  - I ask the client what they want. What is their goal for their case
  - And what do they think will be helpful in achieving those goals.
  - I also make sure I tell the client there are things the court is likely going to require as part of a release plan or a disposition plan.
  - Agreeing to those tasks is helpful to the overall effort to help the client achieve his / her goal.

- Strengths based means
  - I frame things and think through things by understanding where the client "is" and
  - Identifying those protective factors, those strengths on which we can build a plan.
  - Resilience is an important factor to identify for a youth and to share with the youth what that means and how you identify times when the youth was resilient.
  - Sample questions you can ask that can be helpful and go beyond What are you good at...
    - Tell me what you enjoy doing. What about that do you enjoy. Is that something that you share with others?
    - If someone (parent, friend, teacher, etc) were to describe you what would they say...
    - What do you want the judge and the probation officer or DCS person to know about you. what is important for them to understand about you.
    - All of us at times have difficult experiences or challenges in life... When you think about that, what are some things you relied on to overcome or work through those difficulties?
    - What was helpful to you in that situation? A specific person? A specific strategy or task? *Coloring playing music, journaling, walking away*
    - So how did you figure out that those strategies would be helpful?
    - In this situation can we use that experience, your success in handling that situation and build on that in this situation?

- Commitment to community-based programs and placement.
    - Research tells us that youth do best when they remain with family in the community and receive services.
    - I always start with. what can we do to help you remain at home. What are the needs? What services or programs or supports are important to stabilizing the home, strengthening the home, etc.
    - If that is not an option, what other family members or close family friends (godmother, etc) can we reach out to and ask to participate in your plan (as a support person or a place for you to live)
    - If the youth requires removal from the community due to high risk, can we pursue residential treatment through the insurance.
    - If the youth goes into DCS custody what is our role then. How do we approach the CFTM and placement decisions? (Page 4 contains additional information)
    - Typically, the only time I support DCS JJ custody is when it is an alternative to transfer to criminal court.

Overall focus

- Next we talk through the 5 domains.
- Individual
- Family
- Education
- Mental Health
- Community Connection.
- We identify Risk Factors and Protective Factors.
    - I want to identify what is already in place, what strengths are present,
    - I want to identify what needs are present, where are the gaps, what are the risk factors
    - I want to identify what types of services, what types of programs, what strategies will benefit the youth, reduce the risk factors, and increase the protective factors.
    - And I want to link the youth participating in those services or programs with the identified strengths and as part of reaching the overall goals for the youth.

Thinking about programs and services and resources: this is not an exhaustive list

- Mental health treatment
  - Mental Health Coop
  - Centerstone
  - Elam Center
  - Camelot
  - Health Connect America
  - Vanderbilt Outpatient Clinic
  - Black Mental Health Village
  - Neighborhood Health
  - Omni/LifeCare Family Services
  - Family and Children's Services
  - TN Voices FAST program
  - Catholic Charities
  - SAC
  - Child Advocacy Center
  - Oasis Center
  - Radical Change Counseling Center
  - SCARAB
  - Youth Villages Intercept and MST

- Substance abuse treatment
  - YODA through STARS
  - Health Connect America
  - Bradford Health Services IOP and Inpatient
  - Elam Center
  - CADAS / Scholtz Center (30-day inpatient)
  - Cumberland Heights Arch Academy (30-day inpatient)

- Education:
  - Special Education IEP
  - 504 Plan of Accommodation
  - Trauma Informed Specialist at the schools
  - School based mental health providers – Centerstone and Vanderbilt
  - S Team
  - FBA and BIP
  - Diploma Tracks
  - The 3 Academies
  - School options—
  - Adult High School
  - GED/ HI Set—YWCA

- Life enhancement areas
  - Systems of Care
  - Youth Connections—Monroe Harding
  - LifeSet—Youth Villages
  - Epic Girls
  - REAL program through Oasis
  - TN Voices Connecting Forward
  - The Family Center
  - Office of Family Safety
  - YWCA
  - Girls, Inc.
  - RAPHAH
  - Casa Azafran
  - YMCA-- Y-CAP, Black Achievers, Latino Achievers, Y Literacy, Y Quest
  - Family Resource Centers: Metro United Way
  - Café Momentum

DCS Child and Family Team Meeting

The guide on the DCS website is lengthy. It can be helpful to read through it and see what policies are there that will impact your client's meeting, whether in custody or not in custody.

Type of Visit (tn.gov) -- DCS Child and Family Team Meeting Protocol
https://files.dcs.tn.gov/policies/chap31/CFTMProtocol.pdf

Specific things I think about are

- Is my client in the meeting?
- Has DCS completed a CANS assessment or FAST assessment (non-custodial cases) and has the CANS consultant approved the assessment. Do I have a copy of it and can we discuss it in the meeting? What are the actionable factors?
- Does my client understand the meeting, the purpose—has the specific meeting type been identified and are the correct people present—initial, placement, stability, discharge
- Does my client understand that the meeting is not confidential. That information is handled with respect and is not talked about casually, but that information from the meeting will be shared with the court, placement agencies, providers
- Does my client know we can take a break... to get some emotional space
- Does my client know that summary notes will be available and that reading those notes and making sure they are accurate is important
- Does my client understand the appeal rights / Notice of Action
- If a level 3 residential is recommended, can I challenge that? What are the driving factors that indicate a Level 3 is required? Or is DCS putting a Level 3 as the recommendation because of a lack of lower level placements.

RELEASE MEETING SUMMARY: Date:

Client: Charge:

Those in attendance:

Identified Risk Factors and Strengths by domain

Individual: *including issues related to charge*

Family: *Who has custody, any N/D issues, Who lives in the home, work schedule of adults who will supervise,*

Mental Health needs: *Diagnosis, current provider, type of service, A/D concerns*

Education needs: *current school, ALC?, credits, 504 plan, IEP, needed?*

Supervision/ Community: *co defendants, runaway issues, community supports, employment, involvement with place of worship, or other programs*

Plan of intervention and stabilization: *this is short term plan created to support the youth when released from detention and pending the court date to resolve the charge.*

Supervision to be provided by: **Names and phone numbers**

Address:

Individual:

Family:

Mental Health:

Education:

Supervision/ Community needs:

Plan of intervention and stabilization: YOUTH

Supervision to be provided by: **Names and phone numbers**

Family:

YOUTH will return home to live with his mother, her partner and his siblings. His mother and her partner will provide supervision of YOUTH and participate with probation and any services the court requires.

Mental Health:

YOUTH is referred for counseling services through TN Voices FAST program. TN Voices will work with YOUTH and his mother to access therapy services and psychiatric services through Omni LifeCare. (615-781-0013). Through TN Care, he qualifies for therapy, case management, and psychiatric assessment and services through Comprehensive Continuing Therapy (CTT).

While not part of a probation plan, MOM and his siblings (especially younger siblings) might benefit from intervention to focus on the domestic violence history. She is given information about the Family Safety Center (Metro Government).

Education:

MOM has decided to enroll YOUTH in home school. She is looking at Penn Foster as a possible school and will make the decision upon his release from detention. Since she is home during the day, she is able to supervise him and support his progress with school curriculum.

Supervision/ Community needs:

YOUTH will be released on Strict Home Detention and probation services.

With permission of the court and as part of probation, YOUTH will participate with TN Voices for Children FAST program. Working with TN Voices and probation, he will attend an intake appointment with Omni Lifecare outpatient clinic.

With permission of the court and as a part of probation, YOUTH will pursue employment. His mother will provide transportation to and from work once he gets a job.

With permission of the court and with the permission of probation, YOUTH will attend church with his mother and family.

Also YOUTH might benefit from a referral to the Youth Connections Works Wonders program through Monroe Harding and to Café Momentum. Both programs offer employment support.

YOUTH might also benefit from a referral to RAPHAH if probation determines that is an appropriate intervention.

- We can think about our client behaviors in "treatment" terms.
  - Externalizing behaviors: those behaviors that are exterior to the person and most often impact others.-- aggression, stealing, verbal defiance, vandalism,
  - Internalizing behaviors: those behaviors that are internally or directed to the person and most often impact the person: -- withdrawal, shutting down, not communicating, cutting, suicidal ideations/thoughts,
- These behaviors can often be attributed to a mental health diagnosis, V Code, or emotional difficulty.
  - Mental Health Diagnosis - meets criteria for the DSM as a diagnosis;
    - Common ones we see are depression, anxiety, mood disorder NOS, ADHD, Conduct Disorder, Disruptive Mood Dysregulation Disorder, Disruptive Behavior Disorder, Bi-Polar, PTSD
  - V Codes are areas of concern and focus of treatment but they do not meet the criteria for a full diagnosis.
    - Example: parent child conflict, grief,
  - Emotional Difficulties—this category is a catch all for concerns, behaviors, etc.. that have not been diagnosed by a mental health professional.
- The focus of current research gives us helpful terms or useful paradigms to view client behaviors.
  - "Trauma Issues" and "ACE - adverse childhood experiences" can help capture and define client behaviors that better reflect what he/she experiences and can help to access needed services.
  - Instead of asking "why did you do that" it is more helpful and more trauma sensitive to ask "what happened to you"
  - Additional clinical terms that can be helpful lenses through which to see our clients
    - Emotional dis-regulation
    - Impulsivity and / or hyperactivity
    - Compromised thinking process and decision making
    - Triggered by current events that revive the trauma experience
    - Hyper-vigilance—response to environment linked to trauma

- In order to access clinical, mental health treatment, the client must have a diagnosable mental illness or a V Code.

- To access services at an intensive level, a diagnosis is typically required.

- Behavioral Health Services range from
  - Community based
    - Outpatient therapy, Medication Management, Case (sometimes called Care) Management, Intensive In home, Intensive Outpatient Program
  - Residential treatment / Level 3
    - Requires Pre-authorization and ongoing Utilization and Review for continued authorization
    - The least successful type of service as compared to community based
    - Very restrictive
    - Typically lasts for weeks to a few months
  - Acute hospitalization
    - Requires an assessment by Mobile Crisis (contract is held by Mental Health Coop) and signature of 2 mental health practioners (1 must be a MD)
    - The most restrictive level of care
    - Typically only lasts for a few days
    - Requires the person to meet criteria as imminent risk to self or others
    - Is for stabilization

- For every child covered by Tenn Care --
  - Base coverage will provide 42 outpatient therapy sessions per year and
  - Medication management.
  - It is also easy to access low intensive case management which is now called Tennessee Health Link.

- More intensive services typically require pre-authorization from the insurance company.
  - To get pre-authorization the provider will need to show that the service is "medically necessary".
  - The service will likely be time limited and will only continue while it is "medically necessary".

Additional Information and Tips for working with Providers

- Making the referral:
  - It is helpful for the provider and for the consumer if the attorney identifies:
    - the purpose of the referral.
    - the context of the referral.
    - the goal of services
    - any deadlines or pending court dates for which clinical updates will be needed

- Records:
  - Clinical records are protected by HIPPA and other laws that protect records for alcohol and drug treatment.
  - Records can be accessed by requests using
    - Appointment order/ court order that releases records to attorney or GAL
    - Signed release
    - Subpoena – meaning the records will be given to the court.
  - It is helpful to identify for yourself and at times for the provider, for what purpose the records are needed

- Delay of services
  - If Tenn Care is the payor, using the Tenn Care advocacy line or appeal process can assist with services beginning in a timely manner.
    - There are contractual guidelines that determine the timeline the MCOs have to determine if they are going to pay for a service
    - Working with the contact people at the MCOs is a good first step to resolve any delays.
    - If you cannot reach a satisfactory resolution working directly with the MCO, contact Shay Jones at the Crisis Management Team is the next step.

SKILLS CHART

Skill	Define/ describe	Use/ purpose	example
Attending	Skills/ behaviors to make the client feel welcomed and comfortable	To establish initial rapport and help the client feel at ease	Would you like some water? Please, site wherever you like.
Open ended question	A question that requires the client to give more information than a simple yes or no	To explore with the client content of the interview. To gather additional data and help the client think about all aspects of their concerns/ or issues	Can you tell me more about your job? Tell me some of your favorite things to do when you have free time. What are your children like? what are some of their strengths?
Closed ended question	A question that can be answered with a simple yes or no or with specific data	To gather concrete data to aid in assessment. to help the client engage with the social worker	How long have you worked there? Do you enjoy going to the movies with your mother? How many children do you have?
Minimal Encourager	Non Verbal behaviors that communicate to the client that you are listening. They do not interrupt the flow of conversation from the client	Communicates that you are hearing the client and responding. That you are with the client	Nodding head
Paraphrase	Reflecting back to the client the content they have shared, restating it in your own words	One of the best ways to convey empathy The client knows you are listening. can also be used to "check out" that you are hearing what the client thinks he/she is expressing	CLIENT: I just want to be a good mom INTERVIEWER: Being a good mom is very important to you
Summarize	Reflecting back to the client content they have shared, by summarizing it in your own words	Again, conveys empathy. Also helpful in identifying themes or common issues. Can be used to close a session and also a good way to open a session	So not only being a good mom is important, you also want to find a good career path for yourself. So we have talked about a number of issues this week—they seem to mostly be about caring for your children/ making sure they are in the safest and best situation. Last week we talked about..... where are things today
Clarify	Asking for defined information when the client's words are too hazy	Again conveys empathy. Also helps the client to identify manageable issues and name them.	CLIENT: everything is wrong INTERVIEWER: Everything? what is everything?

Reflecting Feeling	Reflecting back to the client the feelings he/she are expressing—verbally or non verbally	Allows the client to identify and own what they are feeling and to be accepted even if the feeling is "negative" or very strong. This is where clients begin the change process	CLIENT: I am so mad at my mom. She always interferes. I hate her! INTERVIEWER: Right now all you can feel for your mom is anger—anger that she is interfering in you life.
Confrontation	Pointing out to the client a discrepancy in what the client is saying and what the client has said or what the client is saying and what the client is expressing nonverbally	Allows the client to identify when they are giving conflicting information or having conflicting feelings. Can be a helpful tool for getting the client to see their situation more accurately and move toward change	CLIENT: I love my job—as she takes a deep breath and has a frown on her face. INTERVIEWER: I hear you saying you love your job but from your expression I am not sure that is accurate. what do you think?
Self Disclosure	Providing personal information to the client about yourself.	USE CAUTION. should only be used when it will clearly benefit the client. can help the client feel less alone in their problem. can convey empathy.	CLIENT: I can't believe my mom is gone. I don't know how I am going to manage. I depend on her so much. INTERVIEWER: I can remember a time when I lost someone close to me. I felt very lost.
Interpreting	Providing to the client insight into their situation by looking for common themes, underlying messages, inconsistent messages, etc..	Used to help the client view their situation in new light. to make connections between behaviors and to identify patterns.	CLIENT: I always end up getting fired. INTERVIEWER: I am wondering if you can see a pattern... you start a job thinking you will get fired, and then go in late...
Communicating Feelings of Immediacy	Identifying for the client feelings that are happening in the moment of the interview. Feelings that are specific to the interview, the agency, the interviewer	Used to work through resistance and to deal with barriers that exist within the interview relationship	CLIENT: You don't even want to help me. all you do is sit there and ask me questions. INTERVIEWER: This process is frustrating for you. You are angry at me and not sure that I am trying to help at all.
Giving Information 5 types or ways of giving information See additional table	Orienting Statement Instructions or Directions Feedback Informational Statement Alternative perspective (reframing)	SEE CHART	SEE CHART
Reframing	Taking a comment made by a client and restating it in a way that makes it positive and strengths based.	Used to allow the client room to change. Often clients can be "stuck" in a pattern of viewing their situation. This brings a new perspective and allows the client to view their situation with an opportunity for change	CLIENT: My kid won't mind me at all. they just need to lock him up. Cause the way he is going , he is going to get killed. INTERVIEWER: I can tell you are very concerned about your son. You love him and want him to be safe.

Table 11.1

An Overview of the Types of Information-Giving Responses

Type of Response	Potential Sources of Information	Content of the Response	Examples
Orienting Statement	Program guidelines, procedure manual, policy manual, knowledge base	Information about a program, a process or a procedure	Overview of the counseling process, introduction to a rehabilitation service, outline of a dental procedure
Instructions or directions	Instruction sheet, procedure manual, agency policy, knowledge base	Information describing a proposed behavior, how to carry it out, and its potential positive and negative effects	The client's role during the period of involvement, test instructions
Feedback	Test data, performance appraisal, observational data, laboratory reports	Information about performance, personal characteristics, or outcomes	Test results, performance review, health review
Alternative perspective (reframe)	Client's description of events, resources, people, alternatives, outcomes, procedures	Information about alternative frames of reference describing the situation	Half-full or half-empty glass
Informational Statement	Knowledge base, reference source, data bank, library, educational materials	Information about events, resources, people, or alternatives	Overview of information-seeking, occupational information, description of community resources

Bilingual Mental Health Counselors

Insight Counseling Centers
www.insightcounselingcenters.org | 615-383-2115
Asesoramiento individual, en pareja y en familia, asesoramiento prematrimonial, terapia grupal. Áreas de especialidad: Recuperación de adicciones, Ansiedad, Niños y adolescentes, Depresión, Género y sexualidad, Adlicción y pérdida, Crianza de los hijos, Consejería prematrimonial, Estrés postraumático, Problemas de relación, Problemas de autoimagen, Problemas sexuales, Español, Problemas espirituales, Estrés , Trauma. Los servicios están disponibles en español.

Victoria Valdez
Masters of Marriage and Family Therapy
Cell: (931)-674-1205
Email: victoriavaldezmft@gmail.com
7105 Peach Court, Suite 103
Brentwood, TN 37027

Central Care Counseling Services
1161 Murfreesboro Pike #503,

Nashville, TN 37217

(615) 398-9242

Hispanic Support Groups
(615) 269-5355
Use este número para hablar con Claudia Avila-Lopez sobre el Grupo Educativo para Mujeres Hispanas y los Servicios de Información y Referencia de Salud Mental Hispana.

Agape Counseling Services
www.agapenashville.org | 615-781- 3000
Adopción, cuidado de crianza, servicios de apoyo de embarazo no planeado y consejería basada en la fe y servicios psicológicos

Mental Health Cooperative
https://www.mhc-tn.org | 615-726-3340
Un centro de atención médica de servicio completo para todas las edades. Usan un enfoque que combina la administración de la atención basada en la comunidad, la psicoterapia, la psiquiatría, los servicios de crisis y la atención primaria en un sistema integrado de atención centrada en la persona.

www.centerstone.org | 615-463-6610
Trabaja con todos los grupos de edad en diferentes servicios de salud mental, que incluyen: abuso de alcohol y sustancias, salud mental, orientación familiar y otros.

	Population Served	Business #
Victoria Valdez	Young Adults, teens, children (parenting), brain spotting ENG/SP	931-674-1205
Dr. Pamala Hernandez-Kaufman	Children, Teens, Adults, Couples, Parenting, EMDR ENG/SP	(714) 878-2151
Brenda Romero-Herrera	Children,teens,adults ENG/SP	(615)933-3496
Aleyda Sanchez	Adolescents, Adults, Couples, Groups, Parenting ENG/SP, EMDR	615-398-9242
Hannah Feliciano	Adults, Adolescents, Children/Parenting, Couples ENG/SPANISH	615-383-2115 ext.2
Paula Rampulla	All ages. Required Victims of a crime (History of trauma)	615 953 7188
Alicia Bunch Vargas	children and adults (specializing in trauma/attachment)	615-669-5198
Sexual Assault Center	children and adult survivors of sexual assault	615-259-9055
Rosa Chavez	All Ages & EMDR @ Agape Counseling Services ENG/SPANISH	615-781-3000
Adrianne McKeon	ages 3 and up, individual, families and couples, psych evaluations (sliding scale upon request)	615-800-5667
Rita Cuellar	youth and adults	615-930-1121
Margaret Brittingham	adults, Brainspotting, somatic, embodiment, perinatal ENG/SP	615.601.0647

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1 **Risk Factors, Protective Factors and Prevention**

Juvenile Delinquency: Prevention, Assessment, and Intervention
Chapter 2
Pages 19 - 31

2

- Broadly defined: external or internal influences or conditions that are associated with or predictive of a negative outcome
  - Some correlate
  - Some causal relationship
- Static Risk Factors—those that cannot be changed and typically are historical.
- Dynamic Risk Factors—those that can be modified or changed, reduced or increased,
-

3

- Static risk factors are most useful for research purposes and can help inform policy decisions
- Especially in the sense of allocation of resources
- Examples of static risk factors
  - Age at first offense
  - Number of prior arrests
  - Gender
  -

4

- Most interventions focus on dynamic factors
- Examples of dynamic factors
  - Access to weapons
  - Substance abuse
  - Peer group association
  -

5 **Ecological Model**

6

- Divides risk and protective factors into
  - Individual
  - Family
  - Community
  - Environmental
- Public Health Perspective for reducing and preventing disease, illness and injury.
- "Underlying premise is that an individual functions within a complex and interrelated network of contexts that exert an independent influence on risk level." ie.. Systems theory
- Thus it considers the individual in the context of the surrounding environment.
-

7 ☐ **PROTECTIVE FACTORS**

- Those factors which reduce risk of engagement in anti-social behaviors
- Less studied and researched
- Current policy and programs almost always include strategies to strengthen protective factors
- As with risk factors they can be examined
  - Static and dynamic
  - Within 4 areas: individual, family, community and environmental

8 ☐ **INDIVIDUAL FACTORS --RISK**

- Caution
  - Examine risk factors within the developmental process of the child
  - While we examine them separated from the other risk factors it is important to remember that is not realistic
  - Individuals behave within their environmental setting and the assessment of risk factors must be aware of that
  - Risk factors can only be thoroughly understood as examined within the context of the person's life

9 ☐

- History of early aggression
- Age at first adjudication
- Number of prior arrests
- Number of out-of-home placements or institutional commitments
- Substance abuse
- Drug dealing
- Early onset of violent behaviors
- Some psychiatric diagnosis: ADHD, depressive disorder
  - These are likely linked with the listed risk factors.. For example: drug use is often linked with depressive disorder or ADHD.

10 ☐ **INDIVIDUAL PROTECTIVE FACTORS**

- Recent research:
- Intelligence/ education is a protective factor
- Commitment to pro-social behaviors and rejection of negative behaviors or those that violate social norms
- Social skills strengths including: sociability, positive temperament, ability to seek support, and control of impulsivity

11 ☐ **Individual Protective Factors continued**

- Utilize flexible coping strategies
- View situations from many perspectives
- Empathy
- Problem solving skills
- Conflict resolution skills

- Anger management
- Critical thinking

12 ☐ **FAMILY FACTORS --RISK**

- Child abuse and neglect
- Low levels of parental involvement
- High levels of hostility, conflict and aggression within the family
- Parental criminality
- Family conflict
- Inadequate parental supervision
- Early parental loss
- Emotional deprivation
- Anti-social parents
- Poor family management practices
- Child maltreatment
- Low levels of parental involvement
- Parent-child separation

13 ☐

- Strongest predictive for juvenile anti-social behavior are
- intrafamilial violence
- Poor parental supervision
- Antisocial parents
- OTHERS
- Exposure to spouse abuse / child abuse
- Parent engagement in criminal behavior

14 ☐

- "delinquency should be viewed as a multidetermined phenomenon and intervention approaches should address multiple risk factors

15 ☐ **PROTECTIVE FACTORS FAMILY**

- Absence of significant family disturbances
- Encouraging family warmth
- Nonaggressive role models
- Strong attachment between parent and child
- Clear and consistent norms for behavior
- High levels of parental supervision
- Close relationship with at least one supportive adult
- Unconditional acceptance by adult caregiver—
  - Does not necessary need to be a parent--mentoring

16 ☐ **SCHOOL RISK FACTORS**

- Factors related to academic performance/ achievement impact delinquency
- Low academic achievement

- Poor academic performance
- Low commitment to school/ truancy
- Failing to complete school

All factors which increase juvenile delinquency and juvenile violence/ aggression

17 ☐ **PROTECTIVE FACTORS SCHOOL**

- Educational achievement
- Commitment to school
- Participation in extracurricular activities
-

18 ☐ **RISK FACTORS—PEER RELATED**

- Influence of peer group more significant than influence of family
- Negative peer relations
- Socially isolated or withdrawn
- Associating with delinquent youth

19 ☐ **PROTECTIVE FACTORS: PEER RELATED**

- Much debated topic
- Research has yielded mixed results
-

20 ☐ **ENVIRONMENTAL RISKS**

- Includes living arrangements
- Cultural
- Community
- Neighborhood variables
-

21 ☐

- Socioeconomic status: being raised in low income neighborhood
- High correlation for those receiving public assistance
- Small house
- Unemployed father
- Poorly educated mother
- Living in high crime and low socio-economic status neighborhood

22 ☐

- Living in high crime and low socio-economic status neighborhood less access
  - Structured activities
  - Healthy school environment
- Exposure to violence –media based violence or in the community
  - Violence can become normative
  - children can be de-sensitized to violence
-
-

-

23 ☐ **ENVIRONMENTAL PROTECTIVE FACTORS**

- Little research of environmental protective factors
- strong community infrastructure
  – Allows for participation in pro-social activities
- Community cohesion
-

1 ☐ **JUVENILE DELINQUENCY**

INTERVENTION STRATEGIES

Chapter 2 pages 31 - 39

2 ☐

- What works
- There is much that doesn't work and at times researchers have struggled to find any interventions or strategies that are effective
- Now we have better science about programs and strategies that can impact offenders and their behaviors
- Because we have a better understanding of risk factors and developmental pathways for delinquency
- This knowledge scientifically based and effective programs.

3 ☐

Variety of reasons programs are ineffective

- Common reasons are
- Address only one or two risk factors
- Fail to address most important risk factors for delinquency
- Are not individualized to the child
- Are based on unproven theory
- Are improperly implemented
- Fail to maintain program quality
- Do not hold service providers accountable for outcomes
- Are of insufficient duration.

4 ☐

- Importance of prevention and early intervention cannot be understated
- Those youth who progress to serious and violent offenders typically demonstrate identifiable risk factors as children
- Some can be identified as young as age 3
- And early intervention strategies are proving to be effective

5 ☐ **Public Health Perspective**

- Prevention and treatment can occur at
- Primary—attempt to reduce incidence of violence before it begins
- Secondary—attempt to reduce the prevalence of existing violence
- Tertiary levels —attempt to prevent reoccurrence of violence
-

6 ☐

- Most successful programs are based on the following
  - Individualized and family-centered intervention
  - That reduce multiple risk factors associated with anti-social behavior
  - And strengthen protective factors

- In a comprehensive and integrated manner

(Stated in another way)

- 3 General characteristics of effective prevention and treatment strategies
  - Comprehensive and individualized assessment
  - Simultaneous focus on risk factors and protective factors
  - Coordinated, multipronged, multi-targeted treatment approach.

7 ☐

- Still recognizing and understanding role of and impact of mental health disorders and offending behaviors
- And while scientist and providers are beginning to recognize and take into account mental illness
- Evidence indicates judges and others in the system are not educated on these issues
- In addition there continues to be significant barriers to accessing appropriate and excellent mental health treatment services

8 ☐

- Specific successful interventions
- Cognitive behavioral programs emphasizing social skills and problem solving training
- Behavioral programs
- Parent management training
- Functional family therapy

9 ☐ **Risk factors amenable to treatment:**

Child level:

- Substance abuse
- Mental health problems
- Impulsivity
- Poor social problem solving skills

Parent Level:

- Low parental warmth
- Poor parental supervision
- Ineffective or harsh discipline practices

10 ☐

School level

- Untreated learning disabilities
- Low academic achievement
- Alienation from school
- Truancy

Peer group level
- Association with delinquent peers
- Gang membership

Community level
- Exposure to violence
- Exposure to drug dealing
- Access to firearms

11 ☐ **PRIMARY PREVENTION**
- Identify existing static and dynamic risk factors
  - Individual, family, peers, community, environment
- Implement strategies to reduce the risk factors
- Implement strategies to increase protective factors
- Target of the prevention strategies is high risk populations, not individuals
-
-
-

12 ☐
- Family Focused
  - Provide needed social support,
  - Focus on economically disadvantaged
  - Examples include child care, counseling, assistance,
  - Comprehensive in scope
  - Reduce risk factors across several psychosocial domains

13 ☐ **School based approaches**
- Effectiveness due to the presence of many risk factors for violence exist in schools
- Allows for interventions focused at many risk factors
- Low achievement, poor performance, low commitment to school, school overcrowding, truancy, school transitions, and delinquent peers

14 ☐ **Examples**
- Preschool programs
  - Includes a diverse array of social services to reduce existing barriers to learning
- Social skills programs
  - Help at risk students develop techniques for creating and maintaining positive social relationships
- Social intervention strategies aimed at school environments
  - Involve changing school procedures to improve problem solving skills and promote involvement by students

15 ☐ **Community based approaches**
- Intervention strategies to increase community organization and making constructive activities available to adolescents.

- Effective examples include recreation and activities programs.
- "Participation in a structured activity has been shown to be an effective protective factor with respect to youth violence."

16 **SECONDARY INTERVENTION STRATEGIES**

- Target adolescents who have been identified as being at risk for engaging in antisocial behavior
- Typically through contact with police or the juvenile justice system
- Typically more narrowly focused and aimed at adolescents who present risk behaviors... in the community or school settings

17

- Main purpose of these strategies
- Identify risk factors at the individual, family, and school levels
- Provide social and clinical services to reduce the risk the child will engage in negative behaviors.
-
- "Success of secondary intervention strategies partially lies in understanding the risk factors that distinguish between juveniles who exhibit short-term behavioral problems and juveniles who are likely to engage in serious and chronic offending."
-
-

18

- Focus is to modify the risk behaviors before they become engrained delinquent / antisocial patterns of behaviors.
- Strategies used in primary prevention can also be successful at this level.
- Difference lies in the target of the interventions
- Diversion programs—
- Alternative and vocational education programs
- Family therapy and skills training
-

19 **TERTIARY INTERVENTION STRATEGIES**

- Aimed at adolescents who have engaged in antisocial behavior
- Who may have been adjudicated delinquent
- Intervention efforts are considered treatment
- Recipients are typically chronic and serious juvenile offenders
-

20

- Goal: minimize the impact of existing risk factors and
- Foster development of protective factors
- To reduce the likelihood that the at-risk adolescent will engage in future negative or law violating behaviors.
- Inpatient treatment

- Institutional and residential
- Community based treatment
  - Outpatient, intensive outpatient, partial
- Always tension between punishment vs restorative justice and treatment
-

1 ☐ **THE IMPORTANCE OF SAFETY**

- Physical and emotional safety are basic needs we automatically fight to preserve.
- Fear is a natural response that promotes self-preservation.
-
- Our experiences shape how we perceive threat and understand strategies for self-preservation.
- A traumatic event is an occurrence experienced by an individual as physically or emotionally harmful and makes an individual feel that his/her life is threatened or the life of someone s/he loves is threatened.
-

2 ☐ **Trauma is...**

According to the Substance Abuse Mental Health Services Administration (SAMHSA), trauma is formally defined as:

- An event, series of events, or set of circumstances that is experienced by an individual as:
  - Physically or emotionally harmful
  - Life threatening
  - Having lasting adverse effects on the individual's functioning and social, emotional, or spiritual well-being
- Why is assessing for and responding to Trauma Important?
-

3 ☐

4 ☐ **Types of Trauma**

- Acute Trauma
  - Single, time-limited event (e.g. natural disaster, accident)
- Chronic Trauma
  - Multiple traumatic events, occurring over time, that are severe, pervasive, and result in long-term consequences
  - Interferes with children's abilities to form secure attachments and complete developmental tasks
- Historical Trauma
  - Refers to cumulative and collective traumas experienced by specific populations across multiple generations
  -

5 ☐ **DISSECTING TRAUMA**

- Acute traumatic experience versus chronic traumatic experiences
  - Different people can view the same traumatic experience differently.
  - Traumatic experiences impact how a person assesses threat and their automatic strategies for self-protection.
  - Sometimes it limits how a person copes with stress
-

6 ☐ **Trauma Reminders**

- Things, events, situations, places, sensations, and even people that a youth consciously or unconsciously connects with a traumatic event

7 ☐ **Reaction... is influenced by...**

- A child's response to a traumatic event will vary depending on such factors as:
  - The child's age and developmental stage
  - The child's temperament
  - The way in which the child perceived the danger
  - The child's past experience with trauma
  - What happens afterward
  - The availability of adults who can offer help, reassurance, and protection

8 ☐ **Rates of Trauma in JJ Youth**

- 93% of juvenile offenders reported at least one or more traumatic experiences.
- The average number of different traumas reported was six.
- Youth in the JJ population have rates of PTSD comparable to those of service members returning from Iraq.

9 ☐ **Traumatic Events in the Lives of Youth Involved with the Justice System**

1 • •Physical, emotional, or sexual abuse

• •Community violence and victimization

• •Abandonment and neglect

• •Domestic violence

• •Traumatic loss

•

2 • •Prostitution/Sex trafficking

•

• •Serious accident

• •Medical trauma, injury, illness

•

• •Natural disaster

•

10 ☐ **Potentially Traumatizing Events in JJ Settings**

- Seclusion

- Restraint
- Routine room confinement
- Strip searches/pat downs
- Placement on suicide status
- Observing physical altercations
- Fear of being attacked by other youth
- Separation from caregivers/community
-

11 ☐ **How Youth Can Respond to Trauma:**

12 ☐ **A CLOSER LOOK AT PROBLEMATIC COPING**

- Post-Traumatic Stress Disorder (PTSD)
  - A diagnosis that helps explain reactions to trauma.

- Common traumatic stress reactions include:
  - Intrusive thoughts
    - Nightmares
    -
  - Re-experiencing
    - Increased reporting of somatic symptoms
  - Avoidance
    - Withdrawal and isolation
  - Negative thoughts & feelings
    - Traumatic play
    - Negative changes in mood and behavior
    - Self-destructive thoughts, plans, or actions
  - Dissociation
    - Difficulty with focus and concentration
    - Checking out
  -
  - Hyper/hypo arousal
    - Difficulty with focus and concentration
  -
-

13 ☐ **INTRUSIVE SYMPTOMS**

- Images, sensations, or memories of the traumatic event recur uncontrollably.
- This includes

- •nightmares
- •disturbing thoughts
- •flashbacks
- •physiological reactions
- •intense/prolonged psychological distress
-

14 ☐ **AVOIDANCE SYMPTOMS**

- Avoidance of *internal reminders*
- •thoughts, feelings, or physical sensations
-
- Avoidance of *external reminders*
- •People, places, objects
- •Activities, situations, conversations
-

15 ☐ **ALTERATIONS IN AROUSAL & REACTIVITY**

-
- Irritable or aggressive behavior
- •Self-destructive or reckless behavior
- •Jumpiness or quick to startle
- •Problems with concentration
-
- •Sleep disturbance
-
- •Hyperarousal/Hypervigilance

16 ☐

NEGATIVE ALTERATIONS IN COGNITION/MOOD

-
- Inability to remember parts of traumatic event
- •Persistent negative emotions
- •Persistent difficulty experiencing positive emotions
- •Decreased interest or participation in activities
- •Feeling detached from others
- •Persistent exaggerated negative expectations
- •Persistent distorted blame of self or others
-

17 ☐ **DISSOCIATION**

- Mentally separating the self from the experience
- May experience the self as detached from the body, on the ceiling, somewhere else in the room
- May feel as if in a dream or unreal state
-

18 ☐ **SURVIVING TRAUMA**

-
- Resilience is the ability to experience a difficult life situation and recover
  - Individual and environmental factors impact the development of resilience
  - Healthy coping skills for traumatic experiences can be learned and help to foster resilience.
-
- Strategies include:
  - Practicing mindfulness exercises that involve regulating breathing and increasing general awareness.
  - Education that increases understanding of the impact of trauma.
  - Learning verbal and nonverbal communication skills for expressing anger.
  - Opportunities to connect with others who can model healthy ways of coping.
  - Practicing strategies for reading situations accurately and staying safe when emotionally overwhelmed.
  - Addressing underlying emotional difficulties such as depression and anxiety

19 ☐ **PRACTICAL STRATEGIES FOR MANAGING TRAUMA**

-
- Clearly define roles, set expectations and develop routines that create predictability.
  - Provide choices to help empower youth.
  - Practice calming behaviors in non-crisis situations.
  - Create a calming/safety zone
  - Ensure safe environment for communication.
  - Support strategies for processing information.

1 ☐ **10 Things Every Juvenile Court Judge Should Know**
About Trauma and Delinquency

2 ☐ **A traumatic experience is an event that threatens someone's life, safety or well being**

- Can include direct encounter with a dangerous or threatening event
- Witnessing the endangerment or suffering of another living being
-
- The events overwhelm a person's capacity to cope.
- Events include: emotional, physical, sexual abuse, neglect; physical assaults; witnessing family, school or community violence; war; racism; bullying; acts of terrorism; fires; serious accidents; serious injuries; intrusive or painful medical procedures; loss of loved ones; abandonment; and separation.

3 ☐

- Acute Trauma: "A single traumatic event that is limited in time. An earthquake, dog bite, or motor vehicle accident are all examples of acute traumas" (Child Welfare Committee (CWC) National Center for Child Traumatic Stress Network (NCTSN) 2008, p. 6).
- Chronic Trauma: "Chronic trauma may refer to multiple and varied (traumatic) events such as a child who is exposed to domestic violence at home, is involved in a car accident, and then becomes a victim of community violence, or longstanding trauma such as physical abuse or war." (CWC/NCTSN, 2008, p. 6).
- Complex Trauma: "Complex trauma is a term used by some experts to describe both exposure to chronic trauma—usually caused by adults entrusted with the child's care, such as parents or caregivers—and the immediate and long-term impact of such exposure on the child." (CWC/ NCTSN, 2008, p. 7).

4 ☐

- Hypervigilance: "Abnormally increased arousal, responsiveness to stimuli, and scanning of the environment for threats" (Dorland's Medical Dictionary for Health Consumers, 2007). Hypervigilance is a symptom that adults and youth can develop after exposure to dangerous and life-threatening events (Ford et al., 2000; Sipprelle, 1992). The American Psychiatric Association's diagnostic criteria manual (DSM-IV-TR) identifies it as a symptom related to Post Traumatic Stress Disorder (American Psychiatric Association, 2000).
- Resiliency: "A pattern of positive adaptation in the context of past or present adversity" (Wright & Masten, 2005, p. 18).
- Traumatic Reminders: "A traumatic reminder is any person, situation, sensation, feeling, or thing that reminds a child of a traumatic event. When faced with these reminders, a child may re-experience the intense and disturbing feelings tied to the original trauma." (CWC/NCTSN, 2008, p. 12).
-

5 ☐ **Child traumatic Stress can lead to Post Traumatic Stress Disorder**

- Impact of potentially traumatic event is determined by nature of the event and Child's subjective response to the event. What is traumatic for one child may not be for another.
- Child impacted by trauma is influence by:
  – temperament,

– way the child interprets what has happened,
– basic coping skills;
– level of exposure;
– home and community environment;
– access to strong and healthy support systems.

6 ☐ **Trauma impacts a child's development and health throughout his or her life**

- Impact children in all areas of social, cognitive, and emotional development.
- Early exposure to trauma (before age 2) can negatively impact brain development.
- Childhood trauma negatively impacts relationship building/ maintenance skills including development of empathy
- These have long term impact of the person's functioning throughout adulthood

7 ☐

- Chronic trauma is a typical pattern of juvenile justice involved youth. (a pattern or series of events without opportunities for healing).
- The negative impact of chronic trauma extends into adulthood and can result in increased risk of serious diseases, health problems, and early mortality.

8 ☐ **Complex trauma is associated with risk of delinquency**

- Effect of trauma is cumulative—the greater the number of traumatic events the greater the risks to a child's development and emotional and physical health
- Children exposed to complex trauma – high potential to disrupt child's development
- Recognizing and addressing the role trauma has in the lives of youth is a more effective response to the youth's negative or self destructive behaviors.

9 ☐ **Traumatic exposure, delinquency and school failure are related.**

- Youth exposed to trauma operate in a state of "hypervigilance" -- abnormally increased psychological arousal and responsiveness to stimuli, and scanning of the environment
- Youth may have trouble sleeping, remaining focused on the task at hand, and managing their emotions
- These areas are all needed for success in school setting
- Difficulty in the school setting is a risk factor for increased involvement with the juvenile justice system.

10 ☐ **Trauma assessments can reduce misdiagnosis, promote positive outcomes, and maximize resources**

- Diagnosis often attributed to youth who have been exposed to chronic trauma—ADD, ODD, CD
- Diagnosis based on observable behaviors
- If treatment only addresses these externalizing behaviors and does not respond to the underlying trauma, it can actually contribute to the negative behaviors.
- Systems need to assess for trauma

11 ☐ **There are mental health treatments that are effective in helping youth who are experiencing child traumatic stress.**

- Evidence Based Practices are available to address the trauma issues of system involved youth.
- These programs typically contain the following interventions and focus
  - Psychoeducation, caregiver involvement and support, emotional regulation skills, anxiety management, cognitive processing, construction of a trauma narrative, and personal empowerment training.

12 ☐ **There is a compelling need for effective family involvement**

- Courts need to work hard at meaningful engagement with caregivers.
- Caregivers including: biological parents, extended family members, kinship caregivers, adoptive families, foster parents and others
- It is important to educate these involved team members about trauma in general and to share specific information about the child's history.
- Courts need to remove barriers (concrete and emotional) that interfere with full caregiver engagement.

13 ☐ **Youth are resilient**

- Resiliency is the capacity for human beings to thrive in the face of adversity.
- Resiliency is impacted by risk factors and protective factors that exist for the child
- To increase resiliency systems need to decrease risk factors and increase protective factors
- Relationships with a caring adult or adults is a key factor that enhances resiliency.

14 ☐ **Next Steps The juvenile justice system needs to be trauma informed at all levels**

- Informed systems understand the impact of traumatic stress on the youth and the family
- It provides services and supports that prevent, address and ameliorate the impact of trauma.
- Court systems need a system that does not compound trauma or subject youth to additional trauma.

15 ☐

- The system needs to reduce triggers and increase the feeling of safety for the children and families
- The system needs to provide evidence based trauma focused treatment.
- They need to have strong partnerships with youth, families, professionals and other stakeholders.
- They need to keep data to review and evaluate efforts always looking to improve
- They need transparent and frequent feedback to stakeholders about the system's response to the trauma exposed population.
-

1 ☐ **When the Cure Makes You Ill:**
7 Core Principles
to Change the Course of Youth Justice
By Gabrielle Prisco

- Juvenile justice system: is a cure that worsens the very thing that it is suppose to be fixing
- Often results in
- Increased violence and recidivism
- Fails to meet the goals of holding youth accountable in accordance / balance with their behaviors or
- Reducing juvenile violence or crime.

2 ☐

- In addition, the system responds more harshly to children of color and/or children involved with social services or having social service needs even though they may have a lower offense history.

3 ☐

- "Decades of research demonstrates that children who have committed a crime or delinquency and then interact with the system—particularly those who are detained or incarcerated- commit more future acts of crime and violence as compared to children who commit similar crimes or delinquencies and never become system involved or those who are not detained or incarcerated and instead receive community-based supervision, treatment and services."

(Prisco)

4 ☐ **Impact of System involvement**

- Increase future rates of delinquency (recidivism) and involvement in adult corrections
- Increased violence
- Increase in poor life outcomes
- For those with mental health concerns both detention and incarceration– exacerbate mental health symptoms and increase likelihood that youth will engage in self harm and commit suicide
-

5 ☐ **Impact of incarceration**

- Less likely to return to school
- Decreases future earning potential
- Decreases likelihood youth will remain in the labor market

6 ☐ **But they only lock up the bad ones?**

- No.
- 70% of youth in pretrial detention are held for nonviolent charges
- Nationwide only 24% of incarcerated children have been convicted of violent felonies...

7 ☐ **7 core principles to change the course of youth justice**

- "Reality is that many young people in the youth justice system should not be system-involved at all"

- Often these children are involved in normative adolescent behaviors
- In upper middle class/ white they are seen as teens will be teens
- For those who do need assistance from the justice system, it simply fails to meet their needs

8 ☐ **1. Treat Children as Children**

- Children's brain development is not complete until age 20 or beyond
- yet all jurisdictions in the US have "transfer" laws on the books allowing children to
- Be prosecuted as an adult
- Given an adult sentence
- Placed in an adult facility
- Leave corrections as a convicted felon

9 ☐ **1. Current Status**

- Some jurisdictions mandate that 16 and 17 year olds charged with some charges are automatically transferred to adult court jurisdiction
- Some jurisdictions mandate that at age 17, all charges are transferred
- Some states have laws that allow for the transfer of children as young as 13 or younger
- Some jurisdictions allow for life without the possibility of parole

10 ☐ **1. Current Status continued**

- Impact of transfer:
- Increases recidivism
- Youth face great physical and mental danger
  - 50% more likely to face an armed attack from a fellow prisoner
  - Twice as likely to face physical assault by prison staff
  - Five times as likely to be sexually abused or raped
- Increased risk of suicide
  - Thirty six times more likely to commit suicide
- Increased exposure to violence
  - Even if they are not a personal victim of violence exposure to violence negatively impacts these children

11 ☐ **1. Treat Children as Children**
Principle Based Policy Solutions

- A) "Youth justice system should operate as a child serving system:"
  - philosophical, operational and programmatic orientation should reflect the social, emotional, and developmental needs of children
  - jurisdictions need prevention, supervision and treatment resources
  - police, courts, youth serving agencies, and stakeholders need training, tools and resources to effectively assess and serve

12 ☐ **Treat Children as Children**
Principle Based Policy Solutions

- B) "raise the age of criminal responsibility to at a minimum 18 years of age for all youth, regardless of offense."
  - Treating children as children creates better outcomes

- Reduces harm to the child's mental health, educational and employment opportunities, and positive life outcomes.

13 **Treat Children as Children**
Principle Based Policy Solutions

- C. "stop housing children in adult jails and prisons
- D. "Waiver Reform" (automatic transfer)
- E. "Eliminate the sentence of juvenile life without parole"

14 **2. Fund and Use only what Works**

- Current Status:
- Youth who are detained or incarcerated are more likely to reoffend than those who are referred to community based supervision, treatment and services.
- But jurisdictions lack adequate continuum of community based options

15 **Current Status continued**

- Average cost of incarcerating a youth for a stay of 9 months is @ $60,000.
- Community based non-residential programs range from $603. to $9,902.
- Future savings (in the form of saved future criminal justice cost savings and future crime victim benefits) can total from $5,679. to $131,918.

16 **"The problem is not that we are spending a lot of money on children in the youth justice system,**
it is that we are investing tremendous resources in detaining and incarcerating children, despite extensive evidence that this approach results in poor outcomes for young people, communities and the public."

17 **Fund and Use only what Works**
Principle Based Policy Solutions

- A. Fund community-based continuums of supervision, programs and services.
  - Jurisdictions need a continuum of high quality, evidence informed and rehabilitative options for supervision, treatment, and in very limited cases confinement of youth.
  - Clear standards for quality and safety in both community based and residential settings
  - All stakeholders should be aware of the continuum of services and "decisionmakers should be legally required to make use of the least restrictive option possible"

18 **Fund and Use only what Works**
Principle Based Policy Solutions

- A. Continued
  - Programs and services be developed and funded so that children can access timely,

culturally competent, age-specific and developmentally appropriate services.

- Integrate family and community as key partners
- Focus on positive youth development and strength based approaches
-

19 ☐ **Fund and Use only what Works**
Principle Based Policy Solutions

- B) handle social service needs outside of the justice system.
  - Jurisdictions should differentiate between a youth's social service needs, family needs, and underlying delinquent or criminal act.
  - Identify social service needs can be used to convince or enhance a safety / risk issue leading to incarceration
  - Mental health, substance abuse, child welfare, and education needs may be identified within the juvenile justice system involvement but should be handled outside of the formal system

20 ☐ **Fund and Use only what Works**
Principle Based Policy Solutions

- C. Public transparency of performance-based data and system contracts.
  - Agencies, courts and providers need to set and achieve performance based goals, and base work on best practices with community input
  - There should be data driven analysis for improvements
  - Stakeholders, including the community should have awareness of relationships between governments and providers with transparency a goal

21 ☐ **Fund and Use only what Works**
Principle Based Policy Solutions

- D) incentive Community-Based alternatives to detention and incarceration
  - Avoid financial dis-incentives. Ie.. Make sure funding is available for non detention alternatives
-
- Facilities and programs that hurt children should be shut down.

22 ☐ **3. End racial and ethnic inequality**

- Current Status
- Children of color are not, however, merely disproportionately represented, instead they almost exclusively populate the youth justice system.
- DMC-Disproportionate Minority Contact– has existed since the creation of the juvenile justice system.

23 ☐ **3. End racial and ethnic inequality Current Status continued**

- Children of color remain over-represented and continue to receive unequal justice
- White children who are system involved generally receive better outcomes or a reduced likelihood of detention or incarceration
- Youth of color are discriminatorily treated at all points of the system
- Youth of color have a higher case rate, more frequently detained, more likely to have their case petitioned to the court and are consistently waived into the adult system at higher

rates than white youth.

24 ☐ **End racial and ethnic inequality Current Status continued**

- African American youth represent on 17% of the overall youth population but make up 30% of those arrested and 62% of those prosecuted in the adult criminal system.
- They are 9 times more likely than white youth to receive an adult prison sentence
- The negative impact of minority race increases at each point in the system.
- The unequal racial breakdown of arrest, detention and incarceration does not reflect the racial breakdown of crime rates.

25 ☐ **End racial and ethnic inequality**
Principle Based Policy Solutions

- Research racial disparities and take action on the results
  - Determine the rate
  - Assess decision points
  - Identify plausible reasons for disparity
  - Design and implement strategies to reduce
  - Monitor effectiveness.
- Legally mandate the collection and public release of relevant data
  - Specific data needed
  - Collected in juvenile justice system, child welfare, education, healthcare, and social service systems

26 ☐ **End racial and ethnic inequality**
Principle Based Policy Solutions

- Acknowledge the cumulative and systemic nature of racial disparities
  - Effective strategies engage systemic solutions
- Work across decision points
  - Strategies at each decision making stage
- Congress reauthorize JJDP Act
  - Plan and implement data driven approaches
  - Set measurable objectives
  - Publicly report progress

27 ☐ **4. Equal Justice and Culturally Competent Services for Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning Youth.**

28 ☐ **LGBTQ**
Current Status

- Disproportionately represented in the youth justice system
- Face stiffer sanctions
- Suffer routine and systemic mistreatment in detention and placement as a result of their perceived or actual sexual orientation, gender expression, or gender identity.
-

29 ☐ **LGBTQ**

Current Status

- Survey on conditions for LGBTQ youth incarcerated in youth justice facilities @ 80% felt that lack of safety in detention was a serious problem.
- Vulnerable to sexual abuse inside youth justice facilities
- Using isolation to "protect" these youth has damaging results that often do not quickly resolve
- Transgendered youth are often placed in facilities based on their assigned birth sex not their gender identity. This can lead to psychological stress as they must conform to gender roles and expectations. And they my not receive specialized needed medical care.
-

30 ☐ **LGBTQ**
Principle Based Policy Solutions

- Develop and implement non-discrimination policies that protect gender identity and sexual orientation
- Mandatory and regular training of those having direct contact with LGBTQ youth
- Increase funding for LGBTQ competent community based programs and services
- Eliminate zero tolerance and punitive policies in favor of positive interventions.

31 ☐ **5. Share Power and Resources with Families and Communities**

32 ☐ **Share Power and Resources with Families and Communities**
Current Status

- Traditionally been excluded or blamed
- Parents report feeling demonized and treated as "the criminals who raised a new generation of criminals"
- Communities suffer when the youth are removed and placed at a distance, when they have to support expensive facilities
- Communities have not been viewed as stakeholders in a solutions focused perspective.

33 ☐ **Share Power and Resources with Families and Communities**
Current Status

- The system is unlikely to engage the parents, other family members, or the child's community in the rehabilitative process
- System does not see them as partners in the solutions
- Engagement is lacking– there are not the important partnerships that can be tools toward enhancing how youth are treated

34 ☐ **Share Power and Resources with Families and Communities**
Principle Based Policy Solutions

- Invest in local knowledge and programs with strong family and community engagement components
- Outreach and listen to families and communities
- Orient families to the system and provide peer support

- Give families and communities access to the levers of change
- Family access to detained and incarcerated youth
- Opening facilities up to family and community inspections
- Link community based support systems to the youth justice system
- Engage youth people in identifying the people and programs that support them
- Invest resources in families and communities

35 ☐ **6. JUSTICE IS NOT FOR SALE**

36 ☐ **Justice is not for Sale**
Current situation

- Concern about for profit corporations involvement in juvenile justice/ juvenile corrections
- Is treatment sacrificed for profit?
- Incentive to detain/ incarcerate more youth?
- "abusive treatment of youth has systemically occurred in jurisdictions that have allowed for for-profit youth justice facilities
- Although marketed as cheaper there are often hidden costs

37 ☐ **Justice is Not For Sale**
Principle Based Policy Solutions

- "all residential facilities for children should be operated by governmental or not-for-profit entities.
- Independent researchers should evaluate the cost & recidivism claims of the private prison industry."

38 ☐ **7. ALWAYS HAVE STRONG OUTSIDE EYES**

39 ☐ **ALWAYS HAVE STRONG OUTSIDE EYES**
Current situation.

- This population is highly vulnerable to neglect, abuse, and violation of constitutional rights
- There is a huge gap in oversight both of public and private facilities and little to no independent oversight.
- Since there is a lack of oversight there is no clear assessment of risk areas and no acknowledgement of areas of strength for a facility, treatment model, or strategy.

40 ☐

Always have strong outside eyes
Principle Based Policy Solutions

- We need strong oversight and independent monitoring.
  - Can include licensing and accreditation, legal protections
  - ABA outlined 20 standards for effective youth and adult prison oversight.
  - Independence with a solid budget are important
- System transparency
  - Data (that does not compromise confidentiality) must be easily available to the public
  - Inspection reports, visits results, etc.. Must be easily accessible, especially to advocacy groups.

Brief
Research-to-Results
Child TRENDS

...information for program providers, funders, policy makers, and researchers on the meanings of a common phrase, "at risk."

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DEFINING THE TERM "AT RISK"

Kristin Anderson Moore, Ph.D

WHAT DOES "AT RISK" MEAN?

The term *at risk* is used frequently to describe children and youth and has a strong intuitive meaning. However, the term has no consistent definition and can be viewed as stigmatizing certain groups. Nevertheless, it is widely used. The positive side of this confusion is that program providers have some leeway in how they define "at risk" for their programs. Despite this flexibility, it still is important to have a standard or a reference point for clear communication between providers, funders, policy makers, and the media about what "at risk" means. This brief highlights some of the issues surrounding the concept. Who is at risk? What are they at risk of? What can the information on risk be used for? Is a quantitative measure of "at-risk" desired? And what about protective factors?

WHO IS "AT RISK"?

Is it the child or adolescent? Is it the family? Or is it the community?

Some would argue that all children are at risk in some way or another, while others emphasize that some children face much higher risks than do other children. For example, children are seen as at risk if they are disabled, have low self-esteem, or have been abused.

Alternatively, some contend that one should not view children themselves as being at risk, but rather the environments in which children develop. For example, it could be said that the family is at risk. Families are the most critical setting for the development of children, and family risk factors, such as poverty, single parenthood, and low parental education levels, regularly have been found to undermine children's development.

A third approach would focus on the community, neighborhood, or school context as an at-risk environment. For example, a low-income community with a high crime rate and a low high school graduation rate might be viewed as a place that puts children and adolescents at risk of poor outcomes.

WHAT ARE CHILDREN AT RISK OF?

Surprisingly, rather than specifically indicating what children are at risk of, the phrase is often used vaguely to refer to poor life outcomes in general. When outcomes for children are mentioned, they tend to refer to very general, long-term deficits, such as school failure, death, economic dependency, or incarceration. However, particular out-of-school-time programs in the community are likely to have more specific goals for "at-risk" children, such as improving grades in school, delaying sexual initiation, or developing conflict resolution skills. Moreover, any given program is likely to have just one or two specific targets; in other words, few programs are seeking to improve arts performance, sports competence, academic skills and test scores, and to encourage volunteering. Thus, in the field, different program providers are likely to have quite different outcomes in mind when they think a

child is "at risk" of a poor outcome. Also, as discussed below, both general goals and specific target outcomes can be useful, but for different purposes.

How can measures of "at risk" be used?

Programs increasingly are being asked to develop logic models, provide program plans, and implement evaluation strategies. Each task might call for assessing "at risk," but different measures of "at risk" might be used for each purpose. For example, in developing a logic model, program staff might want to understand the characteristics of the community. Are children "at risk" because of poverty, crime, toxins or pollution, low levels of English proficiency, poorly performing schools, unemployment, or several of these kinds of factors? On the other hand, decisions about which children to enroll in a program or to target for a program may be based on current or historical information about the child or his/her family. For example, has the child frequently been absent from school or been suspended or expelled? Is the family in poverty? In evaluating a program, however, the focus moves to the specific outcomes for which children and adolescents are at risk in the future. These outcomes might include pregnancy, school dropout, arrest or drug use.

How should "at risk" be assessed?

To assess risk, a survey could be administered, or administrative data or government statistics could be used.

If children are at the center of the "at risk" definition, then it will be necessary to obtain data about individual children from school records or other administrative data or from a survey of children or parents.

If family characteristics are used to define risk, data might be available from the school, or it might be available from other administrative record systems, such as those pertaining to food stamps or Medicaid. Also, it might be possible to administer a survey to parents to obtain information about the family that would inform the program about the levels of risk that a family experiences.

If community characteristics are used to define risk, local area data from the U.S. Census or the American Community Survey might be used to describe the community. Crime statistics are also available for every city, as are vital statistics data on teen births and mortality. Community-level surveys also provide information about risks faced at the community level.

What about protective factors?

Do programs only want to know about the risks faced by children and families in their schools and communities? Assets, strengths, and protective factors also can be valuable to assess. Even though some children, families, and communities face multiple risks, most also will have assets and protective factors.[1] For example, a positive, caring relationship with a parent can inoculate against many risks.[2] Ongoing positive relationships with other adults represent another critical protective factor.[3]

What measures are used to assess "at risk"?

Children have been defined as "at risk" with a variety of different indicators, including having limited reading proficiency, having experienced abuse or trauma, having a disability or illness, or having exhibited behavior problems.[4]

Measures of family risk include poverty, a low level of parental education, a large number of children, not owning a home, single parenthood,[5] welfare dependence,[6] family dysfunction, abuse,[7] parental mental illness, parental substance use, and family discord or illness.[8]

Measures of community risk might include rates of poverty, crime, unemployment, or teen parenthood in the community.

Conclusion

It is critical to note that "at risk" is a concept that reflects a chance or a probability. It does not imply certainty. Risk factors raise the chance of poor outcomes, while protective factors raise the chance of good outcomes. It is valuable for programs to understand the levels of risk and protective factors in their program clients, as well as of their potential clients. Such understanding can help in developing programs and also in obtaining funding for them.

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