Mental Health Training Curriculum for Juvenile Justice

Module 1: Introduction
Mental Health Training Curriculum for Juvenile Justice

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Warm-Up Exercises
Purpose of the Exercises

- You and your role in the juvenile justice system
- How you think about the importance and challenges of what you do
- How you think about teenagers
  - What teenagers are like
  - How teenagers relate
- The universal aspects of adolescence
  - How we are all alike
Adolescent Development and Juvenile Justice

Why is it important?

- Universal facts about youth
- Youth more than just “little adults”
- View youth through the lens of developmental processes
- Emotional versus cognitive development
  - A “speeding car without brakes or steering wheel”
- Youth as inseparable from their families and communities of origin
Mental Health Training Curriculum

Throughout the training, consider the following:

- each of the topics in the context of your job
- developmental issues in the context of your experience with teenage development (e.g., your own, your kids, your relatives, etc.)
- the difficulties of adolescence complicated by mental health, substance abuse, or trauma issues
- the added complication of juvenile justice involvement
- the experience of youth with mental health issues involved in the juvenile justice system
Training Goals

This training is designed to

- facilitate increased understanding of justice-involved youth with mental health, substance use, and trauma disorders;
- increase familiarity with issues of adolescent development and how they impact youth behavior;
- emphasize the role of the family and community in obtaining optimal outcomes for youth and the public;
- provide practical tips for successful, positive interactions with youth;
- increase knowledge of effective, evidence-based practices to treat youth with mental illnesses, co-occurring disorders, and histories of trauma;
- improve job safety and reduce job-related stress; and
- increase job satisfaction.
Training Overview

**Module 2:** The Interface between the Juvenile Justice and Mental Health Systems

**Module 3:** Understanding Adolescent Development

**Module 4a:** Mental Health and Substance Use Disorders

**Module 4b:** Child Trauma

**Module 5:** Treatment of Youth with Mental Health Disorders

**Module 6:** Working with Youth – What You Can Do

**Module 7:** Family Engagement
Getting Started

- What sort of questions/comments comes to mind so far?
- What challenges do you face in understanding or assisting youth in the juvenile justice system?
- What challenges have you encountered working with youth with mental illnesses in the juvenile justice system?
- What would YOU like to get out of the training today?
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Module 3: Understanding Adolescent Development
Objectives

At the conclusion of this session, participants will be able to

- describe basic brain development in adolescents;
- describe basic adolescent development across physical, emotional, and cognitive tasks; and
- discuss adolescent risk-taking and impulsive behavior.
Introduction to Brain Basics
Brain Basics – Development

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

The brain is an amazing organ that controls most of the things we do. As the brain develops, it focuses on different areas of functioning:

- **first** – **physical** (breathing, heart rate, blood pressure)
- **next** – **emotional** (happiness, anger, attachment)
- **last** – **thinking** (planning, impulse control)
Brain Basics – Plasticity

- Critical Periods – 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.
  - Don’t confuse a youth’s age with his or her developmental level.
Brain Basics – Plasticity

Activity-dependent changes

- 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.
Teenage Brain Development

- Adolescent changes begin around ages 10-13.
  - physical appearance (puberty)
  - emotions (feelings and identity)
  - thinking (planning and impulse control)

- We usually identify adolescence as starting when we see physical changes. These physical changes will be followed by less obvious changes in emotional expression and thinking.

- But, changes in thinking aren’t in place until the early 20s.
Functioning of the frontal lobes is not at adult levels.

Why is that important?

(Steinberg, 2008)
Teenage Brain Development

Adolescence is like giving a teenager a car that
- has a new body with a lot of horsepower (physical);
- is powered by a sensitive gas pedal that can go from 0-60 mph in a few seconds (emotional);
- is controlled by a brake system that won’t work completely for several years (thinking); and
- shares the same race track with many other cars of the same age (social).
Physical and Emotional Development

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

How do you think the rate of maturation can impact a teen’s life?
Cognitive Development

Science has taught us that the part of the brain that develops last during adolescence is the prefrontal lobe, which controls some important functions:

- weighing pleasure and reward
- susceptibility to peer pressure
- self-control
- complicated decision-making
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?
Cognitive Development

- 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.
Cognitive Development

- Even though teenagers start to look like adults, they are still limited by their cognitive development.
- Don’t confuse physical development with emotional or cognitive development.
Cognitive Development

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
Impulsivity Declines with Age

(Steinberg et al., 2008)
Sensation-Seeking Declines with Age

(Steinberg et al., 2008)
Risks of Adolescence

Mid-adolescence is a time of high sensation-seeking, but still-developing self-control, which can be a potentially dangerous combination.
Preferences for Risk Peaks in Mid-adolescence

(Steinberg et al., 2009)
Risk Perception Declines and then Increases After Mid-adolescence

(Steinberg et al., 2009)
Short-Sightedness
Short-Sightedness

- 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.

But, we know from the new brain research that the teenage brain will continue to mature and that over time, adolescents will begin to think more like adults.
Future Orientation Increases with Age

(Steinberg et al., 2009)
Older Individuals Are More Willing to Delay Gratification

(Steinberg et al., 2009)
With Age, Longer Time Spent Thinking Before Acting

Easiest Problems

Hardest Problems

10-11 12-13 14-15 16-17 18-21 22-25 26-30

Age

(Steinberg & Monahan, 2007)
Susceptibility to Peer Pressure
Susceptibility to Peer Pressure

- Looking for affiliation
- Social approval and risk
- When you were a child, most of your world revolved around home and family. When did that start to shift to your peers?
- When did you stop telling your parents everything you did with your peers?
Peers Increase Risky Driving among Teenagers and College Students, but Not Adults

(Gardner & Steinberg, 2005)
Summing Up Cognitive Development

- Adolescents are less able to control impulses and more driven by the thrill of rewards.
- Adolescents are more short-sighted and oriented to immediate gratification.
- Adolescents are less able to resist pressure from peers.
What can adults do to help adolescents?

- Brain plasticity – Brains develop 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
Coming up –
How would you expect a youth to act. . .

- when he or she has a mental health issue?
- when he or she has had adverse experiences in early childhood?
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Module 4a: Mental Health and Substance Use Disorders
Exercise
Objectives

At the conclusion of this session, participants will be able to

- discuss the prevalence of mental health and substance use disorders within the juvenile justice population;
- understand the differences between screening and assessment for disorders;
- identify possible signs of mental health and substance use disorders; and
- discuss warning signs for suicidal and self-injurious behavior.
Mental Health Disorders

A mental health disorder is characterized by a clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior.
Mental Health Disorders (cont’d.)

Depending on the exact nature of the mental health 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.
Prevalence of Mental Health Disorders in the Juvenile Justice System

- Approximately 70% of youth in the juvenile justice system meet criteria for at least one mental health disorder.

- Evidence across studies suggests that 27% of youth in the juvenile justice system have a serious mental health disorder.

- Rates of mental disorder among youth in the juvenile justice system are three times higher than that of the general population.

(Merikangas et al., 2010; Shufelt & Cocozza, 2006)
### National Center for Mental Health and Juvenile Justice’s Multi-State Study of Mental Disorders

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<th>Types of Disorder</th>
<th>Percentage</th>
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<tr>
<td>Any Disorder</td>
<td>70.4%</td>
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<tr>
<td>Disruptive Disorder</td>
<td>46.5%</td>
</tr>
<tr>
<td>Substance Abuse Disorder</td>
<td>46.2%</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>34.4%</td>
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<tr>
<td>Mood Disorder</td>
<td>18.3%</td>
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</tbody>
</table>

(Shufelt & Cocozza, 2006)
Co-occurring Disorders

- More than half (55.6%) of youth met criteria for at least two diagnoses.

- 60.8% of youth with a mental disorder also had a substance use disorder.

(Shufelt & Cocozza, 2006)
## Mental Health Disorders by Gender

![Table showing mental health disorders by gender](table.png)

<table>
<thead>
<tr>
<th>Types of Disorders by Gender (n=1437)</th>
<th>Males %</th>
<th>Females %</th>
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</thead>
<tbody>
<tr>
<td>Any Disorder</td>
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<td>81.0</td>
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<tr>
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<td>44.9</td>
<td>51.3</td>
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<tr>
<td>Anxiety Disorder</td>
<td>26.4</td>
<td>56.0</td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>14.3</td>
<td>29.2</td>
</tr>
</tbody>
</table>

(Shufelt & Cocozza, 2006)
Mental Health Disorders

Given the high prevalence of mental illness in justice-involved youth,

- how are those youth with a mental health disorder identified?
- how do we determine their individual treatment needs?
What is a mental health screening?

- Screening instruments are
  - short,
  - quick to administer,
  - easily scored, and
  - focused on a few critical issues.

- Screening instruments are designed to be administered by non-mental health professionals.
Mental Health Screening

- The goal is to identify youth
  - in immediate mental health crisis or
  - as possibly having a mental health disorder.
- Screening results indicates the need for
  - crisis intervention and/or
  - follow-up assessment.
What is a mental health assessment?

Assessments...

- provide a more detailed evaluation of a youth after a screening has indicated further evaluation is warranted.
- are individualized.
- 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.
- are administered and interpreted by persons with advanced mental health training.
Diagnostic vs. Functional Assessments

Diagnostic
- a formal classification
- stable over time
- e.g., depression or schizophrenia

Functional
- describes severity of symptoms or behaviors
- changes over time
- e.g., suicidal or hearing voices
Assessments

Assessments (in general) are used to determine the following:

- diagnosis,
- intellectual functioning,
- risk (e.g., violence, suicide),
- placement,
- treatment needs, and
- strengths.
Mental Health Screening and Assessment in Juvenile Justice

Screenings are recommended for
- prevention and diversion programs,
- intake probation offices,
- detention centers, and
- reception into juvenile corrections.

Assessments may be conducted for
- trial,
- sentencing,
- comprehensive treatment planning,
- transition from institutional custody, and
- institutional treatment planning.
Screening and Assessment Instruments
Commonly Used in Juvenile Justice

**Screening**
- MAYSI-2
- GAIN-SS
- YASI

**Assessment**
- V-DISC (diagnostic)
- CAFAS (functional)
- CANS (functional)
What kinds of mental health disorders are most likely to be seen among youth in the juvenile justice system?
Mental health diagnoses are listed in the Diagnostic and Statistical Manual (DSM).
Consider Other Factors

Not all “misbehaviors” are signs of mental illness. 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.
DSM-5 Categories of Mental Disorders Most Common to Youth

- Disruptive, Impulse-Control, and Conduct Disorders
- Substance-Related and Addictive Disorders
- Anxiety Disorders
- Trauma- and Stressor-Related Disorders
- Depressive Disorders
- Bipolar and Related Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
- Neurodevelopmental Disorders
Disruptive Disorders

Past studies have found that 46.5% of youth in the juvenile justice system experienced disruptive disorders.

- Conduct Disorder
- Oppositional Defiant Disorder
- Attention-Deficit/Hyperactivity Disorder*
This disorder is 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

This 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)
Substance-Related Disorders

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

- taking the substance in larger amounts or over a longer period than intended
- craving the substance
- making unsuccessful attempts to reduce substance use
- recurring interpersonal problems

Past studies have found that 46.2% of youth in juvenile justice have had substance–related issues.
Substance-Related Disorders

Problematic effects of the substance can include

- craving,
- tolerance,
- withdrawal, and
- inducing other disorders (e.g., delirium, depression, sleep disorder, and sexual dysfunction).
Co-occurring Disorders

- Substance use can precipitate or worsen existing mental health disorders.
- Mental illness in combination with substance abuse increases the risk of violent behavior.
- Heavy use of some substances can disrupt brain development and lead to lasting impairment.
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
- Posttraumatic Stress Disorder

Past studies have found that 34.4% of youth in the juvenile justice system experienced anxiety disorders.
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
Trauma-Related Disorders

There are multiple trauma-related diagnoses. All of them include three essential components:

- a stressful event
- an ongoing intense, negative emotional experience
- lasting, negative effects
Posttraumatic Stress Disorder

Exposure to actual or threatened death, serious injury, or sexual violence can result in PTSD.

Symptoms include the following:
- re-experience of the event (e.g., flashback, nightmares)
- avoidance behaviors
- heightened arousal and hypervigilance
- exaggerated negative beliefs about the world
Depressive Disorders

Past studies have found that 18.3% of youth in juvenile justice experienced mood disorders, which include depression and bipolar disorders.

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

- Bipolar disorder is characterized by extreme mood swings between depression and mania/hypomania.

- Mania
  - Inflated self-esteem
  - Rapid speech
  - Decreased need for sleep
  - Grandiosity
  - Distractibility

- Bipolar disorder can present in childhood, especially when there is a strong family history of the disorder.
Psychotic Disorders

- Prevalence within the juvenile justice population is very low (2%).
- However, when present, these disorders can be extremely disruptive.
- Symptoms can include the following:
  - hallucinations
  - delusions
  - paranoia
  - bizarre speech
Neurodevelopmental Disorders

- Intellectual Disabilities
- Communication Disorders
- Autism Spectrum Disorder
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
Suicide in the General Youth Population

- Youth suicide is a significant public health issue.
- Suicide is the second leading cause of death among youth ages 10-18.
- One in thirteen high-school students attempt suicide.

(National Action Alliance for Suicide Prevention, 2013, Need to know...)
Suicide in the Juvenile Justice System

- Youth in the juvenile justice system have an increased risk for suicide.

- Suicide is the leading cause of death for youth in confinement.

- Youth in residential facilities have nearly three times the suicide rate of peers in the general youth population.

(National Action Alliance for Suicide Prevention, 2013, Need to know….)
Suicide Risk Factors for Youth in the Juvenile Justice System

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

Signs that immediate help for suicide risk is needed include the following:

- perceived crisis (e.g., transition within the juvenile justice system)
- unusual or sudden changes in personality, behavior, or mood
- talking about wanting to die or kill oneself
- 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)
What can juvenile justice systems do to prevent juvenile suicide? (cont’d.)

- 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.
Module Summary Questions

- Were you able to draw parallels between the discussion of mental health disorders common among youth in the juvenile justice system and the youth you see and work with every day?
- Given our earlier discussion of normal adolescent development, risk taking, and impulsivity, what is the added impact of mental illness?
- In your experience, what staff responses have been effective in dealing with youth’s mental illnesses?
- What responses have been ineffective?
Mental Health Training Curriculum for Juvenile Justice

Module 4b: Child Trauma
Objectives

At the conclusion of this session, participants will understand:

- current definitions of trauma, including traumatic events, experiences, and effects;
- the prevalence of trauma among youth involved with the juvenile justice system;
- the impact of childhood trauma on youth development, behavior, and delinquency; and
- emerging responses to trauma among youth in the juvenile justice system, including trauma screening, assessment, treatments, and recovery.
It’s About Perspective
A Common Theme for Child Systems

- Child Welfare
- Education
- Substance Abuse
- Mental Health
- Children Exposed To Violence
- Juvenile Justice

Trauma
Trauma, Defined by NIMH

The experience of an event by a person that is emotionally painful or distressful and which often results in lasting mental and physical effects.
Traumatic events can include . . .

- abuse (physical, emotional, sexual),
- neglect,
- victimization,
- domestic/community violence,
- accident/illness,
- natural disaster, and
- war/terrorism.
Trauma experiences can . . .

- be life threatening;
- be overwhelming;
- be a subjective, internal state;
- vary between people;
- vary over time with the same person, per developmental level; and
- be a single incident or chronic incidents.
Symptoms of Trauma Effects

- Nightmares
- Flashbacks
- “Fight or Flight”
- Dissociation

- Cutting
- Hyper-arousal
- Overreaction
- Misinterpretation of cues
Events can be experienced; or, in some cases, witnessed; or even learned about later. First responders, such as police officers and firefighters, are specifically acknowledged as being at risk.

After experiencing the event, the person must exhibit four types of symptoms:
- re-experiencing
- avoidance
- hyper-arousal
- ongoing negative thoughts and moods
Most people can get through adverse experiences without developing trauma symptoms.

Resilience and protective factors contribute to this.

Recovery is possible.
Prevalence of Traumatic Experiences for Youth

- In a longitudinal general population study of 9- to 16-year-old youth, 25% had experienced at least one traumatic event, with 6% having experienced a traumatic event in the past three months.

- The Fourth National Incidence Study of Child Abuse found 1,256,000 children maltreated in one year.

(Sedlak et al., 2010)
Prevalence of Traumatic Experiences for Youth in Juvenile Justice

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

- As many as 50% of these youth may have symptoms of trauma. (Effects)

(National Child Traumatic Stress Network, 2009)
Prevalence of Traumatic Experiences for Youth in Juvenile Detention

- 93% of children in detention report exposure to adverse events. These adverse and potentially traumatic events include accidents and serious illnesses, physical abuse, sexual abuse, neglect, traumatic loss, and domestic and community violence.

- The majority of youth were exposed to six or more events.

- Girls reported greater exposure to all adverse events, except physical abuse and traumatic loss.

(Abram et al., 2004; Ford et al., 2007)
The Adverse Childhood Experiences Study (ACES) examined youth who experienced

- physical abuse and neglect,
- emotional abuse and neglect, and
- sexual abuse.

It also examined youth growing up in a household with

- an alcohol or drug abuser;
- an incarcerated household member;
- someone who is chronically depressed, suicidal, institutionalized, or mentally ill; and
- domestic violence.
Trauma – Long-Term Impact

Exposure to these adverse experiences increases a youth’s risk for the following:

- major mental illness
- substance abuse
- AIDS and sexually transmitted diseases
- impaired physical health
- academic difficulties
- early death
Trauma – Long-Term Impact

Childhood Experiences Underlie Chronic Depression

% With a Lifetime History of Depression

ACE Score

0  1  2  3  >=4

Women
Men
Trauma – Long-Term Impact

Childhood Experiences Underlie Suicide

% Attempting Suicide

ACE Score

0 1 2 3 4+

0 2 10 18 20

0 2 4 6 8 10 12 14 16 18 20
Trauma – Long-Term Impact

![Bar Chart: Childhood Experiences vs. Adult Alcoholism](chart.png)
Trauma – Long-Term Impact

Adverse Childhood Experiences vs. History of STD

Adjusted Odds Ratio

ACE Score

0 1 2 3 4 or more
Trauma – Long-Term Impact

In terms of physical health, ACES found an increased risk of the following:

- smoking
- obesity
- heart disease
- cancer
Impact of Trauma on Academics

- Youth are less ready to start school.
- Youth don’t perform as well in school.
- Youth who aren’t performing well have more behavioral difficulties.
- Youth have an increased likelihood of dropping out of high school.
Adverse Childhood Experiences: Influence on Health and Well-Being over the Lifespan

- Adverse Childhood Experiences
- Disrupted Neurodevelopment
- Social, Emotional, and Cognitive Impairment
- Adoption of Health Risk Behaviors
- Disease, Disability & Social Problems
- Early Death
- Death
- Conception
Trauma’s Impact on the Brain

Disruption in neural development can include:

- failure to expose youth to appropriate experiences at the critical times (neglect) and
- overwhelming the brain’s alarm system (abuse).
Normal Brain Development

Newborn  6-year-old  Newborn  6-year-old
Disrupted Brain Development from Childhood Neglect

3 Year Old Children

Normal

Extreme Neglect

www.childtrauma.org

Bruce D. Perry, M.D., Ph.D. ©2002
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
- Dissociation (Freeze)
  - Nonresponsive
  - Self-mutilation
  - Passing out
After experiencing trauma, youth may:

- be on constant alert,
- over-interpret signs of danger, and
- overreact to normal situations.
Trauma Screening and Assessment

Screening and assessment instruments include the following:

- Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2)
- Traumatic Events Screening Inventory (TESI)
- Child Adolescent Needs and Strengths (CANS)
- Trauma Symptom Checklist for Children (TSCC)

See the National Child Traumatic Stress Network’s Listing of Trauma Measures.
Effective Treatments for Child Trauma

Individual Therapy
- Trauma-Focused Cognitive Behavior Therapy (TF-CBT)

Group Therapy
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

Psychopharmacological Interventions
- Treats symptoms but does not cure
Trauma in Juvenile Justice Settings

- Trauma Affect Regulation: A Guide for Education and Therapy (TARGET)
- Trauma Recovery and Empowerment Model (TREM)
- Seeking Safety
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 Adults Can Do

1. Safety
2. Supportive adult relationship
3. Self-soothing
4. Strengths
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.

Structure and predictability can help youth feel safe.

Set limits appropriately.

- No violence.
- No yelling.
- No retaliation: Separate out your anger.
Recovery – Support

- You don’t have to be a therapist to be therapeutic.
- Be consistent during interactions with youth.
- Model appropriate coping, anger management, and problem-solving behavior.
- Follow up with youth after a crisis.
- Each interaction presents an opportunity . . .
  - to build skills.
  - to foster a helping relationship.
Recovery – Self-Soothing

Teach calming skills.
- Recognizing physical signs of escalation
- Incorporating relaxation techniques

Teach coping skills.
- Using verbal rather than behavioral responses
- Seeking adult support

Teach problem-solving skills
- Alternating responses
- Practicing, practicing, practicing
Recovery – Strengths

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

- Intergenerational Issue
  - Child
  - Parent
  - Grandparent

- Breaking the cycle

- Redefining “normal” events
Websites

- www.childtrauma.org - Dr. Perry and The ChildTrauma Academy
- www.nctsn.org - National Child Traumatic Stress Network
- www.acestudy.org - ACES Study
- www.ncmhjj.com - National Center for Mental Health and Juvenile Justice
Mental Health Training Curriculum for Juvenile Justice

Module 5: Treatment of Youth with Mental Health Disorders
Objectives

At the conclusion of this session, participants will be able to

- 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
- discuss psychopharmacological treatment interventions.
Your Perspective

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

Some of the items researchers look at include

- decreased mental health symptoms;
- 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
How do these goals impact your . . .

- work culture?
- ability to do your job?
- satisfaction with your job?
- community?
Evidence-Based Practices: Treatment Proven to Be Effective
Evidence-based practices...

- are standardized treatments that result in improved outcomes.
  - Outcomes are replicated in a variety of studies with different types of youth.
- take into account adolescent development.
- can be incorporated into a program serving youth and their families.
- are increasingly being mandated by states.
Resources on EBPs

- www.nrepp.samhsa.gov
- www.colorado.edu/cspv/blueprints
- www.ojjdp.gov/mpg/
Types of EBPs

- Family and community-based models
- Psychosocial treatments
- Psychopharmacological interventions
Examples of EBPs for Youth in Contact with the Juvenile Justice System

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

- Cognitive Behavioral Therapy
- Brief Strategic Family Therapy
- Dialectical Behavior Therapy
- Aggression Replacement Therapy
Substance Abuse Treatments

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

- Addressing co-occurring disorders
- Trauma-focused treatments
  - Trauma-Focused Cognitive Behavioral Therapy
- Gender-specific considerations
- Culturally sensitive interventions
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.
### Examples of Psychopharmacological Interventions

<table>
<thead>
<tr>
<th>Mental Health Disorder</th>
<th>Class of Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>Stimulant (Ritalin, Concerta) or non-stimulant (Strattera)</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>Mood stabilizer (Lithium), atypical antipsychotics (Abilify)</td>
</tr>
<tr>
<td>Depression</td>
<td>Antidepressants – SSRIs (Prozac), Zoloft, Lexapro</td>
</tr>
</tbody>
</table>
Are evidence-based practices really cost effective?
### Examples of Benefits of Selected Programs for Juvenile Justice Youth

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Effect on JJ Outcomes</th>
<th>Cost Savings (benefits-costs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multisystemic Therapy</td>
<td>- 10.5%</td>
<td>$18,213</td>
</tr>
<tr>
<td>Functional Family Therapy</td>
<td>- 15.9%</td>
<td>$31,821</td>
</tr>
<tr>
<td>Multidimensional Treatment Foster Care</td>
<td>- 22.0%</td>
<td>$77,798</td>
</tr>
<tr>
<td>Scared Straight</td>
<td>+6.8%</td>
<td>-$14,667</td>
</tr>
<tr>
<td>Regular Surveillance-Oriented Parole</td>
<td>0%</td>
<td>-$1,201</td>
</tr>
</tbody>
</table>

(Washington State Institute for Public Policy, 2007)
Discussion

- 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?
Resources for Identifying EBPs and Programs Utilizing EBPs

- Center for the Study and Prevention of Violence. *Blueprints for Violence Prevention*

- National Child Traumatic Stress Network. *Empirically Supported Treatments and Promising Practices*

- Skowyra & Cocozza. *Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System*
Mental Health Training Curriculum for Juvenile Justice

Post-lunch Exercise
Where do you stand?
A youth’s family is his or her best support system.
Youth repeatedly involved in juvenile justice are beyond rehabilitation and unlikely to become productive citizens.
Families and communities are essential components of positive youth development.
Incarcerated youth should be provided with the supports necessary to enable them to return to their biological families once they are released.
All youth in the juvenile justice system need mental health treatment.
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.
Mental Health Training Curriculum for Juvenile Justice

Module 6: Working with Youth – What You Can Do
Objectives

At the conclusion of the module, participants will be able to

- use the information presented to make their jobs easier, safer, and less stressful;
- describe the various types of de-escalation techniques they can use when youth are in crisis;
- positively interact with youth and families to achieve the best possible outcomes; and
- apply this knowledge with mentally ill and trauma-exposed youth.
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?
Key Interventions

Key interventions are based on a best-practices approach to responding to youth in crisis and include the following:

- crisis prevention
- crisis de-escalation
- crisis intervention
- crisis follow-up
Keys to Successful Crisis Management

Skill Building

Prevention
Coaching
Modeling

De-escalation

Early Intervention
Crisis Prevention
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

I. 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

II. 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)
III. 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)
EXERCISE ONE
Incident Reports from Juvenile Detention

Report 1: 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.
EXERCISE ONE
Incident Reports from Juvenile Detention

Report 2: 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. [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.] After her 36 hours were up, Jenny was returned to the regular unit schedule with no follow-up discussion or mental health referral.
Crisis De-escalation
De-escalation

De-escalation resolves a crisis through problem-solving, rather than by violence.

- 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)?
Keep It Neutral

- 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
- Interest and caring versus anger and judgment

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.
Shhhhhhhhhhhhhhhhhhhhh!

- 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.
Listen

- Listening is a powerful **skill** that can be developed and enhanced.
- Listening is more than just hearing.
  - Active listening is hearing with engagement, empathy, and understanding.
- Listening is often the key to a successful intervention.
Features of Active Listening

- Repeat what you are hearing.
- Label feelings.
- Encourage expression of thoughts.
- Focus on the positive.
- Summarize.
EXERCISE TWO: Video Clips

Re-enactment 1
Re-enactment 2
Re-enactment 3
Re-enactment 4
Crisis Intervention

- Unfortunately, some incidents will still escalate to a crisis.
- Safety is the primary concern.
- Follow departmental or institutional policies regarding progressive levels of intervention, seclusion, and physical and mechanical restraints.
- Follow an existing treatment plan.
Crisis Follow-Up
Crisis Follow-Up: Learning New Skills

- Youth are not going to learn new behaviors in the middle of crisis.
- But, youth may learn from their mistakes after they have calmed down and with the help of staff.
- Otherwise, youth may keep repeating the same violent, unsuccessful behaviors.
- Staff members need to follow up with youth after the crisis.
The Calm after the Storm

- Reflect on the event.
- Ask open-ended questions.
- Avoid power struggles.
- Acknowledge mistakes.
- Identify alternatives.
Communication

- Express caring.
- Offer support.
- Catch youth doing something right.
- Work with the treatment team to modify the treatment plan.
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.
EXERCISE THREE:
Case Description of Mentally Ill Youth in the Community

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.

(continued on next slide)
EXERCISE THREE:
Case Description of Mentally Ill Youth in the Community

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.
Taking Care of You – Indicators of Stress

Physical
- Headaches, stomach aches, lethargy, constipation

Emotional
- Anger, sadness, anxiety, depression

Personal
- Self-isolation, cynicism, mood swings, irritability with spouse and family

Workplace
- Avoidance of certain people, tardiness, missed appointments, lack of motivation
Taking Care of You

Are there ever times a staff member needs to...

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

Physical
- Sleep well, eat well, exercise

Emotional
- See friends, cry, laugh, praise yourself, use humor

Personal
- Relax, travel, pursue quiet time, pray

Workplace
- Take breaks, set limits, establish peer support, get supervision, use vacations
Mental Health Training Curriculum for Juvenile Justice

Module 7: Family Engagement
Objectives

At the conclusion of this module, participants will be able to

- describe the importance of positive family engagement in the juvenile justice system;
- explain the challenges experienced by families involved in the juvenile justice systems; and
- create meaningful opportunities to engage families and promote partnerships.
Let’s Talk About Families

- The nuclear family
- Single parents
- The extended family
- Younger parents
- Older parents
- Grandparents or older siblings raising kids
- Same-sex parents
- Working parents
- Blended families
- Adoption
What creates stress for families?

- Financial struggles/poverty
- Divorce or conflict in relationships
- Death of a family member
- Substance use in family
- Other children
- Transportation
What creates stress for families? (cont’d.)

- Physical illness or disability of family member
- Mental health issue of parent
- Parental incarceration
- Work schedule
- Experience of trauma
- Family violence
- Fear of child
Family of Youth in the Juvenile Justice System

Think about the family of youth involved with the juvenile justice system.

- What are they thinking?
- What are they feeling?
- What concerns do they have?
Family of Justice-Involved Youth with Mental Illness

What if the youth has a mental illness?
- What questions does the family have?
- What are they feeling?
- What concerns do they have?
What would you want to know?

- Where is my child?
- Is he/she safe?
- What is the juvenile justice process?
  - What can I expect?
- What treatment is my child receiving?
  - Do I have a say in decision-making?
What would you want to know? (cont’d.)

- What happens if my child gets sick or hurt?
  - Will my child get his/her medicine?
- What are the rules?
  - When can I visit? What can I bring?
- Is my child in school?
- Key terms, dates, and staff involved
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.
Mental Health of Youth in Juvenile Justice

The majority (70.4%) of youth in the juvenile justice system meet criteria for at least one mental health disorder.

(Shufelt & Cocozza, 2006)
National Alliance for Mental Illness Survey (1999)

- 36% of survey respondents said their child was in the juvenile justice system because mental health services were unavailable to them.
- 23% were told they would need to relinquish custody in order to get necessary services.
- 20% said they actually relinquished custody to obtain services for their child.

(National Alliance for the Mentally Ill, 1999; Osher & Hunt, 2002)
Survey of Data from Three National Surveys (2002)

One out of five youth who have mental health problems receives services.

(Kataoka et al., 2002; U.S. Department of Health and Human Services, 1999)
Help Wanted
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 Mental Health Diagnosis on the Family

- Family’s social-support system
- Family’s previous experience with and/or knowledge of the illness
- Family’s coping patterns and resources
- Access to and quality of health care
Influencing Factors on the Effect of a Child’s Mental Health Diagnosis on the Family (cont’d.)

- Financial status
- Type of onset of the illness
- Nature of symptoms
- Demands upon family
- Compliance or refusal to participate in his/her care
- Course/prognosis of the illness
Intergenerational Issues

- Family cycles through child welfare and juvenile justice systems
- Family poverty and lack of resources
- Family histories of mental illness and substance abuse
What is family engagement?

“Family engagement is an active and ongoing process that facilitates opportunities for all family members to meaningfully participate and contribute in all decision-making for their children, and in meaningful involvement with specific programs and with each other.”

(Fette et al., 2009)
Why is family involvement 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 and behaviors 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
How do you know when a family is engaged in services?

- The family’s rate of attendance at appointments is high.
- The family follows through with interventions.
- The family completes assignments and tasks.
- Clients are fully present and involved.
- Family members are actively involved in decisions and make progress toward treatment goals.
- Family members are forthright.
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.
- Service providers begin to use the word “non-compliant” to describe the family.
Factors Influencing Family Dropout

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

- Loss of power
- Fear of child
- Geographic separation
- Family mental illness, substance use, or trauma
- Multiple and often competing demands
  - Financial limitations
Challenges for Families (cont’d.)

- Cultural and ethnic barriers
- Mutual mistrust between families and the juvenile justice system
  - Stereotypes and blame
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?
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
How do we engage families?

- Remember that 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 person staff person could do and are aimed at the systems level.
What do ALL families want?

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

(Osher & Huff, 2006)
What can you do to support families?

- Provide information and answer questions.
- Encourage continued engagement.
- Provide reassurance.
- View the “whole” child.
What can you do to support families? (cont’d.)

- Identify potential resources.
- Emphasize strengths.
- Encourage ownership of decision-making.
- Be empathic versus sympathetic.
- Listen in an active, nonjudgmental way.
Active Listening: Establishing a Dialog

- Ask open-ended questions.
- Pose clarifying questions.
- Use “I” messages.
- Repeat back what you are hearing.
- Label feelings.
- Focus on the positive.
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.
What can systems do to support families? (cont’d.)

- Recruit family members to serve on planning and advisory groups or be peer support specialists.
- Offer seminars with experts on topics chosen by families.
- Whenever possible, invite family members to attend or present at pre-service trainings or in-service programs scheduled for staff.
- Survey family members annually or semi-annually for feedback.
Moving Forward with Family Engagement

- Where are you in your readiness to engage families?
- Where is your organization’s readiness?
- Is there something you will do differently or want to change?
Planning and Implementing Family Involvement: A Worksheet