Adolescent Mental Health Training for School Resource Officers
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Background and Overview

Introduction
In light of recent high-profile school shootings and other instances of school violence, many school communities have sought the help of law enforcement to promote school safety and protect schools from violence. If school resource officers are to be used on campus, it is imperative that they receive training that links the traditional roles and responsibilities of law enforcement on campus to skills and concepts around adolescent development, mental health, and crisis intervention to improve outcomes for youth, schools, and communities.

Schools are among the first places where mental health conditions and behavioral issues are identified. Too often, when children display disruptive behavior in school, authority figures respond without fully addressing the underlying problem. When youth have problems, the adults in their lives should be able to identify problem behaviors, predict that things may get worse if nothing is done, and offer ways to intervene or change the behavior before it gets to a point of crisis.

The response by school resource officers to a youth with a mental health crisis, and the immediate decisions that are made about how to handle the situation, can have a significant and profound impact on the youth and his/her family. This contact also represents an opportunity for school resource officers to connect the youth with emergency mental health services or refer the youth for mental health screening and evaluation. However, the ability of school resource officers to respond this way requires that they be appropriately trained to recognize the signs and symptoms of mental health conditions among youth and have resources available as options for helping youth and their families.

Adolescent Mental Health Training for School Resource Officers

The Adolescent Mental Health Training for School Resource Officers (AMHT-SRO) is a two-day training course designed to help school resource officers better identify and respond to students who are suspected of having a mental health need. It was developed by the National Center for Mental Health and Juvenile Justice (NCMHJJ) at Policy Research Associates, with support from the John D. and Catherine T. MacArthur Foundation. The AMHT-SRO is intended to help school resource officers develop the critical skills and capacity for appropriately responding to the many predictable behavior issues that are typically observed among adolescents with mental health problems. School administrators and teachers may also participate in the training to ensure that all team members are receiving consistent information, as well as have the opportunity to jointly discuss any issues related to school-based policies and procedures that may arise during the training.

The seven-unit AMHT-SRO curriculum helps school resource officers enhance their prevention and response skills and addresses the following critical topics:

- Important adolescent development concepts
- Mental health conditions common among youth and treatment options for those disorders
- Crisis intervention, de-escalation, and communication techniques for SROs
- Strategies for applying these intervention techniques in a school setting
- Enhancing the role of SRO’s
- Working with families
- School and community resource options available for youth in need of services
## Suggested Training Delivery Schedule

### Day One

<table>
<thead>
<tr>
<th>Session Time</th>
<th>Topic</th>
<th>Instructor</th>
<th>Supplements/Handouts/Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 A.M. - 9:00 A.M.</td>
<td><strong>Unit 1</strong> Introduction and Overview</td>
<td>Mental Health Provider</td>
<td>• Pre-course Assessment</td>
</tr>
<tr>
<td>9:00 A.M. - 10:00 A.M.</td>
<td><strong>Unit 2</strong> Understanding Adolescent Development</td>
<td>Mental Health Provider</td>
<td>• Case Study</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Supplement for Trainer: <em>Inside the Teenage Brain</em></td>
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<td></td>
<td></td>
<td>• Videos (3)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• References</td>
</tr>
<tr>
<td>10:00 A.M. - 10:15 A.M.</td>
<td><strong>Break</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15 A.M. - 10:45 A.M.</td>
<td><strong>Unit 2</strong> Understanding Adolescent Development</td>
<td>Mental Health Provider</td>
<td>• True/False cards</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Disorder and Symptoms cards</td>
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<tr>
<td></td>
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<td>• Handout: <em>Myths and Facts</em></td>
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<td></td>
<td></td>
<td></td>
<td>• Supplement for Trainer: <em>Disorders and Symptoms</em></td>
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<td>• Case Studies</td>
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<td>• Handout: Resources on Trauma</td>
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<td></td>
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<td>• Handout: <em>Helping Traumatized Children: Tips for Judges</em></td>
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<td>• Handout: <em>Creating a Trauma-Informed law Enforcement System</em></td>
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<td>• Handout: Medication Information Sheet</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Videos (8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• References</td>
</tr>
<tr>
<td>10:45 A.M. - 12:00 P.M.</td>
<td><strong>Unit 3</strong> Adolescent Mental health conditions &amp; Treatment</td>
<td>Mental Health Provider</td>
<td></td>
</tr>
<tr>
<td>12:00 P.M. - 12:45 P.M.</td>
<td><strong>Lunch</strong></td>
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<tr>
<td>12:45 P.M. - 1:15 P.M.</td>
<td><strong>Unit 3</strong> Adolescent Mental health conditions &amp; Treatment</td>
<td>Mental Health Provider</td>
<td>See above</td>
</tr>
<tr>
<td>1:15 P.M. - 2:30 P.M.</td>
<td><strong>Unit 4</strong> Crisis Intervention and De-escalation</td>
<td>Law Enforcement</td>
<td>• Discussion and Demonstration of De-escalation Techniques</td>
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<td>• Handout: <em>Behavioral Change Stairway Model</em></td>
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<tr>
<td>2:30 P.M. - 2:45 P.M.</td>
<td><strong>Break</strong></td>
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</tr>
<tr>
<td>2:45 P.M. - 4:00 P.M.</td>
<td><strong>Unit 4</strong> Crisis Intervention and De-escalation</td>
<td>Law Enforcement</td>
<td>See above</td>
</tr>
<tr>
<td>4:00 P.M. - 4:15 P.M.</td>
<td><strong>Day 1 – Wrap-up</strong></td>
<td>All</td>
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</tr>
</tbody>
</table>
## Day Two

<table>
<thead>
<tr>
<th>Session Time</th>
<th>Topic</th>
<th>Instructor</th>
<th>Supplements/Handouts/Activities</th>
</tr>
</thead>
</table>
| 8:30 A.M. – 10:15 A.M. | Unit 5 SRO – Role and Responsibility | All        | • Locally developed SRO job description  
• Handout: *Protective and Risk Factors Associated with Delinquent Behavior*  
• Handout: *The Effect of Arrest and Justice System Sanctions on Subsequent Behavior*  
• Case Study  
• Videos (2)  
• References |
| 10:15 A.M. - 10:30 A.M. | Break                         |            |                                                                                                |
| 10:30 A.M. – 11:00 A.M. | Unit 5 SRO – Role and Responsibility | All        | See above                                                                                      |
| 11:00 A.M. - 11:30 A.M. | Unit 6 The Family Experience | Mental Health Provider | • Video (1)                                                                                     |
| 11:30 A.M. - 12:30 P.M. | Unit 7 Connecting to Resources | Provider Panel | • Brochures, pamphlets and other resources describing school and community-based services for youth |
| 12:30 P.M. - 1:30 P.M. | Lunch and Day 2 – Wrap-up     | All        | • Feedback Session  
• Post-course Assessment  
• Training Evaluation |
Unit One: Introduction and Overview

Unit Goal
The goal of this unit is to provide participants with information about the Adolescent Mental Health Training for School Resource Officers (AMHT-SRO) and the requirements of course completion.

Scope
In this unit, participants will receive an overview of the AMHT-SRO.

Performance Objectives
At the conclusion of the unit, participants will be able to:

- Complete the pre-course assessment
- Describe the goals of the AMHT-SRO course
- List the different units of the course

Materials to Prepare

- Resource Tables (for guidance on preparation, see supplement at end of unit)

Provided Materials

- Pre-course Assessment

Unit Outline

- Introduction
- Pre-course Assessment
- Objectives
- Expectations
- Overview of Training

Time

- Approximately 30 minutes
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<tr>
<th>Slide 1-3</th>
<th>Content/Instructional Delivery Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction and Overview and Housekeeping Reminders</td>
<td>Introduce yourself and explain your role as course director. Tell the group where the restrooms are, ask them to put their cell phones on vibrate, and address any other similar pre-training details. Thank all participants for being a part of the training.</td>
</tr>
<tr>
<td>Slide 1-4</td>
<td>Explain to participants that they are going to identify their own current level of understanding of adolescence and youth mental health by completing a short pre-assessment. The assessment should take no longer than 15 minutes. Participants will revisit the assessment at the end of the course to determine personal growth and understanding.</td>
</tr>
<tr>
<td>Slide 1-5</td>
<td>Explain that this first unit is designed to give participants a brief overview of the training days. Review the goals of the course and briefly describe each unit. Participants just completed the pre-course assessment; a corresponding post-course assessment will be completed at the end of the second day.</td>
</tr>
</tbody>
</table>
| Slide 1-6                                                                | **Activity:** Before providing an overview of the course, ask participants to share what they hope to get out of the training. One trainer should call on participants and acknowledge responses, while the other trainer lists responses on easel paper, chalkboard, or whiteboard. (For relatively small classes, all participants can share; for larger classes, pick several SROs to share.) **Example of possible response:** SRO shares, “I would like to know how to handle disruptive kids.” While one trainer writes this down, the trainer leading the discussion might reply, “That is certainly within the scope of this course. In fact, we’ll have opportunities to learn and practice a number of options.” Be prepared that these exercises typically elicit “venting” responses. Redirect and keep audience focused on positive learning. For example, the response of “I don’t have anywhere to send a kid for services” can be addressed by replying, “So, you’d
Introduction and Overview

Slide 1-7
Overview of the Training
- Understanding adolescent development
- Adolescent mental health conditions and treatment
- Crisis intervention and de-escalation
- SRO’s role and responsibility
- The family experience
- Connecting to resources

Presentation:

like a better idea of the local resources available for children?”

If expectations for the course fall beyond the scope of this course, consult additional resources listed in this manual, ask for suggestions of local sources, or refer participants to prepared resource tables.

Present a brief overview of training, referring to the units listed on the slide.

The AMHT-SRO was developed because most law enforcement training courses contain very little information on youth and have traditionally focused on adults. The AMHT-SRO focuses on youth, particularly those who may be experiencing mental health problems.

More targeted than general law enforcement training, this curriculum addresses participants’ work in schools. It addresses common mental health issues among youth on campus. Throughout the course, there is time to practice the skills demonstrated in the training that will assist SROs in their daily interactions with youth. These skill-building activities and discussion focus on problem solving, de-escalating, communicating, role modeling, and decision making.

Briefly mention any other instructors with specific content expertise who will be presenting.

This would also be a good time to mention any specific instructions regarding lunch and other housekeeping issues.

Slide 1-8
Why is SRO training important?

Explain that the AMHT-SRO enhances previous training in law enforcement by focusing on participants’ roles as problem solvers and role models on campus. Skills learned in this course can be added to their “tool boxes” to make interactions more efficient and safer for everyone involved.

This course provides information that can serve as a framework for SRO interactions with youth. It will help participants understand how using a school-community specific approach can have important benefits for all: students, SROs, teachers, and families. To achieve this, the goals of this training include sharing information about the important role...
that SROs play in effectively intervening with youth who have mental health needs.

Review overall goals of the course listed on the slide and point out the resource tables (if available) to participants.
Materials: Supplement for Trainer

Resource Tables

Before the course delivery date, request materials from local and school resource groups to display in the back of the training room. These supplemental resources should provide descriptions of the various services and programs available locally and in the schools.

Request materials on issues that concern your region, as well as broader topics such as health and wellness for teens, family communication, mentor programs, events and activities before and after school, summer camps, and other activities that SROs may not be aware of, but, in the course of their duties, may have the opportunity to make referrals or discuss options with those they contact.

National organizations with local or state chapters, such as the National Alliance on Mental Illness, the Federation of Families for Children’s Mental Health, and Mental Health America, may have written materials that could be useful to training participants. In addition, representatives from these organizations could be asked to attend and/or participate in the training.
Unit Two: Understanding Adolescent Development

Unit Goal
The goal of this unit is to provide participants with a basic understanding of healthy adolescent development and the impact of environmental factors on brain development and psychosocial development.

Scope
In this unit, participants will gain insight into the adolescent brain and how different stages of development affect emotions, thinking, and social functioning, all of which play a vital role in an adolescent's behavior and decision-making processes.

Performance Objectives
At the conclusion of the unit, participants will be able to:
- Explain basic adolescent development in relation to physical, emotional, social, and cognitive tasks
- Describe the impact of brain research on understanding adolescent behavior
- Discuss adolescent risk-taking and impulsive behavior
- Explore potential disruptions in normal adolescent development

Provided Materials
- Case Study: Henry
- Video 2.1: The Wiring of the Adolescent Brain (clip length: 5:58)
- Supplement for Trainer: Inside the Teenage Brain
- Video 2.2: Peer Influence and Adolescent Behavior (clip length: 4:04)
- Video 2.3: Putting It All Together (clip length: 2:45)
- References

Unit Outline
- Objectives
- What Is Adolescence?
- Adolescent Development
  - Physical Development
  - Emotional and Social Development
  - Cognitive Development
    - The Teen Brain
• Differences between Adolescents and Adults
  o Self-Control
  o Short-Sightedness
  o Susceptibility to Peer Pressure
• Important Considerations
• Purpose of Criminal Punishment

**Time**

• Approximately 1 hour and 30 minutes
### Slide 2-1
Unit 2: Understanding Adolescent Development

<table>
<thead>
<tr>
<th>Training Aids</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduce yourself, your professional history, and topic expertise.</strong> Provide information about your relationship to the AMHT-SRO program and your agency’s support for AMHT-SRO training.</td>
</tr>
<tr>
<td><strong>Preview contents of this unit: human development in relation to adolescence. Understanding key brain and behavior relationships will establish the foundation for other units in this training, which discuss how mental health, substance use, and trauma can disrupt and alter the developmental process. This knowledge can help participants better understand and approach everyday situations with “normally developing” kids, as well.</strong></td>
</tr>
<tr>
<td><strong>Note to Trainers:</strong> This unit can be presented by just one person. Audience members should be encouraged to provide their own examples. This unit should take approximately 1 hour and 30 minutes to administer.</td>
</tr>
</tbody>
</table>

### Slide 2-2
Objectives

- Explain basic adolescent development in relation to physical, emotional, social, and cognitive tasks
- Describe the impact of brain research on understanding adolescent behavior
- Discuss adolescent risk-taking and impulsive behavior
- Explore potential disruptions in normal adolescent development

### Content/Instructional Delivery Notes

The objectives of this unit are to provide information on the developmental process of adolescence and to identify areas that influence that process. This includes:

- Explaining adolescence and identifying key developmental changes in adolescence:
  - physical
  - emotional and social
  - cognitive
- Describing the impact of brain development research and information on juvenile justice policy and practice
- Exploring disruptions in normal adolescent development

This unit will:

- Familiarize SROs with the developmental processes that take place in adolescence
- Enhance SROs’ ability to identify changes that occur during adolescence that will impact interaction with youth
- Foster an understanding of how to promote positive outcomes for youths as a law
Slide 2-3

Activity: Defining Adolescence

- What does adolescence mean to you?
- What words would you use to describe this stage of life?

Slide 2-4

Adolescent Development

- Adolescence begins around ages 10 to 13 and involves changes in:

**Note to Trainers:** This unit describes brain development in very basic terms. It does not go into detail of the complexities of brain structures and function. The goal is to help participants understand generally how the brain develops, the sequence of that development, the behaviors associated with each area of the brain, and the implications for adolescent development.

As stated by Dr. Laurence Steinberg, head of the MacArthur Research Network on Adolescent Development and Juvenile Justice, before the U.S. Senate Judiciary Committee in 2007:

We have always known that adolescents behave differently than adults. Young people are more impulsive, more short sighted, more willing to take risks, and more susceptible to the influence of their peers. Anyone who has raised a teenager, taught a teenager, counseled a teenager, or been a teenager knows this. Scientific discoveries about brain development have helped us understand why this is true, but they haven’t changed the basic story line. Those who founded a separate system of juvenile justice in America some 100 years ago had it right, even without the benefit of brain scans, when they made a commitment to treating young people who have violated the law differently than how we treat adults. It is a commitment that we need to reaffirm today. If brain research helps us do this, I’m all too happy to tell you what scientists are learning.

**Small group task:** Ask participants to work with the people at their table to write a definition of adolescence and choose a spokesperson to present the definition. Allow 3 minutes to complete this task. Ask each spokesperson to present definition and write down key words on board/flip chart.

Explain that there are a number of beliefs about adolescence as a phase of development between childhood and adulthood, as well as about when adolescence begins and ends.
The dictionary defines adolescence as the period of physical and psychological development between puberty and maturity. Most people view adolescence as a complex “growing up” period between childhood and adulthood. Link discussion back to participants’ definitions of “adolescence.”

Adolescence begins around the ages of 10 to 13 and ends between 19 and 22. It involves significant changes in thinking, feeling, social skills, physical appearance, and moral beliefs. During this period, youth are gearing up for adult responsibilities.

Adolescence involves moving toward independent thinking and living. Adolescents are on their way to adulthood, but are not there yet. They need structure, supervision, safety, support, and guidance for healthy development.

We might compare adolescence to a speeding car with limited brakes and a lot of things that influence its steering. “Normal” adolescence can be a time of risk-taking, poor decision-making, and lack of attention to long-term consequences. These behaviors can be enormously frustrating to adults. However, it is important to remember that these are normal, predictable features of this developmental stage and the majority of youth go on to be mature, responsible adults.

**Large group discussion:** Pose the question on the slide to participants. The expected response is anything related to physical changes.

Acknowledge that in addition to having once been teenagers, participants may be raising teens. Ask participants what physical changes occur around age 10 to 12 and what activates these changes. Record responses on a flip chart.

Adolescent development differs among individuals and between genders. Physical changes are activated by the increase of hormone production at about age 10 for girls and age 12 for boys.

- For girls, this includes a growth spurt, menstruation, pubic hair growth, and
development of breasts. Girls are now ovulating and capable of getting pregnant.

- For boys, physical changes include a growth spurt, enlargement of the testes, deepening of the voice, and pubic hair growth. Between the ages of 11 and 16, male adolescents experience the first discharge of semen (sperm). Boys are now always fertile and can produce a child if sexually active.

Compared to both male and female peers, the late maturing boy is usually smaller, less muscular, not as athletic, and has lower social status among his peers. He may be perceived as a younger child by adults and treated as less competent or intelligent. In reaction, or to compensate, he may act dependent or display immature behavior, including aggression (Craig, 1999; White, 1999).

What about girls?

For girls, early maturation can bring both advantages and disadvantages. Girls who mature early are taller, more developed, report feeling attractive, are more popular with older peers, and are more likely to date than their late-maturing peers.

Girls who mature early often have less in common with their friends and experience distress regarding the physical changes of puberty, resulting in feeling isolated. They may be sexually teased or approached by male peers and older boys. Girls who experience their menstrual period early and were not prepared by their parents describe it as traumatic (Craig, 1999; White, 1999).

Late maturing girls are more popular among peers, report higher self-esteem, and are more focused on academics (White, 1999).

**Note to Trainers:** Consider leading a brief (2-3 minute) discussion about early versus late maturing adolescents:

- What impact might early development have on a boy versus a girl?
- What about late development for a boy? Or, for a girl?
Handout: Case Study of Henry

Henry is a 15-year-old white male. He has been arrested in the past for theft and possession of marijuana. He's on probation for those delinquent acts. Henry is small for his age. He never participated in sports and has few friends. His mother and aunt refer to him as their "little man." Teachers report that Henry has a history of being aggressive toward other youth and teachers, and appeared to be slower to understand school information than his classmates.

When Henry went through the local Juvenile Assessment Center, testing showed that Henry had difficulty thinking about if-then and what-if situations. When asked about where he would like to be in 2 or 3 years, Henry stated, "I'm not sure; maybe going to school." Henry stated that he took some clothes from a local shopping mall because, "Everyone had jacked some really cool stuff and I was the only one that didn't have anything. They said I was a momma's boy. The only problem was I was the one stupid enough to get caught." His response for smoking marijuana was, "I don't know why everyone is freaking out and making a big deal out of this with me. Everyone does it."

Others describe that Henry has never been involved in any type of community or school organization. He never has played any type of organized sports or participated in clubs/organizations at school. Henry has very little contact with his father. His father has been in and out of jail since Henry was a year old and is currently serving time in another state. Henry's mother has been in and out of jail herself for crimes such as possession of drugs and worthless check writing. Henry has lived with his grandmother, his aunt, and/or his uncle when his mom is in jail.

Slide 2-10

Emotional and Social Development

- Sense of purpose
- Participating in activities and gaining acknowledgement for participation
- Pro-social behavior rewarded; deviant behaviors punished

Case Study: Ask participants to read the first paragraph of the case study (on page 22 of the Participant's Guide) and underline all the items that may indicate that Henry is “late maturing,” such as small for age, no athletic participation, few friends, “little man,” aggressive. Discuss responses.

Discuss how a sense of purpose develops through sports, arts, hobbies, community service, and part-time jobs.

Gaining acknowledgment is a powerful reinforcer and the rate of reinforcement is a powerful predictor of behavior. Schools can offer positive experiences in academics, sports, or other extracurricular activities. Communities can offer experiences through participation in church
activities, clubs, and organizations. All of these can build an adolescent’s self-confidence.

**Small group task:** Ask participants to brainstorm in small groups: How can your interaction with a developing youth promote his or her sense of purpose?

Discuss the idea of control and the importance of consistency in an adolescent’s life.

The more an adolescent can anticipate the results of behavior, the greater his/her sense of “control.” Adolescents are in the process of learning how to “think” before “doing.”

A sense of control is promoted when adults consistently reward or recognize pro-social, positive, or good behaviors and consistently discipline or ignore deviant, destructive, or wrong behaviors. Consistent feedback lets adolescents correctly predict the result of their actions. They know what to expect before they act. CONSISTENCY is key and requires an adult who is actively engaged in the life of the youth.

Point out how a youth’s sense of control changes from the external to the internal as a developmental process: “I decide” begins to occur more often “others decide for me.”

**Large group discussion:** Ask participants how their interventions with youth can promote a sense of “control” for a developing youth.

A good connection with positive adult role models often predicts healthy development. A sense of belonging comes from the belief that parents and/or other adults from the community are interested and want to be involved. Adults can nurture this sense of belonging by monitoring and supervising adolescents’ activities and encouraging adolescents to talk about their interests and problems. Adolescents who have a sense of belonging or connection with good adult role models are less likely to engage in delinquent behaviors and are more likely to do well in school.

In adolescence, questions such as “Who am I?” and “Where am I going?” are important. Feeling
- Sense of identity
  - Belief in abilities, control, and relationships

- Social skills
  - Conversation skills
  - Assertiveness skills

competent and useful contributes to a positive identity. A positive sense of identity or self comes from relationships, community involvement, parental and adult support, respect for individual opinions, and a sense of control.

As children move into adolescence, new social situations require different skills. Relationships with parents and family change while friendships are being redefined. Adolescents want to be accepted by a peer group, clique, or other group they admire. Instead of turning to the family for support, they begin to turn to friends. Adolescents begin to “date” and engage in romantic partnerships as one of the major social events in adolescence.

**Large group discussion:** Ask participants, “What other major social events occur in adolescence?” Discuss events such as jobs, school socials, sports, and driving. Discuss what connections youth will make if there are no concerned, engaged adults. Where will adolescents seek belonging and acceptance (e.g., gangs, other delinquent youth)?

**Large group discussion:** Ask participants to generate a short list of the types of risky or reckless behavior likely to bring a youth into contact with law enforcement. Examples include fighting, substance use, and speeding.

Ask participants to think about behaviors they may have engaged in as teens that, in retrospect, were reckless or risky. What does that say about cognitive development?

Cognitive development refers to the way individuals learn, solve problems, and think about the environment/world around them. At about age 11 or 12, adolescents can think about abstract ideas. They begin to generate their own thoughts and focus on what could be. Adolescents can imagine, for example, what they would be like if they were born into a rich versus a poor family. Adolescents have a developing ability to plan and think ahead, but this ability is not fully formed.

**Large group discussion:** Ask participants who or what might influence a youth’s thinking, specifically what he/she values and believes (e.g., peers, church, parents, grandparents, school,
Slide 2-15
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

Four changes are especially important in the cognitive development of adolescents.

1. Around the time of puberty, there is a dramatic change in the brain systems that govern our experiences of pleasure and reward. This helps explain why adolescents are especially inclined toward sensation-seeking and experimentation with alcohol, tobacco, and other drugs, and why teenagers pay so much attention to the immediate and rewarding aspects of risky behavior that they often ignore its potential costs.

2. During this same period, there are also major changes in the brain systems that process social information, which tells us why adolescents become so sensitive to the opinions of their peers and so susceptible to their influence (Steinberg, 2008).

3. The next major brain change is in the regions that are responsible for self-control. These systems put the brakes on impulsive behavior and permit us to think ahead and more accurately weigh the risks before acting. The maturation of the self-control system is more gradual and not complete until the early 20’s. As a consequence, middle adolescence is a period of heightened vulnerability to risky and reckless behavior, including crime and delinquency.

4. Finally, throughout adolescence and into young adulthood, the connections between different brain regions are maturing, allowing for more efficient brain power and better coordination of emotions and reason. When 16-year-old individuals are in controlled environments where they have time to think before acting or when they can turn to an adult for guidance, they often demonstrate adult-like maturity. But, their judgment is still fragile and easily taxed by coaches, etc.). Point out that among the teens with whom they work, some of these influences are largely absent.
situations that are emotionally arousing or stressful. The mental health and substance use needs of many youth in the juvenile justice system may make them more vulnerable to poor decision-making.

Introduce Video – The Wiring of the Adolescent Brain (clip length: 5:58) from Frontline’s episode, Inside the Teenage Brain. The video clip introduces key concepts involved with adolescent development. In particular, it explains early brain development and how this relates to risk behavior. (More information on the video is provided at the end of the unit.) There will be references back to this film clip during this unit.

Large group discussion: Ask participants “How do some of the things you saw the teens doing in that video clip relate to our discussion on cognitive development?” If necessary, prompt conversation by asking, “Do you remember what the teenager said about the skateboarding?”

- “Sometimes I wear a helmet.”
- “Nah, it’s not that risky.”

While demonstrating, ask participants to form fists with both hands and put them together side-by-side.

This is the approximate size of the adult brain, which weighs about three pounds. In regard to its development, the most important conclusion to emerge from recent research is that brain development continues long after childhood, well into the early adult years. In fact, scientists now believe that adolescence may be as important in brain development as the first three years of life, a developmental stage that has received far more attention from researchers, journalists, and policymakers. (Steinberg, 2007).

Interacting with adolescents can be frustrating because they are so impulsive and often don’t plan. As noted in the video, brain research, brain scans (e.g. MRI), and other developmental science research offer explanations. Physically, the brain of a teenager is still developing. The size of the brain is as big as it is going to get, but it is not fully developed.
Adolescents may simply not be able to handle structured planning (what is sometimes referred to “executive functioning”) since the area of the brain (note the arrow pointing to the frontal lobes) that coordinates impulse control is the last part of the brain to develop.

**Large group discussion:** Ask participants to think back to the video while reflecting on the points just summarized. Facilitate discussion by asking, “What does knowing that the brains of adolescents are not fully developed suggest about working with teenagers?”

Brains have billions and billions of cells. Each of these cells can connect to thousands of other brain cells. These cells and their interconnections produce enormous processing power. The number, quality, and speed of these connects will be based, in part, by what occurs in childhood. Positive, nurturing, and stimulating environments are necessary for optimal brain development. Abusive, deprived, and unstimulating environments can have a profound, negative impact on brain development.

Ask participants to re-form the “brain” they made with their fists. Explain that, generally speaking, the brain develops from back to front and from the inside out.

First to develop is the part of the brain that controls basic, life-sustaining physical functions (for example, breathing and heart rate). This area is located toward the back of the brain. In the brain you made with your fists, think of your wrists as representing this area.

The next part to develop contains many of the emotional centers of the brain. Again, in the “brain” you made with your fists, the emotional centers would be the palms of your hands.

The last area to develop is the thought-processing center of the brain, which covers the emotional centers and is on top of the physical controls. If you go back to the “brain” you made with your fists, the thought-processing center is your fingers and back of your hand. In human brains, the
largest part is the thought-processing part of the brain called the cortex.

Think about newborns. At birth, life-sustaining physical functions (such as heartbeat and respirations) are present. Emotional features (smiling, laughing) develop later as a result of bonding with parents. Later still, as the thought-processing centers of the brain develop, thinking is expressed through words. Teens are going through this development explosion again: physical changes, emotional changes, and thought changes.

Large group discussion: Lead a brief (1 – 2 minutes) discussion about how this information relates to audience members who have children.

- "Have you noticed this sequence just described in your own children?"
- "How do children initially express emotion? [crying] How does that change and develop?"

Some teenage behavior is simply the result of immaturity (literally, a lack of development). In short, even though teens might look like adults, they should not be expected to have adult capacities or competencies.

Ask participants to silently reflect on their own teenage behavior by asking, "As a teen, did you do anything ‘immature’ that could have resulted in police involvement? Why does your behavior seem immature now, but not then?"

Explain that adolescent cognitive development ultimately leads to improved self-control, decreased short-sightedness, and decreased susceptibility to peer pressure.

Going back to the race car example, as adolescents mature, their “steering” and “brakes"
Self Control

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

Introduce the next section of the training, which describes differences between adults and teens in how they think and are influenced. The first key difference is self-control.

Note to Trainers: As part of the introduction, refer participants to the research by the MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice, chaired by Dr. Steinberg (see end of unit). Researchers in the network studied over 900 individuals, ages 10 to 30, who were NOT in the juvenile or criminal justice systems. Research subjects participated in performance and self-report measures of planning, preference for immediate gratification, impulsivity, risk processing, sensation-seeking, and susceptibility to peer pressure.

In the study described in the handout, participants completed a test to measure their willingness to react in a quick, rash manner or more carefully think through their next move.

This study of “normal” teens revealed that impulsivity declines with age, with a notable reduction in impulsivity around age 16-17, but still maintaining a substantial impact until well into early adulthood (ages 26-30).

Large group discussion: Ask participants if they are surprised by these results:

- Do these results reflect your experience with youth?
- Are you surprised by the impulsiveness of children who are of ages 10-11?

Study participants were also observed in their preference for risky situations. Adolescents between the ages of 12 and 17 were more likely to choose high-risk options.

As noted in the next several slides, adolescents view risk very differently than adults. There are
Risk Perception Declines and Then Increases after Mid-adolescence.

(Steinberg et al., 2009)

Some specific, structural reasons for this in terms of the brain development process.

Not only are adolescents more prone to taking risks, their perception of risk is faulty. As interest in and preference for engaging in risky situations peaks, adolescents’ perception that the activity is actually risky is declining. Though the youth in the Frontline clip said “It’s not that risky” when referring to his skateboarding activities, many adults would judge that to be very differently.

Given this information, it’s not surprising that insurance rates are so high for teens and law enforcement spends so much time working teenager-related traffic situations.

Lastly, in a measure of impulsivity, study participants were given problems that were simple and complex in nature. They were then timed to see how long they took to solve those problems.

On the simpler problems, results for all age groups were very similar, with individuals taking about the same amount of time to decide their move.

However, on the more complex problems, only the older age category of young adults (18-30) took the additional time to decide their move. The younger age groups (10-15) took virtually the same amount of time to decide to move, ignoring the difficulty and moving impulsively instead of strategically.

This is a great example of why so many teens when asked, "What were you thinking?" respond with "I don’t know" or "Nothing." They are telling the truth. They probably weren’t thinking at any more of a sophisticated level when they engaged in that behavior then when they were deciding what to eat for breakfast that morning.

Introduce the next key difference between teens and adults: short-sightedness. As noted in the Writ of Certiorari for Roper v. Simmons (Brief of the American Medical Association, et al., 2004):

Cognitive experts have shown that the difference between teenage and adult behavior is not a function of the adolescent’s inability to distinguish right from wrong. Nor is it a function, as early studies suggested, of an inability to conduct any cost-benefit analysis at all. Rather, the difference

Slide 2-26
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, new brain research shows that the teenage brain will continue to mature and that over time, adolescents will begin to think more like adults.

lies in what scientists have characterized as “deficiencies in the way adolescents think,” an inability to perceive and weigh risks and benefits accurately. “[B]ecause of developmental influences,” teens “differ from adults in the subjective value[s] that they attach to various perceived consequences in the process of making choices.” They focus more on opportunities for gains and less on protection against losses. They put greater emphasis on short-term consequences than adults and discount future consequences more than adults. (pg. 9)

**Large group discussion:** Keeping in mind how teens manage self-control, imagine a teen and an adult going gambling in Las Vegas.

- Would you expect the gambling style of the teen to be the same or different than that of the adult?
- What sorts of choices at the gaming table would you expect the teen to make? Why?

Information from the MacArthur study may shed even more light on this.

When participants in the MacArthur study were asked to consider matters in the future, those in mid-adolescence had the shortest view/perspective into the future. Until much closer to adulthood, adolescents are much more worried about the game on Friday night, the dance, what’s for lunch, or how they appear to their peers right now than for things in the future like college, jobs, family, a criminal record, etc.

**Large group discussion:** Prompt participants to think of this in a practical application. A teenager gets into a fight and gains “status” as the victor among his peers. Adults threaten him with expulsion, arrest, legal proceedings, detention, etc. Who holds more weight then and there: peers or adults?

Also, it’s not until late adolescence and into adulthood that a willingness to delay gratification for a better reward/outcome appears.

In the study, participants were offered two options. They could accept $100 today or they could wait one year and get $1,000.
As shown on the graph, the lack of future orientation, short-sightedness, and unwillingness to delay gratification is a real factor for younger adolescents. It’s not until late adolescence and into adulthood that a willingness to delay gratification for a better reward/outcome appears.

**Large group discussion:** Facilitate a brief (1 – 2 minute) discussion on how the lack of future orientation, short-sightedness, and unwillingness to delay gratification impacts juvenile justice involvement.

- Can these behaviors bring youth into contact with the juvenile justice system? How?

Slide 2-27

Case Study: Henry

When Henry went through the local Juvenile Assessment Center, testing showed that Henry had difficulty thinking about if-then and what-if situations. When asked about where he would like to be in 2 or 3 years, Henry stated, “I’m not sure; maybe going to school.” Henry stated that he took some clothes from a local shopping mall because, “Everyone had jacked some really cool stuff and I was the only one that didn’t have anything. They said I was a momma’s boy. The only problem was I was the one stupid enough to get caught.” His response for smoking marijuana was, “I don’t know why everyone is freaking out and making a big deal out of this with me. Everyone does it.”

Slide 2-28

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?

The last key difference between teens and adults involves peer pressure.

One of the most important goals of adolescence is to successfully transition to independence and autonomy. Ironically, this means that at a time when youth most need adult guidance to mediate some of their impulsive, short-sighted behavior, they are simultaneously trying to move away from their parents’ influence and control.

Susceptibility to peer pressure is a hallmark of adolescence and can serve to either reinforce or counteract healthy adult influences.
Slide 2-29
With Age, Individuals Become More Resistant to Peer Influence

(Steinberg & Monahan, 2007)

Slide 2-30
Video 2.2: Peer Influence and Adolescent Behavior

Slide 2-31
Contextual Factors Impacting Teen Development

Behavior is a function of characteristics of the person and environment.

- Family
- Neighborhood
- School
- Culture
- Trauma and victimization

In the MacArthur study (remember, study participants were not involved in the juvenile or criminal justice systems), participants were given pairs of statements and asked to choose the statement that best depicts their perception and rate it as “Really True” or “Sort of True.” For example, “Some people go along with their friends just to keep their friends happy” BUT “Other people refuse to go along with what their friends want to do even though they know it will make their friends unhappy.”

The study found that when placed in situations with peer influence, the ability to resist peer influence increases with age and moves toward average adult levels in very late adolescence.

Please note: Peer pressure is not all negative. It can be a very positive influence on most teens.

Note to Trainers: To supplement the information just discussed, consider playing the Peer Influence and Adolescent Behavior video clip (clip length: 4:04) from Chedd-Angier Production Company’s Brains on Trial with Alan Alda: Deciding Punishment series. This video requires access to the Internet. Start the video by clicking on the screenshot on PowerPoint slide 2-34, which links to the video on the Internet.

Introduction to suggested video: This video features Dr. Steinberg discussing the risky driving tendencies among adolescents described on the previous slide. It is from episode two of the Brains on Trial with Alan Alda series (Chedd-Angier Production Company, 2013).

As already mentioned, a number of social and environmental factors impact how youth behave and how their identities are shaped.

Large group discussion: Facilitate a brief discussion about the contextual factors listed on the slide, addressing how neighborhoods, cultures, trauma (which is discussed later in the training) and victimization, and sexual orientation/gender identity might influence development.
- Gender differences, sexual orientation, gender identity

Poor, rich, black, white, Hispanic, religious, non-religious, traumatized, straight, male, female, lesbian, gay, bisexual, and transgender youth all share the adolescent need for support, acceptance, and validation from peers, family, and adults. Teens’ experiences, good or bad, contribute to their identity development, fear of rejection, school experience, feeling stigmatized, etc.

For example, one outcome of the rejection and school experience of many youth that identify themselves as lesbian or gay is that they represent the largest group of homeless teenagers in the nation and are confronted with higher rates of victimization and suicide.

It is important to recognize that these contextual issues are all layered on top of a general idea of adolescent development. Other trainings are available to develop greater competency in working with a number of these factors. For this training, discussion focuses on brain development.

**Note to Trainers:** Play the clip (clip length: 2:45) from *Thirteen* by Fox Searchlight Pictures (Levy-Hinte, London, & Hardwicke, 2003). This video requires access to the Internet. Start the video by clicking on the screenshot on PowerPoint slide 2-37.

**Large group discussion:** Ask participants how the information on brain development discussed during this unit helps them understand the video. Expected responses include peer influence, risk-taking, impulsivity, and short-sightedness. Guide the discussion to “bad act” versus “bad kid.”

Discuss the implications of considering delinquency in the context of development. Based on the MacArthur study, age-norms are based on “average” youth in the general community. These were kids from average schools and young adults from average colleges and neighborhoods. They are like the majority of kids with whom participants work as SROs.

However, SROs also work with kids who are committing delinquent acts and interacting with the juvenile courts. What studies consistently show is...
that many of these youth are not “average.” They tend to have greater intellectual deficits, more developmental delays (recall the key areas of development: physical, cognitive, emotional), and a greater prevalence of mental health conditions (anxiety, depression, bi-polar, substance abuse, trauma disorders, etc.).

All of these factors increase the risk for poor decision-making, so the population encountered by law enforcement would likely have amplified results if given the same tests administered in the MacArthur study.

Also, many “delinquent behaviors” are actually normative during adolescence because of teens’ preference for risk, susceptibility to peer pressure, short-sightedness, etc.

- Alcohol use is normative for the majority of teens *(not desirable)*.
- Delinquent behavior like stealing, trespassing, some drug use (particularly unauthorized use of over the counter/prescription medications and marijuana) is normative *(not desirable)*.
- Aggressive behavior, like school-yard fighting, is normative *(not desirable)*.

An adolescent’s involvement in the juvenile justice system is often a combination of individual, family, environmental, and systemic factors, rather than adolescence alone.

Summarize what was discussed about adolescent brain development and how it relates to adolescent behavior:

- Adolescence is a period of substantial brain development.
- During adolescence, there is a dramatic change in the areas of the brain that regulate pleasure and reward. This may explain the sensation-seeking need for immediate gratification observed in many adolescents.
- In contrast, the areas of the brain that govern self-control develop much more gradually. As a result, the ages of 13-17 are periods of heightened vulnerability to risky and reckless behavior.
behavior, some of which may bring a youth into contact with the juvenile justice system.

- As brain development continues, the adolescent's capacity for mature judgment is fragile and context dependent.
- Because cognitive development is incomplete, adolescent behavior is often impulsive, sensation-seeking, risky, and susceptible to peer influence – all behaviors that substantially diminish in adulthood.

**Large group discussion:** Facilitate discussion by asking:

- What do you do with this information when responding to a situation as law enforcement?
- How do you take into account a youth's limitations in thinking?
- What about the heightened impact of emotional influences or peers in the situation?
- Can you assume that every youth you encounter is the same and equally punishable as a person who may have broken the law?

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**Slide 2-35**

Purpose of Criminal Punishment

- To **prevent crime** – through deterrence, incapacitation or rehabilitative intervention
- To **“do justice”** – to impose justly deserved punishment in proportion to offender's blameworthiness

(Steinberg, 2007)

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**Slide 2-41**

Important Caveat

- Juvenile offenders are not adult criminals.
- “…immaturity is morally relevant to blameworthiness and should have mitigating weight” (Steinberg, 2007)
- Our focus is on mitigation, not excuse.

(Steinberg, 2007)

According to Steinberg (2007):

There are several important implications of this brain research for juvenile justice policy and practice.

First, adolescents are less responsible for their behavior than adults are. In a legal system like ours, which punishes in proportion to an offender's responsibility for his actions, juvenile offenders should not be punished as harshly as we punish mature adults, even when they have committed comparable crimes.
Second, teenagers are still “works in progress,” and many of them do things out of youthful impetuosity (i.e., impulsivity, recklessness) that they would not do just a few years later, when their brains are more fully developed. It is therefore important that we treat adolescents who have broken the law in ways that will not impair their subsequent development. We have the capacity to hold juveniles accountable for their misdeeds in ways that get them back on track, instead of punishing them in ways that derail their transition to productive adulthood.

Finally, and perhaps most important, we know that adolescent behavior is not driven by the brain alone. In supervised and supportive environments, teenagers behave better. That’s why we should focus our efforts on creating family and community contexts that help protect teenagers from their own immaturity. One thing we know for certain is that preventing delinquency in the first place is less costly and far easier than responding to it after the fact.

Having this information about adolescent brain development can help SROs work with adolescents. Remember, the brain is still developing, cognitive connections are still being made, and “internal wiring” is still a work in progress.

Large group discussion: Facilitate discussion by asking, “What does that mean in terms of your work with youth?”

Point out that connections are established through experience and strengthened through repetition. Every event or interaction is an opportunity to create, strengthen, or expand existing connections.

Participants can have a powerful and enduring influence on developing youth. Creating opportunities for negative connections to be overridden by more positive, healthy ones can support and enhance a youth’s cognitive development.
Materials: Case Study of Henry

Henry is a 15-year-old white male. He has been arrested in the past for theft and possession of marijuana. He’s on probation for those delinquent acts. Henry is small for his age. He never participated in sports and has few friends. His mother and aunt refer to him as their “little man.” Teachers report that Henry has a history of being aggressive toward other youth and teachers, and appeared to be slower to understand school information than his classmates.

When Henry went through the local Juvenile Assessment Center, testing showed that Henry had difficulty thinking about if-then and what-if situations. When asked about where he would like to be in 2 or 3 years, Henry stated, “I’m not sure; maybe going to school.” Henry stated that he took some clothes from a local shopping mall because, “Everyone had jacked some really cool stuff and I was the only one that didn’t have anything. They said I was a momma’s boy. The only problem was I was the one stupid enough to get caught.” His response for smoking marijuana was, “I don’t know why everyone is freaking out and making a big deal out of this with me. Everyone does it.”

Others describe that Henry has never been involved in any type of community or school organization. He never has played any type of organized sports or participated in clubs/organizations at school. Henry has very little contact with his father. His father has been in and out of jail since Henry was a year old and is currently serving time in another state. Henry’s mother has been in and out of jail herself for crimes such as possession of drugs and worthless check writing. Henry has lived with his grandmother, his aunt, and/or his uncle when his mom is in jail.
Materials: Supplement for Trainer

Inside the Teenage Brain
Length: 60 minutes
PBS Frontline

Instructions

This film consists of several sections that can be used as a filler during breaks, or to supplement a trainer presentation or to provide more information for participants.

Sections:

- The Teen Brain is a Work in Progress
- How Much Can Science Tell Us
- Do your Teens Seem Like Aliens
- From Zzzzzzzz’s to A’s - Sleep

Summary of Film

In "Inside the Teenage Brain," FRONTLINE chronicles how scientists are exploring the recesses of the brain and finding some new explanations for why adolescents behave the way they do. These discoveries could change the way we parent, teach, or perhaps even understand our teenagers.

New neuroscience research has shown that a crucial part of the brain undergoes extensive changes during puberty – precisely the time when the raging hormones often blamed for teen behavior begin to wreak havoc.

The vast majority of brain development occurs in two basic stages: growth spurts and pruning. In utero and throughout the first several months of life, the human brain grows at a rapid and dramatic pace, producing millions of brain cells.

“This is a process that we knew happened in the womb, maybe even in the first 18 months of life,” explains neuroscientist Dr. Jay Giedd at the National Institute of Mental Health. “But it was only when we started following the same children by scanning their brains at two-year intervals that we detected a second wave of overproduction.”

This second wave – occurring roughly between ages 10 and 13 – is quickly followed by a process in which the brain prunes and organizes its neural pathways. “In many ways, it’s the most tumultuous time of brain development since coming out of the womb,” says Giedd.

Confronted by these new discoveries, academics, counselors, and scientists are divided on just what all this means for children.

“The relationship between desired behaviors and brain structure is totally unknown,” John Bruer tells FRONTLINE. He is president of the James S. McDonnell Foundation and author of The Myth of the First Three Years. “This simple, popular, newsweekly-magazine idea that adolescents are difficult because their frontal lobes aren’t mature is one we should be very cautious of.”

This FRONTLINE report also looks at research that is helping scientists understand another puzzling aspect of adolescent behavior – sleep.
**Mary Carskadon**, director of the E.P. Bradley Hospital Sleep Research Laboratory at Brown University, has spent years mapping the brains of sleepy teens. She has calculated that most teens get about seven and a half hours of sleep each night, while they need more than nine. Some say these sleep debts can have a powerful effect on a teen’s ability to learn and retain new material – especially abstract concepts like physics, math, and calculus.

Despite all the new scientific research, “Inside the Teenage Brain” suggests that there is a consensus among experts that the most beneficial thing for teenagers is good relationships with their parents. Even Dr. Giedd wonders about the kinds of lessons parents can draw from his science. "The more technical and more advanced the science becomes, often the more it leads us back to some very basic tenets. ... With all the science and with all the advances, the best advice we can give is things that our grandmother could have told us generations ago: to spend loving, quality time with our children."

**Ellen Galinsky**, a social scientist and the president of the Families and Work Institute, has seen scientific fads come and go. But she says her research for a book about children shows there are enduring lessons for parents. Drawing on her interviews with more than a thousand children, she found that, to her surprise, teens were yearning for more time and more communication with their parents, even when they seemed to be pushing them away. She told FRONTLINE, “Even though the public perception is about building bigger and better brains, what the research shows is that it’s the relationships, it’s the connections, it’s the people in children’s lives who make the biggest difference.”

**American Academy of Child and Adolescent Psychiatry**:
http://www.aacap.org/page.ww?name=Resources+for+Families&section=Resources+for+Families
In 2005, in a landmark decision, the U.S. Supreme Court outlawed the death penalty for offenders who were younger than 18 when they committed their crimes. The ruling centered on the issue of culpability, or criminal blameworthiness. Unlike competence, which concerns an individual's ability to serve as a defendant during trial or adjudication, culpability turns on the offender's state of mind at the time of the offense, including factors that would mitigate, or lessen, the degree of responsibility.

The Court's ruling, which cited the Network’s work, ran counter to a nationwide trend toward harsher sentences for juveniles. Over the preceding decade, as serious crime rose and public safety became a focus of concern, legislators in virtually every state had enacted laws lowering the age at which juveniles could be tried and punished as adults for a broad range of crimes. This and other changes have resulted in the trial of more than 200,000 youth in the adult criminal system each year.¹

Proponents of the tougher laws argue that youth who have committed violent crimes need more than a slap on the wrist from a juvenile court. It is naïve, they say, to continue to rely on a juvenile system designed for a simpler era, when youth were getting into fistfights in the schoolyard; drugs, guns, and other serious crimes are adult offenses that demand adult punishment. Yet the premise of the juvenile justice system is that adolescents are different from adults, in ways that make them potentially less blameworthy than adults for their criminal acts.

The legal system has long held that criminal punishment should be based not only on the harm caused, but also on the blameworthiness of the offender. How blameworthy a person is for a crime depends on the circumstances of the crime and of the person committing it. Traditionally, the courts have considered several categories of mitigating factors when determining a defendant’s culpability. These include:

- impaired decision-making capacity, usually due to mental illness or disability,
- the circumstances of the crime—for example, whether it was committed under duress, and
- the individual’s personal character, which may suggest a low risk of continuing crime.

Such factors don’t make a person exempt from punishment — rather, they indicate that the punishment should be less than it would be for others committing similar crimes, but under different circumstances.

Should developmental immaturity be added to the list of mitigating factors? Should juveniles, in general, be treated more leniently than adults? A major study by the Research Network on Adolescent Development and Juvenile Justice now provides strong evidence that the answer is yes.

**The Network’s Study of Juvenile Culpability**

The study of juvenile culpability was designed to provide scientific data on whether, in what ways, and at what ages adolescents differ from adults.
Many studies have shown that by the age of sixteen, adolescents’ cognitive abilities – loosely, their intelligence or ability to reason – closely mirror that of adults. But how people reason is only one influence on how they make decisions. In the real world, especially in high-pressure crime situations, judgments are made in the heat of the moment, often in the company of peers. In these situations, adolescents’ other common traits – their short-sightedness, their impulsivity, their susceptibility to peer influence – can quickly undermine their decision-making capacity.

The investigators looked at age differences in a number of characteristics that are believed to undergird decision-making and that are relevant to mitigation, such as impulsivity and risk processing, future orientation, sensation-seeking, and resistance to peer pressure. These characteristics are also thought to change over the course of adolescence and to be linked to brain maturation during this time. The subjects – close to 1,000 individuals between the ages of 10 and 30 – were drawn from the general population in five regions. They were ethnically and socioeconomically diverse.

The study’s findings showed several characteristics of adolescence that are relevant to determinations of criminal culpability. As the accompanying figure indicates, although intellectual abilities stop maturing around age 16, psychosocial capability continues to develop well into early adulthood.

**Short-Sighted Decision-Making**

One important element of mature decision-making is a sense of the future consequences of an act. A variety of studies in which adolescents and adults are asked to envision themselves in the future have found that adults project their visions over a significantly longer time, suggesting much greater future orientation.

These findings are supported by data from the Network’s culpability study. Adolescents characterized themselves as less likely to consider the future consequences of their actions than did adults. And when subjects in the study were presented with various choices measuring their preference for smaller, immediate rewards versus larger, longer-term rewards (for example, “Would you rather have $100 today or $1,000 a year from now?”), adolescents had a lower “tipping point” – the amount of money they would take to get it immediately as opposed to waiting.

How might these characteristics carry over into the real world? When weighing the long-term consequences of a crime, adolescents may simply be unable to see far enough into the future to make a good decision. Their lack of foresight, along with their tendency to pay more attention to immediate gratification than to long-term consequences, are among the factors that may lead them to make bad decisions.

**Poor Impulse Control**

The Network’s study also found that as individual’s age, they become less impulsive and less likely to seek thrills; in fact, gains in these aspects of self-control continue well into early adulthood. This was evident in individuals’ descriptions of themselves and on tasks designed to measure impulse control. On the “Tower of London” task, for example – where the goal is to solve a puzzle in as few moves as possible, with a wrong move requiring extra moves to undo it – adolescents took less time to consider their first move, jumping the gun before planning ahead.
Network research also suggests that adolescents are both less sensitive to risk and more sensitive to rewards—an attitude that can lead to greater risk-taking. The new data confirm and expand on earlier studies gauging attitudes toward risk, which found that adults spontaneously mention more potential risks than teens. Juveniles’ tendency to pay more attention to the potential benefits of a risky decision than to its likely costs may contribute to their impulsivity in crime situations.

**Vulnerability to Peer Pressure**

The law does not require exceptional bravery of citizens in the face of threats or other duress. A person who robs a bank with a gun in his back is not as blameworthy as another who willingly robs a bank; coercion and distress are mitigating factors. Adolescents, too, face coercion, but of a different sort.

Pressure from peers is keenly felt by teens. Peer influence can affect youth’s decisions directly, as when adolescents are coerced to take risks they might otherwise avoid. More indirectly, youth’s desire for peer approval, or their fear of rejection, may lead them to do things they might not otherwise do. In the Network’s culpability study, individuals’ reports of their vulnerability to peer pressure declined over the course of adolescence and young adulthood. Other Network research now underway is examining how adolescent risk-taking is “activated” by the presence of peers or by emotional arousal. For example, an earlier Network study, involving a computer car-driving task, showed that the mere presence of friends increased risk-taking in adolescents and college undergraduates, though not adults.²

Although not every teen succumbs to peer pressures, some youth face more coercive situations than others. Many of those in the juvenile justice system live in tough neighborhoods, where losing face can be not only humiliating but dangerous. Capitulating in the face of a challenge can be a sign of weakness, inviting attack and continued persecution. To the extent that coercion or duress is a mitigating factor, the situations in which many juvenile crimes are committed should lessen their culpability.

**Confirmation from Brain Studies**

Recent findings from neuroscience line up well with the Network’s psychosocial research, showing that brain maturation is a process that continues through adolescence and into early adulthood. For example, there is good evidence that the brain systems that govern impulse control, planning, and thinking ahead are still developing well beyond age 18. There are also several studies indicating that the systems governing reward sensitivity are “amped up” at puberty, which would lead to an increase in sensation-seeking and in valuing benefits over risks. And there is emerging evidence that the brain systems that govern the processing of emotional and social information are affected by the hormonal changes of puberty in ways that make people more sensitive to the reactions of those around them—and thus more susceptible to the influence of peers.³

**Policy Implications: A Separate System for Young Offenders**

The scientific arguments do not say that adolescents cannot distinguish right from wrong, nor that they should be exempt from punishment. Rather, they point to the need to consider the developmental stage of adolescence as a mitigating factor when juveniles are facing criminal prosecution. The same factors that make youth ineligible to vote or to serve on a jury require us to treat them differently from adults when they commit crimes.

Some have argued that courts ought to assess defendants’ maturity on a case-by-case basis, pointing to the fact that older adolescents, in particular, vary in their capacity for mature decision-making. But the tools needed to measure psychosocial maturity on an individual basis are not well developed, nor is it possible to distinguish reliably between mature and immature adolescents on the basis of brain images. Consequently, assessing maturity on an individual basis, as we do with other mitigating factors, is likely to produce many errors. However, the maturing process follows a similar pattern across virtually all teenagers. Therefore it is both logical and efficient to treat adolescents as a special legal category—and to refer the vast majority of offenders under the age of 18 to juvenile court, where they will be treated as responsible but less blameworthy, and where they will receive less punishment and more rehabilitation and treatment than typical adult offenders. The juvenile system does not excuse youth of their crimes;
rather, it acknowledges the development stage and its role in the crimes committed, and punish appropriately.

At the same time, any legal regime must pay attention to legitimate concerns about public safety. There will always be some youth – such as older, violent recidivists – who have exhausted the resources and patience of the juvenile justice system, and whose danger to the community warrants adjudication in criminal court. But these represent only a very small percentage of juvenile offenders. Trying and punishing youth as adults is an option that should be used sparingly.

Legislatures in several states have begun to reconsider the punitive laws enacted in recent decades. They have already recognized that prosecuting and punishing juveniles as adults carries high costs, for the youth and for their communities. Now we can offer lawmakers in all states a large body of research on which to build a more just and effective juvenile justice system.


For More Information
MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice
Temple University, Department of Psychology
Philadelphia, PA 19122
www.adjj.org

*The Research Network on Adolescent Development and Juvenile Justice is an interdisciplinary, multi-institutional program focused on building a foundation of sound science and legal scholarship to support reform of the juvenile justice system. The network conducts research, disseminates the resulting knowledge to professionals and the public, and works to improve decision-making and to prepare the way for the next generation of juvenile justice reform.*
References


Unit Three: Adolescent Mental Health Conditions and Treatment

Unit Goal

The goal of unit is to provide participants with a broad understanding of several common adolescent mental health problems and to introduce general treatment options for these issues.

Scope

In this unit, participants will be introduced to common adolescent mental health conditions and how these disorders may present in a school environment. Participants will also learn about several factors that may increase a student’s risk for suicide or self-injurious behaviors.

Performance Objectives

At the conclusion of the unit, participants will be able to:

- Relate national estimates of mental health condition prevalence rates among youth in general and among those involved with the juvenile justice system specifically
- Describe the signs, symptoms, and characteristics of several common mental health conditions among youth
- Discuss the warning signs for suicidal and self-injurious behavior
- Identify general treatment options and settings for youth

Materials to Prepare

- State and/or local mental health prevalence data for slide 3-4
- Sets of true/false cards to be used in exercise on slide 3-7
- Disorder and symptoms cards to be used in exercise on slide 3-10

Provided Materials

- Handout: Myths and Facts
- Supplement for Trainer: Disorders & Symptoms
- Case Studies: Mike, Louis, Eric, Angela, Jack
- Video 3.1: Classroom Scene I (clip length: 1:27)
- Handout: Resources on Trauma
- Handout: Helping Traumatized Children: Tips for Judges
- Handout: Creating a Trauma-Informed Law Enforcement System
- Video 3.2: What Depression Might Look Like - 1 (clip length: 1:24)
- Video 3.3: What Depression Might Look Like - 2 (clip length: 1:24)
- Video 3.4: What Depression Might Look Like - 3 (clip length: 1:27)
- Video 3.5: Mind Matters – Part 1 (clip length: 1:92)
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- Video 3.6: Mind Matters – Part 2 (clip length: 3:00)
- Handout: Medication Information Sheet
- Video 3.7: Intervention & Treatment: A Youth’s Perspective – I (clip length: 3:32)
- Video 3.8: Intervention & Treatment: A Youth’s Perspective – II (clip length: 1:41)
- References

Unit Outline

- National Mental Health Prevalence Data
- What are Mental health conditions?
- Myths and Facts
- Signs of Mental health condition in Youth
- Mental health conditions and Symptoms
  - Disruptive Disorders
  - Substance-Related Disorders
  - Anxiety Disorders
  - Trauma-Related Disorders
  - Depressive Disorders
  - Psychotic Disorders
  - Neurodevelopmental Disorders
- Suicide and Self-Injurious Behavior
- Treatment

Time

- Approximately 1 hour and 45 minutes
Training Aids

Slide 3-1
Adolescent Mental Health Conditions and Treatment

Slide 3-2
Objectives

- Understand the prevalence of mental health conditions and substance use disorders within the juvenile justice population
- Identify possible signs of mental health conditions and substance use disorders
- Describe the impact of trauma
- Discuss warning signs for suicidal and self-injurious behavior

Slide 3-3
What Are Mental health conditions?

Depending on the exact nature of the mental health condition:

- 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
- there can be long periods of healthy functioning

Content/Instructional Delivery Notes

If you have not already done so, introduce yourself, your professional history, and your area(s) of professional expertise.

Briefly state the objectives for this unit of the training. Encourage participants to engage in the training by asking questions and participating in discussions.

Mental health conditions are health conditions that impact a person’s thinking, feelings, or behavior (or all three) and cause the person distress and difficulty in functioning.

Mental health conditions can impact a student’s mood and behavior. These disorders can be quite serious and impair a student’s perception, judgment, and thinking. Untreated, these impairments can disrupt functioning in the family, in school, with peers, and in the community. Early identification and treatment of mental health conditions can have a significant impact on the course of the illness over a lifetime. That is why it is important to be especially alert to the early signs of a mental health or substance use disorder so that students can be quickly referred to an appropriate mental health professional.

Everyone has emotional difficulties from time to time. Adolescence is a time of emotional upheaval, as discussed in Unit 2. Mental illness involves symptoms that fall outside of this range of normal challenges. Symptoms of mental illness occur episodically, not continuously. Thus, even though a
person may have a diagnosis of mental illness, that person may be functioning quite well. However, later, often in response to stress, the individual will start to show symptoms again and need to re-stabilize. With proper help, that person should be able to return to previous levels of functioning.

A culturally accepted response to a common stressor is not a mental health condition. Also, socially deviant behaviors (such as political, religious, or sexually deviant behaviors) or conflicts that are primarily between an individual and society are not necessarily mental health conditions.

Remember from the unit on adolescent development that not all “misbehavior” is a sign of mental illness. Normal adolescence is a time of risk-taking behavior and often impulsive behavior.

**Large group discussion:** Facilitate discussion by asking, “What are mental health conditions?”

Summarize discussion by offering the broad definition of mental health conditions as problems with thinking, emotions, and/or behavior to the point of impaired functioning.

The purpose of this slide and the AMHT-SRO training as a whole is to provide school resource officers with the appropriate information needed to identify some basic signs and symptoms of adolescent behavioral health conditions. This will allow officers to intervene with youth more effectively.

Share statistics about the national juvenile population.

Nearly 1.5 million youth under the age of 18 are arrested in the United States each year. Many of these youth formally end up in the system – either in juvenile detention or correctional facilities.

Data suggest that the prevalence of mental health conditions among youth in the juvenile justice system is significantly higher than among youth in the general population.
• More than 90 percent of youth in the juvenile justice system have experienced trauma.
  (Abram et al., 2013)

• Youth in residential facilities have nearly three times the suicide rate of peers in the general population.
  (National Action Alliance for Suicide Prevention, 2013, Need to Know…)

• General youth population: 20 percent of youth have a diagnosable mental health condition.
• Juvenile justice population:
  - 70 percent of youth have a diagnosable mental health condition
  - Over 60 percent have multiple disorders, including substance use disorders (i.e., co-occurring disorders)
  - 27 percent are believed to be seriously impacted by their disorder.

**Note to Trainers:** Make these numbers come "alive" by asking all participants to stand up. The class as a whole represents the juvenile justice population.

Ask 30 percent of the participants to sit down. Those still standing represent (approximately) the 70 percent with a diagnosable disorder.

Ask another 20 percent to sit down. Those still standing represent (approximately) those with multiple disorders.

Ask all but 30 percent of the participants to sit down. Those still standing represent youth who are considered seriously impaired, to the point that their ability to function is limited without intervention.

**Large group discussion:** Facilitate discussion by asking, "How does this information mirror your experience as SROs interacting with students and families?"

**Note to Trainers:** If available, include state or local mental health prevalence data or information for youth involved with your state's juvenile justice system. Discuss how your state or community's numbers resemble or differ from the national estimates.

**Large group discussion:** Ask participants, "How do you know that a student might be experiencing a mental problem?" It is likely that officers will rely on past professional and personal experience, offering the obvious: suicidal behavior, psychotic symptoms (e.g., hearing voices). Encourage participants to think specifically about students.

**Note to Trainers:** Youth born into a family with a history of mental health conditions will not
necessarily inherit them. Furthermore, adolescents tend to be resilient, so a diagnosis of a mental health condition does not guarantee they will struggle for their entire lives.

Review the signs presented on the slide, noting that they are possible indicators of an emerging or existing mental health condition. These signs are important to note when interviewing teachers, parents, siblings, or others in assessing a situation that involves an adolescent.

**Large group discussion:** Facilitate discussion by asking, “How are these “signs” similar and different from what we just learned about adolescent development?”

**Note to Trainers:** It is important to note that any one of these signs in and of itself does not warrant a diagnosis. This training does not seek to make participants into clinicians, but rather to sensitize participants to the signs and symptoms that may indicate mental health conditions in students.

**Small group exercise:** Ask participants to form groups of 3 to 5 (preferably at a table). Give each small group prepared cards (see instructions at end of unit). Ask participants to work in their small groups to match the symptoms cards to the disorder cards.

**Note to Trainers:** Participants should leave the cards on the table in front of them as they will be referenced during the remainder of the training. Participants are not expected to be 100 percent accurate and can self-correct as the training proceeds.

**Disorder Card:** Depressive Disorder

**Symptoms Card:**
- Extreme sadness
- Feel hopeless and helpless
- Trouble concentrating

**Disorder Card:** Bipolar Disorder

**Symptoms Card:**
- Grandiosity
- Lack of need to sleep at times
### Slide 3-10
Common Disorders and Their Potential Impact on Interactions with Students

- Alternate between depression and mania

**Disorder Card:** Attention-Deficit/Hyperactivity Disorder (ADHD)

**Symptoms Card:**
- Difficulty maintaining attention
- Severe impulsivity
- Tendency to start tasks but quickly lose focus

**Disorder Card:** Conduct Disorder

**Symptoms Card:**
- Repeated violation of rules or rights of others
- Lack of concern about the feelings of others
- Lack remorse

**Disorder Card:** Post-traumatic Stress Disorder (PTSD)

**Symptoms Card:**
- Frequent nightmares
- Flashbacks
- Tendency to startle easily

**Disorder Card:** Psychotic Disorders

**Symptoms Card:**
- Paranoia
- Hallucinations
- Delusions

Reinforce the concept that understanding mental health conditions can help SROs deal with troubled students. Introduce participants to the eight broad categories of disorders that will be discussed:

- Disruptive Disorders
- Substance-Related Disorders
- Anxiety Disorders
- Trauma-Related Disorders
- Depressive Disorders
- Psychotic Disorders
- Neurodevelopmental Disorders

Disruptive disorders are relatively common, particularly in the juvenile justice population, but much less so in the general population of adolescents.

Disruptive disorders involve problems in the self-control of emotions and behaviors that may violate
Prevalence in the juvenile justice population is 46.5 percent; in general adolescent populations, it is less than 10 percent.

- Oppositional Defiant Disorder
- Attention-Deficit/Hyperactivity Disorder

Diagnosing disruptive disorders is especially difficult because, in adolescents, clinical conditions often manifest themselves as behavioral problems. For example, a depressed teen may appear irritable and angry rather than sad. A traumatic reaction may result in hyper-arousal and hyper-vigilance, making it difficult for a student to sit still or pay attention. These will be further discussed later.

**Note to Trainers:** In the DSM-5, ADHD is considered a neurodevelopmental disorder. In previous editions, it was included with conduct and oppositional defiant disorders as part of behavioral disorders. For the purposes of this training, ADHD continues to be discussed with behavioral (i.e., disruptive) disorders. (Neurodevelopmental disorders other than ADHD are discussed later.)

Oppositional defiant disorder is characterized by a pattern of disobedient, defiant, and hostile behaviors towards authority figures and often an angry/irritable mood. Youth with oppositional defiant disorder often have temper tantrums, are fiercely argumentative, and stubbornly refuse to comply with rules or requests.

A recent study of youth in detention found that 14.5 percent of males and 17.5 percent of females met the criteria for the diagnosis of oppositional defiant disorder (Teplin et al., 2006).

Attention-deficit/hyperactivity disorder is commonly seen in both schools and in the juvenile justice population. It is estimated to affect approximately 5 percent of youth in the general school-aged population and about 20 percent of youth in the juvenile justice system population.

**Large group discussion:** Facilitate discussion by asking, “ADHD can impact all areas of functioning. Looking at this description on the slide, when do you think it is most likely to become the focus of attention?”

The expected response to the question is “school-time.” ADHD is most likely to become the focus of attention when a child starts school. Often, the
Unit 3
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Child’s difficulty maintaining attention, completing tasks, and functioning within a highly structured environment is most readily observed at this time.

Some of the hyperactive features of ADHD diminish in adolescence, but often not before an extensive history of school difficulties and failures have been established. The problems with inattention and difficulty with concentration associated with ADHD can continue into adulthood.

ADHD is much more common in males, but not exclusive to males. In females, the diagnosis is easily missed because it can be more inattention and less hyperactivity/impulsivity, resulting in diminished academic performance.

ADHD commonly co-occurs with other mental health conditions like substance use disorder. Some youth find drugs help slow down their hyperactivity; others may simply begin using substances earlier due to impulsivity.

Note to Trainers: Most participants will have some familiarity with ADHD. Facilitate a brief discussion of their experience.

Case study: Ask someone to read the case study out loud (on page 56 in the Participant’s Guide). Ask participants, “What is the likely mental issue?”

Large group discussion: After confirming the answer is ADHD, facilitate discussion on possible SRO responses to Mike. Remind participants that much of the disruptive behavior associated with students is related to brain development. Students may not have the cognitive ability to control the disruptive behavior. Discussion should include the importance of closely investigating situations to avoid automatically assuming that the student is acting in a willfully disruptive manner. For this scenario, the SRO might consider the following questions:

- Is Mike being treated for ADHD?
- Did Mike take his medication today as prescribed?
- Is this a novel and unstructured environment compared to Mike’s normal environment? (Structure is key for a student with ADHD to succeed.)
Is there an existing behavior management plan in place for Mike?
Can the SRO support teachers/parents with an established response to Mike?
Other options for SROs in addressing this situation are:
- Providing positive and simple instructions (Mike, I know you have handled things like this well in the past. Please sit down so that we can talk and figure this out.)
- Frequently repeating instructions (Mike, you’re not sitting down yet.)
- Providing immediate feedback to Mike. (Thanks for sitting down, Mike).
- Explaining social cues; don’t assume students detected them (Mike, it looks like your teacher is very angry).
- Encouraging students to STOP-THINK-ACT so they can better handle the moment. Praising them for desired behavior “in the moment” is critical.

The core features of conduct disorder are aggression (directed toward people, animals, or property), fighting, lying, theft, rule violations, bullying, and intimidation. Given that most of these behaviors are illegal, youth with conduct disorder are highly likely to come in contact with the juvenile justice system.

Again, though more common in males than females, the presentation of conduct disorder in females may involve more interpersonal features and verbal behaviors (lying and relational aggression), truancy, running away, substance use, and prostitution than physical aggression. Males may engage in more fighting, stealing, vandalism, school discipline problems, and physical aggression.

The early onset of conduct disorder (prior to age 10) is strongly associated with increased risk of criminal behavior and substance-related disorders in adulthood (McMahon, Wells, & Kotler, 2006). However, the most common trajectory for youth with conduct disorder is desistance, not entry into adult crime.

From a cultural perspective, the diagnosis of conduct disorder may be misapplied to individuals...
in settings where some patterns of disruptive behavior are viewed as necessary for survival (e.g., in very threatening high-crime areas or war zones) (American Psychiatric Association, 2013).

Before moving onto the next category of mental health conditions, address any questions that participants may have on behavioral/disruptive disorders.

Introduce Video 3.1 – This classroom scene filmed by Home Box Office (clip length: 1:27) depicts adolescents displaying some behaviors associated with the disorders just discussed.

**Video and large group discussion:** After playing clip, facilitate discussion by asking:
- “Did you suspect any of the stated disorders because of the students’ behavior? Have you encountered these behaviors in your school?”
- “How well did the teacher and onlookers interact with the students?”
- “If this had scene had occurred in your school, what would have been the outcome?”

**Slide 3-17**

*Substance-Related Disorders*

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

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

Introduce the next topic: substance-related disorders. Substance-related disorders are especially common in the juvenile justice population. As mentioned earlier, substance use (not at the level of a disorder) can be normative but, certainly from an adult/parent perspective, not a desirable part of most adolescents’ development experience.

The term “substance” includes alcohol, drugs, paint, glue, etc. Substance-related disorders include diagnoses of substance abuse and substance dependence.

A *substance abuse* diagnosis is appropriate when an individual’s substance use adversely impacts his/her functioning at work, in school, or in relationships, or brings him/her in contact with the legal system (e.g., driving under the influence).

A *substance dependence* diagnosis is appropriate when an individual develops tolerance or experiences withdrawal (explained below).
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Slide 3-18

Prevalence

Studies have found that 46.2 percent of youth in juvenile justice have had substance-related issues, compared to 3.4 - 4.6 percent of youth 12 to 17 in the general population.

Problematic effects of the substance can include:

- craving
- tolerance
- withdrawal
- inducing other disorders
- delirium, depression, sleep disorder, and sexual dysfunction

Research has shown that the earlier youth become involved in substance use, the more debilitating it can be. According to the National Longitudinal Survey of Youth, the odds of developing alcohol dependence decreased with each year that the onset of drinking was delayed (US Department of Labor; Grant, Stinson, & Harford, 2001). Sadly, some youth in substance abuse treatment have reported initiating their alcohol use at age 11, progressing to weekly use by age 13 (Brown et al., 1996). For youth with co-occurring disorders, these numbers trend toward even earlier onset and progression to regular use (Abrantes et al., 2004).

Symptoms can include “craving” (intense desire or urge for the drug), “tolerance” (needing increasing amounts of the substance in order to achieve the same effect), and “withdrawal” (varies by drug but may include acute anxiety, tremors, seizures, vomiting, and hallucinations when the use of the substance is abruptly interrupted or discontinued). It should be noted that some prescribed medicines can also result in tolerance and withdrawal.

Slide 3-19

Co-occurring Substance Use Disorders

- Among youth with other major mental health conditions, over 60 percent had a co-occurring substance use disorder.
- Substance use can precipitate or worsen existing mental health conditions.
- Mental illness in combination with substance use increases the risk of violent behavior.
- Heavy use of some substances can disrupt brain development and lead to lasting impairment.

Symptom of Substance Use Can Mimic Other Mental health conditions

- Anxiety from withdrawal
- Bipolar symptoms from cocaine and opioid intoxication
- Psychotic symptoms from chronic alcohol use, amphetamine withdrawal, use of hallucinogens and cannabis

Co-occurring disorders, most often a mental health condition and a substance use disorder occurring at the same time, are common. Studies have indicated that among youth with other major mental health conditions, over 60 percent had co-occurring substance use problems.

The presence of a substance use disorder can precipitate (bring on) or worsen existing mental health conditions, even though a person’s perception may be that substance use reduces stress, suffering, and symptoms. Youth with a mental health condition sometimes “self-medicate” with substances as a coping mechanism.

The use of substances in childhood and adolescence can adversely impact brain development in ways that may not be reversible even after the person discontinues their use.

It can be difficult to tell the difference between substance use and signs/symptoms of a mental health condition.

Remind participants to always ask if the student has ingested any substances.
Case Study: Louis

Louis is 14. He has been smoking marijuana and drinking four or five times a week since he was 12. Most recently, he has been using almost every day. His older sisters smoke marijuana and let him try it for the first time when he was 10. In fact, many of his aunts, uncles, and even his parents smoke marijuana on occasion. Most of his friends at school and in the neighborhood smoke as well. Louis gets stoned before class almost every day, and he skips class with friends or by himself to drink or get stoned several times a week. He is failing most of his classes.

Louis’ family life is full of conflict; he and his mom fight all of the time. She calls him lazy because he refuses to help out most of the time and would rather lie around, watching television. Lately, Louis has been fighting with other youth in his neighborhood. He was recently arrested after assaulting a kid who called Louis a punk and talked about “hooking up” with Louis’ sister.

Large group discussion: Ask for a volunteer to read the case study out loud (on page 56 in the Participant’s Guide). Frame the case study further by explaining that the SRO knows Louis’ history, but has not “caught” him stoned or possessing.

Facilitate discussion by asking, "As an SRO, what would you do when you see Louis at school?"

Discussion points might include:

- Talk about positive expectations with Louis, letting him know that he is better than letting the drugs ruin his life.
- Don’t allow drug use to be glorified.
- Counteract Louis’ possibly valid argument that “Everyone I know uses” by helping him link up to drug-free activities and groups of kids who are not using drugs.
- Encourage Louis to get help and to not give up once he starts treatment.
- Don’t give up on Louis, even if he has given up on himself.
- Point out to Louis that there are healthier ways than using substances to have fun and to cope with life’s challenges.

Remind participants that in this case, Louis has not yet been “caught” using substances or engaging in illegal activities. If he had been, an arrest for possession or use may serve as an eye-opening opportunity to steer Louis to treatment and/or healthy ways to cope.

It is also important for participants to remember that there is no reasoning with a stoned or drunk person. If a student is high or drunk, the SRO must proceed in a matter-of-fact, purposeful manner to maintain the safety of the student, of the public, and of themselves.

Jails are filled with more substance abusers than anyone else, but they are not a place for treatment. Once released from jail, many youth return to their old habits of using because they did not learn any skills to avoid relapsing.
Introduce the topic of anxiety disorders: “Anxiety is a normal reaction to stress. It helps one deal with a tense situation or study harder for an exam, etc. In general, it helps one cope.

However, anxiety that becomes excessive or leads to extreme reactions, or manifests as an irrational dread of everyday situations, might be a disorder that requires attention and treatment.”

Anxiety disorders involve emotional responses of fear and anxiety as primary symptoms.

- Fear is an emotional response to real, imminent threat.
- Anxiety is the anticipation of future threat that is not immediately apparent.

Anxiety disorders are experienced by both males and females, but the number of symptoms experienced and their severity are often more intensely presented in females (Ollendick et al., 1996).

There are several types of anxiety disorders. The types most critical to the work of SROs are noted on the slide.

- **Panic disorder** involves intense anxiety, nausea, sweating, and chest pain. It can look and feel as if someone is having a heart attack. People who have panic disorder may fear they are dying. Scared that an attack may occur in public, they may choose to stay home and risk isolation. Emergency medical service personnel might be asked to bring a student experiencing a panic attack to an emergency room.

- Youth dealing with **generalized anxiety disorder** are described as “worrywarts.” They have excessive fears, worries, and tension.

**Separation Anxiety** is marked by age-inappropriate anxiety related to separation from individuals to whom the student is attached.

Panic disorder is characterized by short, intense periods of panic, with symptoms of shortness of breath, sweating, palpitations or chest pains, and a sense of unreality. These attacks seem to come out of the blue, with no specific danger or precipitant.
For this reason, people with panic disorder often report feeling as if they are “going crazy.”

Much of the panic disorder experience involves worrying about another attack occurring, rather than experiencing large amounts of time in an attack. Often, people with panic disorder will begin to avoid situations in which they fear a panic attack will occur.

Panic disorder rates are significantly more common in adolescence than in earlier childhood. However, overall rates of panic disorder in youth in the community are estimated at 1-2 percent.

Generalized anxiety disorder is characterized by excessive anxiety or worry, which often results in fatigue, irritability, and sleep disturbance. Research findings indicate that 7.1 percent of males and 7.3 percent of females in juvenile detention have generalized anxiety disorder (Teplin et al., 2006). In children and adolescents in the general population, prevalence is 1.6 to 4 percent (American Psychiatric Association, 2013).

Separation anxiety disorder is characterized by excessive and age-inappropriate anxiety concerning separation from individuals to whom the student is attached.

Youth worry about the well-being or death of the person from whom they are separated and constantly want to know the whereabouts of that person. They may become particularly upset when they do not hear from the person at a scheduled time.

**Large group discussion:** Ask for a volunteer to read the case study aloud (on page 56 in the Participant's Guide) and state what mental health condition might be involved.

After confirming that Eric may be suffering from generalized anxiety disorder, facilitate discussion by asking, “How would you respond to Eric?”

Discussion points may include:

- When anxiety becomes bottled up, it may emerge as physical anger directed at oneself (Eric) or at individuals surrounding Eric. The best short-term intervention is to encourage
have said that they think Eric often carries knives, and maybe even a gun, when not in school. Eric to talk, so that stress is released verbally and not physically.

- Anxiety can set a very stressful tone in the environment, which can negatively impact the mood of individuals trying to assist Eric. The SRO should stay calm even as tension is mounting. Verbal hostility is not a physical threat, so there is usually no need to resort to a physical response.
- Ensuring Eric of his safety in the moment may help de-escalate the situation.
- If Eric is experiencing acute panic, he may benefit from slowing down and breathing. The SRO should model a calm response and prompt Eric to engage in slow-breathing exercises.
- Anxiety can heighten risk-taking behaviors and impulsivity. A gun (non-sporting/hunting use) is a risk in any situation with an adolescent. Eric's anxiety will likely make gun possession more dangerous. This safety issue should be targeted immediately.

Slide 3-23
Depressive Disorders

Studies have found that 18.3 percent of youth in the juvenile justice system (versus about 7 percent in the general population) experience mood disorders, which include depression and bipolar disorders.

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

Depressive disorders are often referred to as “mood disorders” because they involve disruptions of affect or emotion. The most common mood disorders seen in youth are major depressive disorder and bipolar disorder.

The American Psychiatric Association recently added disruptive mood dysregulation disorder to clarify symptoms that may have been too quickly referred to as bipolar disorder previously.

Note to Trainers: In previous editions of the DSM, bipolar disorder was listed under depressive disorders, but in DSM-5 it is a separate category.

Slide 3-24
Depression in Youth

- More somatic complaints
  - Headaches
  - Stomachaches
  - Can lead to frequent absences from school
- Irritability
- Temper tantrums
- Running away
- Social withdrawal

Depression in youth can present like a typical adult depression, including:

- depressed mood most of the day
- decreased interest in pleasurable activities
- loss of energy
- feelings of worthlessness
- recurrent thoughts of death, etc.

However, often youth present with more somatic complaints (such as headaches or stomachaches), irritability, and social withdrawal. Present the follow
Unexplained crying
Extreme sensitivity to rejection or failure

Slide 3-25
What Depression Might Look Like

*More Than Sad: Teen Depression* from the American Foundation for Suicide Prevention

Video 3.2

Video 3.3

Video 3.4

Note to Trainers: As time allows, play one or more of the suggested videos of what depression might look like.

Video 3.2 length: 1:24
Video 3.3 length: 1:24
Video 3.4 length: 1:27

Following the video, ask participants, “Were you surprised by what you saw?”

Slide 3-26
Bipolar Disorder

- Bipolar disorder is characterized by extreme mood swings between depression and mania/hypomania.
- The mood changes can cycle from depression to mania or vice versa.

Remind participants that bipolar disorder used to be known as “manic depression.”

In bipolar disorder, periods of depression (just discussed) alternate with periods of mania (the opposite of depression, as described on the next slide). The cycle between depression and mania can be fairly rapid (hours or days) or extend over a period of months.

The symptoms of bipolar disorder can be quite overwhelming to the individual and to authority figures, particularly when a more rapid cycling form of the disorder is present. For example, when a student is experiencing an episode of mania, SROs may find it very difficult to impose limits on the

analogy to participants: “Think of mood disorders like a physical illness. We all may catch a cold, but our symptoms are different: some of us have nasal congestion, while others have a sore throat. Depression can be confusing because there may be multiple ‘symptoms’.”
In bipolar disorder, symptoms of both depression and mania are present. Mania is manifested by a decreased need for sleep, rapid speech, racing thoughts, impulsivity, recklessness, and grandiosity. Some individuals experience mania as “feeling fabulous” or “over the moon;” others experience it as extreme restlessness and agitation, as if a freight train is moving inside of them, trying to get out. These feelings can vary between individuals and even within the same individual during different episodes of mania.

Bipolar disorder can present in childhood, especially when there is a strong family history of the disorder. Earlier onset is more commonly observed in males. Bipolar disorder can lead to increased rates of substance abuse and dependence.

**Large group discussion:** Facilitate discussion by asking, “Can anyone describe an interaction you had with a manic child?”

Summarize discussion by highlighting the critical safety issues associated with such interactions. The impulsivity and intensity of manic symptoms can magnify the danger of a situation. Things can change very quickly and unexpectedly.

Note that the description on the previous slide pertains to youth as well as to adults. This slide is more specific (although not exclusive) to youth.

After reading the first three bullets, ask participants, “What do these remind you of?” Explain that youth with ADHD present with similar symptoms. However, youth with bipolar disorder have additional symptoms not seen in youth with ADHD (e.g., flight of ideas, decreased sleep, grandiose ideas).

It is common for youth with bipolar disorder to have “multiple cycles” during the day. That is, they can be “high” or euphoric and then quickly move to the depressed phase and feel suicidal.
Mind Matters from the Idaho Federation of Families for Children’s Mental Health

Slide 3-29
Case Study: Jack

Jack, age 15, is happy and even hyper one week and then depressed, angry, and irritable the next. His teachers, family and even friends say he is moody and don’t understand how he can sometimes go for days with little to no sleep and then get so depressed and over-react to even the smallest things. When he is in one of those “up” phases, it is hard to get him to slow down. He even races through things as he talks, barely catching his breath. As soon as all that seems to appear, he shifts back to his “low” mood and, if he talks, he says how everyone is out to get him and no one understands.

Note to Trainers: As time allows, play the suggested video (clip length: 1:92). Please note that the clip requires Internet connection. Start it by clicking on the hyperlink screenshot on PowerPoint slide 3-49, which links to the video on the Internet.
Facilitate discussion by asking for any thoughts on or reactions to the video.

Large group discussion: After presenting the case study of Jack (on page 57 in the Participant’s Guide), facilitate discussion by asking, “What mental health issue do you think Jack is experiencing?”

After confirming that Jack is likely dealing with bipolar disorder, facilitate further discussion on appropriate SRO responses to Jack. Discussion points may include:

- The SRO should find out if Jack has been prescribed medication and if he is actually taking it. Medication is one of the most effective interventions for bipolar disorder.
- People with bipolar disorder live for the “high” (the mania) and its associated energy. They are often willing to forgo medication, even if it means bouts of depression, to occasionally have the manic swing. Discussing Jack’s cycle of typical moods or behaviors with Jack, his teacher, and his parent might remind everyone that the cycle is due to his mental health condition.
- Coping skills for those caring for the student, good structure, and behavior management should be ensured. Youth with bipolar disorder typically need to be actively involved in mental health services and medication management.

Unlike mood disorders or substance use disorders, psychotic disorders in adolescent populations are extremely rare. Psychoses are the most severe and debilitating forms of mental health conditions.

Psychoses typically involve a disturbance of both perception and thought.

Slide 3-30
Psychotic Disorders

Prevalence within both juvenile justice and general adolescent populations is very low (two percent or less).
However, when present, these disorders can be extremely disruptive. Symptoms can include the following:

- Hallucinations
- Delusions
- Bizarre speech or behaviors
- Paranoia
- Disturbances of perception occur when an individual’s contact with reality is severely impaired and is evidenced by hallucinations (auditory and visual) or delusions (a fixed, false belief).
- Evidence of thought disorder is typically noted in an individual’s speech and verbal responses. A person with a psychotic disorder will often have disorganized speech. Verbal responses will be illogical, irrelevant, and incoherent. Students who are experiencing a thought disorder may be extremely withdrawn, avoiding eye contact and interpersonal interactions.

Schizophrenia is a well-known example of a psychotic disorder. The onset of schizophrenia in children can be quite gradual. Development of the full disorder before age 12 is extremely rare, although developmental problems may appear as early as age 6-7.

When you encounter a student who is experiencing a psychotic disorder:

- Maintain eye contact.
- Talk directly to the student.
- Help the student understand what is being asked.
- Do not attempt to talk the student out of a delusion.
- Keep the student safe.

Note to Trainers: As time allows, play the suggested video (clip length: 3:00). Please note that the clip requires Internet connection. Start it by clicking on the hyperlink screenshot on PowerPoint slide 3-55, which links to the video on the Internet.

Facilitate discussion by asking for any thoughts on or reactions to the video.

Neurodevelopmental disorders have early onset (often at pre-school age). The developmental deficits can impair personal, social, academic, and
• Intellectual Disabilities
• Communication Disorders
• Autism Spectrum Disorder

**Intellectual Disabilities**

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

**Communication Disorders**

- 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 students having difficulty understanding basic instructions from school staff and officers

Occupational functioning. These deficits, like other mental health conditions, can co-occur.

Intellectual disabilities are more prevalent in juvenile justice than they are in the general population, although autism is not more prevalent.

Intellectual disabilities (which previously included the diagnosis of “mental retardation”) are characterized by significant intellectual and adaptive functioning deficits. Without ongoing support, the person has limited functioning in daily living skills.

Communication disorders can result in a significant discrepancy between measured achievement and age, school level, or ability.

Studies have found that close to 20 percent of incarcerated females experience language and communication problems, and could not define or describe words such as *penalty, verify, priority, caution, or crucial* (Sanger et al., 2001; Snow et al., 2012)

Given this, students may have difficulty understanding staff or you as an SRO. It is important to give instructions clearly and slowly, with repetition. You should not assume that students who do not follow instructions are intentionally ignoring you.

**Slide 3-34**

**Engaging Students with Neurodevelopmental Disorders**

- Be patient.
- Be appropriate.
- Speak clearly and concisely.
- Expect to repeat directions.
- Be prepared to de-escalate.

Supplement information on slide with the following:

- Exercise patience. Do not rush students who have neurodevelopmental disorders.
- Ensure that tasks given to students with neurodevelopmental disorders are appropriate to their abilities.
- Encourage students to complete tasks that are within their capabilities.
- Provide verbal cues on a frequent basis and in concise language.
- Expect to repeat directions.
- Rely on prompts and behavioral cues.
- Be aware that transitioning from one activity to another may be difficult for students with neurodevelopmental disorders.
- Be alert for incidents that may agitate students with neurodevelopmental disorders.
Be prepared to de-escalate students before agitation has reached the point of uncontrollable rage.

**Note to Trainers:** Check for participant questions before starting the next topic of suicide.

Trauma disorders involve exposure to a highly arousing frightening event over an extended period of time.

There are multiple trauma-related diagnoses. All of them include three essential components (sometimes referred to as the “three ‘Es’”):

- a stressful **event**
- an ongoing intense, negative emotional **experience**
- lasting, negative **effects**

The most well-known of these disorders, PTSD, was originally used in response to acute stress reactions to combat some soldiers experienced. However, the PTSD diagnosis is not limited to combat soldiers; anyone (even children and adolescents) can develop trauma symptoms.

Types of traumatic events vary widely: a natural disaster, plane crash, sexual violence, etc. A traumatic event is different for different people. PTSD effects can develop immediately or up to six months after the event.

Many youth have a history of multiple traumatic events. Law enforcement situations can create multiple opportunities (use of force, hand-cuffs, etc.) for triggers and symptom reactivation.

A re-experience of the event (flashback) can be triggered by sights, sounds, smells, or touch that would seem ordinary to a non-traumatized individual, but which the traumatized person associates with the original event. This re-experience can include visualizing the experience and “dissociating” or disconnecting from the present reality.

In contrast to how flashbacks are often portrayed on films and television, they often last for just seconds. It is important to remember that the person is truly re-experiencing some part of the trauma. A
flashback is actually re-living, feeling, and/or seeing part of a traumatic event at any given time. It is not a dream. The brain actually replays part of the trauma while the person is awake. He or she may appear to “zone out” and have a blank stare. He or she may say things or physically react to the trauma (e.g., become frightened for no apparent reason).

Other symptoms of PTSD include hyper-arousal (difficulty sleeping, irritability, and difficulty with concentration) and hyper-vigilance (scanning the environment for real or anticipated threats).

This picture of the vase/human profiles is symbolic of the multiple ways to look at a student’s behavior. Some adults might see a student’s acting out behavior as indicative of being a “bad kid.” Others might see the behavior as a symptom of mental health condition. Still other adults might see the behavior and be reminded of child trauma. How adults view a student’s behavior will determine how they choose to intervene with the youth. Is the student bad, mad, or sad?

As illustrated on the slide, there are a variety of child-serving systems that have contact with youth who may have trauma histories.

Not all children are traumatized. However, every child-serving system (education, mental health, child welfare, juvenile justice) encounters youth who have been mistreated and who act out.

Trauma theory offers an understanding of some of these children and their behavior, regardless of which system they are involved with or have been placed in.

The first of the three “Es” of trauma – events – can include many of the occurrences listed on the slide. While not exhaustive, this list captures common examples of traumatic events.

The event can be a single, isolated, intense event, like a natural disaster of some sort. It can also be a series of less intense events, like living in a violent community with the threat of violence a daily and common concern.
Point out to participants that the student’s perception of a stressor is most important and will determine the response. What one person perceives as stressful may not be the same for someone else. Unique histories trigger different responses/outcomes.

The second “E” is the painful or distressful experience. This is an internal reaction.

Different people can react to the same situation in very different ways. For example, a young child might run across the street and nearly get hit by a car, but not think much about it. However, the child’s mother witnessing the event might have a very powerful and distressful experience.

Same situation – two very different reactions and, hence, two different experiences.

The third “E” – the effects – can include some instantly recognizable symptoms, like nightmares and a re-experiencing of the event (flashbacks).

Flashbacks can be triggered by sights, sounds, smells, or physical contact that would seem ordinary to a non-traumatized individual, but which the traumatized person associates with the original event.

This re-experience can include visualizing the experience and “dissociating” or disconnecting from the present reality.

However, some effects are more indirect, like the person who remains constantly on alert and overreacts to neutral situations.

Symptoms of trauma include heightened arousal (difficulty sleeping, irritability, and difficulty with concentration) and hypervigilance (scanning the environment for real or anticipated threats).

Group Discussion: Ask participants whether they have ever known anyone with any of these symptoms:

Do you know anyone who never feels quite safe?

• …never sits with his/her back to the door?
Slide 3-42
Most people can get through adverse experiences without developing trauma symptoms.
Resilience and protective factors contribute to this.

Slide 3-43
In a longitudinal general population study of 9- to 16-year-old youth, 25% had experienced at least one traumatic event in the past three months.

Prevalence of Traumatic Experiences for Youth in Juvenile Justice
In a longitudinal study of youth detained at a detention center:
- 92.5 percent of youth had experienced at least one trauma
- 84 percent had experienced more than one trauma
- 56.8 percent were exposed to trauma six or more times
- More than 1 in 10 detainees had PTSD in the year prior to being interviewed.

(Abram et al., 2013)

Point out to participants that, as SROs, they should be aware of the higher prevalence of traumatic experiences among youth who are in contact with juvenile justice/law enforcement. Data indicate that the vast majority of detained juveniles had experienced traumatic victimization and as many as 1 in 10 detainees had PTSD.

Large group discussion: Facilitate discussion by asking, “How do these numbers translate to your school population?” Encourage participants to reflect on the impact that traumatic experiences may have on the students with whom they work.

Remind participants that not everyone exposed to an adverse event (abuse, neglect, abandonment, etc.) or potentially traumatic event develops a traumatic reaction. This is due to protective factors that serve as insulation from negative aftereffects.

In addition to protective factors, youth also have tremendous resiliency. They can often recover and thrive despite exposure to adverse events. However, the more frequent, intense, and prolonged the exposure to adverse events, the more difficult it is for youth to endure.

The Adverse Childhood Experiences Study (ACES) examined youth who experienced physical abuse and neglect, emotional abuse and neglect, and sexual abuse.
• Major mental illness
• Substance use disorder
• Sexually transmitted diseases
• Impaired physical health
• Academic difficulties
• Early death

It also examined youth growing up in a household with:
• an alcohol or drug user;
• an incarcerated household member;
• someone who is chronically depressed, suicidal, institutionalized, or mentally ill; and,
• domestic violence.

The Adverse Childhood Experiences (ACE) Study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being.

The study is a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente’s Health Appraisal Clinic in San Diego, which is a Health Maintenance Organization (HMO).

More than 17,000 HMO members undergoing a comprehensive physical examination chose to provide detailed information about their childhood experience of abuse, neglect, and family dysfunction.

The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States (excerpted from http://www.cdc.gov/ace/index.htm).

ACES found that the more adverse categories a youth experienced, the more likely it is that youth will have struggles as he or she gets older.

These are actual slides from the Centers for Disease Control. Note that the higher a person’s ACE score, the higher the person’s risk of suicide and adult alcoholism.

Childhood Experiences Underlie Suicide
• ACES researchers consider a person experiencing four types of adverse experiences as putting that person at high risk.
• Recall that our earlier prevalence data showed that youth in juvenile detention averaged six types of adverse experiences.

Childhood Experiences vs. Adult Alcoholism
In the study, the number of ACEs was the best predictor of which females would develop substance use problems as they got older.

Our earlier module on brain development described how all experiences have some effect on brain cells.

With traumatic events, the effect can be quite negative.

Problems of neglect cause the failure of normal brain development, while problems of extreme threats overwhelm the brain’s emotional system.

Introduce the impact of childhood trauma on brain development by discussing the images on the slide. The CT scan on the left is of a healthy three-year-old child with an average head size (50th percentile). The image on the right is from a three-year-old child suffering from severe sensory-deprivation neglect. This child’s brain is significantly smaller than average (3rd percentile) and has enlarged ventricles and cortical atrophy.

Facilitate discussion by asking participants:

- Which of these children is less likely to be ready to start school?
- Which child is less likely to perform better in school?
- Which child is more likely to have behavior problems when not performing well?
- Which child is more likely to drop out of high school?

The answer to all four questions is the child pictured in the CT scan on the right. A student with a history of trauma is at increased risk for school failure, misconduct in school, and ultimately dropping out of high school. These factors, in turn, place the student at increased risk for coming in contact with the juvenile justice system.

For more discussion of how a traumatic experience can cause disruption in brain development and have a major impact on the brain’s alarm system, see the resources included at the end of this unit.
When our brains trigger a survival response, it is often described as one of three types: fight, flee (or flight), or freeze.

People can express different responses in different settings. The most difficult one to recognize may be dissociation (or freezing).

These people may report no longer being able to feel anything (and sometimes hurting themselves as a way to start feeling again).

Facilitate a discussion by asking:
- “What may this look like in your work?”
- “How might these traumatic responses impact your questioning, searching, arresting, or detaining a youth?

Youth who have been mistreated and traumatized may have a very different view of the world than we do.

- They see other people as threatening.
- They expect others to be against them.
- They interpret others’ actions as being dangerous and react accordingly.

In many cases, the other person may not have done anything wrong from an objective point of view. But the traumatized person will react anyway.

For example, you might walk down a crowded hallway and not even notice as others brush against you. But a traumatized person might take this as an assault and “fight back.”

You could ask if anyone can think of other examples where they felt a juvenile misinterpreted an officer’s actions and overreacted.

As other modules emphasize, we must always keep in mind that working with a youth also means working with the youth’s family.

Most adolescents are attached to some family member. Family members may be dealing with their own adverse experiences and traumatic reactions.

Trauma can be an intergenerational issue that affects all family members.
For example, a child’s parents might also have grown up in a violent neighborhood or struggled with family losses.

Officers should be able to respond differently when recognizing signs of trauma. Part of trauma work is educating a family to recognize adverse events and to realize that, just because something or things happened to them or just because it happened frequently in their neighborhood, that does not mean that it is “normal” for those things to happen.

The challenge is to talk about adverse childhood experiences and trauma in a way that respects a family and their culture.

The groundwork for severe damage can be laid at a very early age. Therefore, it is not enough to simply remove the student from the adverse environment. Adults must actively intervene with the student to change the trajectory.

SROs, in particular, play important roles. They can help students by:

- protecting them from further trauma
- securing medical care and counseling for them
- refraining from asking students to recount traumatic experiences over and over
- reassuring students that they are safe and will not be harmed, particularly during flashbacks
- avoiding the use of handcuffs (unless absolutely necessary), as restraint may prompt strong startle reactions or flashbacks
- ensuring the use of procedures less likely to re-traumatize students (e.g., engaging female officers to search/pat-down a teenage girl who may have been sexually abused in the past)
- being knowledgeable about local services that specialize in reducing the impact of trauma (This is discussed in more detail in Unit 7.)

For more information about creating a trauma-informed law enforcement system, see The National Childhood Traumatic Stress Network’s Service Systems Brief: "Creating a Trauma-Informed Law Enforcement System," included at the end of this unit.

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**Slide 3-52**

**Helping Students Cope with Trauma**

- Protect students from further trauma
- Secure medical care and counseling
- Don’t ask students to recount traumatic experiences
- Reassure students that they are safe and will not be harmed
- Avoid restraining students whenever possible
- Use procedures that are less likely to re-traumatize students
- Be knowledgeable about local services

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Recovery – What Can Officers Do?
Any adult can help a traumatized adolescent by being aware of the youth’s current environment and the four “Ss”
- Safety
- Supportive Adult Relationships
- Self-regulating
- Strengths

The next few slides go into more detail about the four Ss.
This material is very similar to what will be recommended in the module regarding what officers can do. So, trainers may want to treat these next slides as an introduction to that later module.

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.

The first S is “safety.” Context matters. The more a traumatized youth, who is prone to overreact, can be helped to feel safe, the better for everyone.

Predictability helps and this can be enhanced through structure and schedules. None of this involves being punitive, even when the traumatized youth still overreacts. It will take a while for a youth to feel safe in a new setting.

You could ask the group about their own childhoods: When you were frightened as a child, was there a place you would go that felt very safe?

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

The second S is for “support.” Traumatized youth typically do not trust adults and yet this is one thing that can ultimately help them.

Youth are not going to learn new behaviors in the middle of a crisis, but they may learn from their mistakes after they have calmed down.

It is essential for officers to work with youth during calm times for the youth to begin to change. Some teaching is direct, some is by example.

Without officers’ assistance, the traumatized youth may just keep repeating the same violent, unsuccessful behaviors.

Again, you could potentially ask the group about their personal experiences:
When you were frightened as a child, was there a person you would go to who seemed very supportive?
Prior to playing video 3.7 (clip length: 3:32), explain to participants that the youth featured in the video is going to share what he was like before treatment, what treatment was like for him, and a key component of his treatment. Ask participants to reflect on the students with whom they interact as they watch the video.

**Large group discussion:** Facilitate discussion by asking:

- “Did the young man’s explanation for why he would fight or ‘snap’ resonate with any of you and your experiences with students?”
- “Were you surprised by the young man’s feelings (‘They are trying to control me’) at the onset of treatment or by his statement about not giving treatment a chance at first?” Prompt the audience to think back to the material covered in Unit 2 and to consider how this response is normative.
- “What do you think of the advice the young man gives to those who work with youth?”
- “When the young man talked about his treatment, how important was his family?”

The third S is for “self-soothing.” A traumatized youth overreacts because he or she is hyper-aroused and feeling threatened.

When a youth feels safe and an adult offers some support, the youth can calm down more easily.

The goal is for the youth to learn to recognize when he or she is escalating and acquire the coping skills to de-escalate.

We want youth to learn to verbalize, problem solve, and seek assistance rather than fight, flee, or freeze.

Expecting youth to never become upset is an unreasonable goal. Rather, youth should develop skills that will allow them to handle being upset without harming themselves or others. This will be addressed in more detail in later modules.
The final S is for “strengths.” Working with traumatized youth is more than getting them to stop negative behaviors. We also want them to learn positive behaviors and to learn to enjoy positive feelings. They need to learn that life can hold positive experiences where they can achieve some success. The key is finding an area that interests them or a talent they possess and helping them develop it. This may help them understand the world differently. When is the last time you praised a student? What talent or skill have you helped him/her develop? You could prompt discussion by asking:

- For those in the group with children, what talents do your children have and how do you encourage your children to develop these talents?
Suicide in Youth

- Every year, nearly 5,000 people between ages 15 and 24 die by suicide.
- One in twelve high-school students attempt suicide.
- Suicide is the second leading cause of death in adolescents.
- Suicide threats/attempts within schools can occur in “clusters.”
- Girls are two times more likely to attempt suicide.
- Boys are four times more likely to die by suicide.

Introduce the topic of suicide by noting that it is the second leading cause of death among adolescents. Emphasize to participants that attempted suicide is more common than completed suicide.

Supplement information on slide with other facts on suicide:

- In a survey of high school students:
  - 1 in 5 seriously considered suicide.
  - 1 in 6 made plans for suicide attempt.
  - 1 in 12 made actual suicide attempts in the last year (Centers for Disease Control, 2000).
- The National Youth Behavior Survey found that suicide attempts were higher for Hispanic students than black or white students (Kann et al, 2014).
- Youth who are sexual minorities (LGBTQ) are frequent targets of victimization and have higher rates of depression (Centers for Disease Control, 2014).

Here are some other relevant facts:

- Nearly 88,000 youth ages 10-18 were treated in emergency rooms for self-harm injuries in 2011.
- Certain populations of youth (e.g., American Indian, Alaskan Native) have increased rates of suicide. (National Action Alliance for Suicide Prevention, 2013, Need to Know…)

**Large group discussion:** Facilitate discussion by asking, “Why do you think suicide threats/attempts sometimes happen in clusters?”

(Responses might include social learning, observing the honoring of a youth who died by suicide, experiencing the loss of a close friend or romantic partner due to suicide, etc.)

After reviewing the slide, ask, “Why do you think gender differences exist?” Emphasize the likelihood that males are action oriented and much more likely to find the lethal means necessary to complete suicide.

**Large group discussion:** Prior to showing the next slide, facilitate discussion by asking, “How do you detect suicidal thoughts in students?”
Detecting Suicidal Thoughts in Students

- Withdrawal
- Loss of interest or pleasure in activities
- Preoccupation with death
- Talk of suicide (verbal statements or threats)
- Note, text, email, post
- Injury to self
- (Realistic) plan
- Previous attempt
- Signs of depression or expressions of hopelessness
- Giving away prized possessions or putting things in order

Explain that SROs should always be alert to sudden changes in a student’s behavior or mood. Expressions or indications of suicide should always be taken seriously; the student should be seen immediately by a mental health professional.

Some evidence suggests that whereas adults who attempt suicide often have chronic problems that influence their decision to try to kill themselves, adolescent suicide attempts will more likely be an acute reaction to a specific precipitating event (e.g., romantic break-up). Many times, suicides occur “by accident” (i.e., the adolescent hoped to get someone’s attention and did not intend to be successful with the suicide attempt, but did die).

Any expression of suicidal thought or intent should be taken seriously. It is far better to err on the side of being overly cautious. Always follow the policies and procedures of the school and/or department when responding to suicidal or self-injurious students.

There are also known risk factors that may increase suicide risk among all youth, including the following:

- Mental illness and/or substance use disorder
- History of suicide attempts, self-harm behavior, and death by suicide in family
- Social isolation or separation from family
- Impulsive, aggressive, or reckless behavior
- History of bullying or being bullied
- Access to lethal means
- History of trauma or child maltreatment

Introduce the topic of self-injurious behavior. Though not a formal mental health diagnosis, self-injurious behavior is a significant issue for many youth.

Much of the research on self-injurious behavior does not distinguish between types or levels of self-injurious behaviors. Similarly, in some systems (such as schools), all levels of self-injurious behavior (minor scratching, cutting, etc.) and genuine suicide attempts are universally labeled “suicidal behaviors.” This designation likely triggers an automatic referral for a full evaluation of suicidal risk. As noted earlier, it is far better to be cautious than to overlook a preventable tragedy.
Many youth engage in self-mutilative and self-injurious behaviors for reasons other than a desire to kill themselves. For example, cutting can be a means of releasing emotional or physical pain and doesn’t mean the person is suicidal. However, any self-harming behaviors must be taken seriously.

Regardless of the type, severity, or motivation, all self-destructive behavior should be taken very seriously and be brought to the immediate attention of a mental health professional. This includes when the self-destructive behavior is observed as a group activity.

Indications for Immediate Help
- Unusual or sudden changes in personality, behavior or mood
- Talking about wanting to die
- Withdrawal from friends, family or usual activities
- Actively securing access to lethal means

First and foremost, the most important thing you can do is demonstrate a belief that suicide can be prevented. Take any threat seriously.

Be direct. Do not be afraid to ask questions such as:
- Are you thinking of killing yourself?
- Are you considering taking your life?
- Do you ever feel like things would be better if you were dead?

Listen and do not judge anyone who you think might be thinking of suicide. Active listening and empathy go a long way (as discussed in later units).

Be sure to share any threat of suicide with a mental health professional, supervisor, and other administrators (i.e., follow the established policy; if there is none, be sure one is created).

If you hear a student verbalize a desire or intent to commit suicide, observe a student engaging in self-harm, or otherwise believe a student is at risk for suicide, the student should remain under constant observation and not be left alone until an evaluation
by an appropriate mental health or medical professional has been completed.

Remember, you are the critical eyes and ears for the suicide prevention program in your school and your community.

**Large group discussion:** Lead a brief discussion on how participants view their role in preventing youth suicide. Questions to pose may include:

- Have you ever intervened with a suicidal student?
- Have you ever known a student to engage in self-injurious behavior?

Remind officers that this curriculum is not intended for them to become experienced in identifying and diagnosing disorders.

It is intended for officers to learn some early warning signs of potential disorders and to respond based on those signs.

Not all “misbehaviors” are signs of mental illness. In many cases it’s just kids being kids. The following video will help to put this into perspective.

**Slide 3-69**

**Video 3.8: Intervention & Treatment: A Youth’s Perspective – II**

Introduce the short video clip (length: 1:41) featuring a young woman who received treatment. She describes how she was before treatment and what she learned from treatment, before offering advice about working with kids.

**Note to Trainers:** When the young woman in the video says, “…right after that had happened,” she is referring to her offense.

If time allows, facilitate a brief discussion by asking:

- “What skills did this young woman learn?”
- “Would the students with whom you work benefit from these same skills?”
- “What do you think of the advice the young lady offers?”

Conclude the unit by asking participants to discuss as many of the following questions as time allows:

- What did you learn from this unit?
- What will most impact your work?
Myths & Facts

Myth 1: All youth in the juvenile justice system are mentally ill.
Facts:
- 65 percent to 70 percent of youth in juvenile correctional facilities have a mental health condition.
- About 50 percent of youth in juvenile correctional facilities are in need of special education classes.
- Mental health conditions may be significantly different than behavioral problems alone.

Myth 2: All mental health conditions cause criminal behavior.
Facts:
- Mental health conditions may or may not be associated with criminal/delinquent offenses. For example, most research shows that substance use introduces people to different types of crime, but doesn’t necessarily cause the crime.
- Mental Illness and delinquent behaviors may be related, but not necessarily the cause. The disorder, if undetected or untreated, can manifest in behaviors that could bring a youth to the attention of law enforcement.
- Mental health conditions may be genetic or environmental in nature.

Myth 3: Family members of youth with mental health conditions are resistant to treatment.
Facts:
- Family members often feel disconnected from treatment (or even blamed).
- Many evidence-based practices focus on taking the blame off of any one person in a family and refocus attention so that problems (mental health conditions included) are an issue for everyone in the family to address and everyone can be part of the solution.
- Family members may assist in transitioning youth back into the community and school. For example: after an out-of-home placement has been used, youth need support and resources to sustain change. When there is a smooth transition from detention or institutional care back to the community and school, treatment is more effective and can continue to help the child beyond an out-of-home placement.

Myth 4: Mental health conditions and intellectual disabilities are the same.
Facts:
- "Intellectual disabilities" (what used to be called "mental retardation") refers to a separate and distinct set of problems affecting intelligence and educational abilities.
Mental health conditions are complex and affect thinking, perception, mood, and behaviors.

**Myth 5: Mental health programming and treatment does not work with delinquent youth who have mental health conditions.**

**Facts:**

- Certain treatments have been shown to be effective.
- Interventions with youth in the context of their environment (family, home, peer, school, work, neighborhood) have been found to be more effective than traditional office-based or institutional interventions.
- Treatment that focuses on teaching skills and reinforcing youth and family as they utilize those skills in the “real world” are more effective than educational programs or interventions that only allow youth to demonstrate skills in a controlled environment (e.g., office or detention).

**Myth 6: The Americans with Disabilities Act does not apply to mentally ill youth being disciplined in school or juvenile justice settings for violating the rules or law.**

**Facts:**

- Accommodations must be made for youth with mental health disabilities.
- Youth need to be held accountable for their actions, but should not be punished for a symptom of their mental health conditions. They should be treated.
Materials: Supplement for Trainer

Disorders & Symptoms

Prepare 3x5" cards by writing one disorder on each card and the three symptoms associated with the disorder on another card (see list below), for a total of 12 cards. Distribute cards to participants in small groups, asking them to match the symptoms cards to the disorder cards.

Participants should leave the cards on the table in front of them as they will be referenced during the remainder of the training. Participants are not expected to be 100 percent accurate and can self-correct as the training proceeds.

<table>
<thead>
<tr>
<th>Disorder Cards</th>
<th>Symptoms Cards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive Disorder</td>
<td>Extreme sadness</td>
</tr>
<tr>
<td></td>
<td>Feel hopeless and helpless</td>
</tr>
<tr>
<td></td>
<td>Trouble concentrating</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>Grandiosity</td>
</tr>
<tr>
<td></td>
<td>Lack of need to sleep at times</td>
</tr>
<tr>
<td></td>
<td>Alternate between depression and mania</td>
</tr>
<tr>
<td>Attention-Deficit/Hyperactivity Disorder (ADHD)</td>
<td>Difficulty maintaining attention</td>
</tr>
<tr>
<td></td>
<td>Severe impulsivity</td>
</tr>
<tr>
<td></td>
<td>Tendency to start tasks but quickly lose focus</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>Repeated violation of rules or rights of others</td>
</tr>
<tr>
<td></td>
<td>Lack of concern about the feelings of others</td>
</tr>
<tr>
<td></td>
<td>Lack remorse</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder (PTSD)</td>
<td>Frequent nightmares</td>
</tr>
<tr>
<td></td>
<td>Flashbacks</td>
</tr>
<tr>
<td></td>
<td>Tendency to startle easily</td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>Paranoia</td>
</tr>
<tr>
<td></td>
<td>Hallucinations</td>
</tr>
<tr>
<td></td>
<td>Delusions</td>
</tr>
</tbody>
</table>
Materials: Case Studies

Case Study of Mike

Mike, who is 14 years old, never seems to be listening. Not able to sit still most of the time in his classes, he often rocks and gets out of his seat. His teachers say he is “out to lunch” and daydreaming all the time. Even with all the reminders to do his work, he typically doesn’t get it done. Instead of writing his answers, he taps his pencil. If he does complete his homework, it is often forgotten at home, on the bus, or in his locker, resulting in no credit. He is reprimanded several times a day in class and both his teachers and parents are frustrated with the constant repetition of telling him the rules and expectations. Mike’s typical reaction to all this is irritability and anger for a short period and then moving on to something else.

Case Study of Louis

Louis is 14. He has been smoking marijuana and drinking four or five times a week since he was 12. Most recently, he has been using almost every day. His older sisters smoke marijuana and let him try it for the first time when he was 10. In fact, many of his aunts, uncles, and even his parents smoke marijuana on occasion. Most of his friends at school and in the neighborhood smoke as well. Louis gets stoned before class almost every day, and he skips class with friends or by himself to drink or get stoned several times a week. He is failing most of his classes. Louis’ family life is full of conflict; he and his mom fight all the time. She calls him lazy because he refuses to help out most of the time and would rather lie around, watching television. Lately, Louis has been fighting with other youth in his neighborhood. He was recently arrested after assaulting a kid who called Louis a punk and talked about “hooking up” with Louis’ sister.

Case Study of Eric

Eric, age 13, appears very stressed. He’s withdrawn from his peers and looks like he has so much on his mind. His school counselor can tell you that Eric is easily frustrated and can dish out personal insults quickly. Eric seems to do better when teachers reach out to him and get him to talk. Left alone, his frustration and stress mount quickly. He often tends to fidget, pace, and is hypervigilant of every little thing going on around him. A few kids have said that they think Eric often carries knives, and maybe even a gun, when not in school.

Case Study of Angela

Angela, age 13, frequently appears on her probation officer’s caseload and is well known among the school counselors. She spends substantial periods of time angry and/or depressed. She watches everyone like a hawk, but rarely makes eye contact. Her peers say she is hypersensitive and can become enraged or even cry with little provocation. Most of her peers just leave her alone. She refused to talk with a male SRO after he handcuffed her once. She accused the SRO of trying to restrain her as he “felt her up” in a search. Girls tease her for being a “slut” and having sex with male peers, although she doesn’t actually “date” any of them. In class and on her skin, Angela has drawn pictures that include words like “ugly” and “trash” or “use me.” Based on disclosed information, her counselor reported Angela’s stepfather to child protection for abuse. It is suspected that Angela was raped around the age of 11.
Case Study of Jack

Jack, age 15, is happy and even hyper one week and then depressed, angry, and irritable the next. His teachers, family and even friends say he is moody and don't understand how he can sometimes go for days with little to no sleep and then get so depressed and over-react to even the smallest things. When he is in one of those “up” phases, it is hard to get him to slow down. He even races through things as he talks, barely catching his breath. As soon as all that seems to appear, he shifts back to his “low” mood and, if he talks, he says how everyone is out to get him and no one understands.
Materials: Resources on Trauma

It may be difficult to believe that what happens (or does not happen) to children under five years of age will have much impact because they are so young. However, studies show that traumatic experiences affect the brain, mind, and behavior of even very young children, causing similar types of reactions as those seen in older children and adults.

Resources on working with traumatized youth include:

- National Child Traumatic Stress Network (available at: http://www.nctsn.org/)
- The Amazing Human Brain & Human Development, a free online course by the Child Trauma Academy (available at: www.childtraumaacademy.com/index.html)
- Handout: Creating a Trauma Justice System, a Service Systems Brief produced by the National Child Traumatic Stress Network (included in this guide, and available at: http://www.nctsn.org/nctsn_assets/pdfs/SS_brief_law_enforcement.pdf)
Materials: Medication Information Sheet

Trainer may wish to illuminate the variety and number of medications taken by children and adolescents for conditions that may be present as one condition, co-occurring conditions, and medications for side effects.

A simple method to display the complexity of medications is to use buttons or candies that are color coded and identified as a specific medication. Pass out to the class the “dosage” for a day for one, two, co-occurring, and side effect medications that are commonly seen in this population.

Facilitate discuss on what it might be like to remember to take these pills and to experience their side effects. Include in the discussion the stigma of mental health conditions, what kids think of other kids who are always at the nurse’s station, etc.

(See next page for Medication Information Sheet.)
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic Name</th>
<th>Indication</th>
<th>Common Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilify</td>
<td>Aripiprazole</td>
<td>Antipsychotic, mood stabilizer, lower aggression</td>
<td>Nausea, headache, dizziness, insomnia, anxiety</td>
</tr>
<tr>
<td>Adderall</td>
<td>Dextroamphetamine/amphetamine</td>
<td>Stimulant (for ADHD)</td>
<td>Difficulty sleeping, feeling irritable or restless, dry mouth, dizziness, loss of appetite, headache, feeling shaky, nausea</td>
</tr>
<tr>
<td>Ambien</td>
<td>Zolpidem</td>
<td>Sedative</td>
<td>Drowsiness, dizziness, difficulty with coordination, headache, nausea</td>
</tr>
<tr>
<td>Anafrani</td>
<td>Clomipramine</td>
<td>Antidepressant</td>
<td>Dry mouth, blurred vision, constipation, sedation, dizziness</td>
</tr>
<tr>
<td>Antabuse</td>
<td>Disulfiram</td>
<td>Alcoholism</td>
<td>Drowsiness, headache, &quot;metallic&quot; taste</td>
</tr>
<tr>
<td>Asendin</td>
<td>Amoxapine</td>
<td>Antidepressant</td>
<td>Dry mouth, blurred vision, constipation, sedation, dizziness, stiffness</td>
</tr>
<tr>
<td>Ativan</td>
<td>Lorazepam</td>
<td>Antianxiety</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>BuSpar</td>
<td>Buspirone</td>
<td>Antianxiety</td>
<td>Drowsiness, dizziness, dry mouth, headache, nausea, fatigue</td>
</tr>
<tr>
<td>Catapres</td>
<td>Clonidine</td>
<td>Impulsive/aggressive behaviors</td>
<td>Drowsiness, dizziness, dry mouth, headache, weakness, constipation</td>
</tr>
<tr>
<td>Campral</td>
<td>Acamprosate</td>
<td>Alcoholism</td>
<td>Dizziness, headache, nausea, tremor, diarrhea, insomnia, sweating</td>
</tr>
<tr>
<td>Celexa</td>
<td>Citalopram</td>
<td>Antidepressant</td>
<td>Nausea, nervousness, drowsiness, headache, change in appetite</td>
</tr>
<tr>
<td>Cymbalta</td>
<td>Duloxetine</td>
<td>Antidepressant</td>
<td>Nausea, dry mouth, constipation, dizziness, drowsiness</td>
</tr>
<tr>
<td>Clozapine</td>
<td>Clozapine</td>
<td>Antipsychotic</td>
<td>Sedation, increased salivation, constipation, increased appetite, low blood pressure (Seizures may occur at high doses)</td>
</tr>
<tr>
<td>Dalmane</td>
<td>Flurazepam</td>
<td>Sedative</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>Depakote</td>
<td>Valproate, valproic acid, divalproex</td>
<td>Mood Stabilizer (Antimanic)</td>
<td>Nausea, vomiting, sedation, increased appetite</td>
</tr>
<tr>
<td>Desyrel</td>
<td>Trazodone</td>
<td>Antidepressant</td>
<td>Sedation, dizziness, dry mouth, blurred vision, headache</td>
</tr>
<tr>
<td>Dexedrine</td>
<td>Dextroamphetamine</td>
<td>Stimulant (for ADHD)</td>
<td>Difficulty sleeping, feeling irritable or restless, dry mouth, dizziness, loss of appetite, headache, feeling shaky, nausea</td>
</tr>
<tr>
<td>Effexor</td>
<td>Venlafaxine</td>
<td>Antidepressant</td>
<td>Headache, dry mouth, nausea, constipation, drowsiness, nervousness, trouble sleeping</td>
</tr>
<tr>
<td>Elavil</td>
<td>Amitriptyline</td>
<td>Antidepressant</td>
<td>Dry mouth, blurred vision, constipation, sedation, dizziness</td>
</tr>
<tr>
<td>Eskalith CR</td>
<td>Lithobid Lithotab Lithonate</td>
<td>Mood Stabilizer (Antimanic)</td>
<td>Nausea, shakiness and tremor, dry mouth, diarrhea, drowsiness, increased thirst, increased urination With overdose: confusion, slurred speech, seizures, muscle twitching, severe vomiting, coma and death</td>
</tr>
<tr>
<td>Geodon</td>
<td>Ziprasidone</td>
<td>Antipsychotic</td>
<td>Sedation, restlessness, dizziness, constipation, nausea, tremor</td>
</tr>
<tr>
<td>Halcion</td>
<td>Triazolam</td>
<td>Sedative</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>Haldol</td>
<td>Haloperidol</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Invega</td>
<td>Paliperidone</td>
<td>Antipsychotic</td>
<td>Sedation, restlessness, dizziness, nausea, headache</td>
</tr>
<tr>
<td>Klonopin</td>
<td>Clonazepam</td>
<td>Antianxiety, anti-seizure</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>Lamictal</td>
<td>Lamotrigine</td>
<td>Mood Stabilizer, anti-seizure</td>
<td>Dizziness, nausea, diarrhea, headache, blurred vision, drowsiness, incoordination</td>
</tr>
<tr>
<td>Lexapro</td>
<td>Escitalopram</td>
<td>Antidepressant</td>
<td>Sedation, nausea, diarrhea, sweating, dizziness</td>
</tr>
<tr>
<td>Librium</td>
<td>Chlordiazepoxide</td>
<td>Antianxiety</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>Loxitane</td>
<td>Loxapine</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Luvox</td>
<td>Fluvoxamine</td>
<td>Antidepressant</td>
<td>Nausea, nervousness, drowsiness, headache, change in appetite</td>
</tr>
<tr>
<td>Mellaril</td>
<td>Thioridazine</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Brand Name</td>
<td>Generic Name</td>
<td>Class</td>
<td>Side Effects</td>
</tr>
<tr>
<td>------------</td>
<td>--------------</td>
<td>-------</td>
<td>--------------</td>
</tr>
<tr>
<td>Moban</td>
<td>Molindone</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Nardil</td>
<td>Phenelzine</td>
<td>Antidepressant</td>
<td>Dizziness, dry mouth, nausea, shakiness, blurred vision, increased appetite, difficulty sleeping</td>
</tr>
<tr>
<td>Navane</td>
<td>Thiothixene</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Neurontin</td>
<td>Gabapentin</td>
<td>Antianxiety, nerve pain</td>
<td>Dizziness, fatigue, incoordination, drowsiness, tremor</td>
</tr>
<tr>
<td>Norpramin</td>
<td>Desipramine</td>
<td>Antidepressant</td>
<td>Dry mouth, blurred vision, constipation, sedation, dizziness</td>
</tr>
<tr>
<td>Pameler</td>
<td>Nortriptyline</td>
<td>Antidepressant</td>
<td>Dry mouth, blurred vision, constipation, sedation, dizziness</td>
</tr>
<tr>
<td>Paxil</td>
<td>Paroxetine</td>
<td>Antidepressant</td>
<td>Nausea, nervousness, drowsiness, headache, change in appetite</td>
</tr>
<tr>
<td>Prolixin</td>
<td>Fluphenazine</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Prozac</td>
<td>Fluoxetine</td>
<td>Antidepressant</td>
<td>Nausea, nervousness, drowsiness, headache, change in appetite</td>
</tr>
<tr>
<td>Remeron</td>
<td>Mirtazapine</td>
<td>Antidepressant</td>
<td>Sedation, increased appetite, dizziness, nausea, dry mouth, constipation, impaired motor skills</td>
</tr>
<tr>
<td>Restoril</td>
<td>Temazepam</td>
<td>Sedative</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>ReVia</td>
<td>Naltrexone</td>
<td>Alcoholism</td>
<td>Nausea, vomiting, nervousness, dizziness, anxiety, insomnia</td>
</tr>
<tr>
<td>Risperdal</td>
<td>Risperidone</td>
<td>Antipsychotic</td>
<td>Insomnia, anxiety, constipation, some stiffness at higher doses</td>
</tr>
<tr>
<td>Ritalin Concerta</td>
<td>Methylphenidate (for ADHD)</td>
<td>Stimulant</td>
<td>Difficulty sleeping, feeling irritable or restless, dry mouth, dizziness, loss of appetite, headache, feeling shaky, nausea</td>
</tr>
<tr>
<td>Serax</td>
<td>Oxazepam</td>
<td>Antianxiety</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>Seroquel</td>
<td>Quetiapine</td>
<td>Antipsychotic</td>
<td>Sedation, dizziness, constipation, dry mouth, low blood pressure</td>
</tr>
<tr>
<td>Serzone</td>
<td>Nefazodone</td>
<td>Antidepressant</td>
<td>Dizziness, drowsiness, dry mouth, constipation, weakness</td>
</tr>
<tr>
<td>Sinequan</td>
<td>Doxepin</td>
<td>Antidepressant</td>
<td>Dry mouth, blurred vision, constipation, sedation, dizziness</td>
</tr>
<tr>
<td>Strattera</td>
<td>Atomoxetine</td>
<td>For ADHD</td>
<td>Constipation or diarrhea, dizziness, dry mouth, headache, nausea</td>
</tr>
<tr>
<td>Stelazine</td>
<td>Trifluoperazine</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Symbax</td>
<td>Fluoxetine/Olanzapine</td>
<td>Bipolar depression</td>
<td>Drowsiness, dizziness, headache, dry mouth, increased appetite</td>
</tr>
<tr>
<td>Tegretol</td>
<td>Carbamazepine</td>
<td>Mood Stabilizer (Antimanic)</td>
<td>Dizziness or lightheadedness, clumsiness or unsteadiness, nausea, weakness, blurred or double vision, drowsiness</td>
</tr>
<tr>
<td>Tenex</td>
<td>Guanfacine</td>
<td>Impulsive/aggressive behaviors</td>
<td>Drowsiness, dizziness, dry mouth, headache, weakness, constipation</td>
</tr>
<tr>
<td>Thorazine</td>
<td>Chlorpromazine</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Tofranil</td>
<td>Imipramine</td>
<td>Antidepressant</td>
<td>Dry mouth, blurred vision, constipation, sedation, dizziness</td>
</tr>
<tr>
<td>Tranxene</td>
<td>Clorazepate</td>
<td>Antianxiety</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>Trilafon</td>
<td>Perphenazine</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Trileptal</td>
<td>Oxcarbazepine</td>
<td>Mood stabilizer</td>
<td>Dizziness, nausea, tremor, headache, blurred vision, unsteady gait</td>
</tr>
<tr>
<td>Valium</td>
<td>Diazepam</td>
<td>Antianxiety</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>Wellbutrin SR/XL</td>
<td>Bupropion</td>
<td>Antidepressant</td>
<td>Anxiety, trouble sleeping, dry mouth, loss of appetite, headache, constipation, shakiness</td>
</tr>
<tr>
<td>Xanax</td>
<td>Alprazolam</td>
<td>Antianxiety</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>Zoloft</td>
<td>Sertraline</td>
<td>Antidepressant</td>
<td>Nausea, nervousness, drowsiness, headache, change in appetite</td>
</tr>
<tr>
<td>Zyprexa</td>
<td>Olanzapine</td>
<td>Antipsychotic</td>
<td>Sedation, constipation, increased appetite, dizziness, tremor</td>
</tr>
</tbody>
</table>
References


Unit Four: Crisis Intervention and De-escalation

Unit Goal
The goal of this unit is to provide participants with crisis intervention and communication techniques specific to law enforcement for gaining compliance with youth in crisis and using de-escalation skills tailored to youth.

Scope
Participants will learn how to establish rapport and avoid roadblocks while communicating with youth who are in crisis.

Performance Objectives
At the conclusion of the unit, participants will be able to:

- Define a crisis
- Differentiate various methods of gaining compliance before, during, and after a crisis event with youth
- Understand elements of effective communication to prevent and intervene in a crisis, including establishing contact; building rapport; and using calming techniques, reflective statements, and active listening.

Provided Materials
- Handout: Behavioral Change Stairway Model
- Supplement for Trainer: Discussion and Demonstration of De-escalation Techniques

Unit Outline
- Objectives
- Define Crisis and Crisis Intervention
- Triggers for Adolescents
- Crisis Management
  - Crisis Prevention
  - Crisis Intervention / De-escalation
    - Non-verbal Communication
    - Communication
    - Communicating to Change Behavior
  - Crisis Follow-up
- Discussion and Demonstration of De-escalation Techniques
Crisis Intervention and De-escalation

**Time**

- Approximately 2 hours and 30 minutes
Crisis Intervention and De-escalation

Training Aids

Slide 4-1
Crisis Intervention and De-escalation

Content/Instructional Delivery Notes

Explain to participants that the instruction offered in this unit is not the only appropriate response in all situations where the suspect is mentally disturbed or responding emotionally. Rather, it is presented as a viable option for the SRO who, after assessing the ongoing situation, has decided that the preferred course of action in this circumstance is to attempt to get the youth to voluntarily comply with instructions, commands, or requests.

Physical restraint techniques or defensive tactics are not presented in this course. Participants should already be trained on such techniques from other classes. It is assumed that physical restraint techniques will be used when the safety of all individuals involved warrants such techniques.

Stating the following may help some participants "buy in" to this section: "The job of SROs, like other law enforcement positions, is to both serve and protect. What will be covered in this will increase the chance of everyone – SRO, youth, family, and others in the school/community – remaining safe."

Introduce Unit 4 by noting that information discussed in the previous units serves as background for what will be covered next:

- How this information can make SROs more effective, as well as make their job easier, safer, and less stressful
- How SROs' interactions with youth can positively impact youth development and improve public (school) safety

Further preview the unit by explaining, "In this unit, we'll talk about how to intervene to avoid a crisis, how you can de-escalate a crisis as it is happening, and how to decrease the likelihood of a crisis re-occurring. As we do this, I'd like you to think about examples you've encountered in your own work with youth and how the strategies and practical tips we discuss might be used in those examples.

This unit relies heavily on your participation. I'll be asking you to respond to scenarios and help demonstrate some of the things we will be discussing. The interactivity of this unit provides you
Slide 4-2

Objectives
- Define a crisis
- Differentiate methods of gaining compliance
- Review elements of effective communication
  - Establishing contact
  - Building rapport
  - Using calming techniques, reflective statements, and active listening

Slide 4-3

Crisis Defined
A crisis can be defined as “any situation in which a youth’s ability to cope is exceeded”
- Domestic, peer or partner violence
- Substance abuse/intoxication
- Suicide threat or attempt
- Psychiatric emergency
A more accurate definition of crisis is “any situation in which a youth’s perceived ability to cope is exceeded.”

Slide 4-4

Crisis State
- Emotions are ruling, not reason
- Non-verbal communication dominates.
- Safety must come first.

Explore the meaning of crisis. One definition of crisis is “any situation in which a youth’s ability to cope is exceeded.”

"Crisis” is often used to refer to high-risk situations. While it is true that the high-risk situations listed here are likely crisis events, there are many more crisis events that are not necessarily “high risk” or “high profile.”

A more accurate definition of crisis is “any situation in which a youth’s perceived ability to cope is exceeded.”

When youth think they are in crisis, they are.

In responding to a stressful situation, youth in crisis behave on an intense emotional level, rather than a rational/thinking level.
- The stressful situation is perceived to be a threat to the emotional, psychological, and physical needs of youth.
- Emotions, not reason, are controlling the youth’s actions.

an opportunity to practice and apply practical strategies…and we hope you’ll find it fun as well.”

Note to Trainers: It may be especially helpful for a trained SRO to co-present this unit with school staff (optimally, a member of the mental health staff). This will facilitate incorporation of any school policy and procedure guidelines, as well as actual case examples for discussion.
Slide 4-5
Triggers for Adolescents

- Parent's divorce or separation
- Break-up of a relationship
- Suspension or expulsion from school
- Sickness, injury, or death
- Personal or school-related difficulties
- Loss of health
- Victim of bullying
- Getting caught in illegal activity
- Deterioration of mental health

A precipitating event has usually occurred within the last 24-48 hours and normal coping mechanisms have failed to resolve the situation. Ask participants, “What might be some triggers for adolescents?”

Note that “deterioration of mental health” is listed as a trigger, but all of these triggers can result in deterioration of mental health.

Slide 4-7
What You Can Do

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

- Crisis prevention
- Crisis intervention and de-escalation
- Crisis follow-up

A poorly handled crisis can have serious consequences for the SRO, for the youth, and for the school as a whole. Ideal strategies for working with youth incorporate best practice approaches that reflect the highest standard of intervention and have demonstrated effectiveness in crisis prevention, crisis intervention and de-escalation, and crisis follow-up.

Point out to participants that as uncomfortable as crises are, they do present an opportunity for SROs to:

- help youth practice skills they’ve learned elsewhere (e.g., from the SRO, in a class, or during a treatment session)
- walk youth through a healthy response to whatever triggered the crisis

Unit 4 focuses on the three core components of successful crisis management: prevention, intervention/de-escalation, and follow-up. The techniques and strategies associated with the three components are essentially the same; the primary difference between the three is timing. The earlier someone intervenes in a crisis, the greater the opportunity for a safe, successful outcome.

Additionally, a section of Unit 4 is devoted to key strategies for helping youth manage their own behaviors and emotions more effectively.

**Note to Trainers:** Encourage participation by saying, “As we talk about each of these...”
components, I’d like you to think back to crisis situations in which you have been involved. I invite you to share these experiences and how the techniques we review could have been used. As you recall your experiences, remember that we often learn more from our mistakes than we do from situations where everything goes perfectly.”

Introduce the first component: crisis prevention. What can participants do before a crisis begins? Teaching youth skills in advance of a crisis is similar to fixing a roof before it rains. When a storm occurs, strategies for keeping the situation manageable or safe are already in place. The communication, calming, intervening, and modeling that SROs do with youth today can play a critical role in avoiding or managing a crisis in the future.

Crisis prevention allows an opportunity to proact rather than react.

Spontaneous crises are extremely rare. Often, there are behavioral and environmental cues that indicate a crisis is brewing.

**Large group discussion:** Facilitate discussion by asking participants what in their experience has signaled an impending crisis. Some prompts might be:

- “How can you tell if one of your children is upset?”
- “How did your parents know when you were upset as a child or teen?”
- “What changes in behavior do you see?”
- “What happens to the volume of a youth’s voice?”

Unfortunately, some signs and signals are only detected in retrospect. Failing to notice signs can be minimized when SROs:

- Remain alert to their environment
- Stay attuned to any changes in mood, behavior, and expression of youth
- Don’t wait for things to escalate
- Immediately intervene by checking in with youth to gauge their level of upset, disorientation, etc.

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**Slide 4-8, 4-9**

Crisis Prevention

The best time to intervene in a crisis is before it starts.

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**Slide 4-10**

Crisis Prevention Tips

- Be alert to early warning signs:
  - What sorts of things signal a budding crisis?
  - What cues are in the environment?
  - What sort 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?

Being proactive, rather than reactive, can go a long way toward keeping the environment safe for staff and youth.
Alert other staff about what was observed

The better SROs know the youth in their care, the better prepared they will be to intervene in a crisis before it occurs. Being in schools with the same kids day after day is really like community policing on steroids!

SROs should spend time getting to know youth, talking with their teachers, and talking with family members whenever possible. Observing youth as they interact – with peers and in a variety of settings – can provide a tremendous amount of information on what serves as a trigger to youth and what strategies can be used to avert or de-escalate a crisis.

Youth will often act out in response to a lack of structure, inconsistency, and a feeling of vulnerability. Chaotic and volatile environments contribute significantly to situations that can escalate rapidly and dramatically, so managing the environment can go a long way towards averting crises. It is important that youth feel safe.

Ensure that there are clear rules that are consistently enforced. When youth are unclear about the rules or feel that the rules are arbitrarily or inconsistently enforced, they are more likely to exhibit problematic behaviors that can precipitate a crisis. Students’ awareness of predictable daily schedules can greatly contribute to their sense of security.

Adolescents can be very adept at pushing buttons. Testing limits is a hallmark feature of adolescence. SROs must not personalize situations of youth acting out, being disrespectful, or ignoring attempts to interact. It is common for adolescents to act this way just to provoke a negative response from an authority figure. SROs must refrain from overreacting by:

- Remaining calm
- Being firm without yelling
- Setting limits
- Reminding youth of the rule or repeating the request
- Modeling appropriate behavior

Slide 4-11
Crisis Prevention: What You Can Do

- Are youth safe…
  - from other youth?
  - from mistreatment by staff/adults?
  - from hurting themselves?
- Are clear, simple rules posted?
- Is structure provided?
  - Set schedules.
  - Announce changes to schedules when they occur.

Slide 4-12
Crisis Prevention: What You Can Do

- 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.
Often, escalation can be avoided if the SRO or authority figure does not "rise to the bait." When the SRO’s re-directions are successful and the behavior of the youth improves, it is important for the SRO to acknowledge and praise the improvement.

**Note to Trainers:** Be frank in acknowledging that there will be times that attempts at re-direction are unsuccessful. For these instances, suggest to participants that they:

- Pick their battles. Is this a critical issue or a control issue? If not critical, the issue can be revisited in a discussion between youth and the SRO about how the situation could have been handled better.
- Consider the time sensitivity of the matter. Does the task absolutely need to be done right away OR could walking away for 5 minutes prevent escalation?
- Coach youth on using coping or anger management skills they might already know.

Introduce the next component of crisis management by noting that despite all efforts at crisis prevention and early intervention, a crisis may still develop. Describe crisis intervention/de-escalation in terms of achieving equilibrium (a return to a normal state of functioning).

Discuss the benefits of intervening through crisis de-escalation, rather than going “hands-on.” Benefits include:

- Both the youth and the SRO are safer.
- The youth avoids adverse consequences.
- Crisis de-escalation can make the SRO’s job easier (e.g. less paperwork).
- Crisis de-escalation preserves staff time and resources.

Point out to participants that anyone can develop the skills to successfully de-escalate a youth without losing control of one’s self or the situation.

Step one for SROs is to maintain control of themselves. Staying calm as they enter an emotion-
filled crisis will help SROs get the attention and cooperation of the youth.

Maintaining control can be easier said than done. Emotion loves similar emotion, so when you walk into a tense, anxious, or angry situation, these emotions may be present in you, too. Keep yourself in check.

Ask yourself (or the youth if he or she is willing to talk) what he or she wants. Getting the youth to talk is best. You want the crisis to present verbally, not through physical behavior. The more the youth talks, the more likely you will be able to determine what the youth is really reacting to.

The previous point is critical in crisis de-escalation. To change the direction of the stress and tension, the SRO must not escalate with the crisis or get sucked into of the situation. A calm, confident presence is needed to anchor the situation.

Remind participants of the importance of not personalizing situations in which youth overreact, misinterpret, and provoke others. The youth’s behavior may result from a genuine misunderstanding.

Again, de-escalation is an opportunity to model adaptive behaviors and practice developing skills.

Specific skills to model are presented in the following slides.

Introduce the next section on nonverbal communication: “Communication is not just what you say; it’s also how you say something and what you communicate nonverbally. This is especially true in crisis de-escalation. Let’s talk about the power of nonverbal communication and how you can use it to help you in your work.”

**Demonstration:** Ask for a volunteer from the audience. (If no one volunteers, invite someone from the audience or enlist a co-presenter).

Ask the volunteer, “Using just your body (and no words) how might you communicate….

- anger at me or about something I was saying?”

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**Slide 4-15**
**What You Can Do**
- Be aware of your own feelings.
  - Some youth just want to push others’ buttons and get them to react emotionally.
- Be aware of your own posture, voice, and tone.

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**Slide 4-16**
**Starting Point: 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
- anxiety or nervousness about something I was saying?"
- empathy or understanding when I am feeling sad or afraid?"

Thank the volunteer and ask participants for other examples of communication through body language. Ideally, participants will generate one or two examples of their own to share and demonstrate.

Ask participants, “When verbal communication and nonverbal communication conflict, which carries more weight?” Demonstrate the following examples:

- Do you believe a person who is yelling, “I AM NOT MAD?” [Demonstrate by yelling.]
- Do you believe a person who says “I’m listening,” but who is not looking at you and appears distracted? [Demonstrate what this looks like.]

It is always beneficial for SROs to be aware of both verbal and nonverbal communication conveyed by youth. On the flip side, youth will also be weighing the authority figure’s verbal and nonverbal communication.

Nonverbal communication can provide vital cues to what youth are thinking and feeling, which may be particularly useful to an SRO who is choosing an intervention approach most likely to be successful during de-escalation.

The meaning of verbal communication can be dramatically changed by volume, speed and tone.

Share some examples with participants:

**Demonstration:** “Who left this book here?”
- How would you say this if you meant it as an accusation?
- How would you say this if you meant it to be helpful?

**Demonstration:** “May I help you?”
- How would you say this if you genuinely wanted to be helpful?

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**Slide 4-17**

Starting Point – Verbal Communication

The same phrase can communicate totally different meanings depending on volume, tone, and speed.
### Slide 4-18

**Tips for Communicating with Youth**

- Use simple, direct, age-appropriate language.
- Address youth at eye level.
- Explain your role. (You're there to help.)
- Don't make promises you can't keep. (Be honest.)
- Remove upsetting influences from the scene.

### Slide 4-19

**Initial Approach**

- If practical, monitor youth’s behavior prior to approaching him or her.
- Assume a calm, non-threatening manner.

- How would you say this if you discovered someone somewhere he or she was not supposed to be?

  **Demonstration:** “Have a nice day.”

- How would you say this if you were annoyed at the other person?

- How would you say this if you were sincere?

  Ask participants, “What do these inflections in volume, speed, and tone mean for you on the job and in the heat of a crisis?”

Reinforce that it IS possible to set a firm limit with youth in a way that communicates concern for their safety and compassion. The focus of this unit now moves from general points about communication to strategies for changing or de-escalating behavior.

These guidelines apply to communicating with all youth, but take into account the child's age when choosing appropriate language.

**Large group discussion:** Facilitate discussion by asking, “How do you communicate differently with a 7-year-old child than with a 17-year-old teen?”

Follow discussion with a review of the slide, pointing out the following:

- Don’t necessarily assume that a SRO is a welcome presence. Some groups are suspicious of law enforcement, and the youth may have had previous interactions with police that went poorly.
- Younger children may be afraid of being taken away and being locked up.
- Provide the youth with an opportunity for a face-saving resolution. More importantly, take away any social pressure to behave in a negative way. In other words, “remove the audience.”

Obviously it is only possible to monitor behavior if the youth is not engaging in high-risk behaviors. If possible, SROs should spend a moment observing the youth and gathering impressions. The SRO's calm manner will set the tone for the interaction.

Depending on the state of the youth, allowing greater personal space may be necessary, at least
Consider personal space issues.
- Introduce yourself.

Initially. Consider, for example, a teen-aged boy who is in crisis over being inappropriately touched by a trusted adult. The boy presents as being “in shock” and emotionally numb. He is quietly recounting the events leading up to the traumatic encounter. When the SRO comes within eight feet of the boy, he rapidly becomes agitated and angrily tells the SRO, “Back off! Give me some space.” When the SRO complies, the boy’s agitation level decreases and he continues to talk about the traumatic encounter. The SRO has not only made a concession to the boy (i.e., the officer is giving the boy extra space to help him feel safe and less pressured), but has also increased the reactionary gap, which promotes the officer’s safety.

If, on the other hand, the SRO doesn’t back off, the boy’s agitation may rapidly escalate. The entire crisis may then center on him feeling pressured and needing space.

Remind participants that youth may not realize that the SRO is there to help, so a clear introduction is important. This slide presents a couple of ways of doing this.

Introduce active listening as the next topic of training.

SROs who have been trained in crisis negotiation may recognize this “Behavioral Change Stairway” as it was developed by the FBI’s Crisis Negotiation Unit and is often used in teaching crisis negotiation. (For more information about the Behavioral Change Stairway, refer participants to the Association for Conflict Resolution’s newsletter article provided at the end of this unit.)

Active listening is the starting point to changing behavior. Using active listening skills, such as empathy, facilitates rapport. This leads the youth to begin to trust the SRO. At this point, the SRO
begins to have some influence over the youth that can lead to behavior change.

Remind participants that it can take some time to “climb the stairs.”

Active listening is a skill gained through concentration and practice. During a crisis, it is especially easy to hear but not listen because there are so many distracting factors. The irony is that during a crisis is when it is most critical to listen closely with engagement, compassion, and understanding.

The core feature of a successful intervention is helping youth put words to feelings instead of putting feelings into action. Like adults, youth will be reluctant to talk if they don’t sense that someone is listening. Indications of active listening occur both verbally and nonverbally.

Discuss barriers to active listening.

Avoid creating a conflict.
- Avoid: “You just don’t know the facts here.”
- Instead say: “I am not clear on what led up to this” or “Can you help me understand what led up to this situation?”

Avoid criticizing or making the youth feel worse.
- Avoid: “If you didn’t have such a big mouth, this sort of thing wouldn’t happen.”
- Instead say: “Sounds like the words you chose to use really angered those other students.”

Avoid jumping to conclusions. Don’t tell the youth what you think the problem is.
- Avoid: “You know, I think you are depressed” or “I think you are making too big of a deal about this.”
- Instead say: “Tell me more about what you are feeling” or “Can you think of anything you might change about how you are handling this so far?”

Avoid pacifying or belittling the situation.
- Avoid: “You know, things aren’t really all that bad.”
- Instead say: “Sounds like things are really rough right now if I understand you correctly.”
Avoid derailing. Don’t change the subject too abruptly, unless there is a clear reason to distract the youth.

- Avoid: “Gee, that’s too bad. By the way, weren’t we just out here last week?”
- Instead say: “Do you remember the similar situation we discussed last week? Would any of the ways we dealt with that apply here?”

Avoid name calling or “labeling” the person/behavior.

- Avoid: “Someone would have to be crazy to think of doing that.”
- Instead say: “Tell me more about what was going on when you decided to do that.”

Avoid ordering. Using an authoritative approach early on may create more resistance.

- Avoid: “Just do what I am telling you…”
- Instead say: “What options do you see for handling this as well as you can right now?” or “Please, sit down so we can discuss this together and figure things out.”

Youth in crisis (especially younger ages) often don’t know the answer to “why?” questions. Asking “what” or “how” questions will be more helpful.

Review features of active listening, using the following suggested talking points:

- Communicate you are listening and understanding by repeating (not echoing) what is being said. Use different words and be aware of not sounding patronizing. You might say something like, “Melissa, what I’m hearing you say is that when your mother told you she couldn’t pick you up from the nurses’ station, you felt angry and rejected by her.” “What I am hearing you say” is the key phrase. It affords Melissa the opportunity to correct or agree with you. You can use either of her responses to keep the communication going.

- As you are listening, think back to what was discussed in previous units about adolescent development, mental health, substance abuse, and childhood trauma. Using this information, label (but don’t diagnose) feelings. Think about
the difference between these two statements: “You sound sad” versus “You sound depressed.” Avoid clinical jargon or terminology. Find simple, uncomplicated labels to correspond to the emotions you see and hear.

- Encourage youth to express their thoughts. As noted earlier, the core feature of a successful intervention is helping youth put words to feelings instead of putting feelings into action.

- If you hear something positive, highlight it and praise it. De-escalation doesn't have to be an entirely negative and unpleasant experience. In fact, if you maintain acute awareness of your feelings and attend to verbal and nonverbal communication, the experience can be a valuable learning opportunity for youth. They may walk away feeling more positive about themselves.

- Always summarize what you heard. When the crisis is over, repeat what you heard and the feelings you labeled. A brief summary will bring closure to the crisis and send a signal to youth that the crisis is now behind them. Remember, de-escalation is not a substitute for having consistent limits that are enforced. De-escalation can help youth avoid the most adverse consequences of acting out, while maintaining safety for everyone.

Describe the difference between empathy and sympathy.

- Empathy implies understanding of another’s feelings and thereby builds rapport and trust.
- Sympathy implies pity.

It is important to distinguish between these two feelings. People who can make clear statements of feeling (those with empathy) are in a better position to solve problems.

Provide examples of how to let youth know which emotion is being conveyed:

- “This situation seems to have really made you mad.”
- “It sounds like this is very frustrating to you.”
- You seem to be confused about what to do.”
Large group discussion: Facilitate a brief (2-3 minutes) discussion about the de-escalation techniques discussed (initial approach, active listening, etc.) by asking:

- Have you used these techniques before?
- How do you think the youth with whom you work will respond?
- What seems most difficult?
- Is anyone skeptical about these techniques? Why?
- What seems most challenging?

SROs must try to set the stage for productive communication, and opening statements can set the tone for an entire interaction. If the youth appears to be willing to communicate, an open-ended inquiry can elicit more information by providing an opportunity for a narrative response.

If the youth appears “shut-down,” closed-ended questions (e.g., questions that can be answered with a curt “yes” or “no”) may be effective in opening the lines of communication, but the SRO should switch to open-ended questions as soon as possible.

Describe open-ended questions: “You may recall from interrogation training courses that open-ended questions allow the other person to do more of the talking. The more talking he or she does, the more information you have to formulate your decisions.”

Ask participants for examples of open-ended questions. If none are forthcoming, provide examples, such as:

- “Sarah, what led up to this?”
- “Jim, how did this all start?”
- “Sam, what happened in gym class this morning?”
- “Tell me what happened here.”

Setting the stage for productive communication and a good exchange is especially challenging if youth is engaging in high-risk behavior since initial tone needs to be directive, with specific instructions.

Slide 4-25
Establishing a Dialogue
- Use open- and closed-ended probes.
- Ask clarifying questions.
- Use “I” messages.

Slide 4-26
Open-Ended Questions
Allow the other person to do more of the talking.
Slide 4-27
Questions and Statements
- Express empathy
- Establish rapport
- Initiate dialogue

Clarifying questions help express empathy, establish rapport, and initiate dialogue.

Examples of clarifying questions are:
- “You sound angry. Can you help me understand what is going on here?”
- “You look really upset, I would appreciate it if you can help me figure out why.”

Slide 4-28
“\textbf{I}” messages...
- ... are a way of saying how you feel without accusing or blaming anyone
- ... can help de-escalate conflicts and facilitate constructive dialogue

“I” messages can lessen feelings of accusation and blame. Recipients of “I” messages are less likely to feel like they are being told how to think or feel. To avoid a retort of “You don’t know me; you just met me,” it is better to state “I believe,” rather than “I know.”

Examples of “\textbf{I}” messages:
- “Jim, when you say you are going to kill yourself, I get concerned because I believe that’s not the only way you can handle this.”
- “Sarah, when you say that you will think about what we have been talking about, I feel relieved because I believe you are a strong person.”

Role play: Ask for three volunteers to participate in a role play in front of the room.

Volunteer 1: A student who is extremely angry at the custodian who caught him/her defacing school property with hate-crime graffiti.

Volunteer 2: The custodian who reacts to the student’s anger with additional unfounded accusations.

Volunteer 3: The responding SRO who uses “\textbf{I}” messages to defuse the situation.

Explain that when a listener is able to reflect the speaker’s feelings, the listener is perceived as being empathetic and understanding.

- “You sound angry.”
- “You seem really excited.”
- “I hear you saying how frustrated you feel.”

Slide 4-29
Empathy and Rapport
- Reflecting feelings by labeling/identifying emotion
  - “You sound...”
- “You seem...“
- “I hear...“

- Paraphrasing or mirroring:
  - Capturing the “gist” of the message
  - Putting meaning of youth’s words into your own words

**Slide 4-30**

**Listen for the Hook**

- I am trying. I wish my teachers would just get off my back.
- That’s a stupid rule!
- I can’t do that. What would my friends think?!?
- I just don’t like the way they comment about how I dress.
- This sucks. I don’t see what good talking about it now is going to do.

**TIP:** If words fail you, start the dialogue with, “You sound upset.”

Describe paraphrasing as a strategy for putting the youth’s story and emotions in your own words. Provide an example of paraphrasing, such as:

- “Let me make sure I understand what you’re saying. It seems... (in your own words).”

Introduce next activity: “You don’t want to miss a chance to accurately reflect what is being said. Let’s practice with a few statements that you may hear from youth. How will you respond reflectively so that the youth feels heard?”

**Large group activity:** Read the statements on the slide, pausing after each to allow participants to offer reflective statements. Possible responses include:

Youth: “I am trying. I wish my teachers would just get off my back.”

  **SRO:** “It sounds frustrating to have someone looking over your shoulder.”

Youth: “That’s a stupid rule!”

  **SRO:** “You sound pretty angry right now.”

Youth: “I can’t do that. What would my friends think?!?”

  **SRO:** “Sounds like you are struggling with how to handle your friends’ reaction if you changed.”

Youth: “I just don’t like the way they comment about how I dress.”

  **SRO:** “I hear that you are pretty annoyed with your friends.”

Youth: “This sucks. I don’t see what good talking about it is going to do now.”

  **SRO:** “It sounds like you are feeling stuck and not sure how things might turn out.”

If participants are at a loss for an appropriate response, point out that “You sound upset” is usually a fitting response.
Activity: Closed-Ended Versus Open-Ended Questions

Closed-ended question
SRO: Are you having a bad day?
Student: Yes.

Open-ended question:
SRO: What made your day go so badly?
Student: It started when I missed the bus to school and couldn’t catch a ride right away. That got me detention for being late.
SRO: That is a rough start. Being late can throw your whole day off.

Influence: Slow Down

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

TIP: The passage of time, above any other intervention, tends to de-escalate crisis.

Revisit the difference between closed-ended and open-ended questions and the value of reflection.

Point out to participants that one of the hallmarks of crisis intervention is that SROs “slow down” to spend more time when warranted. Rushing through an intervention with a youth will likely escalate the situation, which then takes more time to resolve.

Given that youth are impulsive and often fail to consider consequences, slowing things down can be very advantageous because it can help disperse the false sense of urgency that may arise during a crisis.

Strategies for slowing things down include:

- Encouraging youth to talk about what they are feeling: simply listening without judgment and accepting the youth’s experience without expressing one’s own opinion can make a tremendous difference in a youth’s life.
- Coaching youth in problem-solving and thinking through options: Avoid quickly telling youth what to do. However obvious the proper course of action is to the SRO, it may be rejected by youth until they feel properly heard.
- Encouraging youth to consider and weigh consequences
- Practicing Stop, Talk, Wait, then Act
- Acknowledging and praising positive responses

SROs should first attempt to connect with youth by being empathetic. However, it may be necessary to
- Be empathetic.
- Use modeling.
  - Attempt to calm youth by displaying own calmness.
  - Speak slowly and evenly.
- Provide actual techniques for calming down.
- Avoid saying “relax” or “calm down.”
- Reassure
  - Calm the agitated youth by acknowledging his/her fears. Assure safety.
- Allow venting
  - Attempt to calm an agitated youth by encouraging communication. Allow him/her to unload, but don’t get so caught up that you forget to work on solving the problem.

help a youth calm down with specific techniques, such as suggesting that he or she:

- Takes a breath
- Tries to sit or stop moving for a moment
- Puts his/her hands in his/her lap and stops speaking just for a moment
- Makes his/her voice as quiet as the SRO’s voice

Remind participants that telling someone in an agitated state to “relax” or “calm down” may escalate the situation, but asking someone to “slow down” can be helpful.

Remind participants that youth often vent for long periods because they are convinced that adults are not listening. Youth feel that they need to say the same thing several times before they will be heard. Paraphrasing, reflecting, and summarizing have already been discussed as strategies for signaling that youth have been heard.

It is also important to watch for signs for whether the venting (or “unloading”) is being helpful. Signs to watch for include:

- The youth seems to be listening to the SRO.
- The youth is slowing down (arms and legs are moving less, breathing is slowing).

The youth is maintaining eye contact without being threatening.

Let the youth talk without interruptions
Do not talk about your own opinions
Listen without judging
Don’t talk as if the youth is not there
Asking “why?” is rarely productive
Its important to acknowledge feelings

Remind SROs that there is a high likelihood that they or their colleagues will interact with this youth again. How this interaction proceeds will influence the next one. The youth will remember what occurred during this interaction, so no promises that can’t be delivered should be made.
**Unit 4**

Crisis Intervention and De-escalation

- Don’t feed into delusions
- Negotiate/provide choices when possible.
- Help both sides get needs met.
- Increase sense of control and safety.
- Be open to a modified version of choices.
  - “I can’t do that; here is another option.”

**Large group discussion:** Facilitate discussion by asking how it is possible to reflect on statements of delusion without reinforcing them. Provide an example of both what to avoid and what to use:

- Don’t feed into delusions: “Yes, I do think that someone is bugging your room” is not appropriate.
- Do express empathy: “I’m sure that feels like a real intrusion into your privacy.”

Continue reviewing slide, being sure to point out that providing limited, appropriate choices when possible can provide youth a sense of control. (“I need you to move from there. You can go over there by the table or over there…”).

**Slide 4-36**

**Role Play**

- What can you tell me about your best day at work ever?
- What made your most memorable birthday so special?
- Tell me about a special recognition you received.

**Partner activity:** Ask participants to pair up with one another. Provide direction for the upcoming activity: “We are going to work on open-ended questions and reflection. One of you will pose an open-ended question to your partner. You will listen to your partner’s response and simply reflect back what you hear. Do not ask your partner another question. Your goal is to make sure your partner knows you heard what he/she said without jumping to another question.”

- What can you tell me about your best day at work ever?
- What made your most memorable birthday so special?
- Tell me about a special recognition you received.

Allow 2-3 minutes for the first round of questioning/reflecting before generating feedback by asking, “Without revealing your partner’s response, will someone share the reflective statement you offered?” Ask the respective partner if that reflection was accurate.

Ask participants to swap roles and repeat the exercise, perhaps using a different question.

At the end of the exercise, facilitate discussion by asking, “Did you feel like your partner was listening to you and that your message was heard? How did you know?”
Frustrated & Emotionally Distraught: Approach

- Identify yourself and purpose of your contact.
- Listen.
- Acknowledge the youth’s frustration.
- Be empathic (reflect feelings).
- Let the youth vent.
- Provide support and alternatives.
- After rapport develops, offer suggestions for the youth to regain internal control.

Hostile/Aggressive Behavior: Approach

- Identify yourself and purpose of your contact.
- Isolate.
- Listen.
- Be empathetic (reflect feelings).
- If youth is unresponsive, set limits and provide alternatives.
- Maintain appropriate eye contact.
- State directives firmly.
- Be ready to be friendly if behavior changes.
- Use diversions.

Role play: To practice what has been learned thus far, volunteers will be asked to act out two role plays involving youth in crisis. The first requires three volunteers:

Volunteer 1: A 14-year-old girl who is pacing and wringing her hands. When not crying or screaming, she says, “Everyone hates me. They’re all texting nasty things about me. Nobody wants me at their lunch table.”

Volunteer 2: The teacher who has been trying for an hour to work with the girl

Volunteer 3: The SRO who has been called for assistance

Volunteers should demonstrate how emotions, behaviors, and verbalizations can quickly change within a short amount of time. Typical emotions vary from depression to anger to anxiety.

Facilitate discussion by asking what went well in the role play and what could be improved. Conclude activity by reviewing the approach suggested on the slide.

Role play: The second role play depicts hostile and aggressive behavior, including physical aggression, verbal aggression, and vandalism. It calls for 3-4 volunteers:

Volunteer 1: A 15-year-old boy who shoves a peer against a wall. When the teacher intervenes, the boy walks away from the peer and kicks a desk, leaving it turned over and dented. The boy swears at his teacher and says, “I’ll get his ass sooner or later.”

Volunteer 2: The teacher who intervenes

Volunteer 3: The responding SRO

Volunteer 4 (optional): The peer who instigates the situation by saying to the 15-year-old, “You smell as bad as your girlfriend’s breath when she tried to kiss me last night.” This peer frequently teases others and is a class clown.
Refer to the approach suggested on the slide. Is it consistent with what occurred in the role play? If not, is there a good rationale for any variation?

If necessary, review each item in greater detail:

- **Isolate** – Do not allow the youth to grandstand in front of others. Bring the youth aside (if possible) or remove audience.
- **Listen/be empathetic** – Remind SROs that it may take some time for the empathetic approach (“I hear how angry you are about that”) to have an impact.
- **Set limits/provide alternatives** – “I am asking you not to kick anything else. Let’s sit down over here away from all this stuff and talk.”
- **State directives firmly** – “I need you to sit right here with me for a few minutes and just talk to me.”
- **Use diversions** – To break the tone, inquire about the surroundings, ask the youth to sit down, etc.

Be sure that participant discussion includes the following points:

- As always, safety is paramount. Only a minimal amount of physical aggression can be tolerated prior to intervention. However, verbal aggression can be defused.
- A youth’s ability to remain calm is largely determined by the level of calm shown by adults in charge. Authority is not derived from being loud and aggressive. On the contrary, the SROs must remain calm because aggressive youth will often escalate to the level of intensity displayed by others, if for no other reason than to “save face.” If the SRO doesn’t escalate as youth expect, youth need to watch and listen to see what will happen next. This gives everyone a moment to catch their breath, so that safe interventions can follow.
- Youth cannot engage in problem solving until they have their bodies under control.

Substance abuse-induced behavior can look similar to the behavior exhibited by frustrated/emotionally
Substance-Induced Behavior
May have rapidly cycling emotions or maintain either an agitated or despondent state

**Approach**
- Be cautious. There is potential for impulsive acts and violence.
- Set firm limits.
- Listen, be empathic, and offer alternatives.

**Slide 4-42**
Suicidal Thoughts and/or Behavior: Approach
- Inquire directly.
- Get specifics.
- Be empathic.
- Think together about alternatives.
- Instill hope.

As mentioned in the last unit on disorders, youth experiencing depression (among others) may have suicidal thoughts. Suicide is the second leading cause of death among adolescents, but some very young children also have thoughts of killing themselves and have even made attempts to do so.

Remind participants that asking youth if they feel like hurting or killing themselves does not prompt them to start feeling that way. In fact, asking this question actually conveys to youth that someone understands how much distress they are feeling. Youth need to be reminded that the pain they are experiencing will not last forever. Death, however, is forever.

Although sometimes anxiety-provoking for SROs, it is important to allow youth to talk about all of their thoughts and feelings. Only after some rapport is established will youth be receptive to the help of authority figures in thinking about alternatives.

**Slide 4-43**
Obtaining Collateral Information from Teachers, Family, or School Staff
Interview others to determine:
- History/severity of problem
- History of mental health care
- Interventions
- Medical problems
- Medications
- Available supports/resources
- Ability to keep youth safe

When reviewing this slide, point out to participants that it is not always possible to obtain every last piece of information, but the more information gathered, the greater likelihood of an effective and safe intervention.

Encourage participants to dig as deep as legally possible when obtaining information. For example, when asking about previous treatment for a psychiatric disorder, it is important to know if the youth is still receiving services, but it also may be instructive to obtain the name of the providing counselor and agency.
Other Considerations in Working with Family and Staff

- Treat other adults as part of the solution. *Working together will increase compliance.*
- Be observant of relationship indicators. *Strategize interventions with this in mind.*
- Be aware that staff and family may have increased expectations of law enforcement and law enforcement interventions.

Introduce the idea of working in partnership with family members and service providers who engage with the youth. SROs should observe (but not necessarily comment on) the interactions between these connections and the youth.

It may help to ask provider staff or family what they expect from the involvement of an SRO. This may provide an opportunity for SROs to clarify their role, what might be possible, etc.

For example, a distraught teacher out of exasperation might comment that she wants the SRO to put the youth in jail to “teach that kid a lesson,” even though no crime was committed. In such situations, the SRO should be empathetic toward the teacher, but explain that that course of action is not an option.

Intervention / De-escalation Summary

- Use active listening techniques to develop rapport.
- Reflect feelings/be empathic.
- Be consistent/firm.
- Use calming/soothing techniques.
- Problem solve.

Summarize the section on intervention/de-escalation by noting that active listening techniques are critical to the process. Refer participants to the Association for Conflict Resolution’s newsletter (provided at the end of this unit) that discusses the communication techniques and active listening skills covered in this unit.

What You Can Do When a Crisis Escalates

Unfortunately, some incidents will still escalate to a crisis.

- Safety is the primary concern.
- Follow departmental or institutional policies regarding progressive levels of intervention, as well as physical and mechanical restraint.
- Always follow up with other staff and youth after an incident.

Despite best efforts toward prevention and de-escalation, a crisis sometimes develops. The first priority, of course, is to maintain safety of the youth, staff, and others in the classroom and school. Always follow institutional policies and practices. As in de-escalation, it is often helpful to remove the audience as a step toward restoring calm.

In managing the crisis, SROs should consider whether the youth is responding to some form of mental health, trauma-related, or family issue. Attempting to identify the root cause of the crisis can provide valuable clues to how to best intervene.

SROs should be aware of their own anger, anxiety, and fear so that it doesn't negatively impact their actions. Throughout the crisis, they are modeling appropriate behavior and response techniques to youth and to provider staff. The coping skills SROs
Crisis Intervention and De-escalation

Slide 4-47
Crisis Follow-up: Learning New Skills

- Youth are not going to learn new behaviors in the middle of the crisis.
- But, youth may learn from their mistakes after they have calmed down and with the SRO’s or other staff member’s help.
- Otherwise, youth may keep repeating the same violent, unsuccessful behaviors.
- SROs should follow up with youth after the crisis.

Introduce the final component of crisis management (follow-up) by rhetorically asking, “After calm has been restored, what can you do to connect back to the skill building and modeling you have already been doing?”

Point out that what SROs do AFTER a crisis is just as important as what they do during a crisis. Failing to follow-up with a youth and talk about the event is a missed opportunity to practice the skills that youth have been learning.

In their review of the incident with the youth, SROs should:

- Include a “freeze frame” (e.g. stop and look at specific components of the crisis to discuss what other options might have been considered) to focus on key decision points and identify alternative responses.
- Review anger management and coping skills practiced in the past. Remember, change takes time and these skills may be very new to the youth. Patience and support will be necessary for the youth to master these new skills. Repetition, practice, coaching, and feedback will be necessary for these skills to become natural responses for the youth.
- Find something the youth did well or did better than he/she did in the past. Acknowledge progress and praise it. Highlight any attempts by the youth to use a skill he/she has been working on.

Slide 4-48
The Calm After the Storm

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

Helping youth talk about the crisis and what led up to it is an important follow-up component. Again, active listening skills will be key to encouraging youth to identify the trigger or triggers to the crisis. Being empathic and supportive does not mean minimizing or excusing inappropriate behavior. It does mean listening with understanding and using the opportunity to teach, rather than just punish.

During crisis follow-up, SROs should remember to express support and understanding and look for signs of youth’s progress. Crisis follow-up efforts...
• Express caring and offer support.
• Catch youth doing something right.

will go a long way to averting or reducing another crisis.

Conclude the unit with a final activity. Introduce it by stating, “To conclude this unit, we will demonstrate and practice the de-escalation skills that have been presented.” Provide activity direction to the participants.

**Note to Trainers:** Details on conducting this activity are presented at the end of the unit.
Materials: Discussion and Demonstration of De-escalation Techniques

Discussing and demonstrating the de-escalation skills that have been presented to class participants allows for enhanced skill development. Trainers should help the group analyze and discuss de-escalation skills via the situations provided and then work with the group to demonstrate via role plays. This provides participants opportunities to provide examples of active listening skills, de-escalation methods, and SRO safety tactics.

INSTRUCTIONS
If time permits, break the class into teams to problem-solve each situation and present their recommended responses to the large group. (If there are time constraints, examine one situation as a large group.) Each situation has elements of communication and de-escalation skills, problem solving, SRO safety, and use of resources imbedded in the potential responses. Facilitate discussion amongst the groups regarding how and why each type of response was conducted.

Situation #1
A student running down the school hall tells you, the SRO, that the teacher is crying and Debra is out of control in the classroom. You respond to the classroom and find the teacher tearful at her desk while Debra, a 13-year-old student, is standing on the chair at her desk. Debra is screaming that the teacher is having sex with students and videotaping it and that the students are all actors in her next film. Debra screams that no one is real and they must all stop talking. Someone has broken the cubbies in the room; papers, boots, and backpacks are strewn about the area. The kids in the classroom have mixed reactions: some are fearful, some are laughing, and some are quietly watching. Two girls are trying to get out of the room by sliding along the wall while Debra’s back is turned.

Useful Information
- Debra is known to be on some kind of medication.
- Debra has been transferred twice in the district due to disruptive behavior.
- Debra’s parents have filed a suit against the school, believing that their daughter has been mistreated by school personnel and the SRO.
- The teacher has a history of depression. She shared this information with you during a disturbance in her class last year.
- The principal has been notified and is expected to respond; however, she has not arrived yet.
- The former SRO was criticized in the past by school staff and parents for being “too aggressive” in a crisis situation which was investigated and found. You are newly assigned to this school.

General Questions
1. What is your first priority?
2. How do you approach the room?
3. What kind of communication will be most effective with each of the identified parties?
4. What kind of resources might you offer?
5. What other concerns do you have to weigh as you respond to this situation?

**Situation #2**

A call comes in that a large group of kids is hanging out on a distant field of the school campus during lunch. The reporting teacher states that the kids are loud and huddled together. There seems to be a commotion in the center of the group that has their attention. The reporting teacher can also hear someone, probably a girl, screaming.

When you arrive on scene, you observe a group of boys standing in a circle. The group of boys are shouting and encouraging two boys to fight. The two are in each other’s faces, challenging each other with fist clinched. One of the few girls present is screaming at one of two boys to stop and leave the other alone.

One boy watches you intently and seems to want to talk to you. Another female, perhaps age 14 or 15, is walking in circles. She is nervously repeating, “My god, please stop him.”

**Useful Information**

- This field is known for after-school fights, as well as drug sales and use.
- Some of these boys belong to a local gang. They have been known to have been caught with knives and homemade weapons on campus.
- One of the boys threatening to fight is a well-known athlete at the school. The other is a member of a loosely organized gang. He has been in fights before on campus and typically ends up in the local alternative school before the school year reaches midway.

**General Questions**

1. What is your first priority?
2. How do you approach the group?
3. What kind of communication will be most effective with each of the identified parties?
4. What kind of problem solving might you offer?
Demonstration / Role-Play Script

INSTRUCTIONS
If time permits, demonstration/role-play seem to fit very well with how most law enforcement training is formatted (i.e. hands-on skills demonstration). You will need to ask for volunteers and or assign roles listed below. The role-plays have a general setting described that should afford opportunities to show communication and de-escalation skills, problem solving, and SRO safety. You may want to focus on active listening as the first point of engagement and then the basics of stopping/slowing the situation, getting the youth's attention, talking, and problem solving. To begin the role play, read the backstory to the class while your actors familiarize themselves with the assigned role-play variation and then come out and act it out (This does not have to be read to the class. The point is to act out what is described.). Facilitate a discussion by the group pointing out the good things observed and any recommendations for improvement. NOTE: SROs involved in the role play MUST NOT have any weapons in their possession during the role play. This is for safety during the role play and to avoid any “automatic” reactions that may result in them inadvertently pulling their weapon.

Title: Break-up

Personnel: 1 SRO, 1 student, 1 coach (possibly the trainer to also act as role play coordinator)

Props: Backpack with scissors in pocket

Information/Back Story
Subject is 15-17 years old. Subject stated to a friend that “life isn’t worth living,” that it is “not worth all the hassles.” Subject also reportedly brought a knife to school, per friend’s report. The coach received the information during the first-hour class and called the SRO immediately because the youth had left the class. The coach wasn’t sure what else to do.

Role-play Variation 1: Subject is a female youth who is only minimally cooperative with an interview initially. She answers inquiries in sarcastic tones, but responds well to empathy. She eventually admits that a break-up with her boyfriend precipitated the current crisis. This was her first “true love” and she can’t envision life without him. When asked, she denies having brought a knife to school, but glances briefly at her backpack. When the SRO searches the girl’s backpack and discovers a pair of scissors, the youth claims it was for an art project. When asked, the girl admits to taking 5-6 pills the night before (after the break-up) and superficially cutting her wrists.

Role-play Variation 2: Subject is a young male who presents similarly to the female subject described above. He admits that his true love told him she doesn’t want to see him anymore. He reports he is not sure why she broke up with him; they did not have a fight. Subject denies having brought a knife to school. He admits that he brought scissors, but is unclear about why he did that.

Role-play Variation 3: As described in variation 1 and 2 above, but the backpack is filled with personal items that appear to be of both sentimental and monetary value. For example, the female’s backpack has several pieces of jewelry and an MP3 player. Male’s backpack has an autographed football or baseball and other ‘collectibles.’ The point here is that subject was planning to give personal items away to others, an obvious sign that suicide was contemplated. The SRO who discovers these items should ask about them.
For Mediators and Arbitrators - In This Corner:
Behavioral Change Stairway Model
by Jeff Thompson, Lynne Kinnucan

Crisis Negotiator Blog by Jeff Thompson

“What is destroyed most in high tension situations is trust, and without trust, things will break down very quickly. When they do, they are replaced by increased anxiety and confusion, destroying the participants’ ability to make good, long-term decisions. It is the negotiator’s presence that keeps the trust intact.” - Michael Tsur, International High-Risk Negotiator

IN THIS CORNER | November 2013
Guest blog by Lynne Kinnucan, Co-Chair ACR Crisis Negotiation Section

An essential part of being a good negotiator, yet the perhaps the part hardest to define, is the quality of “presence”, that attitude of being entirely focused, quietly patient, and flexible enough to be creative in one’s responses to quickly shifting situations.

It is the opposite of rushing in to fix a situation. One negotiator learned this on the job when he began the process by trying to solve the issue right away. He stopped when the subject yelled, “What are you *talking* about?!”

An analysis by the team showed that the negotiator had some great ideas, alright: he just wasn’t in tune with the person. The subject was still in the attunement stage -- so named by Dr. Mitchell Hammer, author of “Saving Lives” -- while the negotiator had jumped immediately to problem-solving. He failed to connect with the subject; rather than being fully present with him, he jumped in full of his own ideas.

“You have to get into their head and wander around there with them,” says retired FBI negotiator Greg Vecchi. You need to be their best friend, the one who “gets it”. Or, as author Kurt Vonnegut wrote: “Only connect.”

How do you get this to happen? How do you attain this quality of presence?

There are tools to set the stage for it: how to develop a theme; how to use delaying tactics; how to influence surrender -- all and more are critical structures, essential to the success of the negotiation. But the fundamental tool is the Behavioral Change Stairway, that series of five steps that take the negotiator from listening to influencing behavior. It is worth noting that the first three steps of the stairway are devoted not to problem-solving, but to connecting with the subject.

Why is this open-mindedness, this curiosity, this flexibility so important? Things can change within a nano-second, says Michael Tsur, an international high-risk negotiator, so a negotiator must be able to keep his emotional and mental balance. Or as Mark Gerzon puts it, “The whole idea of presence is that key information is made available only in ‘this’ moment. It is the living moment that controls the solution.”

The negotiator must alert enough to spot this and flexible enough to go with the sudden twists and turns, to be able to respond creatively as they happen.

No matter what field of negotiation you are involved in, the attunement and sincerity of the negotiator are primary. The Quaker writer Douglas Steere referred to this when he wrote that the speaker knows at once
if the listener is not truly present. If the listener is half-listening, inwardly wondering if so-and-so is going to call, if that car payment went through….the speaker senses it at once and the real communication, the kind that makes for transformation, is lost.

So how do we get that quality of being present and bring it into a crisis negotiation? Here are some thoughts from such experts as Mark Gerzon, Michael Tsur, Kathy Lubar and Belle Linda Halpern.

Listen to your first. Manage your own emotions first.
Are we caught up in the argument instead of attending to what's going on around us? Are we feeling tense but are not aware of it or the effect it is having on the subject? One crisis negotiator's voice began to rise as he was negotiating; his pace of speaking quickened and his tone became increasingly loud. The commanding officer, sensing that the negotiator was now emotionally entangled with the subject, quickly replaced him with another negotiator.
Practice.
Practice listening, as one author put it, as though you were an anthropologist. Stay relaxed and curious. Stay in a state of alert attentiveness.
Listen closely not only for content (what's important to him) but for nuances such as quickening or slowing of speech, sudden silence, or a change in his demands.
Keep your emotions and mental state flexible and steady so that you handle the unexpected with the optimum response.
Focus with 100% of your being.
Be open to what is happening right now –things can change in a moment, and crucial information can be given in that new instant.
Respond to the needs of that moment.
Be able to notice if a current strategy or behavior is not working.
Be creative enough to invent a new strategy in the moment.
Be honest enough to admit it if you don't have a new approach yet.
In the end, it is about the ability of one's presence to engender trust. As Tsur says: “What is destroyed most in high tension situations is trust, and without trust, things will break down very quickly. When they do, they are replaced by increased anxiety and confusion, destroying the participants' ability to make good, long-term decisions. It is the negotiator's presence that keeps the trust intact.”

Or, as Jack Cambria, Commanding Officer of the NYPD Hostage Negotiation Team, puts it: “You have to care, and that person has to know that you care.”

Jeff Thompson biography and additional articles:
http://www.mediate.com/people/personprofile.cfm?auid=973

Lynne Kinnucan biography and additional articles:
http://www.mediate.com/people/personprofile.cfm?auid=1512
Unit Five: School Resource Officers

Unit Goal
The goal of this unit is to review the role and benefit of SROs by linking the traditional roles and responsibilities of law enforcement on campus to adolescent development, mental health, and crisis intervention concepts and skills that will improve outcomes for youth, schools, and communities.

Scope
In this unit, participants will examine and discuss the roles and responsibilities of SROs in relation to other key stakeholders (teachers, administrators, family members, and students), and will discuss existing school policies that guide SRO interactions with students. Skills necessary to effectively approach and interact with students with mental health and behavioral issues will be demonstrated and practiced. Most importantly, positive relations between youth and law enforcement on campus will be discussed, promoted, and linked to concepts from the adolescent development, mental illness, and de-escalation units. This will serve to encourage school safety, create a pro-social environment, and deter juvenile delinquency.

Performance Objectives
At the conclusion of the unit, participants will be able to:

- Discuss the importance and benefit of using an adolescent development- and mental health-informed team intervention approach within a school setting
- Describe the roles and responsibilities of SROs and other key stakeholders within the school environment as related to interactions with youth with mental health issues
- Demonstrate skills specific to the role of SROs, including decision-making, role modeling, and teaching/reinforcing student skills

Materials to Prepare
REQUIRED: Locally developed SRO job description and applicable policy/procedures to use with slide 5-6

Provided Materials
- Video 5.1: Freedom Writers (clip length: 1:12)
- Handout: Protective and Risk Factors Associated with Delinquent Behaviors
- Handout: The Effect of Arrest and Justice System Sanctions on Subsequent Behavior: Findings from Longitudinal and Other Studies
- Case Study: Shaunika
- Video 5.2: Classroom Scene II (clip length: 53 sec)
- References
Unit Outline

- SROs and Mental Health
- Clarification of Roles and Responsibilities
- Developing, Practicing, and Reinforcing SRO Skills Related to Youth with Mental health conditions
  - Decision maker
  - Role model
  - Teacher/reinforcer of life skills
- Taking Care of Yourself

Time

- Approximately 2 hours and 15 minutes
Introduce Unit 5: “In this unit, we will discuss the roles and responsibilities of school resource officers in relation to other key stakeholders, such as teachers, administrators, family members, and students. We will discuss existing school policies that guide SRO interactions with youth. We will practice how to effectively approach and interact with students with mental health conditions. Most importantly, we will discuss and promote positive relations between students and school-based law enforcement which incorporates what we learned in the adolescent development, mental health conditions, and de-escalation units. This will help foster school safety, create a pro-social environment, and deter juvenile delinquency.”

**Large group discussion:** Facilitate discussion by asking: “What has already been taught about effective interactions with students, teachers, and administrators in school settings?” Note responses on flipchart/whiteboard. When appropriate, link responses to information that will be presented in this unit.

Review objectives of the unit:

- Understand the importance and benefit of using an adolescent development- and mental health-informed team intervention approach within a school setting
- Clarify the roles and responsibilities of SROs and other key stakeholders within the school environment as related to interactions with students with mental health issues
- Demonstrate skills specific to the role of SROs including making decisions, role modeling, and teaching/reinforcing student skills

Share with participants how schools are excellent environments to observe, identify, guide, teach, and reinforce behaviors (both positive and negative, depending on the circumstances). SROs have an opportunity to capitalize on this environment for the positive.

Often times, schools are the first places where mental health conditions are identified and where referrals to appropriate services are made. When
- Observe, support, guide, and provide feedback on progress

• Benefits of intervention

  youth have problems, competent adults in their lives should be able to see the concerning behaviors, predict that things may get worse if nothing is done, and offer ways to intervene or change the behavior long before arriving at a point of crisis.

  Schools are often the place for providing initial observations, intervention, and feedback on progress. Remind participants of the importance of feedback by asking, “How many of you have ever tried to start an exercise/workout program or go on a diet? How critical and/or helpful was it for someone to notice that you looked better?”

  Continue by noting that change is hard, but it helps when someone recognizes our efforts along the way. This recognition can be just enough to keep us working toward our goals.

  School personnel and SROs are well poised to offer such recognition. In addition, there are a number of other benefits of intervention at the school level:

  • Proactive crisis intervention (versus reacting once a crisis has erupted)
  • Improved academic performance and attendance (versus students quitting in frustration, anger, or neglect)
  • Increased school safety and improved classroom behavior (versus increased arrests, expulsions, violence, etc.)
  • Access to needed services (versus watching the situation deteriorate to arrest or expulsion)
  • Access to school-based mental health services (versus referral to services that may not be inclusive of the key environmental factors of the school)

  Large group discussion: Facilitate discussion by asking, “What other benefits can you think of?”

  There are important and predictable factors of systems, such as schools, that can either promote or hinder opportunities for effective interventions and behavior change. Introduce next video clip by noting, “Let’s take a look at these systems. This clip is presented from a youth’s point of view.”

  Note to Trainers: This clip (length: 1:12) from Paramount Pictures’ Freedom Writers (Sher,
Shamberg, & LaGravenese, 2007) sets up the next several slides in which SROs are challenged to look at the many factors impacting their work.

*Source: Paramount Pictures*

**Slide 5-5**

Roles and Responsibilities

- Impact of systems
- System roles and stakeholders
- School policies/SRO job description

School systems share characteristics that can impact the work of SROs.

**History** builds strength, both good (healthy) and bad (unhealthy), in systems. The more history people, policies, and procedures share, the harder it is to change because systems seek to "survive" and maintain stability. (An analogy of healthy families versus alcoholic families, both of which survive and have a history, may be suitable here.) Ask participants, "How many of you took your job as an SRO to quickly find out there were rules and expectations already established in the system that had nothing to do with you, but you were now part of?"

The **structure** of a system involves the parts that make up the whole (e.g., the system of the human body is made up of the heart, brain, lungs, etc.). Each part plays a unique role in the overall system.

Changes to the pattern will impact all of the parts. In other words, if an SRO changes his/her pattern of operating, the rest of the system will be impacted. Individual job patterns can be very powerful!

**Individual reflection:** After distributing the prepared handout, encourage participants to reflect on their part of the system: "This description likely describes, at least in part, your own job. Considering either this example or your actual job, think about how you fit with the school system.

- What is the structure of your job?
- How do you interact with school and law enforcement policies?
- What patterns are healthy?
- What can be improved?
- If you want to improve your job functioning, what history are you up against?"
Introduce next section of training by explaining, “Although the specific roles and responsibilities in the sample job description may differ somewhat from your actual job, there are at least three specific skills that will enhance your performance as an SRO: making decisions, serving as a role model, and reinforcing life skills with students.”

Discuss the first skill associated with being an effective SRO: “It is essential for SROs to be effective decision makers. Earlier, we discussed the fundamental decision of delinquency versus mental health conditions in intervention and de-escalation situations. Now, we will look at another decision facing SROs: degree of delinquency risk. Are there factors that increase risk for delinquency or that protect youth from delinquency? Recognizing these factors will help you with one of the most critical decisions associated with school arrests. Are there alternatives for the youth who misbehave? While certain cases warrant arrest, this consequence should be regarded as the last possible resort.

"In short, we want to move away from some long-held beliefs about crime and punishment (e.g. arrest), particularly when it comes to working with youth. We want to instead strongly consider other options.”

Review low versus moderate/high delinquency risk factors. (Note: Most students will be low risk and it is all about relationships with/supervision from appropriate adults and peers. Caution against pushing low-risk youth into high-risk environments with moderate/high-risk youth and severe sanctions.)

We hear a lot about risk factors for young people in terms of delinquency (family conflict, antisocial behavior, lack of involvement in school, drug use). But, there are also factors that can minimize or overcome the risk factors. These are called protective factors: attributes or characteristics that foster resilience and can reduce the effect or impact of stressful events in youth’s lives. By increasing or
• Intelligence
• Positive relationship with an adult(s)
• Consistent system of recognition
• Opportunities for pro-social involvement
• High expectations from adults

strengthening protective factors, a youth’s potential for delinquent behaviors can be reduced and positive development can be promoted. Examples of protective factors for both boys and girls are listed on the slide. **(Note to Trainers:** Review each item on the slide, asking participants for examples.) Girls, in particular, can be positively influenced by the perception of a caring adult, school connectedness, and religiousness during adolescence.

Ask participants to identify ways that they can support and promote protective factors among youth they see in school (examples might include noticing and commenting on something a youth does well; paying special attention to a youth or being available to listen; encouraging youth to join a club or play a sport, etc.)

For more information on risk and protective factors for delinquent behavior, refer participants to the end of the unit for “Protective and Risk Factors Associated with Delinquent Behaviors” and “The Effect of Arrest and Justice System Sanctions on Subsequent Behavior: Findings from Longitudinal and other Studies” (Huizinga and Henry, 2008).

**Case study exercise:** Facilitate discussion of case study (on page 111 in the Participant’s Guide) by asking, “As the SRO in this scenario, you have a decision to make. What do you do?”

Slide 5-11

Case Study: Shaunika

When Shaunika came back from the cafeteria after lunch, she was mad at Ms. Smith because Shaunika wasn’t picked for an out-of-class project. As she entered the class with the other students who hadn’t been selected, Shaunika began hitting her fist against her hand and saying, “That bitch never picks me.” Shaunika kept saying this even after she was told that is was inappropriate language. When informed that she was receiving detention for cursing, Shaunika stood up on her chair and began yelling at Ms. Smith, “You bitch!”

You, the responding SRO, tell Shaunika that if she does not leave the room willingly, she will be put in handcuffs. You forcefully lead her by the arm. Shaunika walks out of the room without further escalating. When she gets to the hall, she encounters the Assistant Principal. Shaunika yanks her arm away from your hold and tells you to “leave
her the hell alone” so she can talk to the Assistant Principal.

**Slide 5-12**
Developing, Practicing, and Reinforcing SRO Skills

- Role modeling is one of the most effective means of delinquency prevention!
- Each interaction with a youth represents an opportunity to model adaptive behaviors, build skills, and foster a helping relationship.

Introduce the next skill of importance to SROs: role modeling.

“One of the best protective factors, or predictors of success, is the presence of a consistent role model. This has been identified as an evidence-based practice for delinquency prevention and intervention.

“It is important to remember that no matter what you, the SRO, are doing, you are modeling behaviors – even if you are not interacting with youth directly. Whether conversing with a teacher or greeting a visitor at the security desk, you are setting an example for students. This example, whether positive or negative, can have a powerful impact. Being aware of these teachable moments can make your job easier.”

**Slide 5-13**
Activity: Role Model

You overslept, had a flat tire, and spilled your coffee on the way into work.

Arriving at work, you are greeted by a student known for his dramatic responses to stress. He says, “Wazzup?”

You manage to smile and respond, “Well, this day didn’t start off great, but I’m going to take a few deep breaths, shake it off, and make the rest of the day better.”

**Large group discussion:** Facilitate discussion by asking, “As the SRO in this example, what have you just modeled for the student? What new skills have you taught? How else can you model behavior for students?”

**Activity:** Ask participants to think of someone from their school days that they consider a role model. What traits of those role models made an impression? List responses on flipchart.

Summarize activity and lead into the next topic by pointing out, “Even though you are not a classroom teacher or counselor, you share many of the traits we just listed. As an SRO, you too have a real, positive, and lasting impact on students. By virtue of the amount of time you spend with the same students on the same school campus, you are uniquely positioned to help teach, coach, and reinforce positive and adaptive behaviors.”

**Slide 5-14**

- Problem solving
- Anger management

Introduce the third role that SROs play: “We all have life skills to pass on to youth. The four skill sets listed on the slide are important for all youth to acquire, and they are particularly important for youth with psychiatric disorders.”
• Impulsivity control
• Communication

"When responding to situations involving youth, the first thing you need to ask yourself is whether the youth has the skills to deal with situation.

• If the answer is no, it is within your role as an SRO to teach youth.
• If the answer is yes, it is within your role as an SRO to coach youth to use their learned skills, reminding them that they know what to do.

When youth use an appropriate skill to positively respond to a situation, be sure to let them know how impressed you are at their ability to resolve the situation. Praise and recognition will increase the chance of the positive behavior happening again."

**Note to Trainers:** To reinforce the value of recognition, it may be useful to ask participants to think of a time when their supervisors commented on how well the participants handled a situation, applied trained skills, etc. How did the participants feel? How would they have felt if their supervisors failed to acknowledge their good work?

Introduce the first of the four skill sets to be explored: "We all do things for a reason. We are constantly faced with issues to address and problems to solve. SROs can help students define the problems they face and review options for solving them. Students may only see one solution, but typically there are many.

"To begin, ask students what interests and motivates them. This will provide an understanding of their values, beliefs, and goals. Explore if students' current behavior is likely to contribute to their goal. If not, they may be open to considering other options.

"Helping students weigh pros and cons of their current or future behavior can also be instructive. Explore with students both positive and negative consequences of the solution they are pursuing. If bad outcomes are likely to outweigh good outcomes, students may be willing to consider another solution.

"Developing a list of options is sometimes referred to as 'brainstorming.' Engaging students in

**Slide 5-15**

**Problem Solving**

• What is the purpose of the behavior? What problems are students trying to solve?
• What are they motivated by?
• What are their options?
• What are the pros and cons of each option?
• How possible is it to implement the best option?
• Have positive outcomes been examined and reinforced?
brainstorming enables them to see not only options, but also consequences for a variety of situations.

“Students may need prompting to think beyond the immediate moment, beyond the temporary relief offered by the possible destructive situation to the consequences that follow (positive and negative). They may also need to be made aware that they don’t have to keep doing things in the same way that they’ve always been done. Do students really want to continue behaviors that have been harmful in the past, or do they want to try something that might get a different result?

“In addition to thinking through consequences with students, you can help them anticipate how good it may feel to avoid harmful behaviors by trying something more productive.”

Continue instruction on problem solving by noting that students often have a different perspective of the desirability of outcomes than adults do.

**Large group discussion:** Facilitate discussion by asking:

- “What problem is the student trying to solve?” (Responses should include threat, shame, and/or anger.)
- “What outcome is most important to HER?” (Responses should include relief, respect, and/or credibility.)
- “What outcome do you think might have the most impact?” (e.g. anger subsides)
- “What outcomes do we as adults often think have the most impact? (e.g. suspension)

**Note to Trainers:** Most adults see suspensions, arrests, etc. as the influencing outcome. Encourage participants to recall the unit on adolescent development, which explained that adolescents tend to be short-sighted and impulsive. Therefore, suspension or arrest may not be the most critical outcome to the student. *Responding adults should focus on the student’s emotion, rather than the outcome.*

To change the outcomes, we need to look at all the parts of the behavior prior to the outcomes.
Remember the student wants relief from his anger. Ask participants:

- “What could you do to change the student’s idea of the outcomes?” (Possible responses: Help the student see others’ behaviors in a different light. Ask the student to consider if the rival gang member was really threatening the student or simply getting to his class; if assault was the only option; and what else the student could do.)
- “How can you as a role model and in the mode of proactively preventing future crises address vulnerabilities on days that the student isn’t feeling a threat or fighting on campus?”

Introduce the next skill set by reviewing basic anger management techniques to use with youth in an escalating situation:

- Maintaining safety is always critical. If students are becoming increasingly upset and appear on the verge of losing control, help them recognize the need to stop whatever they are doing for the safety of everyone.
  Suggestion: The SRO might say, “Sarah, I can see you’re really upset. I want you to be safe and I want everyone else to be safe, too. So, I need you to stop throwing things so we can talk about what’s bothering you.”
- Separation from other students may not always be possible, but creating some distance between an agitated student and others can usually be accomplished. Removing the audience is often a helpful intervention.
- It may be beneficial to help students identify some of the physical signs of their anger and talk them through steps to counter-act those signs.
  Suggestion: The SRO might say, “John, I can see that your teeth are clenched and your fists are balled up. Try to relax a bit with me just for a few seconds. Okay? Take three deep breaths in and out. Loosen up your fingers a bit....”
- As students relax, they should be encouraged to begin the problem-solving skills that have been modeled for them.
Suggestion: The SRO might say, "Stephen, I know you were really mad about having your off-campus lunch privileges taken away. Let's talk about why that made you so angry and how else you could have handled it."

**Large group discussion:** Facilitate a brief discussion on participants' experience with anger management. Ask, "What other anger management techniques have you found work well with agitated students? Why?"

Introduce the third skill set: "Being able to help students slow down, talk, and not react is a great skill. Youth are impulsive and often fail to think before they act. SROs can help students think through situations, beyond the feelings that are driving potentially impulsive behavior. Begin by acknowledging students' thoughts and feelings (e.g., "I know you are thinking this is the worst thing ever and you are angry..."), and then ask students to think through what they want to do (e.g., "I know you want to hit him right now, but then what?")."

"Help students learn from their past experiences. Help them remember that this (or something similar) has happened in the past. Remind them that when they acted impulsively to escape or reacted in the moment, consequences followed. What were those consequences? If they can get past the moment and stay out of trouble, will any of it matter tonight or tomorrow?"

Review ways to slow things down:

- Encourage students to share what's going on and what they are feeling.
- Coach students in problem solving and think through options with them.
- Encourage students to consider and weigh consequences.
- In short: Stop, talk, wait, and then act.
- Acknowledge and praise positive responses.

**Video and large group discussion:** This classroom scene filmed by Home Box Office (2007) depicts an incident in a classroom. After playing the video (clip length: 53 seconds), facilitate discussion by asking:
Unit 5
School Resource Officers

Slide 5-21
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

Slide 5-22
Taking Care of You: Self-Care Strategies
- Physical: sleep well, eat well, exercise
- Emotional: see friends, cry, laugh, praise yourself, engage in humor
- Personal: relax, travel, engage in quiet time, pray
- Workplace: take breaks, set limits, seek peer support, get supervision, use vacations

Think about the video in terms of what we’ve learned and discussed in this training. Did you see any delinquency risk factors?
Did you see any signs of mental health condition?
Is this a likely mental health response, criminal arrest, or both?
Who or what is influencing this youth?
What SRO skills could you use in this situation?

Ask for and address any questions, concerns, or ideas before concluding unit: “In concluding this unit, I want to thank you for working through this with me. You have an incredible individual role to offer the bigger school system. Before we start exploring the various resources available to you within and outside of the of the school system, I would like to briefly discuss one more very important SRO responsibility: taking care of YOU.

"Your jobs are stressful and can be costly, both physically and emotionally. Be aware of your own stress level and signs of overload. Try not to take problems or frustrations home with you. Use your time off to rest, relax, spend time with your loved ones, and rejuvenate yourself."

Continue discussion by noting, “In order to function at your best, it is important to achieve balance in your life. Get plenty of rest, eat well, engage in fun/relaxing activities, and take vacation when you need it. Remember, too, that taking good care of yourself is setting an excellent example for students with whom you work.”

Ask participants to share what they do to relax, rejuvenate, or otherwise defuse job-associated stress.
Materials: Protective and Risk Factors Associated with Delinquent Behavior

Protective Factors
- A resilient temperament/personality
- Positive social orientation (peers)
- Intelligence
- Positive relationship with an adult(s)
- Consistent system of recognition
- Opportunities for pro-social involvement
- High expectations from adults

Risk Factors

Individual
- Low intelligence; cognitive, learning, and language problems
- Poor impulse control
- Not taking responsibility for behavior
- Admiration for antisocial behavior
- Perception of others as hostile
- Early onset of delinquency
- Child working more than 20 hours per week
- Poor social skills
- Poverty
- Low education levels
- Conflict and hostility at home
- Ineffective parental discipline and monitoring
- Physical/sexual abuse
- Familial substance abuse and psychiatric problems
- Parental criminal history
- Lack of warmth and affection between parents and child

Family
- Parental criminal history
- Poverty
- Low education levels
- Conflict and hostility at home
- Ineffective parental discipline and monitoring
- Physical/sexual abuse
- Familial substance abuse and psychiatric problems
- Parental criminal history
- Lack of warmth and affection between parents and child

Peers
- Association with delinquent youth (for older youth/adolescents)
- Peer rejection (for younger children)
- Association with youth who use drugs or alcohol
- Gang membership

School
- Poor achievement/grades
- Falling behind same-age peers
- Sense of isolation or prejudice from peers
- Poor attendance

Community
- Availability of drugs and weapons
- Poor support network
- Isolation from neighbors
- Living in “dangerous” neighborhoods
- Frequent family moves

Materials: The Effect of Arrest and Justice System Sanctions on Subsequent Behavior: Findings from Longitudinal and Other Studies


This summary reviews what is known about the effect of arrest on subsequent behavior, especially delinquent behavior, and what prospective longitudinal studies have added to this knowledge base. It is common in describing the influence of arrest and sanctions on apprehended individuals to consider two opposing views: 1. the deterrence or punishment orientation that suggests that arrest should reduce or eliminate future offending behavior and 2. that arrest may/or will increase subsequent offending behavior by resulting in the official labeling of the arrested individuals as bad or delinquent -such labeling may result in changes in self-identity or self-concept. There are different theoretical positions on what the effect of arrest has on subsequent behavior. However, it is also possible that there is no real effect of arrest or sanctions and that neither of these two alternative theories actually applies in most cases.

The Effect of Arrest and Sanctions on Subsequent Delinquent and Criminal Behavior: A Review of the Literature – Legal sanctions, including arrest, may have both:

A General Deterrent Effect of Arrest –As a deterrent, it hypothesizes that more aggressive policing, employing additional police, improving clearance rates, and/or creating more severe penalties for crime will generally deter people from committing crime. Research on deterrence began with community, state or national studies using aggregate level data, to examine the relationship between (1) the proportion of crimes known to the police that resulted in arrest or other sanctions and (2) official crime rates. These studies found an inverse relationship between the certainty and severity of punishment and subsequent homicide and felony offenses.

And A Specific Deterrent Effect of Arrest – As a deterrent, it hypothesizes that arresting and placing sanctions on an individual will serve as a punishment that will ultimately deter the individual from engaging in future crime. Studies have assessed arrest as a specific deterrent. Research in this area has also resulted in a mixed conclusion, although most of the studies have reported a non-significant or even harmful impact of arrest.

Klein (1986) conducted a true experimental test of the effect of arrest on subsequent adolescent delinquency. The results of the study indicated that referral to community agencies and petitioning toward juvenile court led to a greater probability of recidivism. That is, adolescent who were counseled and released were less likely to be rearrested during the observation period than adolescents who were either referred or petitioned. It was interesting to find out that no significant difference existed between the randomly conditions assigned to the 306 adolescents tested (counsel and release, referral, referral with purchase of service, and petition request) in rate of actual self-report offending. That is, the effect of juvenile justice system processing didn’t result in involvement in more crime. Rather it resulted in a higher likelihood of being rearrested for involvement in crime.
Hemphill, Toumbourou, Herrenkohl, McMoms, and Catalano (2006) conducted a large cross-national longitudinal study, involving a sample from multiple schools in the Washington State, US. Two school surveys were conducted one year apart. Using a variety measure of delinquency they defined antisocial youth as those who committed two or more offenses. They found that individually and, when considered jointly, both arrest and school suspension led to increases in levels of delinquency in the following year. However, in a large regression model that controlled variables such as gender, prior delinquency, other individual risk and protective factors, and risk and protective factors from the family, school, peer, and community domains, as well as country, they found that although school suspension still significantly contributed to an increase in delinquency, the effect of arrest was no longer significant (although being positively related to year two delinquency). The researchers concluded that the main finding from this study was that school suspensions increase subsequent delinquency.

After summarizing various findings about the effects of arrest, it was concluded that arrest either had no effect or increased subsequently delinquency. Interestingly, this general finding seems to hold across studies conducted over the last 35 years or so, suggesting some robustness over time.

### Findings about Sanctioning Following Arrest or Police Contact – Many studies have examined the extent to which various forms of sanctioning following arrest differentially impact subsequent criminal offending.

Thornberry (1971) using data from the Philadelphia Cohort Study found that among adolescents, as the penalty of sanctions increased across being warned and released by the police, being diverted from court, being put on probation, and being incarcerated, the more likely the offender was to be re-arrested.

Although there are thus many studies that find either no effect or increases in offending following the imposition of sanctions, a few studies have found that sanctions decrease future offending. Murray and Cox (1979) reported a beneficial effect of sanctioning. Employing a quasi-experimental design, they assessed the rate of recidivism among serious juvenile offenders who were either 1. incarcerated, or 2. put on probation. While both groups demonstrated a reduced rate of recidivism after having received either an incarceration sentence or probation, the adolescents who were incarcerated showed a lower rate of recidivism. Furthermore, among those on probation, adolescents who received a more restrictive probationary program demonstrated a lower rate of recidivism.

Aos et al (2001) indicate that, overall, court diversion programs result in a slight reduction in future offending in comparison to regular court processing and are less expensive. Diversion programs as practiced in the 1970s and 1980s in the US had substantial variation in outcomes, but in general were as successful or more successful than regular court processing.

### The Effect of Arrest and Sanctions on Factors Related to Subsequent Offending

- Research has shown that justice system processing not only has an effect on one's subsequent delinquent behavior, but also may affect other areas of an offender's life. Often, arrest and other forms of legal sanctioning lead to undesirable outcomes, including limited employment and educational opportunities, early pregnancy/parenthood, and negatively changed attitudes and beliefs. In turn, these undesirable outcomes may be anticipated to affect later offending behavior.

### Effect on Employment – Longitudinal data are needed in order to properly address the relationship between justice involvement and subsequent employment because careful selection of background covariates must be included in order to ensure that the effect of arrest (and other forms of sanctioning) is not spurious.

Bernburg and Krohn’s (2003) assessment on the effects of arrest and juvenile justice interventions within the Rochester Youth Development Study concluded that both arrest/contact and juvenile justice system intervention reduced the chance of high school graduation and employment in young adulthood. They further observed that although educational attainment substantially mediated the effect on adult unemployment, a significant effect of arrest and of juvenile justice intervention on adult employment
remained, even when educational attainment was controlled. They further noted that the effect of arrest and intervention was more pronounced for impoverished families and African Americans.

**Effects on Educational Achievement and Opportunities** – Very few studies have assessed the impact of juvenile justice system sanctions on subsequent educational factor. The studies reviewed in this chapter found that both arrest/contact and juvenile justice system intervention had an adverse effect on both academic performance, and school attendance as well as reducing the chance of staying in school and the chance of high school graduation. It was noted that these negative effects were more robust among youth who had been arrested multiple times.

**Effects on Precocious Transitions to Young Adulthood** – Interpretation of the study findings on the effect of police contact and arrest on precocious transitions to young adulthood can differ depending on the casual ordering of the variables used in the studies. Lizotte et al (2004) found out that boys who reported police contact or who had been arrested in later adolescence were more likely to cause a teenage pregnancy, become a teen parent, drop out of school, and leave home early. Girls who reported police contact or who had been arrested in later adolescence were more likely to become pregnant as a teenager, drop out of school, and leave home early.

**Effects on Attitudes and Beliefs** - The literature relating the effect of legal sanctioning on change in attitudes and beliefs provides mixed results. Several studies such as Jensen (1969) reported that offenders who were punished early in their career were more likely to develop a deviant identity as compared to experienced offenders who were apprehended later in their criminal career. However, Hepburn (1977) reported that punishment had no differential effect on self-identification as a delinquent among novice as opposed to experienced offenders. The conclusion to the study findings reviewed in this chapter suggest that in the high-risk neighborhoods of this study the juvenile justice system is not perceived as a “paper tiger,” and that arrest appears to have generated a more delinquent belief system and increased delinquent and decrease conventional peer involvement.

**Discussion** - In general, these studies demonstrated a negative relationship between perceived certainty of arrest or sanctions and subsequent delinquent behavior. It is evident in the reviews provided in this chapter that the vast bulk of these studies found that arrest (to include studies of police contact resulting in monitoring by the police or others and studies employing conviction) results in equal or higher rates of subsequent offending.

Moreover, taking these various findings together, it appears that arrest and sanctions during adolescence lead to higher chances of high school dropout and to lower chances of high school graduation is also found in most of the studies that examined this issue. There is also some evidence that arrest and sanctions lead to a delinquent orientation, delinquent identity, or delinquent belief structure, although there is conflicting evidence whether such effects vary by stage of delinquent career (novice vs. experienced offender). There is also evidence that sanctioning increases the perceived level of the severity of sanctions, but findings about this are not consistent.

Excluding long term incarceration, there are several reasons to expect that arrest followed by either no or some sanction would not have much effect on apprehended offenders.

1. Following arrest and many other sanctions, most offenders return to the same environment from which they came. Returning to these risk and environmental conditions, involvement in future delinquency, even under the possibility of a future arrest and sanctions, seems likely.

2. The actual probability of arrest per offense (and hence sanctioning) is actually quite low. And, this holds for serious as well as minor offenses. Thus, certainty of apprehension, which has been generally found to be the strongest deterrent factor is low. Also, it is likely that the effect of arrest dissipates over time, especially if it is not regularly reinforced. Since probability of arrest per offense is low, it would be assumed that the effect of arrest would not be high.
3. By the time of arrest, offending behavior may be more entrenched and offenders have already learned that the probability of arrest and sanction per offense is very low, so that the balance of "risk versus reward" for future offenses shifts toward the reward.

4. The severity of the sanctions beyond arrest may not match the severity of offenses of the apprehended individual. As a result, for serious offenders, the sanctions following arrest are unlikely to match the seriousness of their underlying offending behavior. This is an appropriate justice system response given the legal system in a free society, but limits the effect of the specific deterrence of arrest.

5. There are likely to be perceptual distortions in an individual's consideration of the likelihood of arrest, especially at the time of committing another offense when other factors such as opportunities, peer influence, the sense of fun or excitement are in play.

6. It is sometimes noted that general deterrence works only with individuals who are normally law abiding and who have internalized social norms from experiences within their family, school, religious groups, community, and peers. Those who have not internalized such norms are not likely to be deterred by threats of arrest and possible further punishment.

7. The treatment of apprehended individuals by the police also may affect the outcome of the arrest. It is likely that there are other reasons for the lack of "positive" influence of arrest and sanctions on subsequent illegal behavior. However, based on the comments above and the observation that for many arrestees several of these factors are at work in combination, there is ample explanation for the observation that arrest has little or a harmful effect. In fact, under current social and justice system practices, it would seem rather unusual for arrest and ensuing sanctions, in general, to have the anticipated effect of decreasing subsequent delinquent and criminal behavior.

**Current and Future Contribution of the Longitudinal Studies** - The contribution of the longitudinal studies to the understanding of the influence of arrest and subsequent sanctions on subsequent behavior is growing. However, among recent major longitudinal studies, extensive examination of the effects of arrests and sanctions is relatively rare.

**Suggestions for the Future** - With the exception of true experimental studies, the longitudinal studies provide one of the best, if not the best, source for further exploration of both general and specific deterrence.

Most existing longitudinal studies are concentrated in urban areas, so that findings from these studies should not be generalized to suburban or rural areas. If the opportunity occurs to include deterrence measures in new suburban or rural longitudinal studies, this opportunity should not be missed.

Given these comments, and the important policy relevant and practical findings that should result, it would be helpful if future longitudinal studies were encouraged to include a focus on specific deterrence. It would also seem that existing longitudinal studies should be encouraged to conduct deterrence analyses, especially analyses focusing on the effect of arrest and sanctions. Further, given the value of replicated findings, at least some of the studies should be encouraged to work collaboratively, beginning with development of specific research questions, development of common measures, specification of appropriate analyses, and so on.

**PolicyImplications and Suggestions** - The potential effect of arrest and sanctions on offenders is not the only reason for arrest. Issues of public safety, general deterrence, public concern for retribution, and victims' rights are also of concern (c.f., Smith, 2005).

Given the robustness of the finding that arrest either has little effect or results in an increase in subsequent delinquency across multiple studies, time periods, and different juvenile justice systems,
coupled with the observation that increased sanctions also have little effect or result in increased subsequent delinquency, the following suggestions seem reasonable. First, police contact or arrest (or perhaps apprehension by other social actors) is needed for individuals violating legally proscribed norms, and such contact or arrest should be more consistent. Second, such contact or arrest and any subsequent sanction should be as lenient as possible within the limits of public safety. Whether to employ no sanctions, lenient sanctions, or harsh sanctions cannot be determined by the effect on the offender; the outcome is the same. Rather it must be determined on the basis of cost, humanitarian principles, need for victim concerns for retribution, and so on. However, the choice of lenient intervention seems justified on the basis of cost and the available evidence that indicates that more severe sanctions may result in increased subsequent levels of delinquency and crime and prolong delinquent and criminal careers and therefore result in reduced public safety.
Materials: Case Study of Shaunika

When Shaunika came back from the cafeteria after lunch, she was mad at Ms. Smith because Shaunika wasn’t picked for an out-of-class project. As she entered the class with the other students who hadn’t been selected, Shaunika began hitting her fist against her hand and saying, “That bitch never picks me.” Shaunika kept saying this even after she was told that is was inappropriate language. When informed that she was receiving detention for cursing, Shaunika stood up on her chair and began yelling at Ms. Smith, “You bitch!”

You, the responding SRO, tell Shaunika that if she does not leave the room willingly, she will be put in handcuffs. You forcefully lead her by the arm. Shaunika walks out of the room without further escalating. When she gets to the hall, she encounters the Assistant Principal. Shaunika yanks her arm away from your hold and tells you to “leave her the hell alone” so she can talk to the Assistant Principal.
References


Unit Six: The Family Experience

Unit Goal
The goal of this unit is to present information about the important role that families can play in supporting youth with mental health needs who may risk involvement in the juvenile justice system.

Scope
The materials presented in this unit will help SROs build positive relationships with a youth’s family to help ensure the best outcomes for everyone involved whenever possible.

Performance Objectives
At the conclusion of the unit, participants will be able to:

- Describe the experience of living with and caring for youth with mental health conditions
- List ways that the law enforcement community can support families who are caring for youth with mental health needs who come in contact with law enforcement
- Create meaningful opportunities to engage families and promote partnerships

Provided Materials
- Video 6.1: In Their Own Words

Unit Outline
- The Family Experience
- Family Stressors
- The Family’s Role
- From the Perspective of Family Members
- Supporting Families

Time
- Approximately 30 minutes
This brief unit is designed to sensitize SROs to the family’s experience.

**Note to Trainers:** Some participants may have children with mental health conditions. While it can be helpful for them to volunteer to briefly share their experience, be careful that they do not monopolize the class and/or disclose too much personal information.

The facilitator should introduce the unit by reviewing the objectives on the slide.

First discuss families in general. Who are the families of students in your school system?

Like those of us in this room, students come from traditional two-parent families; from households with a single parent; and from extended families sharing a house. Some students have parents who are young; others’ parents are older. Older siblings or grandparents may be raising youth. Some parents are gay or lesbian. Students have parents who don’t work outside the home; who work part-time; or who work two or three jobs to make ends meet. Some students come from blended families; some from adopted families; and some from foster families.

While there is no single defining type of family, the one thing that almost all families of children involved with police or the justice system share is increased stress related to the contact.

We all have stressors in our lives. What creates stress for you?
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
- Physical illness or disability of family member
- Mental health issue of parent
- Parental incarceration
- Work schedule
- Experience of trauma
- Family violence
- Fear of child

What we see is that our families share many of the same stressors that families who are involved with police face. Everyone has something that causes stress. Some of us have financial worries or conflicts with loved ones. We may have lost a loved one to death or substance abuse. We deal with challenging behaviors from our kids; our cars break down; people get hurt or sick or leave. The demands of work, transportation, caring for family members, and our own personal issues can overwhelm any of us.

A child’s involvement with police can add substantially to a family’s stress level.

For many families, their child’s involvement with police comes during a difficult period in their relationship. Family members may feel frustrated and powerless as their child continues to exhibit behaviors or becomes involved in situations that result in contact with the system.

Families may also fear their child and what their child is capable of doing. If there are victims in the home, then ensuring that the victims’ needs are met while participating in treatment for the perpetrating child can be very stressful.

Introduce unit: “Many youth who come in contact with the justice system have had prior contact with the educational, mental health, or child welfare systems. Family members might have unsuccessfully struggled for years to get help. Sometimes youth receive treatment, but continue to experience symptoms or behaviors in school, in the community, or at home that can bring them to the attention of the juvenile justice system.

“Many parents feel guilty and worry that they did something to cause the problems in their child. Often parents feel depressed about the tension in their family life. Weekends can be especially hard. Life with a ‘difficult’ child can be challenging. Parents can feel overwhelmed and angry. They might feel that this particular child is negatively affecting their marriage and other children. Parents may also feel afraid when police become involved.

“What would it be like living with a youth with such severe mental health conditions that police intervention is requested and/or required?”
Large group discussion: Facilitate discussion by asking: "As you think about youth and family members coming into contact with the juvenile justice system for the first time, what sort of concerns and anxieties might they have? What additional concerns might they have if the youth has a mental, substance use, or trauma-related disorder?"

Bias still exists in how parents of children with mental health conditions are viewed. Remind SROs that the less-than-optimal interactions between troubled students and their parents that they've observed are likely a consequence, not a cause, of the mental health condition.

At times, parents experience long waits to get an appointment for help or have difficulty scheduling appointments at non-work times. Treatment can be expensive. Treatment does not always work quickly. Both the student and parents can feel hopeless.

Parents may feel embarrassed and/or humiliated about needing police assistance whether they called for it or the school has called for it. They may also feel blamed by police or others.

Remember, parents may present differently than how they feel. Despite the problems that SROs see during crisis, the family is and will remain the primary emotional, social, cultural, and spiritual support of a student.

Note to Trainers: Show video (clip length: 3:50) on family involvement. Facilitate discussion by asking, "What can the law enforcement community do to build stronger relationships and partnerships with families and community/family advocacy organizations?"

Large group discussion: Facilitate discussion by asking, "For a moment, put yourself in the place of a parent or family member whose child is in the juvenile justice system. Imagine that the child has a..."
Activity: As a Parent, What Would You Want to Know?

- What is the process if my child is arrested at school?
- What can I expect?
- Is my child safe?
- What treatment is my child receiving?
- Do I have a say in decision-making?

Slide 6-12
What Can You Do to Support Families?

- Provide information and answer questions
- Encourage continued engagement
- Provide reassurance
- Identify potential resources
- Listen in an active, nonjudgmental way
- Emphasize strengths
- Encourage ownership of decision making
- Be empathic versus sympathetic

Conclude unit with practical strategies for encouraging family involvement. Encourage SROs to:

- Provide as much information to families as they can as often as necessary. Family members may need to ask questions more than once in order to understand a system that is complicated and unfamiliar to them.
- Tell families that they are an important part of the process. They need to know that SROs want to partner with them to provide the best care for their child. Let them know that the SRO may be calling on them to convey vital information.
- Remember that this may be a time of crisis in the family. The SRO is not likely seeing family members at their best. Be patient and understanding. If family members are worried or anxious about the youth, provide reassurance and support.
- Remember to engage active listening. Listening to family members, especially when they haven’t felt fully heard before, can go a long way to helping them be engaged and stay engaged with the youth. Listen and reflect back what hear.
- Whenever possible, empower families to make decisions – this is essential to continuing and strengthening family functioning.
- As often as possible, communicate that you understand this is a difficult time for the family. Your ability to understand their stressors and express your empathy will help engage families in a lasting way.
Unit Seven: Connecting to Resources

Unit Goal
The goal of this unit is to provide SROs with information about school and community services and resources available to youth with mental health needs.

Scope
This unit will provide SROs with information on resources for assisting students and families. The unit will be regionalized to include local agency contacts for assistance. If possible, a panel of local service providers will be assembled to share information about the services that they offer youth and how these services can be accessed. Panelists are requested to bring pamphlets, brochures and other materials describing the services they offer that can be shared with the SROs and others from the school.

Performance Objectives
At the conclusion of the unit, participants will be able to:

- Generate a local contact list of emergency and non-emergency mental health service providers, as well as other service providers who accept youth referrals from the law enforcement community
- Generate a local contact list of non-emergency community mental health service providers who accept youth referrals from the law enforcement community
- Generate a local contact list of other community service and supports

Materials to Prepare
- List of local resources

Provided Materials
- Post-course Assessment
- Training Evaluation

Unit Outline
- Mental Health Emergency Services
- Other Emergency Services
- Outpatient Services
- Other Services
- Support Groups

Time
- Approximately 1 hour
### Training Aids

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<tr>
<th>Slide 7-1</th>
<th>Connecting to Resources</th>
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### Content/Instructional Delivery Notes

Review all that has been covered thus far in the training: adolescent development and disorders, crisis intervention, SRO roles and skills, and the family experience. Introduce the final unit on local resources and services.

### Slide 7-2

So far, we have covered:
- Adolescent development
- Mental health conditions among adolescents
- Crisis intervention with students and families
- SRO roles and skills
- The family experience

### Slide 7-3

Now, we will develop local contact lists of:
- emergency mental health service providers who accept youth referrals from the law enforcement community
- non-emergency community mental health service providers who accept youth referrals from the law enforcement community
- other community service and supports

**Note to Trainers:** This session could be led by either someone who is very knowledgeable about local resources or a panel of representatives from local agencies, such as:
- local mental health clinics
- specialized mental health service providers
- emergency mental health service providers
- school-based service providers
- juvenile assessment centers
- other community-based service providers

It is important to ensure that 1) presenters come well prepared with a list of resources to share, 2) all relevant services are covered without repetition, and 3) panel members know their time limits.

What follows is an outline of information to be covered in this unit, whether by panel presentation or by expert on local resources.

Following the presentations, an opportunity for questions and answers is recommended. It may also be beneficial to allot time for sharing of situations experienced by participants and how those situations could have been improved for the SRO and the youth.

### Slide 7-4

This slide will help participants develop a list of local providers of emergency mental health services that
# Mental Health Emergency Services

- Hospital emergency rooms/inpatient units
- Mental health resource/screening/drop-off centers
- Other emergency service providers
  - Mobile crisis team

are accessible to SROs 24/7. Generating this list will remind SROs where they can access emergency evaluations, which will reinforce a primary goal of this training: diverting youth with mental health conditions from the juvenile justice system to the mental health system when at all possible.

Not all hospital emergency rooms that are capable of conducting emergency evaluations have adolescent and/or youth inpatient units. SROs should be aware of where youth who need inpatient hospitalization can get hospitalized.

Some local jurisdictions have developed 24-hour “drop-off centers” that are separate from hospital emergency rooms. If a drop-off center is available in the area, it’s important to know whether it accepts youth.

Some communities have a mobile crisis team composed of mental health clinicians that can respond to the scene of the incident.

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### Slide 7-5
**Other (non-psychiatric) Emergency Services**

- Youth shelters
- Others

SROs should be aware of local emergency services that are geared to children and youth, such as shelters for homeless/runaway youth. Respite centers provide youth and guardians time to problem-solve escalating issues with a little space and often a mediator.

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### Slide 7-6
**Outpatient Services**

- Clinics
  - Mental health
  - Substance abuse
- Specialty programs
  - Trauma
  - Developmental disabilities
  - Others

Most individuals seeking help go to outpatient clinics, where therapy (individual, group, and/or family) and medication can be accessed. Although integrated treatment programs that treat both mental and substance use disorders are increasing in number, services for these conditions remain separate in many localities. SROs should have a comprehensive list of local clinics, including any specialty clinics or services for youth (e.g., programs for youth who have witnessed violence or been exposed to other trauma).

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### Slide 7-7
**Other Services**

Other services for youth that may be available include:
Unit 7

Connecting to Resources

- School-Based Services
- Residential Treatment Facilities
- Group Homes
- Mental Health Courts
- Youth and Family Services

- Many school districts have school-based services available for youth.
- Local residential services are generally not available for youth on an emergency basis, but there may be facilities that are geared toward primary mental health issues, substance abuse, or developmental disabilities. This knowledge may be especially useful in cases involving youth who had previously stayed at one of the residences. SROs can help transition youth out of these highly structured environments and back into the school environment. This point of transition is difficult for many youth, families, and schools.

- Mental health courts recognize that routine adjudication for those individuals with behavioral health disorders is often not effective, instead focusing on linking individuals to treatment and monitoring progress. Individuals appear before the court for regular reviews so the court is aware of the progress. Community treatment providers give regular updates to the court.

  Mental health courts in most communities focus on adults. However, even in adult courts, older adolescents sometimes qualify for enrollment in the mental health court. Juvenile mental health courts exist in some communities.

Note to Trainers: Distribute previously prepared material listing local resources. Some groups have found it helpful to put this information on laminated cards that SROs can carry with them. Others have created documents (or photos of documents) that can be easily saved on a phone for the SRO to access.

Slide 7-8
Support Groups

- Federation of Families for Children’s Mental Health
- National Alliance on Mental Illness
- Depression & Bipolar Support Alliance
- ADHD Parent Support Group

Support groups can be very helpful for parents with children challenged by mental health conditions. Knowing that others are going through similar issues can be comforting, and contacts in support groups can offer practical suggestions to specific issues. This slide provides examples of various support groups.
### Connecting to Resources

- Al-Anon

### Slide 7-9

Thank you for taking part in this training!

Questions?

Conclude the session by thanking participants for their attention and input, then ask for and address any remaining questions. Finally, ask participants to complete both the post-course assessment and the training evaluation.