NCYOJ
Research. Policy. Practice.

National Center for Youth Opportunity and Justice

C I T - Y

Crisis Intervention Teams for Youth

Instructor's Manual

Crisis Intervention Teams for Youth

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About the NCYOJ

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

For more information about the NCYOJ, contact us at:

ncyoj.policyresearchinc.org

ncyoj@prainc.com

(866) 962-6455

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

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Background & Overview of CIT for Youth

Introduction

Many youth come in contact with law enforcement for disruptive or delinquent behavior that manifest as a result of an untreated or undetected mental health problem (Skowyra & Cocozza, 2007). Law enforcement officers responding to calls have latitude in determining how best to respond to the situation, and can decide whether the case proceeds into the juvenile justice system or whether the youth can be diverted (Office of Juvenile Justice and Delinquency Prevention, 2004).

The response by law enforcement officers to a call involving a youth in a mental health crisis and the immediate decisions that are made about how to handle the case can have a significant and profound impact on a youth and his or her family. This initial contact with law enforcement also represents an opportunity to connect the youth with emergency mental health services or refer the youth for mental health screening and evaluation (Skowyra & Cocozza, 2007). However, the ability of law enforcement to respond in this way requires that officers be appropriately trained to recognize the signs and symptoms of behavioral health conditions among youth, and that resources be available so that officers have a place to take youth for immediate services.

The CIT Approach

In 1988, recognizing the potential benefits of providing training about behavioral health conditions and response techniques to law enforcement, the first Crisis Intervention Team (CIT) program was developed in Memphis, Tennessee. CIT is a law-enforcement-based, crisis-response and diversion strategy in which specialized law enforcement officers who have received intensive training respond to calls involving individuals with possible mental health problems.

Law enforcement officers on a CIT team typically undergo a 40-hour training in which they learn about mental illness, how it affects people in crisis, and how best to respond to crisis situations. This intensive training is coupled with the development of strong linkages with the mental health system to ensure that mental health resources are available to law enforcement officers when they respond to an individual in mental health crisis or in need of mental health services.

Since 1988, the CIT approach has rapidly proliferated across the country (Schwarzfeld, Reuland & Plotkin, 2008). Currently, there are at least 2,700 CIT programs in the nation (Cochran, 2014). Outcome studies of the CIT approach suggest that CIT may result in positive outcomes for both individuals with mental illness and the law enforcement officers who respond to calls involving those individuals, as well as for the larger criminal justice system and the community. Some studies have found that CIT decreased the need for more intensive and costly law enforcement responses, reduced officer injuries, and increased referrals to emergency health care (Dupont & Cochran, 2000). In addition, the partnerships that are created between the mental health system and law enforcement have been found to improve access to mental health services (Teller et al., 2006).

The CIT for Youth Training

While law enforcement officers are called to respond to incidents involving both adults and youth, the standard CIT training that is offered to most police officers focuses primarily on response techniques for adults. While there are some general similarities between adults and youth, there are important and unique distinctions between the two that require specialized knowledge and training. Youth-focused crisis training for law enforcement officers is especially important given the large numbers of youth in contact with the juvenile justice system who have mental health problems. A study by the National Center for Youth Opportunity and Juvenile Justice (NCYOJ) confirmed that 65 to 70 percent of youth in contact with the juvenile justice system have a

diagnosable mental health condition. For 27 percent of justice-involved youth, their conditions are serious enough to require immediate mental health services (Shufelt & Cocozza, 2006).

Recognizing the need for specialized law enforcement training that is focused exclusively on youth, the Models for Change Mental Health/ Juvenile Justice (MH/JJ) Action Network, supported by the John D. and Catherine T. MacArthur Foundation, developed the ***Crisis Intervention Training for Youth (CIT-Y)*** curriculum. ***CIT-Y*** trains police officers on response techniques that are appropriate for *youth* with mental health needs. It is an 8-hour, supplemental training course for law enforcement officials who have previously undergone standard CIT training and who understand the basic principles and concepts of CIT, but who are looking for more specific information on youth. The ***CIT-Y*** is designed to be administered by a team of instructors with relevant subject matter expertise, experience, and regional specific knowledge.

CIT-Y was developed in conjunction with three states participating in the MH/JJ Action Network: Colorado, Louisiana, and Pennsylvania. The development was overseen and coordinated by the NCYOJ, in conjunction with the Colorado Regional Community Policing Institute.* The lead content developers include Don Kamin, Ph.D.; Stephen Phillippi, Ph.D., LCSW ; and Robert Kinscherff, Ph.D., J.D.

**Additional advisors from Colorado include Sergeant Kevin Armstrong, Judith Brodie, Commander Joe Cassa, Linda Drager, Keri Fitzpatrick, John Patzman, and Elizabeth Sather, PsyD.*

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Cochran, S. (2014). University of Memphis CIT Center. Personal Communication, June 16, 2014.

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CIT for Youth Trainer's Guide

Overview of the Training

The ***CIT-Y*** training curriculum is a 1-day (8-hour) training for CIT-trained law enforcement officers. The training is administered in six separate modules, ranging from .5 to 2 hours.

CIT-Y is intended to provide participating officers with information about

- important adolescent development concepts and behavioral conditions in youth;
- crisis intervention, de-escalation, and communication techniques; and
- community options available for officers and youth.

The training is provided in a classroom setting and is intended to be highly interactive. It includes a mix of didactic presentation, interactive exercises, videos, discussions, and opportunities for feedback. Course participants actively engage with the instructors and other participants, and are encouraged to draw upon their own experiences as first responders and contribute to the discussions.

Target Audience for CIT-Y

CIT-Y is targeted for law enforcement officers who have received prior CIT training. It is intended to supplement, rather than supplant, the CIT training and, therefore, does not cover all of the topics and activities typically included in the full 40-hour CIT training.

A local jurisdiction may consider inviting other stakeholders to the training to learn about the **CIT-Y** program. However, before inviting additional participants, it is important to consider the impact of the presence of additional participants on the target training audience. If there are concerns that the presence of these supplemental audience members will hinder free-flowing discussion and participation in the exercises, the training audience should be limited to the primary target audience.

Planning and Convening a Training: Roles and Responsibilities

Sponsoring a successful ***CIT-Y*** training is a rewarding but challenging task that requires the coordination of several inter-related logistical and substantive responsibilities. At a minimum, someone must be identified to fill each of the following roles:

The Course Director is responsible for creating a cohesive learning environment that integrates a variety of materials, subjects, and learning experiences. This includes working with the instructors and guest speakers prior to the training to ensure that they convey the best possible subject matter information and do so in a manner most absorbable by participants. It also includes identifying subject matter experts who can "localize" units to include site-specific information where necessary. For example, if available, state or local mental health prevalence data for youth in the juvenile justice system could be included in Module 3 (*Adolescent Behavioral Health Conditions*), in addition to the national prevalence estimates that are included in the unit. Module 6 (*Connecting to Resources*) requires the inclusion of site-specific information on local services and resources. A community resource panel of various local agencies can be created and convened to help present at the end of the module. 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. The Course Director should be present during the entire training to facilitate the learning experience of program participants.

The Course Coordinator is responsible for making all logistical arrangements, including arranging for meeting space and audio-visual needs; coordinating with the multiple trainers, guest speakers, and role-play actors; and developing the agenda. The ***CIT-Y*** Coordinator should work closely with the Course Director in managing the

training resources, instructor/presenters, and participants.

Instructors and guest speakers are responsible for delivering portions of the course content and facilitating training exercises and discussions.

Instructor Qualifications

The ***CIT-Y*** training should not be conducted by a single instructor. Rather, localities are expected to identify and involve instructors with relevant content expertise, experience, and region-specific knowledge to administer the units. One option is to use a co-instructor model, in which both a mental health professional and a law enforcement officer teach together and complement the respective expertise of one another. Whenever possible, all instructors should receive formal instruction from the NCYOJ on delivering this training.

How to Use this Guide

This guide is intended to be used by qualified instructors and Course Directors to implement an eight-hour ***CIT-Y*** training. For each of the 6 modules of the ***CIT-Y*** training, this guide includes the following:

- unit content outlines
- presentation slide materials
- training aids and activities
- performance outcomes
- resource articles and references

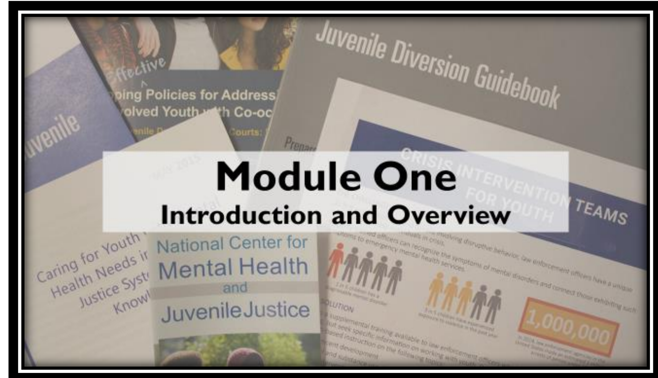
In order to ensure that the ***CIT-Y*** training experience is engaging and relevant for its participants, instructors are encouraged to supplement the materials in this guide with their own experiences and understanding of the local area, its needs, and its resources.

Suggested Delivery Sequence Matrix

This Delivery Sequence Matrix provides a suggested delivery schedule for the eight-hour ***CIT-Y***. It includes the recommended length of each session, recommended instructors for each unit, and recommended instructional activities/materials.

Recommended Length of Session		Topic Area	Recommended Lead Instructor	Recommended Instructional Activities/Materials
8:00 AM - 8:30 AM	.5 hours	Module 1 **Introduction and Overview**	CIT course director	• Pre-course assessment • Video: *Crisis Intervention Teams* • Resource table
8:30 AM - 9:30 AM	1 hour	Module 2 **Understanding Adolescent Development**	Mental health professional	• Video: *The Teen Brain: Under Construction* • Video: *Experiences Build Brain Architecture* • Video: *What fMRI Scans Tell Us About the Adolescent Brain* • Video: *Peer Influence and Adolescent Behavior* • Less Guilty by Reason of Adolescence Handout
9:30 AM - 9:45 AM	.25 hours	Break		
9:45 AM - 11:15 AM	1.5 hours	Module 3 **Adolescent Behavioral Health Conditions**	Mental health professional	• Video: *Idaho Federation Families for Children's Mental Health* • Video: *What Depression May Look Like* • Video: *Intervention & Treatment: A Youth's Perspective* • Video: *Childhood is Not a Mental Disorder* • Resources on Trauma Handout • Myths & Facts Handout
11:15 AM - 12:15 PM	1 hour	Break (Lunch)		
12:15 PM - 2:15 PM	2 hours	Module 4 **Crisis Intervention & De-escalation**	Law enforcement	• Video: *The Initial Approach* • Role Plays • Case Studies Handout • Association for Conflict Resolutions Handout
2:15 PM - 2:30 PM	.25 hours	Break		
2:30 PM - 3:15 PM	.75 hours	Module 5 **The Family Experience**	One trainer, or family member/ family advocacy organization representative	• Suggested outline for family member/ advocacy organization representative presentation
3:15 PM - 4:00 PM	.75 hours	Module 6 **Connecting to Resources**	One trainer and/or a local community resource panel	• Locally created resource guide and/or panel presentation of mental health providers, substance abuse providers, school representatives, child advocacy groups

Module One: Introduction and Overview



Time 30 minutes

Slides 14

Purpose
To provide officers with information about the *Crisis Intervention Teams for Youth (*CIT-Y) eight-hour course and requirements for completion.

Learning Objectives
At the end of this segment, participants will be able to:

- Describe the goals of CIT-Y
- List the different units of the course
- Why CIT-Y?

Activities

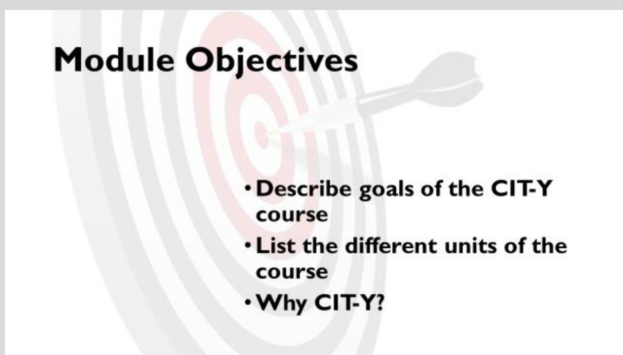
- What Do You Bring/Need?
- Video Activity – *Crisis Intervention Teams*

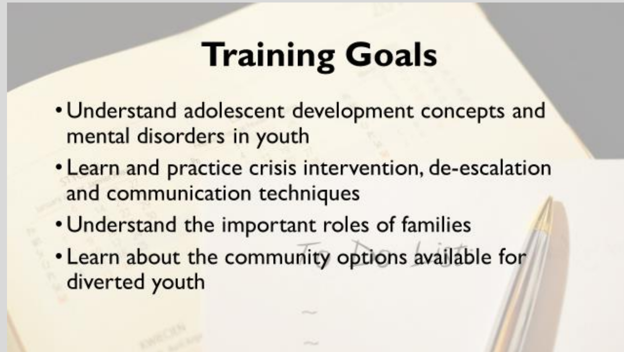
Additional Materials

- CIT-Y Evaluation Component

Module Outline

6. Pre-Course Assessment
7. Objectives
8. Training Goals
9. Overview of the Day
10. Why CIT-Y
    a. Youth Are Different Than Adults
    b. Benefits of CIT-Y
    c. CIT-Y Informed Responses

Training Aids	Delivery Notes
Slide 2	Administer the Pre-Course Assessment located in the back of each participant binder Resource: CIT-Y Evaluation Component
Slide 3 	In this module, we will review the goals of the training and provide an overview of the day. Introduce yourself and describe your specific content expertise.

Training Aids	Delivery Notes
Slide 4 	Review the training goals with the participants. 1. Understand adolescent development concepts and mental conditions in youth 2. Learn and practice crisis intervention, de-escalation and communication techniques 3. Understand the important roles of families 4. Learn about the community options available for diverted youth
Slide 5	*The purpose of this slide is to set the tone for the day and to establish that we are all striving to increase public safety and improve outcomes for youth.*

Training Aids | **Delivery Notes**

Slide 6

Overview of the Day

- Understanding Adolescent Development
- Adolescent Behavioral Health Conditions
- Crisis Intervention and De-escalation Techniques
  - Demonstrating and practicing skills to improve interactions with youth
- The Family Experience
- Connecting to Resources

Present a brief overview of the day. Acknowledge that certain parts of the training will be familiar to officers given their previous CIT training.

However, this training was developed because most CIT courses provide minimal instruction on youth.

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

Slide 7

Activity

What do you bring/need?

Welcome everyone into the training by having them introduce their names and position/location.

Ask them to discuss the strengths/interests they bring.

Training Aids

Slide 8

Delivery Notes

Facilitate conversation by asking officers how they hope to benefit from CIT-Y training.

Remind officers that they are not being asked to be "social workers" or "therapists."

Skills learned in a CIT course can be added to officers' "tool boxes" to make calls more efficient and safer for everyone involved.

Remind officers that much of what they already do will likely be touched on in this class. The class provides a framework for some of the skills they have been using, and reminds them that what they are doing is helpful and is based on what research reveals about child and adolescent development.

CIT-Y training increases officers' opportunities to positively impact the lives of youth struggling with mental health conditions.

Training Aids

Slide 9

Delivery Notes

General similarities exist between adults and youth but there are important and unique distinctions between the two that require specialized knowledge and training.

Partnering with behavioral health intervention and treatment systems helps to divert youth from criminal and/or juvenile justice systems where appropriate.

Training Aids

Slide 10

Delivery Notes

The key is changing how we think so we can change our responses.

If we view an individual as dangerous and out of control, then reacting by exerting force may seem to make the best sense.

If we view an individual as afraid and desperate, then responding by providing a sense of safety makes the best sense.

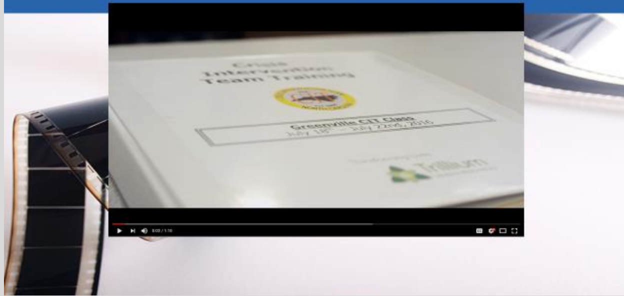
This training is not about asking you to do more, but it is about helping to make your job easier, safer, and more effective.

If we can help participants to better understand a CIT-Y-informed response, this may result in transforming their responses.

Training Aids

Delivery Notes

Slide 11



Purpose: To provide a brief introduction to CIT in general

Time: 1:10 minutes

Start the video by clicking on the image on the slide.

Video Information: *Trillium Direct Connect. (2016, September 6).* Crisis Intervention Team (CIT)/Providing Care Instead of Incarceration.

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

Training Aids

Delivery Notes

Slide 12

CIT-Y-Informed Responses

- Divert youth from the juvenile justice system to more appropriate services when possible
- Fewer incidents
- Fewer injuries
- Less recidivism

CIT-Y-informed responses can help reduce the numbers of youth with behavioral health challenges who are unnecessarily arrested or who re-offend and return to detention.

Training Aids

Slide 13

CIT-Y-Informed Responses

- Ease management
- Help officers do their jobs
- Increase safety for officers and the communities they serve
- The right thing to do

Delivery Notes

Understanding behavior helps officers to respond in ways that de-escalate behavior.

When behavior is less agitated or aggressive (even if defensive aggression), it helps ease management of the situation.

CIT-Y-informed responses promote positive connections, fostering relationships between law enforcement officers and staff.

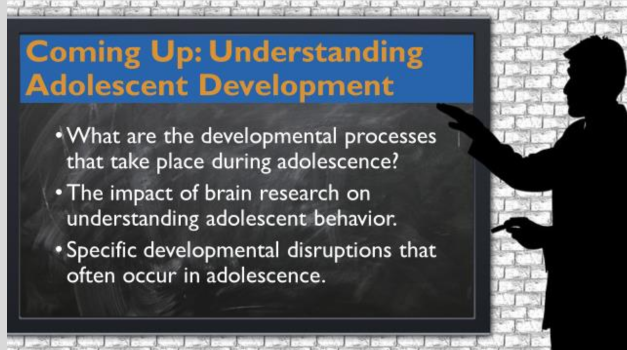
Many officers prefer to see themselves in a helping rather than punitive role.

CIT-Y informed responses helps officers to respond in ways that promote positive interpersonal exchanges.

Training Aids

Delivery Notes

Slide 14



Briefly review the objectives of the next module. Depending on the time, this may be a good spot to take a break.

Supporting Materials
CIT-Y Evaluation Component

The Crisis Intervention Teams for Youth (CIT-Y) training aims to provide law enforcement officers who have previously completed CIT training with an increased awareness of adolescent mental health needs and to improve their ability to effectively and appropriately respond to these youth in their day to day interactions. To determine the effectiveness and impact of the training, the National Center for Youth Opportunity and Justice (NCYOJ) has implemented a strategy to evaluate all CIT-Y training activities. The evaluation process is described below.

Train-the-Trainer Evaluation

The NCYOJ evaluates all CIT-Y Train-the-Trainer sessions to examine the extent to which these sessions successfully prepare trainers to implement the CIT-Y. The data are collected using an evaluation form administered at the conclusion of the Train-the-Trainer session. The evaluation forms are completed by each participant at any Train-the-Trainer session. All completed forms are submitted to the NCYOJ for analysis and a summary of the evaluation results is returned to the site.

Site Training Evaluation:

After participating in a CIT-Y Train-the-Trainer session, the newly trained site trainers are able to deliver the CIT-Y in their state. All trainers will have access to the private CIT-Y Trainer's Portal that contains the following evaluation forms[2]:

- A pre-training questionnaire (administered at the beginning of a training)
- A post-training questionnaire (administered at the conclusion of a training)
- A general feedback evaluation (administered at the conclusion of a training)

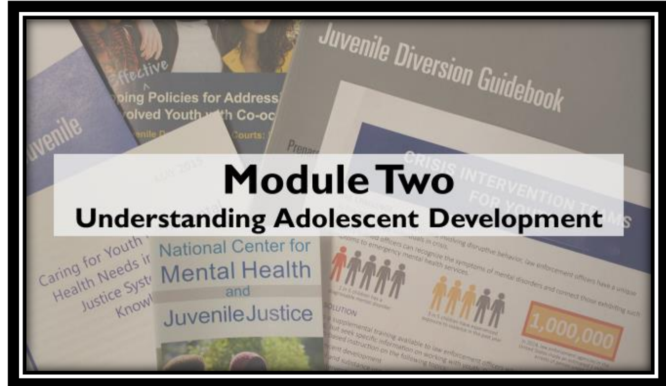
Trainers that conduct a CIT-Y training are strongly encouraged to submit these evaluation forms to the NCYOJ for analysis. Forms should be mailed to:

National Center for Youth Opportunity and Justice
345 Delaware Avenue
Delmar, NY 12054

If you have questions about any of the evaluation requirements, please contact Aly Feye at the National Center for Youth Opportunity and Justice at 518-439-7415 ext. 5238 or by email at afeye@prainc.com

[2] The training evaluation forms as well as the training curriculum for participants are also provided on Trainer's Portal of the National Center for Youth Opportunity and Juvenile Justice. Instructions on how to access the portal are located on the Trainer's Portal handout within your binder.

Module Two: Understanding Adolescent Development



Time 1 hour 15 minutes

Slides 32

Purpose
To provide participants with a basic understanding of healthy adolescent development and the impact of environmental factors on brain development and psychosocial development.

Learning Objectives
At the end of this segment, participants will be able to:

- Name the developmental processes that take place during adolescence
- Describe the impact of brain research on understanding adolescent behavior
- Identify specific developmental disruptions often occurring in adolescence

Activities

- Defining Adolescence
- Video Activity – *The Teen Brain: Under Construction*
- Video Activity – *Experiences Build Brain Architecture*
- Video Activity – *What fMRI Scans Tell Us About the Adolescent Brain*
- Physical and Emotional Development
- Cognitive Development
- Susceptibility to Peer Influence
- Video Activity – *Peer Influence and Adolescent Behavior*
- Putting it All Together

Additional Materials

- Handout: MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice Issue Brief: 3 *Less Guilty by Reason of Adolescence*

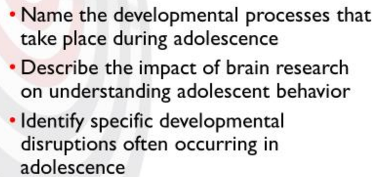
Module Outline

6. Objectives
7. Adolescent Development
    a. Brain Basics
8. Physical and Emotional Development
9. Cognitive Development
    a. Self-control
    b. Short-sightedness
    c. Susceptibility to Peer Pressure
10. Putting It All Together
    a. Some Ways to Help

Training Aids

Delivery Notes

Slide 16

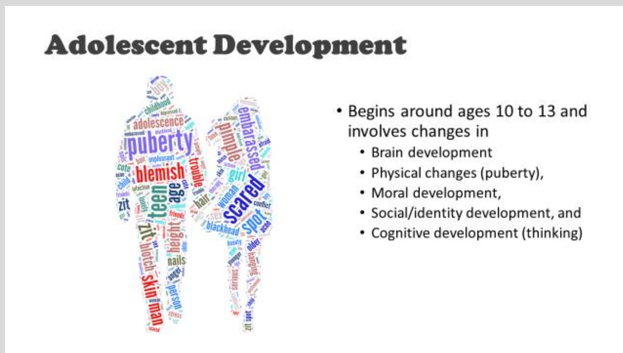


In this module, we will talk about some basics of brain development and how these relate to core features of adolescent development.

Understanding these key brain-behavior relationships establishes the foundation for other modules, where we will discuss how mental health, substance use, and trauma-related conditions can disrupt and alter the developmental process.

This knowledge can help participants better understand and approach everyday situations with "normally developing" kids, as well.

This module can be presented by just one person. However, if you have a co-presenter who is a family member of a justice-involved youth, s/he may provide valuable examples of what you will be presenting. Audience members should be encouraged to provide their own examples as well.

Training Aids	Delivery Notes
Slide 17 	 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. After 3 minutes, ask each spokesperson to present the definition and write down key words on the board/flip chart.
Slide 18  	 *Adolescence begins between ages 10-13 and ends in the early 20s.* *Significant changes in thinking, feeling, and physical appearance occur.* *Adolescents are gearing up for adulthood, but are not there yet.* *Cognitive control, a.k.a. "executive functioning," is the last phase of brain development.*

Training Aids

Delivery Notes

Slide 19

Adolescence is like giving a teenager a car that…

- Has a new engine with a lot of horsepower (physical)
- Is powered by a sensitive gas pedal that can go from 0-60 mph in seconds (emotional)
- Is controlled by a brake system that won't work completely for several years (thinking)
- Shares the same race track with many other cars of the same age (social)

The next section explains:

- Adolescent brain development and how it relates to adolescent behavior.
- That normal adolescence can be a time of risk-taking, poor decision-making, and lack of attention to long-term consequences.
- These behaviors can be frustrating to adults. However, it is important to remember that these are normal predictable features of this development stage. The majority of youth go on to be mature, responsible adults.

Training Aids

Delivery Notes

Slide 20

The Teen Brain: Under Construction

Purpose: To explore the teenage brain, how the brain matures, and what it means from a scientific perspective to be an adult.

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

Time: *2:55 minutes*

Start the video by clicking on the image on the slide.

Video Information: *Discovery News. (2013, December 8).* The Teen Brain: Under Construction.

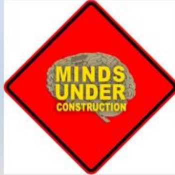
Training Aids

[Slide 21](#)

Brain Basics - Development

As the brain develops, growth happens around different areas of functioning:

- First – physical (breathing, heart rate, blood pressure)
- Next – emotional (happiness, anger, attachment)
- Last – thinking (planning, impulse control)



Delivery Notes

To start, ask participants to take both hands, make them into fists, and put them together side-by-side like this. ***Demonstrate*.**

This is the approximate size of the adult brain, which weighs about three pounds. Let's look at how this organ develops.

- The brain develops from back to front, and from the inside out
- The last area to develop is the thought-processing region of the brain, which covers the emotional centers and is on top of the physical controls

Slide 22

Timing is Key to Brain Development

For some aspects of brain development, timing is critical. Important abilities will be lost or diminished if they don't develop at the right time.

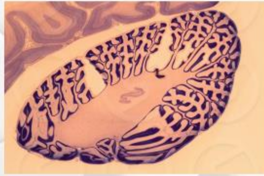
- Childhood is marked by critical developmental milestones.
- Negative childhood experiences can result in developmental delays.
  - Don't confuse a youth's age with his or her developmental level.
- Adolescence is the age of opportunity.
  - This is the last time in the developmental lifespan where so much change is possible in such a little span of time.

As an example, think of the relative ease with which young children can learn languages as compared to adults. This is true because the brain is especially primed to acquire language during this critical time during childhood.

Throughout childhood there are critical times when certain physical, emotional, and thinking functions are at a heightened focus of development. If these developmental milestones are not achieved on time, the associated functions can be much more difficult to develop later and the delay can have significant consequences for physical, social, and academic progress.

Slide 23

Brain Basics – Plasticity



Childhood experiences impact how the brain develops. Experiences can have a powerful impact on the brain.

Practice can strengthen existing connections between brain cells and aid in the development of new ones.

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

This is why we practice behaviors – the more we repeat things, the stronger the brain connections become.

- A single, powerful experience can affect the brain for life.
- Repeated smaller experiences can also change the brain.

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

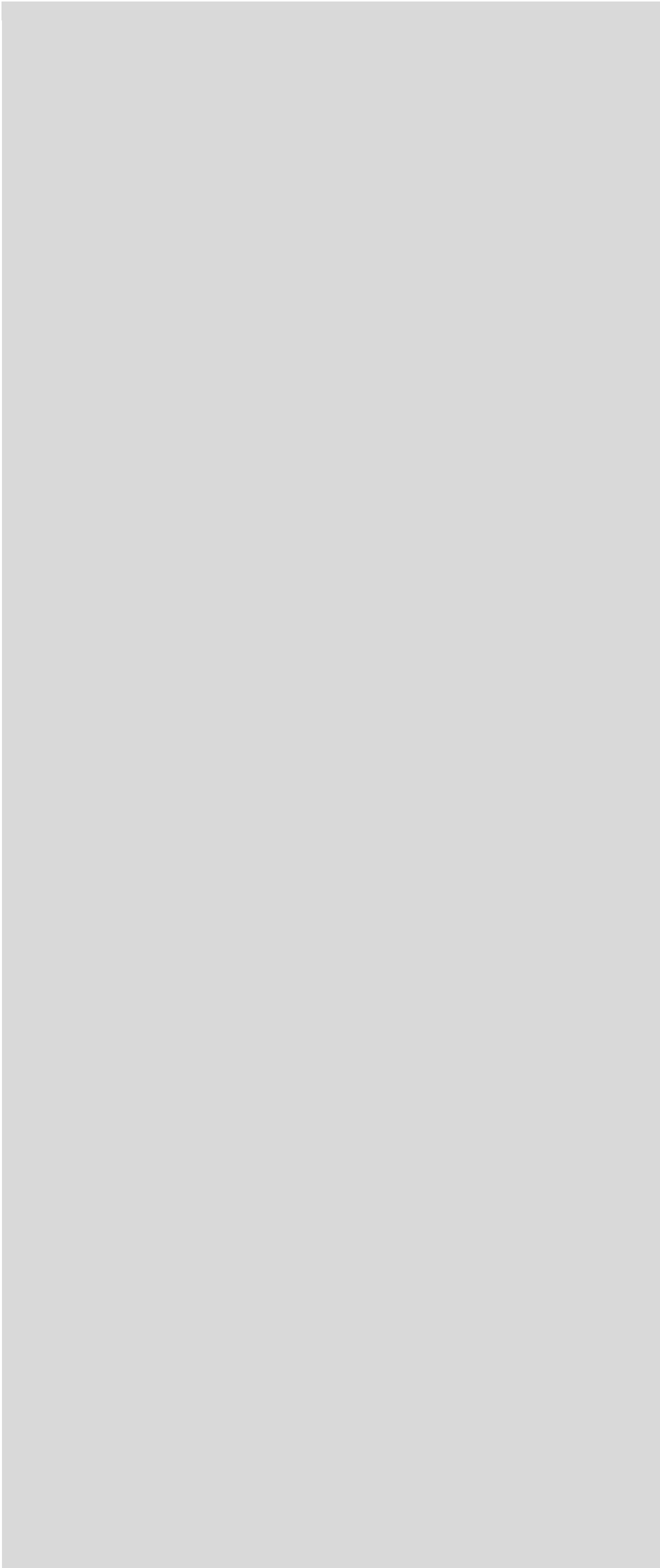
Experiences can have a powerful impact on the brain. These experiences can create a series of cell connections that can be triggered again very easily. Sometimes, this will result in positive associations (hearing a song associated with a positive memory). Other times, this will result in negative associations. For example, a combat soldier may have traumatic memories triggered by hearing a loud bang.

In a normal brain, new brain cell connections can be established. Practicing can strengthen existing connections between brain cells and aid in the development of new ones.

Learning can be thought of as the result of establishing new brain connections. For example, in school when you hear new material, new brain connections are established; then, through repetition, rehearsal,

Training Aids

Delivery Notes



and practice, those connections are strengthened and learning occurs.

Slide 24

Purpose: This video illustrates the basic architecture of the brain and how early construction provides the foundation for all that follows.

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

.

Time: *1:58 minutes*

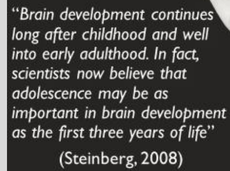
Start the video by clicking on the image on the slide.

Video Information*: Center on Developing Child at Harvard University and the National Scientific Council on the Developing Child. (2011, September 29). Three Core Concepts in Early Development: Experiences Build Brain Architecture.*

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 connections will be based, in part, on what occurs in childhood. Positive, nurturing, and stimulating environments are necessary for optimal brain development. As we will discuss later, abusive, deprived, and unstimulating environments can have a profound negative impact on brain development.

Training Aids

Slide 25



Delivery Notes

Physically, the brain of a teenager is still developing.

Even though the adolescent brain is fully developed in terms of size, the "internal wiring" is not fully developed.

Achieving both optimal physical size and internal "wiring" are necessary elements of brain development.

Slide 26

Purpose: Teens' developing ability to engage in structured planning is described in this video clip. Dr. Jay Giedd of the National Institute of Mental Health shares what he has learned from his many years studying adolescent brain development.

- Brain research has contributed significantly to our understanding of adolescence.
- Even though the adolescent brain may be fully developed in terms of physical size, much of the critical "internal hardware" is still developing.

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

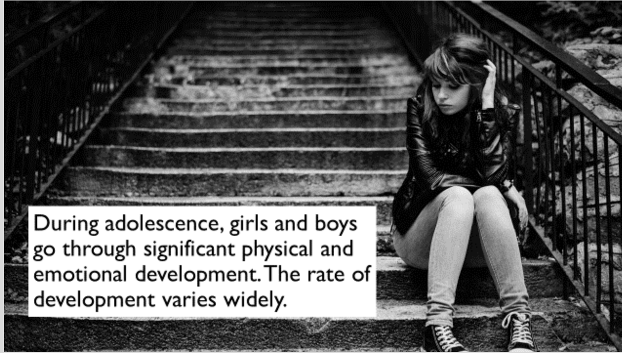
***Time**: 3:24 minutes*

Start the video by clicking on the image on the slide.

***Video Information**: Chedd, G. (Executive Producer). (2013, September 25). What fMRI Scans Tell Us About the Adolescent Brain [excerpt of Episode 2, Deciding Punishment].* Brains on Trial with Alan Alda. *Boston, MA: Public Broadcasting Service.*

Training Aids	Delivery Notes
Slide 27	Lead a brief (1-2 minute) discussion by asking the participants to: Think back to when you were a teenager and started to go through puberty. How was it? How did you feel?

Slide 28



There are important physical, social, emotional, and behavioral differences associated with early versus late maturation in both boys and girls.

Adolescents experience significant physical and emotional changes throughout adolescence. These typically occur between ages 10 and 19.

Boys

Early maturing boys gain social and athletic advantages.

- *They're popular and they excel in sports*
- *Report positive self-esteem*
- *More likely to be leaders of their peer groups*

The slowly maturing boy is usually smaller, less muscular, and not as athletic.

- *Lower social status among his peers*
- *May be perceived as younger and less competent*
- *May act dependent or display immature behavior*

Girls

Early maturing girls can have advantages and disadvantages.

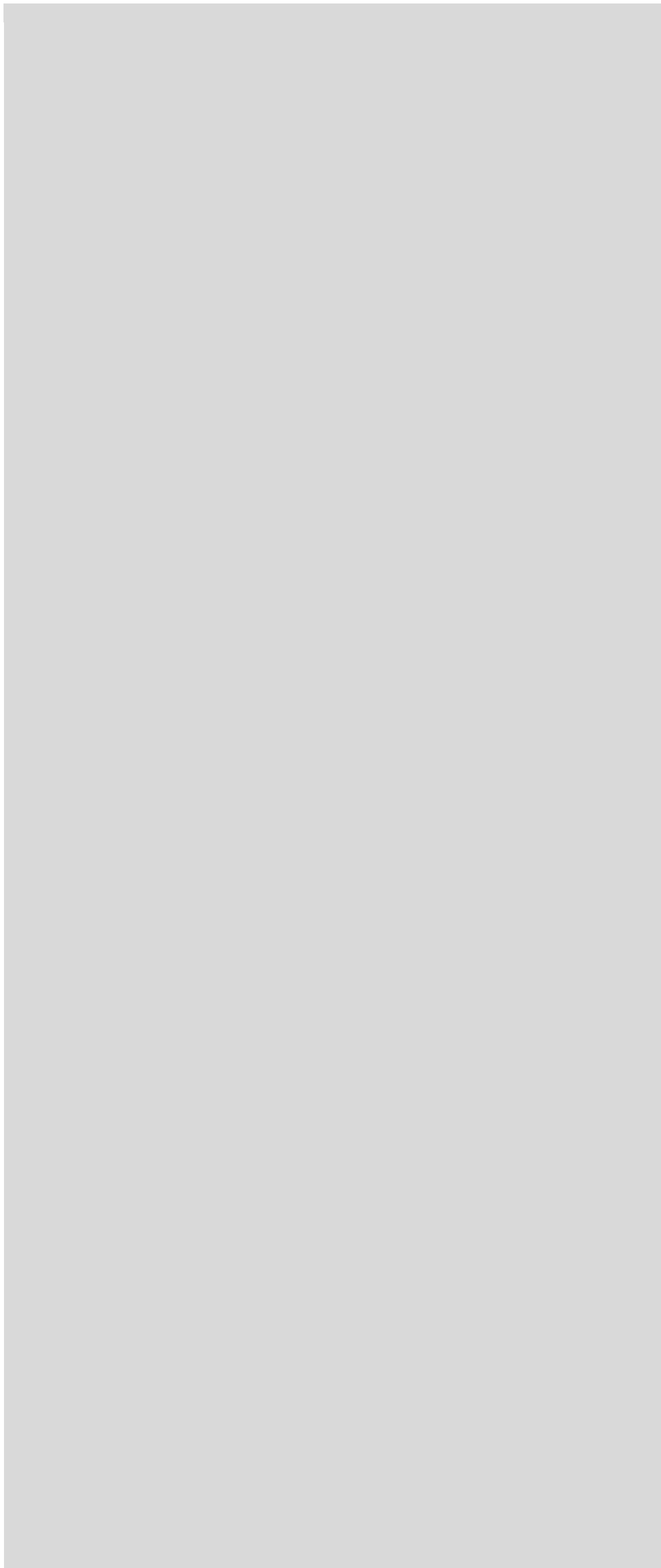
- *Taller, more developed*
- *Report feeling attractive*
- *More popular with older peers*
- *More likely to date*
- *Less in common with friends*
- *Experience distress with puberty*
- *Sexually teased*

Late maturing girls

- *Popular among peers*
- *Report higher-self esteem*

Training Aids

Delivery Notes



- *More focused on academics*
  (Craig, 1999; White, 1999)

Training Aids

Slide 29

Delivery Notes

Youth are especially vulnerable to risky behavior between the ages of 13-17.

- During puberty, there are changes in the brain that govern pleasure, reward, self-control, and judgement.
- This may be why teens are prone to sensation seeking, immediate gratification, and peer pressure.
- Mental health conditions and substance use disorders may compromise this capacity even further.

Slide 30

What is Cognitive Development?

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

Cognitive development refers to the way individuals learn and think about the environment around them (Seifert & Hoffnung, 1994).

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

1. *Early in adolescence, 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).*

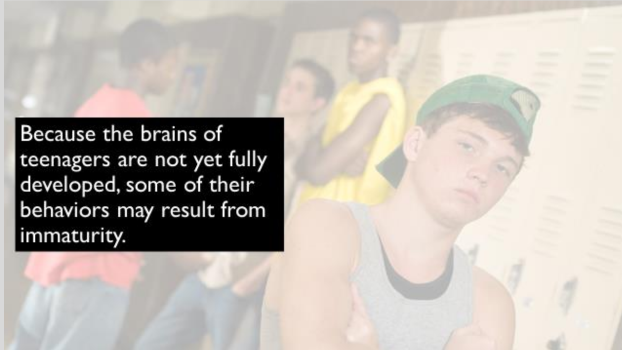
3. *The next major brain change is in the regions that are responsible for self-control. These systems put the brakes on impulsive behavior and permit us to think ahead and more accurately weigh the risks before acting. The maturation of the self-control system is more gradual and not complete until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

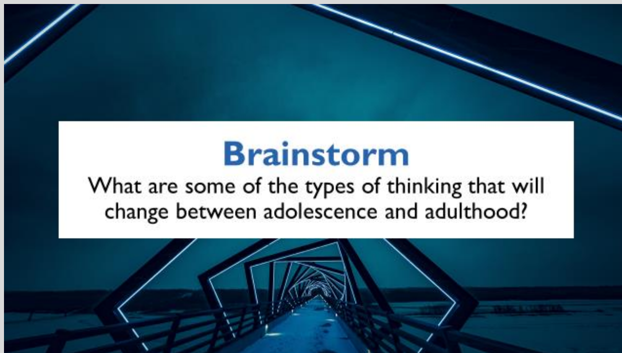
Training Aids

Delivery Notes

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 structured 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 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.*

Training Aids	Delivery Notes
Slide 31 	You could optionally lead a brief (1-2 minute) discussion: Since we know the brains of teenagers aren't fully developed, what does this mean for our work with them?
Slide 32	*Lead a brief (3-4 minute) discussion by asking the participants to:* Recall your own teenage behavior. Did you do anything that could have gotten you stopped by the police? Would you deal with that same situation differently now as an adult?

Training Aids	Delivery Notes
Slide 33	Teenagers are limited by their cognitive development. This means that *some* teenage behavior is simply the result of immaturity (literally, a lack of development). In short, even though teens might look like adults, we cannot expect them to have adult capacities or competencies because this depends on age, experiences, etc.
Slide 34 	Going back to the race car example, as teens mature, their "steering" and "brakes" develop and youth learn to use them appropriately to "keep the car on the road." Remember, however, that these "control" functions mature much more gradually than other aspects of cognitive development.

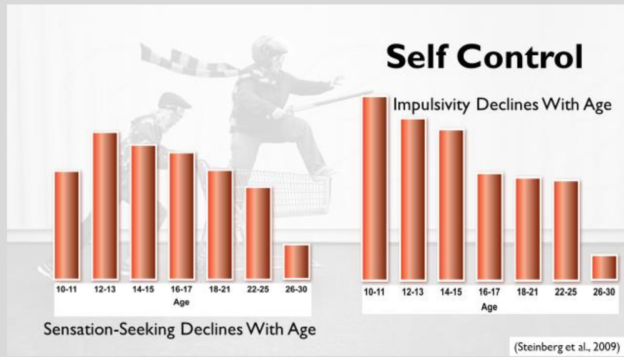
Training Aids

Delivery Notes

Slide 35

Self-control, shortsightedness, and susceptibility to peer influence are three main types of thinking that will change between adolescene and adulthood.

Slide 36



Sensation Seeking Declines With Age (First Graph)

- When given an opportunity to describe their desire for thrill- or novelty-seeking, adolescents between the ages of 12-17 were more likely to choose/endorse the more sensation-seeking options.

Impulsivity Declines With Age (Second Graph)

- Participants were given a test to measure their willingness to react in a quick, rash manner or more carefully think through their next decision/move.
- 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).

Research by the MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice, chaired by Dr. Steinberg.

Researchers studied over 900 individuals of ages 10 to 30 (NOT in the juvenile or criminal justice systems).

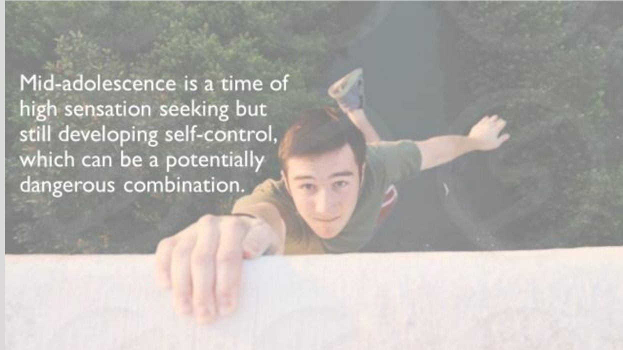
The participants took part in performance and self-report measures of planning, preference for

Training Aids	Delivery Notes
	immediate gratification, impulsivity, risk processing, sensation seeking, and susceptibility to peer pressure. *The findings demonstrate some key differences in how teens think and are influenced as compared to adults.* *(Steinberg, et al., 2008)*

Training Aids

Delivery Notes

Slide 37



In recent years, several psychologists have theorized that the relationship between age and risk-taking is best understood by considering the developmental trajectories of sensation seeking and impulse control (Harden & Tucker-Drob, 2011).

In a 2013 article, Dr. Steinberg described this phenomenon in this way:

- *Sensation seeking is the tendency to pursue novel, exciting, and rewarding experiences. It increases substantially around the time of puberty and remains high well into the early 20s. It then begins to decline.*
- *Impulse control is low during childhood and improves gradually over the course of adolescence and early adulthood.*
- *In childhood (before adolescence), children are typically impulsive, but are not especially prone to sensation-seeking behaviors.*
- *Mid-adolescence can be viewed as a "sweet spot" of sorts: a time of high sensation seeking when impulse control is still developing.*

Training Aids

Delivery Notes

Slide 38

Preferences for Risk Peaks in Mid-adolescence (First Graph)

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

Risk Perception Declines and then Increases after Mid-adolescence (Second Graph)

- Not only are adolescents more prone to taking risks, their perception of risk is faulty. As interest in and preferences for engaging in risky situations peaks, adolescents' perception that the activity is actually risky is declining.

Training Aids

Delivery Notes

Slide 39

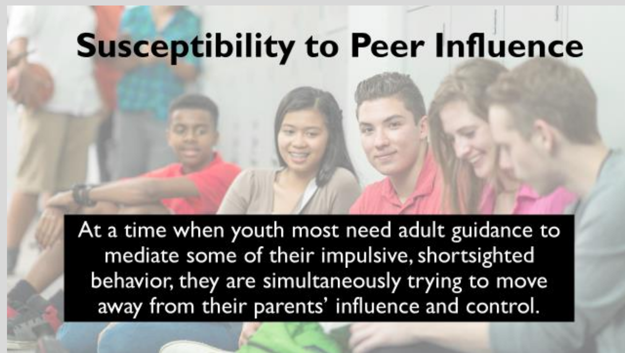
Older individuals are more likely to delay gratification.

- In the study, participants were offered two options. They could accept $100 today or they could wait one year and get $1,000.
- Lack of future orientation, shortsightedness, and unwillingness to delay gratification are real factors for younger adolescents.
- It's not until late adolescence and into adulthood that we see a willingness to delay gratification for a better reward/outcome.

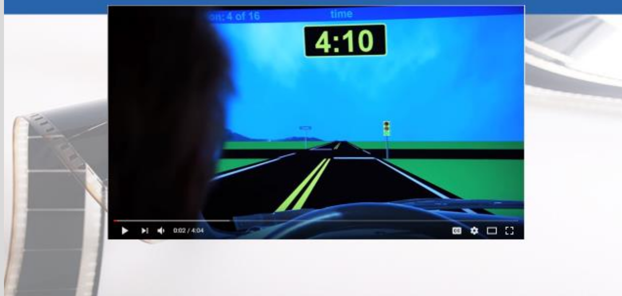
You could lead a brief (1-2 minute) discussion on:

How shortsightedness, the lack of future orientation, and lower likelihood of delaying gratification impacts juvenile justice involvement.

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

Training Aids	Delivery Notes
Slide 40  	 During adolescence youth are: • Looking for affiliation • Looking for social approval • Seeking stimulation and risks
Slide 41 	 Lead a brief (1-2 minute) discussion by asking the participants to: Think back to 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?

Slide 42



Purpose: Video features Dr. Steinberg discussing the risky driving tendencies among adolescents described on the previous slide.

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

***Time**: 4:04 minutes*

Start the video by clicking on the image on the slide.

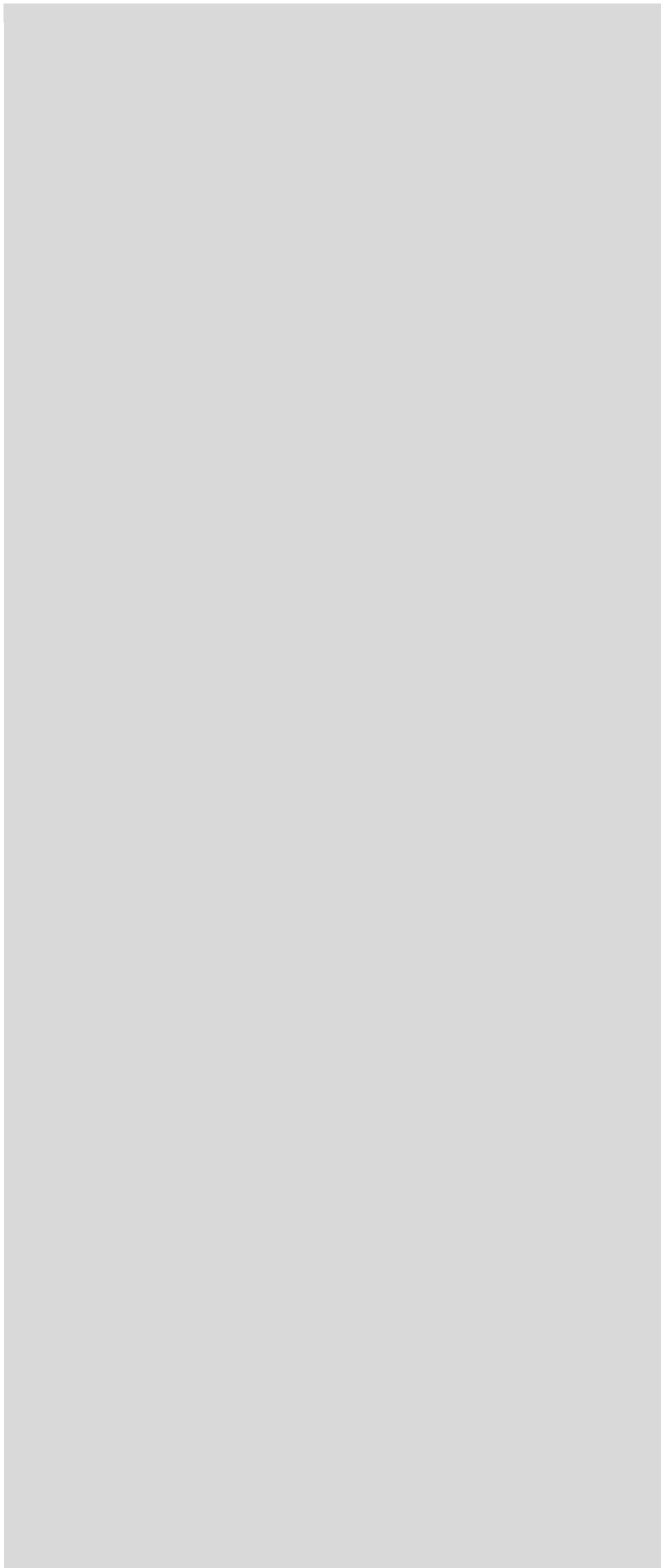
***Video Information**: Chedd, G. (Executive Producer). (2013, September 25). Peer Influence and Adolescent Behavior [excerpt of Episode 2, Deciding Punishment].* Brains on Trial with Alan Alda. *Boston, MA: Public Broadcasting Service.*

The MacArthur study looked at simulated driving behaviors in youth 10-12 years old, teens 13-18 years old, and adults 20-30 years old.

When put in the simulation alone, all three age groups do equally well in managing the driving situations.

However, when peers are added to the simulation

Training Aids



Delivery Notes

- *the adolescents' risk-taking behavior doubles;*
- *the youths' risk-taking increases, but not as much; and*
- *the adults' risk-taking remains unchanged.*

Training Aids

Delivery Notes

Slide 43

Summarizing what we have discussed in terms of adolescent brain development and how it relates to adolescent behavior, we have seen that:

- *Adolescence is a period of substantial brain development.*
- *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 we see in many adolescents.*
- *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, 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 traits that substantially diminish in adulthood.*

Slide 44

Read the following scenario:

Sarah, a 14 year old girl met her friends at a vintage thrift shop. Upon arrival she explained to her friends that she only had $10 and majority of the items in the store were too expensive for her. Her friends began to laugh and Sarah notices that they were shoplifting various accessories. Sarah felt uncomfortable and left the store to get some air

While sitting outside a woman with a ton of shopping bags sat on the bench next to her and convened a phone call. The woman had too many items, was focused on her call, and didn't notice that she left her wallet on the bench.

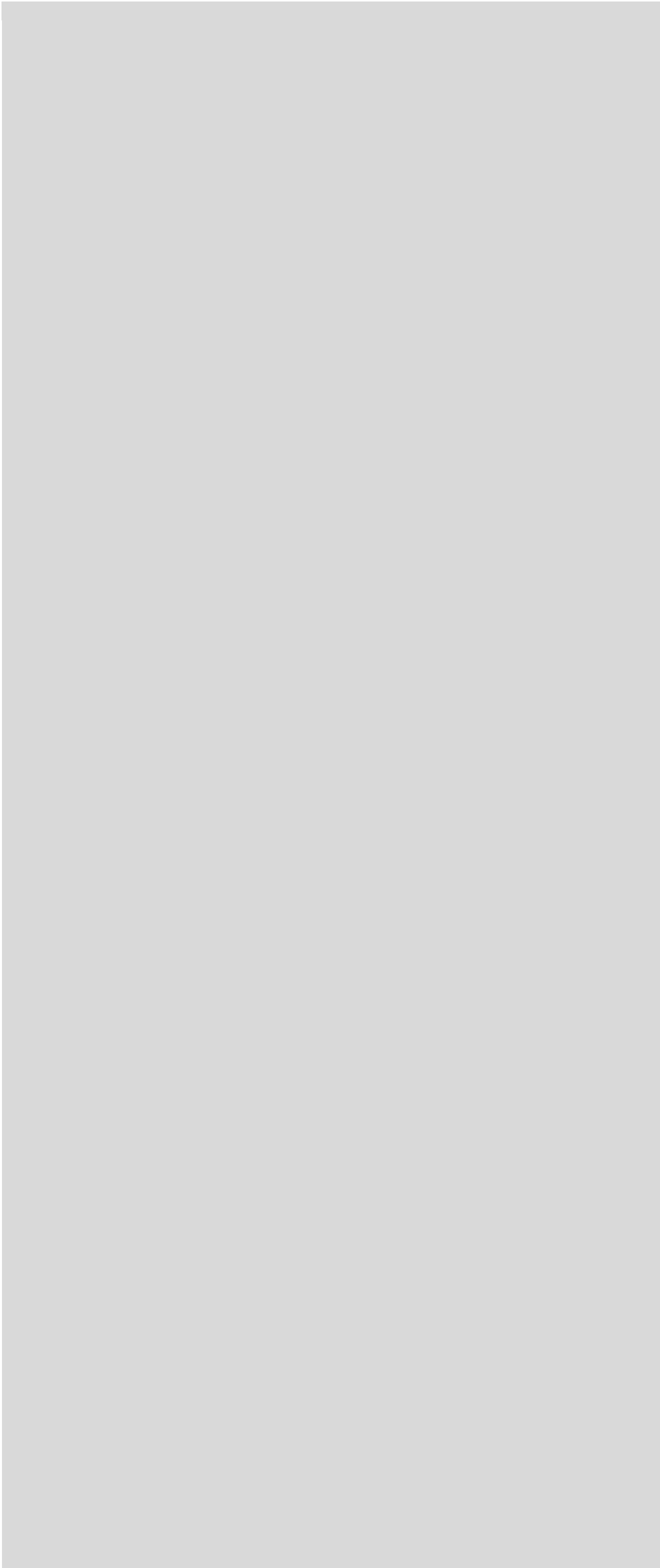
Sarah notices the unattended wallet and decides to steal it. She finds her friends and shows them the wallet. The girls get very excited and decided to go on a shopping spree.

Following the video, lead a brief (1-2 minute) discussion by asking participants:

How the information on brain development discussed during this unit helps them to understand the video.

Expected responses include peer influence, risk-taking, impulsivity, and shortsightedness.

Training Aids



Delivery Notes

Guide the discussion to "bad act" versus "bad kid."

Training Aids

Delivery Notes

Slide 45

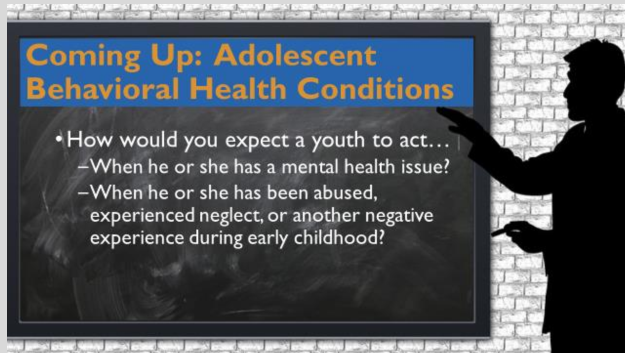
Some Ways to Help

- Adults can help teenagers develop strengths:
  - Calming and self-regulation skills
  - Assertiveness rather than aggression
  - Problem-solving skills

Remember, connections are established through experience and strengthened through repetition.

- Every event or interaction is an opportunity to create, strengthen, or expand existing connections.
- You can have a powerful and enduring influence on the development of the youth in your care. Creating opportunities to override negative connections with more positive, healthy ones can support and enhance a youth's cognitive development.
- Review the ways to help on the slide and instruct the participants that we will dive into these methods in more detail later on.

Slide 46



Briefly review the questions regarding the next module. Depending on the time, this may be a good spot to take a break, or lead the discussion opportunity below.

For youth who have mental health, substance use, and trauma-related issues, adolescence can be an even more challenging period.

Having the guidance of a supportive adult can make all the difference in the ongoing development of the youth. Your role is critical to helping youth navigate the difficulties of adolescence.

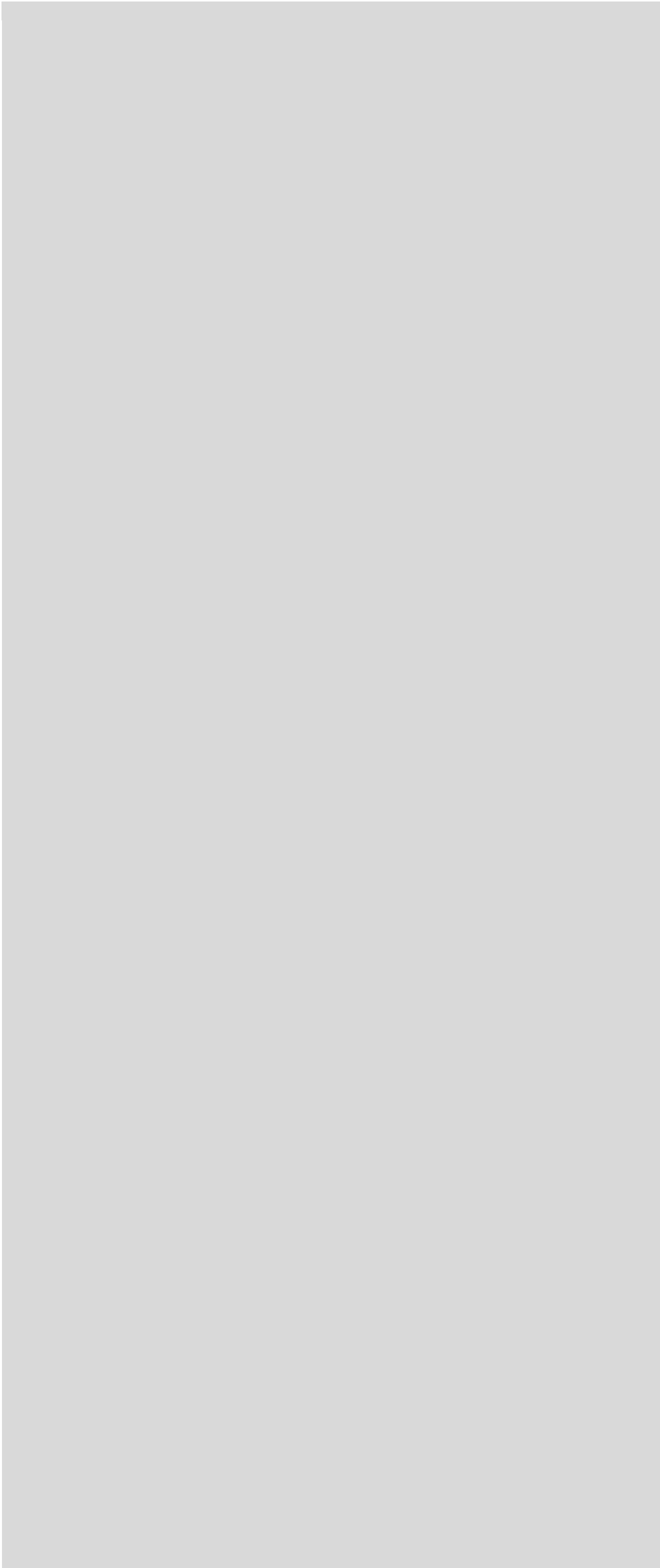
You could lead a brief (3-4 minute) discussion by asking participants about the complicating effect behavioral health and trauma issues can have on adolescent development:

Given that we know adolescents are impulsive, how would you expect the presence of a mental illness to impact that?

If a youth has a substance use disorder, what impact do you think that would have on his/her susceptibility to peer pressure?

Training Aids

Delivery Notes



If a youth had a history of trauma, how do you think that would impact his/her cost-benefit analyses of risky behavior?

Supporting Materials

MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice Issue Brief 3: Less Guilty by Reason of Adolescence

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.

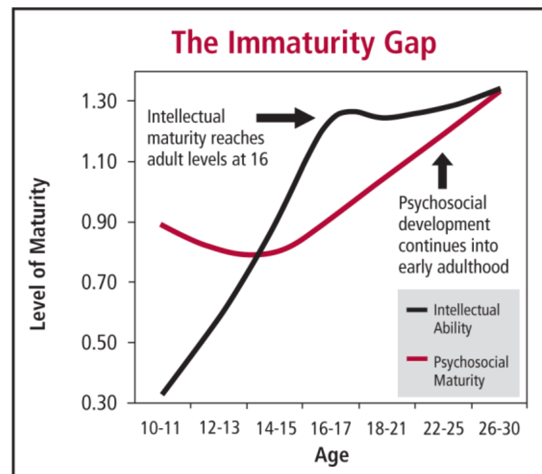
Should developmental immaturity be added to the list of mitigating factors? Should juveniles, in general, be treated more leniently than adults? A major study by the Research Network on Adolescent Development and Juvenile Justice now provides strong evidence that the answer is yes.

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, foften 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 individuals 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 than 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 punishes 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.

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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.

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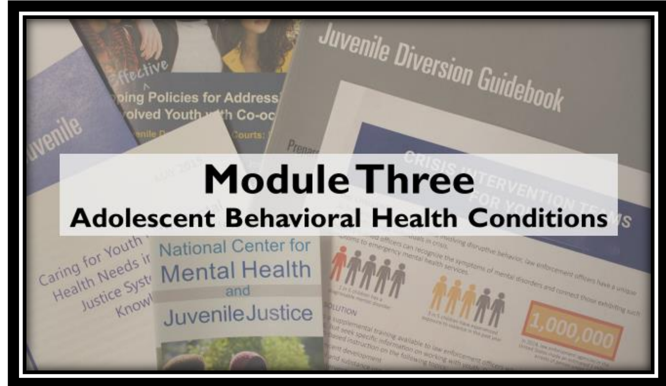
Module Three: Adolescent Behavioral Health Conditions



Time 1.5 Hours

Slides 68

Purpose
To provide officers with a broad understanding of the adolescent mental health and substance use problems they are likely to encounter in a juvenile justice population *and* to increase officer effectiveness in making decisions for the safety of the youth and public.

Learning Objectives
At the end of this segment, officers will be able to:

- 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

Activities

- Symptom Matching
- Juvenile Justice Population
- Video Activity – *Idaho Federation of Families for Children's Mental Health*
- Video Activity – *What Depression May Look Like*
- Video Activity – *Childhood Is Not a Mental Disorder*
- Trauma
- Concerning Juvenile Suicide
- Video Activity – *Peer Influence and Adolescent Behavior*
- What can we do to help adolescents?

Additional Materials

- Handout: Resources on Trauma
- Handout: Myths and Facts

Module Outline

9. Objectives
10. Adolescent Behavioral Health Conditions
    a. Prevalence
11. Mental Health Conditions
12. Screening and Assessment
13. Behavioral Health Disorders Common Among Justice-Involved Youth
    a. Disruptive Behavior Disorders
    b. Substance-related Disorders
    c. Anxiety Disorders
    d. Depressive Disorders
    e. Psychotic Disorders
    f. Neurodevelopmental Disorders
14. Trauma-related Disorders
    a. Traumatic Events
    b. Traumatic Experiences
    c. Symptoms of Trauma: Effects
        i. Prevalence
    d. Trauma's Long-term Impact
    e. Trauma's Impact on the Brain
    f. Traumatic Response Styles
    g. Trauma and Family
    h. What Can Officers Do?
        i. Safety
        ii. Support
        iii. Self-regulating
        iv. Strengths
15. Juvenile Suicide
    a. Prevalence
    b. Suicide Risk Factors
    c. Indications for Immediate Help
    d. Periods of High Risk for Suicide in Juvenile Justice
    e. What Can Officers Do to Prevent Juvenile Suicide?
16. Childhood Is Not a Mental Disorder

Training Aids

Delivery Notes

Slide 48

In this module, we'll review mental health conditions and substance use disorders commonly seen in the juvenile justice population. We'll talk about how certain behavioral health conditions are identified and diagnosed and some of the common symptoms of each. We'll also discuss trauma and its effects on youth as well as suicide and self-injurious behaviors.

The goal of this slide is to prompt the audience to begin thinking about the particular types of behavioral health conditions encountered in a juvenile justice population.

Key Concepts:

- ***In juvenile justice, you will encounter youth who have behavioral health conditions.***
- ***Each disorder is characterized by basic signs and symptoms.***
- ***There is a process for identification and diagnosis.***

Slide 49

Lead a brief exercise to get everybody thinking about mental health conditions and some of their signs and symptoms. Divide the participants into groups of 3-5.

Give the participants a card with each of the disorders below (one disorder per card). Then distribute cards with each symptom below (one per card). Ask participants to match symptoms to disorders and then explain.

Major Depressive Disorder

- Extreme sadness
- Hopelessness
- Trouble concentrating

Bipolar Disorder

- Grandiosity
- Lack of need to sleep at times
- Alternating between depression and mania

Attention-deficit/Hyperactivity Disorder (ADHD)

- Difficulty maintaining attention
- Severe impulsivity
- Tendency to start tasks but quickly lose focus

Post-traumatic Stress Disorder (PTSD)

- Frequent nightmares
- Flashbacks
- Tendency to startle easily

Psychotic Disorders

- Hallucinations
- Delusions
- Paranoia

Training Aids | **Delivery Notes**

Slide 50

Lead a brief (1-2 minute) discussion, asking the officers brainstorm some reasons why they should learn about adolescent behavioral health conditions.

The upcoming slides will provide more reasons why officers should learn about adolescent behavioral health conditions.

Slide 51

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

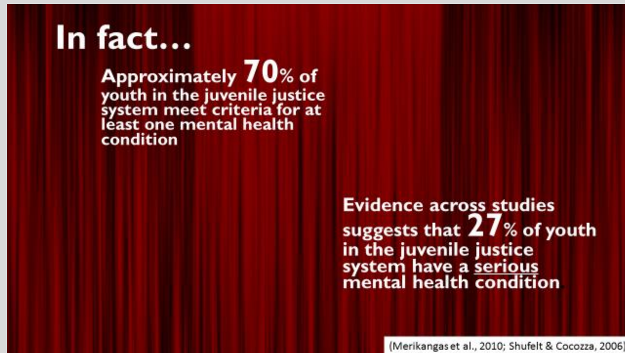
Emphasize that anyone working in juvenile justice is working with youth who have behavioral health conditions.

The goal of this slide is to prompt the audience to begin thinking about the particular types of behavioral health conditions they have encountered with youth in the past.

Training Aids

Delivery Notes

Slide 52



Studies have consistently documented high rates of mental health conditions among justice-involved youth.

In fact, rates of mental health conditions are estimated to be three times higher in the justice population than among the general youth population (Merikangas et al., 2010; Shufelt & Cocozza, 2006).

Data from a 2006 prevalence study suggests that about 70 percent of justice-involved youth qualify for a mental health diagnosis. Further, 27 percent of justice-involved youth meet the criteria for a serious mental health condition (Shufelt & Cocozza, 2006).

For some of these youth, behavioral health issues may already have been identified. For others, you may be among the first to pick up on early signs and symptoms. Those youth who are on psychotropic medication may experience some side effects that will affect their overall functioning and interactions with others.

Training Aids

Delivery Notes

Slide 53

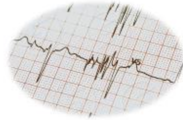
The purpose of this slide and the CIT-Y training as a whole is to provide law enforcement with the appropriate information needed to identify some basic signs and symptoms of adolescent behavioral health conditions.

This will allow officers to intervene with youth more effectively.

Slide 54

Mental Health Conditions

Judgment and behavior can be significantly impaired



Disturbances will be episodic, rather than continuous

Functioning at home, school, or work can be adversely impacted

Mental health conditions can impact a youth's mood and behavior. These conditions can be quite serious and impair a youth's perception, judgement 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 illness over a lifetime.

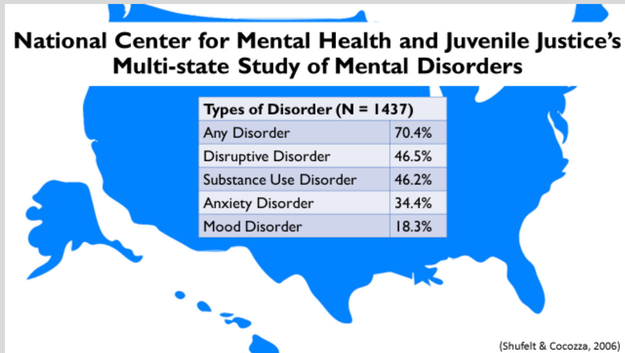
That is why it is important to be especially alert to the early signs of a mental health condition or substance use disorder so that youth can be quickly referred to an appropriate mental health professional.

<u>**Key Concepts**</u>

- **Mental health conditions can be serious.**
- **Mental health conditions are associated with functional impairment across a number of spheres.**
- **Be alert to the early signs of mental health conditions in youth.**

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), "A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (American Psychiatric Association, 2013).

Slide 55



Types of Disorder (N = 1437)	
Any Disorder	70.4%
Disruptive Disorder	46.5%
Substance Use Disorder	46.2%
Anxiety Disorder	34.4%
Mood Disorder	18.3%

The 2006 prevalence study conducted by the National Center for Mental Health and Juvenile Justice offered findings in specific categories of disorders, as displayed on the slide. We will talk about disorder categories in more detail later in this training.

As in similar studies, this study found that nearly 50 percent of the youth qualified for diagnosis of a substance use disorder (Shufelt & Cocozza, 2006).

Key Concepts

- **The overwhelming majority of justice-involved youth have behavioral health conditions.**
- **Approximately half have substance use disorders**.

You could lead a brief (1-2 minute) discussion by asking the officers if these prevalence figures surprise them, why they think they are so high, and what it might mean.

The goal is to help the audience think about the types of behavioral health conditions they are most likely to encounter. It may come up here (and this will be discussed next) that someone can qualify for more than one diagnosis at the same time.

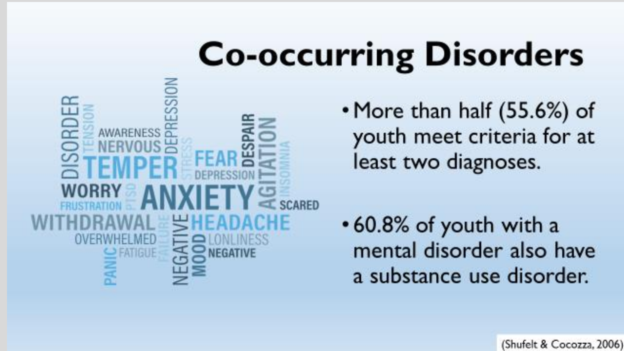
For a detailed analysis of mental health conditions within various juvenile justice settings and including various minority groups, see

Training Aids	Delivery Notes
	Wasserman, et al. (2010). "Psychiatric disorder, co-morbidity, and suicidal behavior in juvenile justice youth."

Training Aids

Delivery Notes

Slide 56



Mental health diagnoses are not mutually exclusive; that is, a person may qualify for more than one diagnosis at one time.

We've already discussed that most justice-involved youth meet the criteria for at least one diagnosis and as you can see here, more than half meet the criteria for at least two.

The term "co-occurring disorder" generally refers to the presence of both a mental health condition and substance use disorder diagnosis. As you can see from this slide, according to the 2006 study, nearly 61 percent of youth had co-occurring disorders. We will talk more about co-occurring disorders later in this module.

Key Concepts

- **Most youth qualify for at least one diagnosis.**
- **Over half qualify for at least two**
- **The incidence of co-occurring disorders in the juvenile justice population is particularly high.**

You could lead a brief discussion (1- 2 minutes) about why the incidence of co-occurring disorders is high.

The goal is to raise the possibility of youth using substances in an effort to "self-medicate" for an undiagnosed or untreated mental illness.

Slide 57

First, prompt the training audience to read the questions on the slide and give them a some time for discussion.

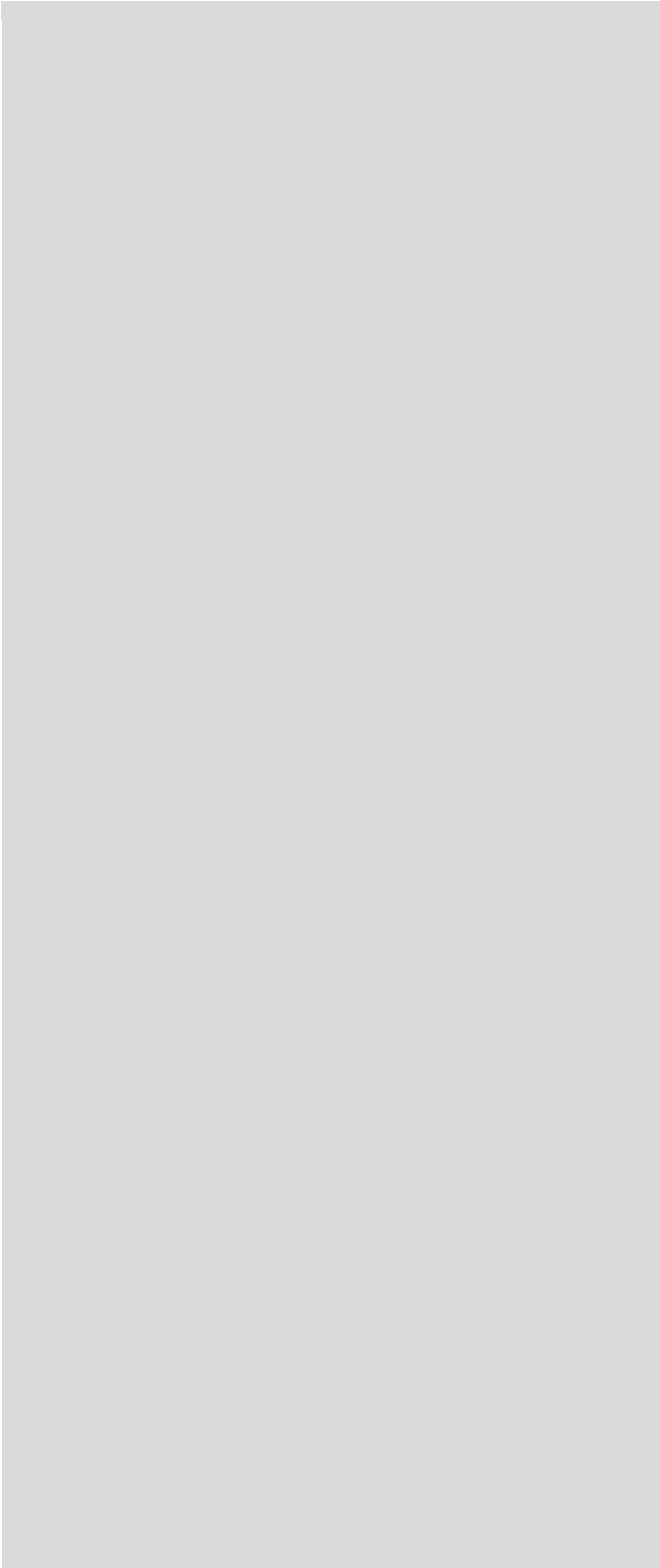
Before we talk about some of the specific mental health and substance use disorders commonly seen in the juvenile justice population, I'd like to spend some time talking about how these sorts of disorders are identified and diagnosed, and how that information is then used to plan treatment and measure outcomes.

We will talk about screening and assessment instruments to use with youth in the juvenile justice system. By collecting the results of these evaluations over time, agencies can determine what their greatest system needs are, as well as how effectively their systems are responding to these behavioral health needs.

Key Concepts

- **Identification of behavioral health conditions begins with screening and assessment.**
- **Information gathered during this process is used to design interventions, plan treatment, and evaluate outcomes**
- **Data can be used to determine system needs and performance.**

Training Aids



Delivery Notes

Again, this is a section where a co-presenter can provide valuable local information. This can help officers understand the screening and assessment processes and their role in the treatment process.

Slide 58

Identification begins with Screening and Assessment

Screening Checklist

- ☑ Short
- ☒ Not individualized
- ☑ Quick to administer
- ☑ Easily scored
- ☑ Focused on a few critical issues
- ?

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

The goal is to identify youth
- in immediate mental health crisis or
- as possibly having a mental health condition.

Screening results indicate the need for
- crisis intervention and/or
- follow-up assessment.

The purpose of a mental health, substance use, or trauma screen is to identify the immediate, urgent, and acute needs of the youth.

The results of the screening are also used to determine whether a more comprehensive, individualized assessment is indicated.

Screens are actually designed to cast a wide net, meaning they will identify people who may have a mental health condition. Some of the people identified in a screen will later be ruled out through a more complete assessment. Thus, the screen identifies some "false positives," which is preferable to missing youth with mental health conditions (false negatives).

You could lead a brief (1–2 minutes) discussion about the things you would want to know about a youth right away.

You might say something like, "When I say immediate, urgent, and acute needs, what comes to mind?

"What sorts of things would you want to know about a youth within the first hour of contact?"

Examples include the following:

- Youth at acute risk for suicide or self-injurious behavior
- Youth at acute risk for aggression or violence

- Youth who are acutely psychotic and in need of immediate hospitalization
- Youth who are at risk for substance withdrawal

CN

Screening and assessment tools should be:

- *Standardized (so they are administered the same way, every time, by everyone);*
- *Valid (actually measure what they say they measure);*
- *Reliable (accurately measure what they say they measure); and*
- *Appropriate to the population (in terms of age, language, etc.).*
- *Screening and assessment tools used in juvenile justice should be validated for the juvenile justice system, as well as for any minority populations being screened and assessed.*

These are some screening measures commonly used in juvenile justice settings.

However, each facility should determine which measures render the most useful data for its population. Screening measures commonly used in juvenile justice are:

Screening

- *MAYSI-2*
- *GAIN-SS*

See the National Child Traumatic Stress Network's listing of trauma measures.

Slide 59

Assessments

- Provide a detailed evaluation of a youth after a screening has indicated further evaluation is warranted
- Are individualized
- Are administered and interpreted by persons with advanced mental health training

Based on the results of a screening, a comprehensive, individualized assessment may be indicated.

Unlike screenings, assessments are usually longer and conducted by a mental health professional.

Assessments are useful to the extent that they inform decisions about the youth's case management and rehabilitative plan.

Key Concepts

- **Assessments are longer than screenings.**
- **They are administered by mental health professionals.**
- **Assessments are individualized based on the results of the screening.**
- **Identification of youth strengths is central to a comprehensive assessment.**
- **Assessments are used to determine clinical, educational, and risk management needs.**

You could ask a co-presenter or member of the facility's mental health staff to briefly (1–2 minutes) review:

- whether mental health/substance use/trauma assessments are conducted at his/her facility;
- when that practice started;
- who conducts the assessments; and
- who reviews the results.

Training Aids

Delivery Notes

This should not be an extended discussion. This should just be a brief overview of the local assessment process.

As with screening tools, assessment instruments should be standardized, valid, reliable, and appropriate to the population.

By reassessing the same youth over time, a system can determine whether youth are improving and how well the system is functioning.

These are some assessment measures commonly used in juvenile justice settings. However, each facility should determine which measures render the most useful data for its population.

Assessment measures commonly used in juvenile justice are:

- *V-DISC (diagnostic)*
- *CAFAS (functional)*
- *CANS-JJ (functional)*

For more information on screening and assessments, please go to www.NCYOJ.com.

Training Aids | **Delivery Notes**

Slide 60

Now that we've talked about screening and assessment, let's review some mental health and substance use disorders common among youth in the juvenile justice population.

Ask participants to work in groups of 3-4 to generate a list of some of the mental health conditions that are most likely to be seen among the youth in the juvenile justice system.

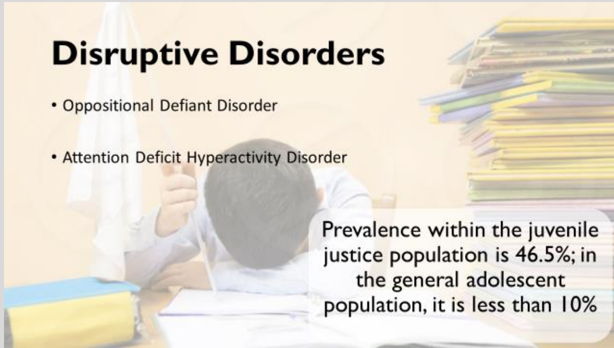
Slide 61

In this next series of slides, you will review formal DSM-5 diagnoses.

The slides will review mental health conditions.

However, in your presentation, rather than go through all of the information line by line, highlight key aspects and engage the audience around related observations or experiences with youth.

Slide 62



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 the rights of others and bring the individual into conflict with authority.

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

Diagnosing disruptive disorders is especially difficult beacause, in adolescents, clincal 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 difficuly for a student to sit still or pay attention.

Oppositional Defiant Disorder
Characterized by a pattern of angry/irritable mood, argumentative/defiant behavior, and vindictiveness Youth with oppositional defiant disorder often have temper tantrums and stubbbornly 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

Training Aids

Delivery Notes

criteria for the diagnosis of oppositional defiant disorder (Teplin et al., 2006).
This disorder involves a persistent pattern of hostile and defiant behavior:

- *Arguing with adults*
- *Defying rules/requests*
- *Blaming others*
- *Being easily annoyed*
- *Being angry*
- *Being spiteful and vindictive*

Attention-Deficit/Hyperactivity Disorder
Types

- *Inattention (difficulties in sustaining attention, listening, following instructions, attending to details)*
- *Hyperactivity/impulsivity (constant squirming or fidgeting, diffiulty in playing quietly, taling excessively)*

ADHD is estimated to affect about 20 percent of youth in the juvenile justice population.

ADHD can impact all areas of functioning. It is most likely to become the focus of attention when children begin school – a time when difficulty with maintaining attention, completing tasks, and functioning within a highly structured environment is highlighted. Some of the hyperactive features of ADHD diminish in adolescence, but the cognitive features of ADHD (such as inattention and diffculty with concentration) can continue into adulthood.

ADHD is more common in males. Females are more likely to have inattention as the primary symptom. ADHD commonly co-occurs with other mental health disorders.

Slide 63

Past studies have found that 46.2 percent of youth in juvenile justice have had substance-related issues.

Early substance use is associated with greater impairment.

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

- 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

According to DSM-5, "the essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems (American Psychiatric Association, 2013, p. 483)."

Problematic effects of the substance can include:

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

Training Aids

Delivery Notes

Research shows that the earlier youth become involved in substance use, the more debilitating it can be. For example, 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 (Grant, Stinson & Harford, 2001). Sadly, some youth in substance use 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).

Slide 64

Anxiety Disorders

- Panic Disorder
- Generalized Anxiety Disorder
- Separation Anxiety Disorder

Past studies have found that 34.4 percent of youth in the juvenile justice system experienced anxiety disorders.

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

Fear is an emotional response to a real, imminent threat.

Anxiety is the anticipation of future threat that is not immediately apparent.

Within the juvenile justice population, anxiety disorders are more common in females than males. In addition, females often present with more intense symptoms of the disorder (Ollendick, 1996).

Examples:

Panic Disorder

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

Generalized Anxiety Disorder

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

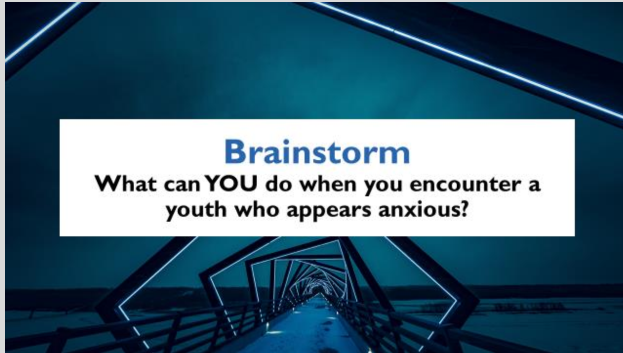
Separation Anxiety Disorder

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

Training Aids

Delivery Notes

Slide 65



Facilitate discussion by asking: "What can YOU do when you encounter a youth who appears anxious?"

Some responses may include

- Being calm, reassuring, and supportive
- Using verbal de-escalation techniques. Patience and active listening provides needed support during times of crisis.
- Being aware that your presence may trigger memories of past traumatic events.

Slide 66

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

Examples:

Major Depressive Disorder
Major depressive disorder is an extremely debilitating, life-threatening illness. Incidence of major depression is higher in the juvenile justice system than in the general population. Major depressive disorder is more common in females.

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

Disruptive Mood Dysregulation Disorder

- *Severe, recurrent temper outbursts*
- *A persistently irritable or angry mood between temper outbursts*
- **A new diagnosis that will not appear in earlier assessments*

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

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

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Delivery Notes

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

In bipolar disorder, both depression and mania are present. The cycling between depression and mania can be rapid or extended.

Diagnosis in children has been controversial.

Training Aids | **Delivery Notes**

Slide 67

Facilitate discussion by asking: "What can YOU do when you encounter a youth who is depressed or manic?

Some responses for mood-based disorders may include

- Be aware of the alterations in mood and behavior, as well as management issues.
- Motivate the youth and encourage the youth to participate in activities.
- Encourage youth to engage others and talk with people.

Some responses for mania may include

- Stay calm. Reasoning someone out of mania will not work. Keep the youth as safe as possible. Mania increases impulsive and unsafe behaviors.
- Maintain eye contact.
- Speak directly and help the youth understand what is being asked.

Training Aids

Delivery Notes

Slide 68

Purpose: To hear from teen youth experiencing ADHD, bipolar disorder, and schizophrenia.

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

Time: *2:01 minutes*

Start the video by clicking on the image the slide.

Video Information: *Mind Matters, from the Idaho Federation of Families for Children's Mental Health.*

Training Aids

Delivery Notes

Slide 69

Purpose: To educate officers about teen depression.

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

Time: *1:24 minutes*

Start the video by clicking on the image on the slide.

Video Information: *American Foundation for Suicide Prevention's Campaign, July 10, 2009.*

Slide 70

When present, these disorders can be extremely disruptive. Symptoms can include the following:

- Hallucinations
- Delusions
- Paranoia
- Bizarre speech

Psychoses are the most severe and debilitating forms of mental health condition.

However, unlike mood disorders or substance-related disorders, psychotic disorders in youth are extremely rare, including youth involved with the juvenile justice system.

Psychoses typically involve a disturbance of both thought and perception.

People with thought disorder will often have disorganized speech. Their verbal responses will be illogical, irrelevant, and incoherent. They may be extremely withdrawn, avoiding eye contact and interpersonal interactions (sometimes referred to as "negative symptoms").

Disturbances of perception occur when an individual's contact with reality is severely impaired and manifested in the form of hallucinations (auditory and visual) or delusions (fixed, false beliefs).

Training Aids

Delivery Notes

DSM-5 emphasizes that cultural and socioeconomic factors must be considered before diagnosing psychosis. As noted in the previous version of the DSM, "ideas that appear to be delusional in one culture (e.g., sorcery and witchcraft) may be commonly held in another.

In some cultures, visual or auditory hallucinations with religious content may be a normal part of religious experience (e.g., seeing the Virgin Mary or hearing God's voice)" (American Psychiatric Association, 2000, p. 281).

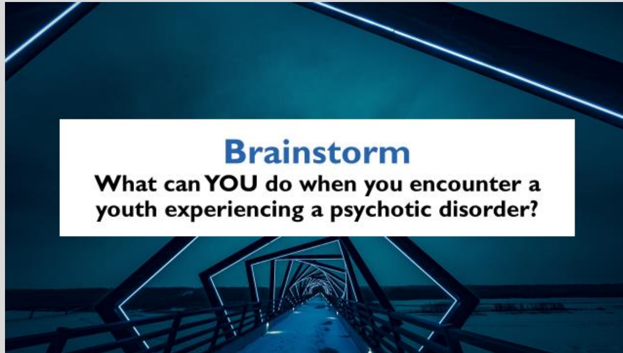
Key Concepts

- ***Psychoses are extremely rare in the juvenile justice population.***
- ***Psychoses typically involve a disturbance of thought and perception.***
- ***Cultural issues must be considered before diagnosing a psychotic disorder.***

Training Aids

Delivery Notes

Slide 71



Facilitate discussion by asking: "What can YOU do when you encounter a youth experiencing a psychotic disorder?"

Some responses for may include:

- Maintaining appropriate eye contact
- Talking directly to the youth
- Helping the youth understand what is being asked
- Being honest ("No, I don't hear that voice, but tell me what it is saying.")
- Being empathetic ("It must be confusing – or scary – for you to hear that when no one else does.")

Stress that it is not possible to talk someone out of a delusion, but it is important to keep him/her safe.

Slide 72

Neurodevelopmental disorders have early onset (often at pre-school age).

The developmental deficits can impair personal, social, academic, and occupational functioning. These deficits, like other mental health conditions, can co-occur.

Examples:

Intellectual Disabilities

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

Communication Disorders

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

It is believed that both intellectual disabilities and communication disorders are more prevalent in juvenile justice than they are in the general population (Quinn et al., 2001).

Some serious disorders, such as autism spectrum disorder, are thought to be relatively rare within juvenile justice and are not reviewed further here.

Note to Trainers:

Training Aids	Delivery Notes
	The DSM-5 includes ADHD as a neurodevelopmental disorder. For the purposes of this training, it is included in the discussion of behavioral disorders.

Slide 73

We will now introduce trauma. *All youth, including those involved with the juvenile justice system, go through the process of adolescent development that we reviewed earlier.*

We learned in this module that many of the youth involved with the juvenile justice system have mental health conditions and substance use disorders. We are also learning that many of these youth have a history of traumatic experiences.

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**

Trauma disorders involve exposure to a highly arousing, frightening event and one's emotional reactions to the event over an extended period of time.

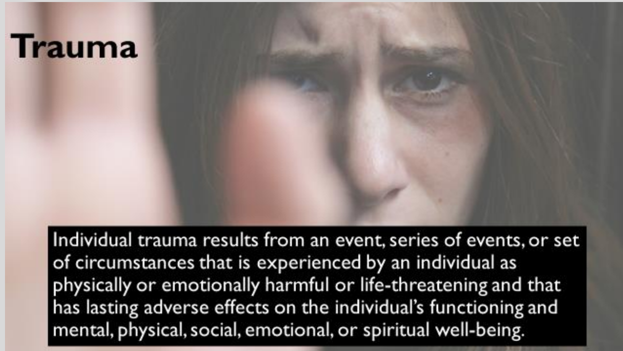
The most well-known of these disorders, PTSD, was originally used to describe acute stress reactions experienced by some soldiers. However, the PTSD diagnosis is not limited to combat soldiers; anyone (even children and adolescents) can develop trauma symptoms.

Many youth in the juvenile justice system have a history of multiple traumatic events. Juvenile justice environments can serve as triggers for symptom reactivation.

Training Aids

Delivery Notes

Slide 74



Child trauma is broader than the traditional diagnosis of post-traumatic stress disorder. Thus, the module begins by focusing on definitions.

Slide 75

What do you see when you look at this slide? It is one picture, but you can focus on it in different ways.

Depending on how you focus, you will interpret the one picture in different ways. The picture with the vase and the human profiles is symbolic of the different ways you can look at a youth's behavior.

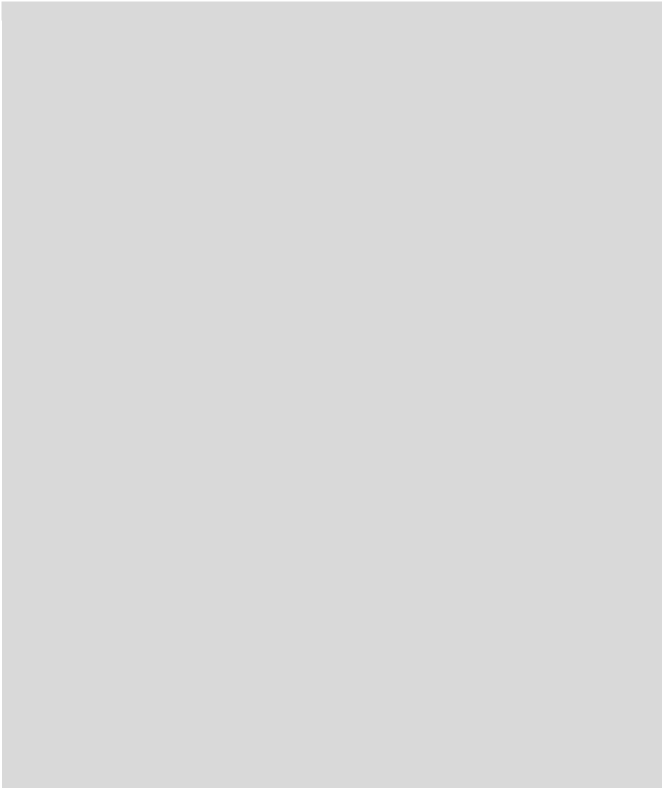
When a youth acts out, some adults might see that behavior as being indicative of that youth being a bad kid. Others might see the behavior as a symptom of a mental illness. Still other adults might see the behavior and immediately think it is the impact of child trauma. One youth, three different interpretations.

All of the adults would agree that there was acting out behavior. But how they interpret that behavior has a dramatic impact on how the adults respond.

The focus that the adult chooses will drive that adult's response to that youth.

This slide is all about getting the group to understand how different people might interpret the same image, event, or situation very differently.

Training Aids



Delivery Notes

Lead a brief (1-2 minute) discussion about how officers regard youth by asking, "Are the youth with whom you work mad? Are they bad? Are they sad? Why do you think so?"

Training Aids

Delivery Notes

Slide 76

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.

You can substitute the systems represented on the slide for child-serving agencies in your own jurisdiction.

Training Aids | **Delivery Notes**

Slide 77

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.

Slide 78

Ask the participants to work in groups of 3-4 to develop a list of events that the group identifies as possibly traumatizing to juveniles.

Training Aids

Delivery Notes

Slide 79

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.

Consider asking the group if there were things that they feared as children that they no longer fear.

This should be a safe way to get them to see how people's experiences change as they develop.

Slide 80

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.

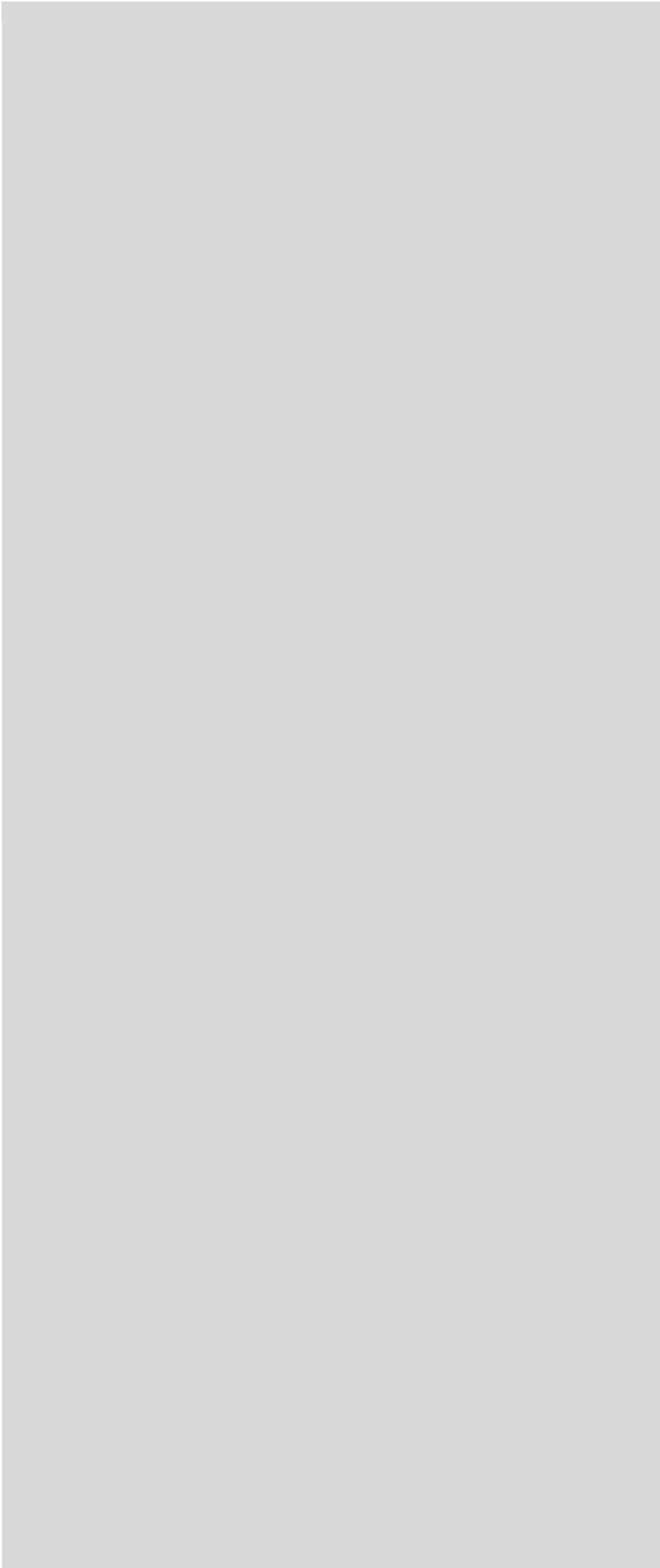
However, some effects are more indirect, like the person who remains constantly on alert and overreacts to neutral situations.

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

You could prompt participant discussion by asking participants whether they have ever known anyone with any of these symptoms:

Do you know anyone who never feels quite safe?

Training Aids



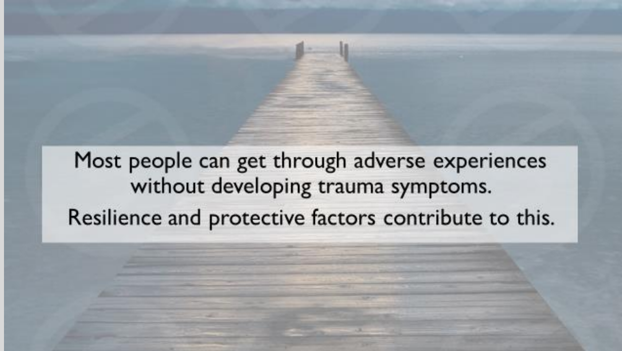
Delivery Notes

- …never sits with his/her back to the door?
- …prefers to keep a weapon close by when sleeping?

Training Aids

Delivery Notes

Slide 81



Most people get through difficult situations without being traumatized. We sometimes describe people who handle difficulties well as resilient.

We also know that there are some skills a person can learn that will help them get through difficult events. We refer to these as protective factors.

Even when a person does get traumatized, there are ways to help him or her recover. Thus, there is always hope when working with traumatized youth.

Training Aids

Delivery Notes

Slide 82

This slide provides a sense of the number of youth who have been exposed to traumatic events in this country.

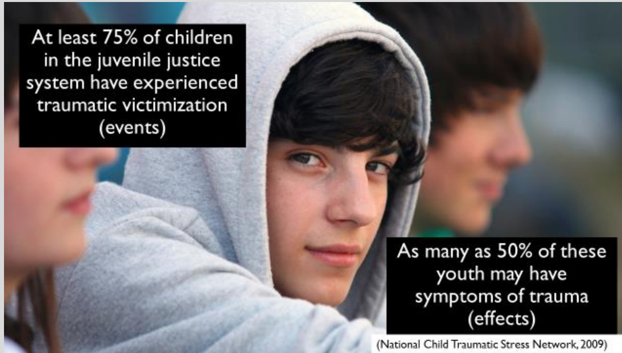
For more information, please see Ford et al. (2007). Trauma among youth in the juvenile justice system: Critical issues and new directions.

Prevalence data is presented on this and the next two slides in order of general youth population, youth in the juvenile justice system, and youth in juvenile detention centers. With each, the prevalence of trauma increases.

Training Aids

Delivery Notes

Slide 83



These numbers specifically refer to youth in the juvenile justice system.

For example, over 11,000 youth were adjudicated in Illinois in 2005; this would mean that from this group, there were over 8,000 trauma victims and 4,000 with trauma symptoms (effects).

Ask participants, "How do these numbers translate to your jurisdiction?"

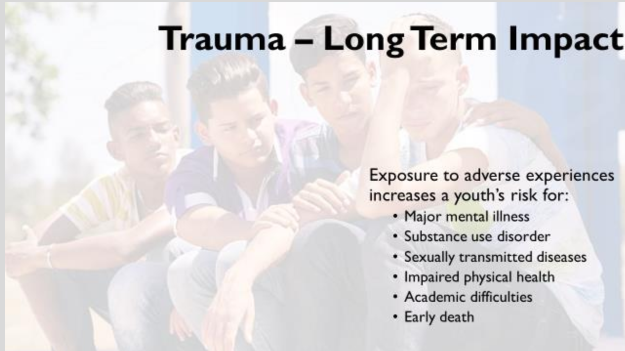
Slide 84

This data focuses on juveniles in detention.

So, our last three slides have gone from the general population to the juvenile justice system to juvenile detention centers.

It shows that, as we go deeper into the juvenile justice system, the prevalence of trauma gets higher.

Slide 85



The Adverse Childhood Experiences Study (ACES) examined youth who experienced physical abuse and neglect, emotional abuse and neglect, and sexual abuse.

It also examined youth growing up in a household with:

- *an alcohol or drug 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

Training Aids

Delivery Notes

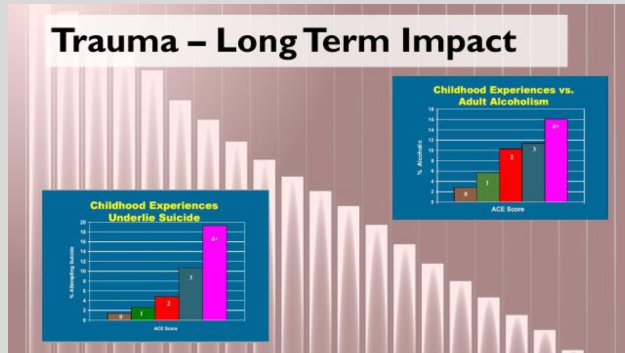
(excerpted from *http://www.cdc.gov/ace/index.htm).*

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.

Training Aids

Delivery Notes

Slide 86



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.

Training Aids

Delivery Notes

Slide 87

Trauma’s Impact on the Brain

Disruption in neural development can include

- Failure to expose youth to appropriate experiences at the critical times (neglect) and
- Overwhelming the brain’s alarm system (abuse)

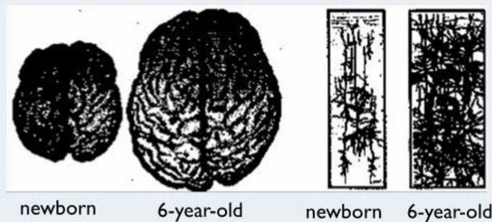
Our earlier module on brain development described how all experiences have some effect on brain cells.

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.

Slide 88

Normal Brain Development



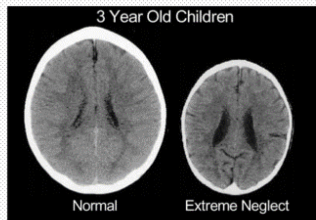
This slide shows normal brain development. As a child gets older, his or her brain gets bigger and it establishes more connections between cells.

This ties back to the discussion in Module 2 on brain development in response to experiences.

Training Aids

Slide 89

Disrupted Brain Development from Childhood Neglect



(Bruce D. Perry, M.D., Ph.D., 2002)

Delivery Notes

Now look at the effect of neglect on a child's brain. These are real images of brains from two 3-year-old children. *(Dr. Bruce Perry's research is used with his permission.)*

Note that the 3-year-old child who has been neglected is not only smaller physically (think of failure to thrive), but his or her brain has many more dark areas that indicate a lack of connection between cells.

You could engage the group in a discussion by asking:

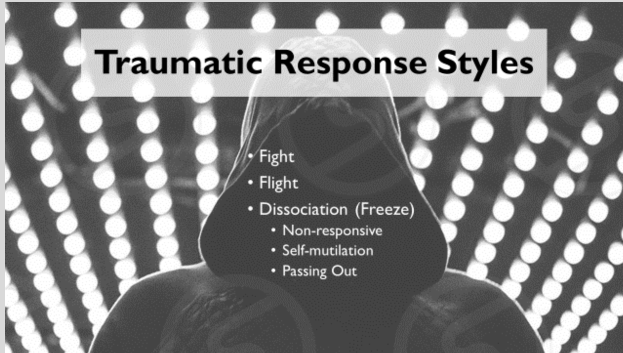
- Looking at these two brains, which 3-year-old child do you think will be less ready to start school?
- Which one do you think will not do as well?
- Who will act out more when frustrated?
- Who will be more likely to drop out of high school?

You could encourage the training audience to visit www.childtrauma.org

Training Aids

Delivery Notes

Slide 90



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:

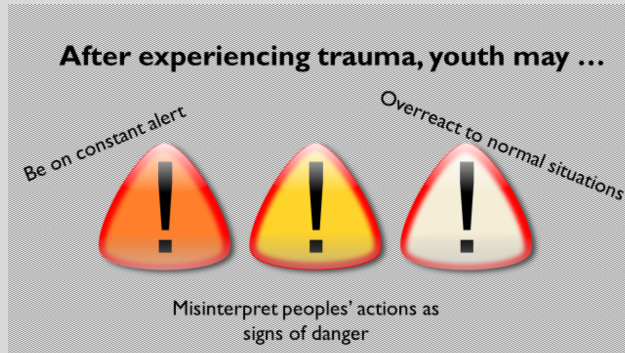
"What may this look like in your work?"

"How might these traumatic responses impact your questioning, searching, arresting, or detaining a youth?

Training Aids

Delivery Notes

Slide 91



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 other's 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.

Training Aids

Delivery Notes

Slide 92

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.

Working with families will be explored more in Module 5.

Slide 93

Lead a brief (1-2 minute) activity by having the officers brainstorm some ways to help youth experiencing trauma

As officers, it is *not* helpful or important to ask the person to recount traumatic experiences over and over. This can cause re-traumatization.

Traumatized youth may have strong startle reactions and even experience flashbacks when being restrained. **Reassuring these youth that they are safe and will not be harmed is critical.** Here are specific suggestions to consider:

- Ask female officers to search/pat-down a teenage girl who reports (or who you suspect has suffered) past sexual abuse.
- Do not use handcuffs unless absolutely necessary.

The upcoming slides will provide more ways in which officers can help youth experiencing trauma.

It is also important to note that in response to the widespread prevalence of violence and its effects in children's lives, many communities have formed partnerships among police departments, mental health service providers, and other child-serving agencies.

Training Aids

Delivery Notes

Mention that it is helpful for officers to become familiar with local services that specialize in reducing the impact of trauma.

For more information about creating a trauma-informed law enforcement system, see: *http://www.nctsnet.org/sites/default/files/assets/pdfs/SS_brief_law_enforcement.pdf*

Training Aids

Slide 94

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

Delivery Notes

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.

Training Aids

Delivery Notes

Slide 95

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.

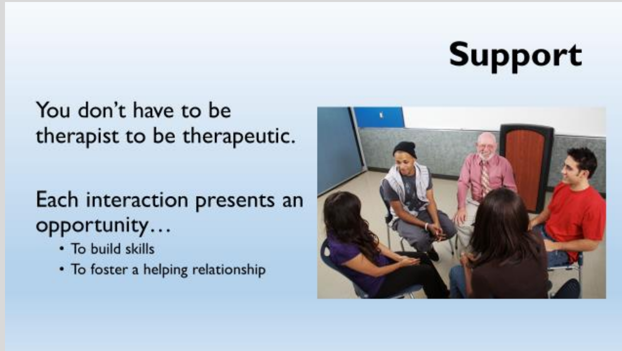
Predictability helps and this can be enhanced through structure and schedules. None of this involves being punitive, even when the traumatized youth still overreacts. It will take a while for a youth to feel safe in a new setting.

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?*

Training Aids

Delivery Notes

Slide 96



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?

Training Aids | **Delivery Notes**

Slide 97

Purpose: 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

Facilitate discussion by asking the participants:

Did the young man's explanation for why he would fight or 'snap' resonate with any of you and your experiences with youth?

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 change at first?

***Time**: 3:32 minutes*

Start the video by clicking on the image on the slide.

***Video Information:** Intervention & Treatment: A Youth's Perspective – I*

Training Aids

Delivery Notes

Slide 98

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

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

Self-regulating

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.

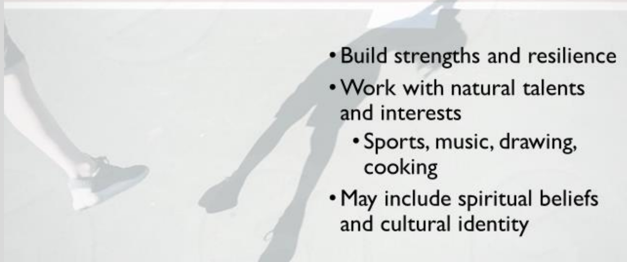
We want youth to learn to verbalize, problem solve, and seek assistance rather than fight, flee, or freeze.

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.

Training Aids

Delivery Notes

Slide 99



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 juvenile? 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?

Training Aids

Delivery Notes

Slide 100

Now we will be switching gears from trauma to juvenile suicide. Youth suicide is a significant public health issue.

Training Aids

Slide 101

Juvenile Suicide

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

Youth in the Juvenile Justice System
- Have an increased risk for suicide
- Suicide is the leading cause of death for youth in confinement
- Youth in residential facilities have nearly three times the suicide rate of peers in the general youth population

(National Action Alliance for Suicide Prevention, 2013)

Delivery Notes

According to National Action Alliance for Suicide Prevention's Youth in Contact with the Juvenile Justice System Task Force (2013, *Need to know…*), youth in the juvenile justice system have an *increased* risk of suicide.

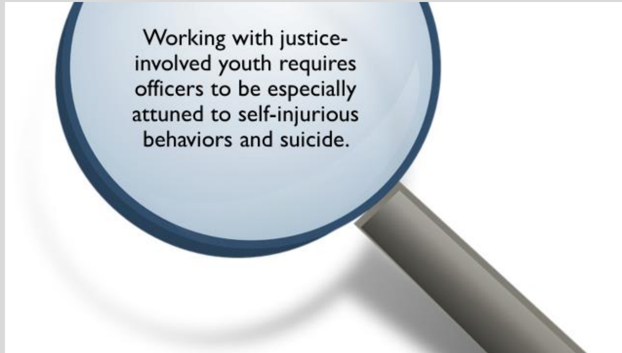
Studies report that over half of juveniles had current suicidal ideation and one-third had a history of suicidal behavior.

Here are some other relevant facts:
- *Nearly 88,000 youths ages 10-18 were treated in emergency rooms for self-harm injuries in 2011.*
- *Males are more likely to die by suicide and females are more likely to attempt suicide.*
- *Certain populations of youth (e.g., American Indian, Alaskan Native, and sexual minority youth) have increased rates of suicide.*

(National Action Alliance for Suicide Prevention, 2013, Need to know…)

Training Aids | **Delivery Notes**

Slide 102



This slide draws off the recent slide and emphasizes that officers working with youth should be alert to the early signs of behavioral health conditions, self-injurious behaviors, and suicide.

Slide 103

Facilitate an open discussion by asking:

What are some known risk factors that may increase suicide risk among all youth?

Training Aids

Slide 104

Suicide Risk Factors

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

Delivery Notes

There are 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*

Risk factors for suicide are often more prevalent among youth in the juvenile justice system and may include those noted on the slide.

Training Aids

Delivery Notes

Slide 105

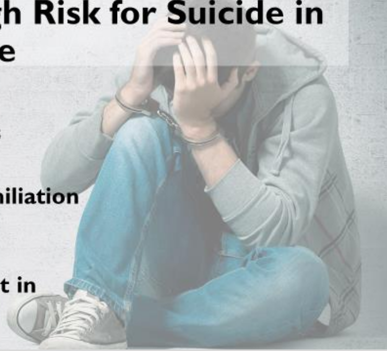
Officers should always be alert to sudden changes in a youth's behavior, appearance, thoughts, emotions, or mood.

Threats of suicide should always be taken seriously and the youth should be seen immediately by a mental health professional.

Training Aids

Delivery Notes

Slide 106



Some points of high risk are easier to identify than others.

For example "receipt of bad news" can occur anytime, such as during phone calls, visits, or mail. It can also be the lack of the call or visit that is upsetting.

If you have a facility co-presenter, you could ask them to talk briefly (3-5 minutes) about institutional policies and guidelines.

- Why is it especially important to use standardized measures when screening or assessing for suicide risk?
- How have suicide screening and assessment measures been used to identify youth at increased risk?

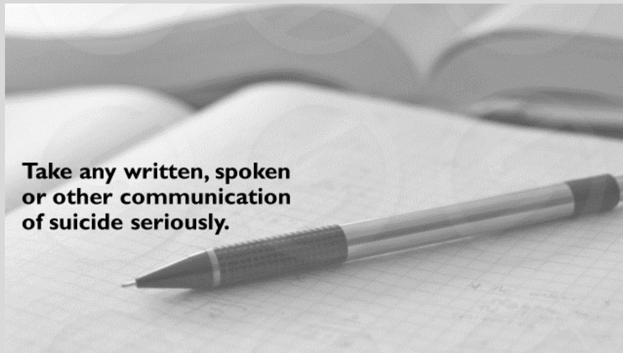
Training Aids | **Delivery Notes**

Slide 107

Lead a brief (1-2 minute) activity by having the officers brainstorm some ways in which they could prevent juvenile suicide.

The upcoming slides will provide more ways in which officers can prevent juvenile suicide.

Slide 108



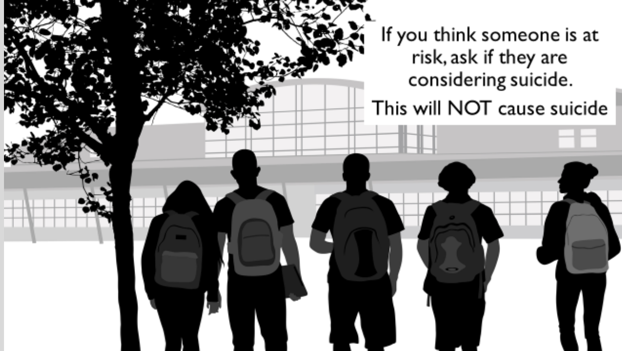
First and foremost, the most important thing officers can do is demonstrate their belief that suicide can be prevented.

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?

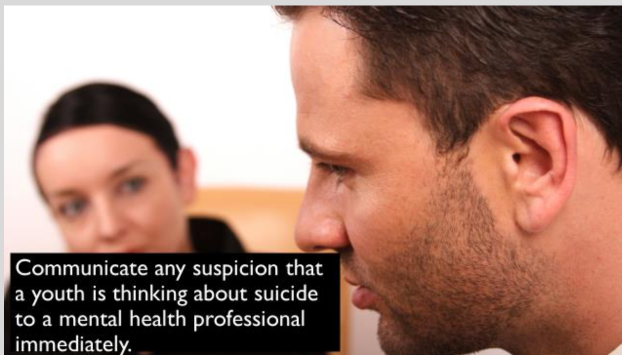
Training Aids | **Delivery Notes**

Slide 109



Remember to listen and not to judge anyone who you think might be thinking of suicide.

Slide 110



Be sure to share any threat of suicide with a mental health professional immediately.

Training Aids

Delivery Notes

Slide 111

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

You could lead a brief discussion (2–3 minutes) on how the audience members view their role in preventing youth suicide. Some questions might be:

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

Training Aids

Delivery Notes

Slide 112

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.

Training Aids

Delivery Notes

Slide 113

Purpose: 20 million kids and adolescents are labeled with "mental disorders" without the proper screening, brain scans, x-rays, or blood tests.

This video helps to remind people that childhood is not a mental disorder and that these children are being saddled for life with false diagnosis.

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

Time: *1:50 minutes*

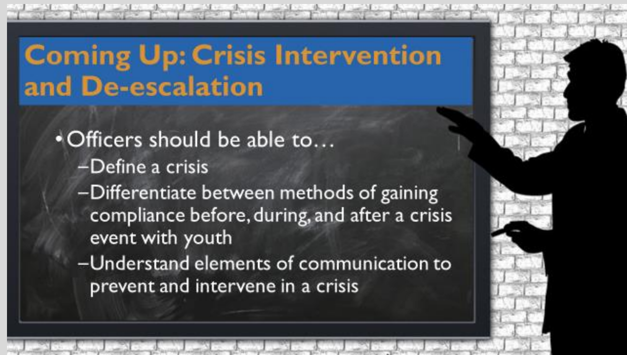
Start the video by clicking on the image on the slide.

Video Information: The Citizens Commission on Human Rights December 20, 2010

Training Aids

Delivery Notes

Slide 114



Briefly review the objectives of the next module.

Depending on the time, this may be a good spot to take a break.

Supporting Materials
Handout

Resources on Trauma

It may be difficult to believe that what happens (or does not happen) to children under 5 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.child trauma academy.com/index.html)
- *Helping Traumatized Children: Tips for Judges*, a brief overview of trauma-informed practices for judges produced by the Justice System Consortium of the National Child Traumatic Stress Network (included in this guide, and available at: http://www.nctsn.org/sites/default/files/assets/pdfs/JudgesFactSheet.pdf)
- *Handout: Creating a Trauma-Informed Justice System*, a Service Systems Brief produced by the National Child Traumatic Stress Network (included in this guide, and available at: http://www.nctsnet.org/nctsn_assets/pdfs/SS_brief_law_enforcement.pdf)

Supporting Materials
Myths and Facts

Myth 1: All youth in the juvenile justice system are mentally ill.
Facts:
- 65% to 70% of youth in juvenile correctional facilities have a mental health condition.
- About 50% of youth in juvenile correctional facilities are in need of special education classes.

Myth 2: 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 health conditions and delinquent behaviors may be related, but are not necessarily causative. The disorder, if undetected or untreated, can manifest in behaviors that could bring youth to the attention of law enforcement.

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), especially in juvenile detention and secure-care settings.
- Many evidence-based practices focus on taking the blame off of any one person in a family and refocus attention so that problems (mental illness included) are an issue for everyone in the family to address. Everyone can be part of the solution.
- Family members may assist in transitioning youth back into the community after an offense has been committed (youth need support and resources to sustain change). For example, treatment is more effective and can continue to help the child beyond confinement when there is a smooth transition from detention or institutional care to the community.

Myth 4: Children and adolescents develop trauma disorders <u>only</u> after exposure to a single catastrophic event.
Facts:
- Trauma-related disorders may develop after a single event or after repeated or cumulative adverse childhood experiences, such as abuse, neglect, domestic violence, or traumatic loss.
- These adverse experiences place youth at increased risk for a variety of negative outcomes, including social problems, disability, disease, and early death.

Myth 5: Delinquent youth have poor family connections, so involving family members is not important.
Facts:
- Maintaining a connection between the youth and the family is essential to the well-being of both.
- Partnering with and engaging family can provide you with valuable information about the youth and make your job easier.
- Involvement of family is associated with positive outcomes.

- It should be noted, however, that some families do not have the capacity to be involved with their child's treatment; in other instances, the family's involvement could actually be damaging to the youth. In these situations, it is important to identify other caring adults who could support and advocate for youth and be involved with their rehabilitation.

Myth 6: 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 that intervene with youth in the context of their environment (family, home, peer, school, work, and 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 institution).

Myth 7: Mental health screening of youth who enter the juvenile justice system should be performed only for a limited number of youth.

Facts:

- All youth entering the juvenile justice system should be screened for mental health and other related issues.
- Screening and assessing youth assist in developing effective treatment planning.

Myth 8: The mental health and juvenile justice systems have competing responsibilities and therefore should function independently.

Facts:

- The mental health and juvenile justice systems have a common mission of meeting the rehabilitative needs of youth.
- The interests of justice-involved youth with mental illnesses are best served when the mental health and juvenile justice systems collaborate around their shared mission and goals.

Myth 9: Youth often become agitated without warning and de-escalation is generally unsuccessful.

Facts:

- Through crisis prevention, officers can be attuned to the early warning signs of a developing crisis.
- Early intervention can prevent a crisis and provide an opportunity for youth to practice adaptive coping skills.

Myth 10: Because youth often threaten suicide to manipulate others or to get attention, it is best to ignore the threat to avoid being manipulated.

Facts:

- A completed suicide is significantly more likely in the juvenile justice population than in the general population.
- Suicidal behavior is extremely common in juvenile facilities.
- All threats of suicide should be taken seriously.

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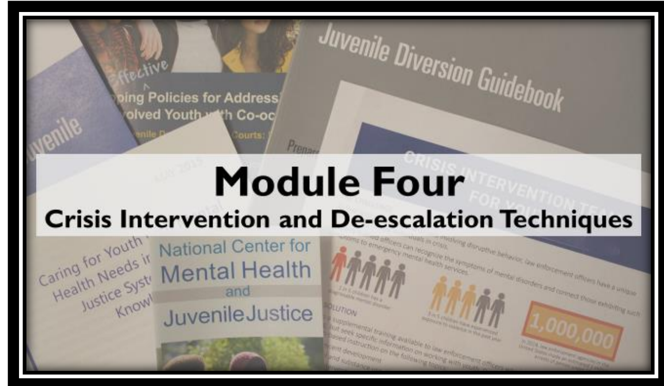
Module Four:
Crisis Intervention and De-escalation



Time 2 hours

Slides 47

Purpose
To provide officers 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.

Learning Objectives
At the end of this segment, officers will be able to:

- Define a crisis
- Differentiate between 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 building rapport and using calming techniques, reflective statements, and active listening

Activities

- Video Activity – *The Initial Approach*
- Crisis Prevention Early Warning Signs
- Numerous Role Plays

Additional Materials

- Handout: Case Studies
- Handout: Association for Conflict Resolutions Newsletter

Module Outline

5. Objectives
6. Crisis
   a. Definition
   b. Crisis State
   c. Triggers for Adolescents
7. Working With Youth – What You Can Do
8. Keys to Successful Crisis Management
   a. Crisis Prevention
      i. Tips
   b. Crisis Intervention/de-escalation
      i. Problem Solving
      ii. What You Can Do
      iii. Tips for Communicating with Youth
         1. Initial Approach
         2. Introduction
         3. Behavioral Change Staircase
         4. Active Listening
         5. Establishing a Dialogue
         6. Influence: Slow Down
         7. Influence: Calming Techniques
      iv. Additional Guidelines for De-escalation
      v. Intervention/De-escalation Summary
      vi. Role Plays
         1. Frustrated and Emotionally Distraught Approach
         2. Hostile/Aggressive Behavior Approach
      vii. Substance-Induced Behavior Approach
      viii. Suicidal Thoughts and/or Behavior Approach
   c. Crisis Follow-up: Learning New Skills
   d. Mental Health Response vs. Criminal Arrest

Training Aids

Slide 116

Module Objectives

- Define a crisis
- Differentiate between 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 building rapport and using calming techniques, reflective statements, and active listening.

Delivery Notes

Stating the following may help some officers "buy in" to this section:

"The job of officers is to both serve and protect. What will be covered in this module will increase the chance of everyone – officers, youth, family, and others in the school/community – remaining safe."

In this module, we'll review crisis intervention and de-escalation. The instruction offered in this unit is not the only appropriate response in all situations where the suspect is mentally disturbed or responding emotionally.

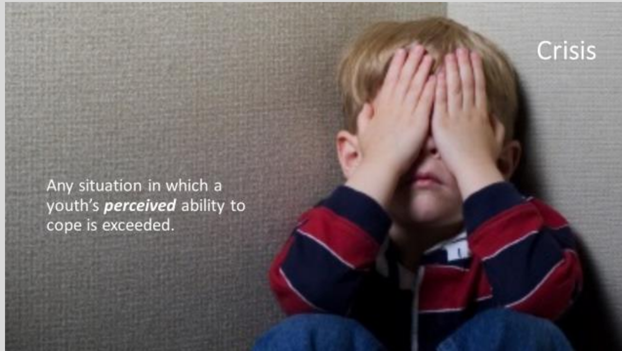
Rather, it is presented as a viable option for the officer who, after assessing the ongoing situation, has decided that the preferred course of action in this circumstance is to attempt to get the youth to voluntarily comply with instructions, commands, or requests.

Physical restraint techniques or defensive tactics are not presented in this course.

Officers 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.

Training Aids | **Delivery Notes**

Slide 117



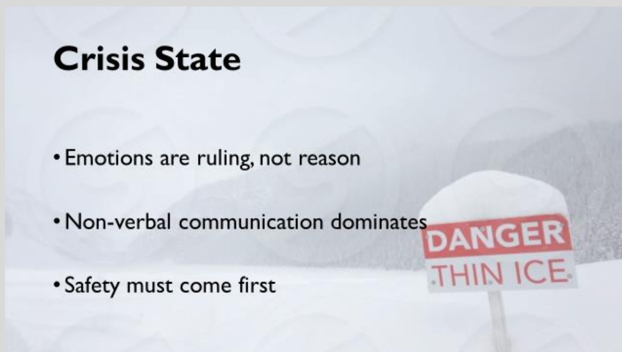
"Crisis" situations might involve:

- Domestic, peer or partner violence
- Substance use/intoxication
- Suicide threat or attempt
- Psychiatric emergency

"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."

When youth *think* they are in crisis, they are.

Slide 118



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.

Training Aids

Delivery Notes

Slide 119

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

Slide 120

A poorly handled crisis can have serious consequences for the officer, for the youth, and for the community 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 officers to:

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

Training Aids

Delivery Notes

Slide 121

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.

You could facilitate a discussion by asking:

"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."

Training Aids

Delivery Notes

Slide 122

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 officers do with youth today can play a critical role in avoiding or managing a crisis in the future.

Slide 123

Ask participants to work in groups of 3-4 to answer the following questions:

What sorts of things signal a budding crisis?
What cues are in the environment?
What sort of behaviors might precede a crisis?

Crisis prevention allows the officer an opportunity to pro-act rather than react.

Being proactive, rather than reactive, can go a long way toward keeping the environment safe for officers and youth.

Training Aids

Delivery Notes

Slide 124

It is also important to note that unfortunately, some signs and signals are only detected in retrospect. Failures to notice signs can be minimized when officers:

- 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.
- Alert other officers about what was observed

Slide 125

Crisis Prevention Tips

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

Adolescents can be very adept at pushing buttons. Testing limits is a hallmark feature of adolescence.

Officers must not personalize situations where youth act out, are disrespectful, or ignore attempts to interact. It is common for adolescents to act this way just to provoke a negative response from an authority figure.

Officers 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

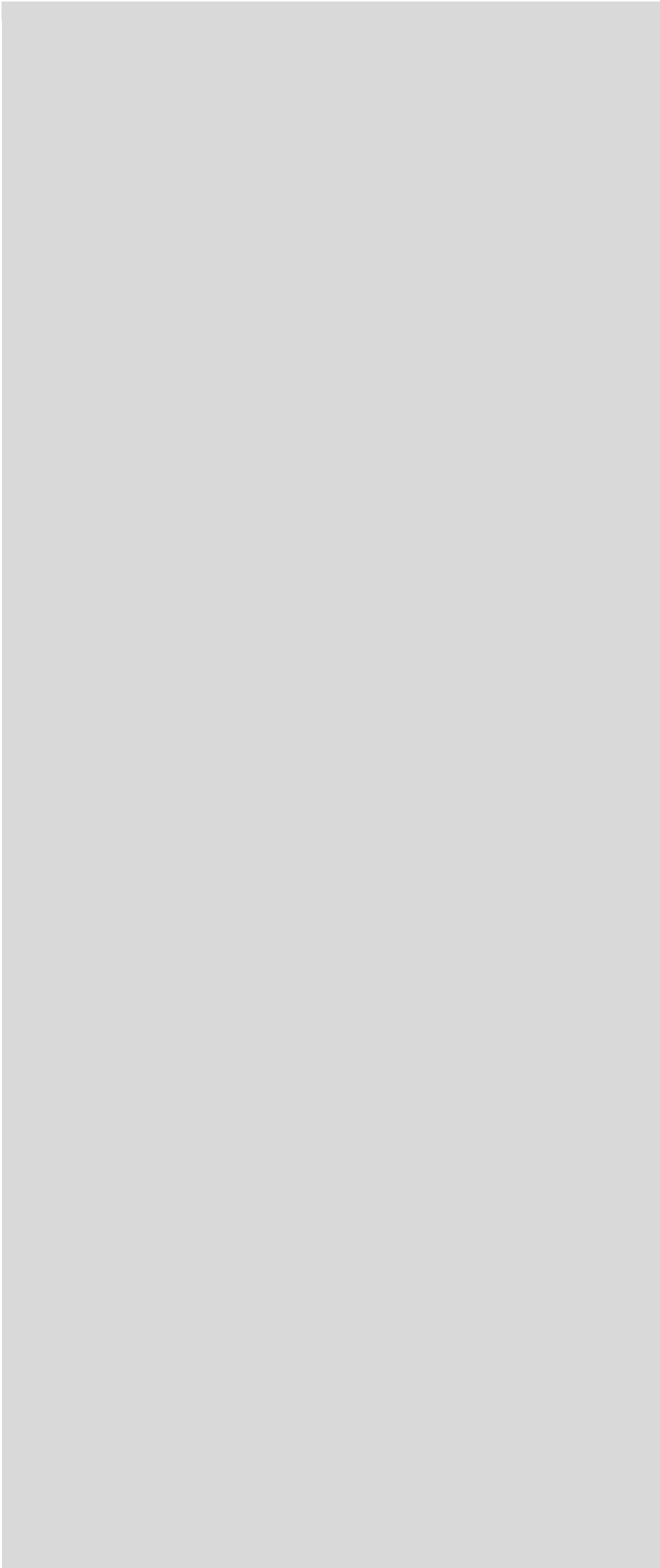
Often, escalation can be avoided if the officer or authority figure does not "rise to the bait." When the officer's re-directions are successful and the behavior of the youth improves, it is important for the officer to acknowledge and praise the improvement.

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 re-visited in a discussion between youth and the officer about how the situation could have been handled better.*

Training Aids



Delivery Notes

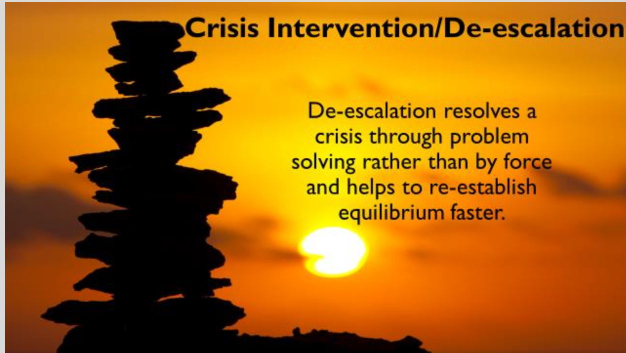
- ***Consider the time sensitivity of the matter.*** *Does the task absolutely need to be done right away OR could walking away for 5 minutes prevent escalation?*

- *Coach youth on using coping or anger management skills they might already know.*

Training Aids

Delivery Notes

Slide 126



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).

Key Concept:
Crisis Intervention/De-escalation can be seen as a short-term, time-limited effort to re-establish a youth's equilibrium and to solve an immediate problem.

Slide 127

Problem Solving, Not Force

Get the youth's attention

Gain the youth's cooperation
- What does the youth really want?
- What is the youth really reacting to (disrespect vs. mental health disorder vs. trauma)?

Discuss the benefits of intervening through crisis de-escalation, rather than going "hands-on."

Benefits include:

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

Point out to officers 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 officers is to maintain control of themselves. Staying calm as they enter an emotion-filled crisis will help officers 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.

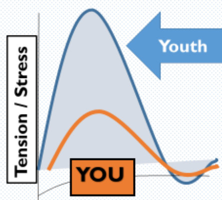
Keep yourself in check.

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.

Training Aids

Slide 128

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

Delivery Notes

The previous point is <u>critical</u> in crisis de-escalation.

To change the direction of the stress and tension, the officer must not escalate with the crisis or get sucked into the situation.

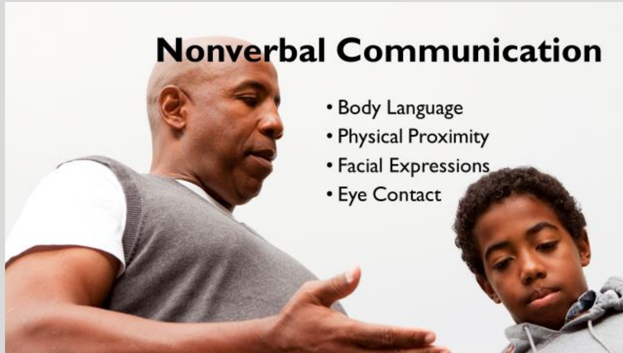
A calm, confident presence is needed to anchor the situation. Officers can be that presence.

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.

Slide 129



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."

It is always beneficial for officers 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 officer who is choosing an intervention approach most likely to be successful during 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? anxiety or nervousness about something I was saying? empathy or understanding when I am feeling sad or afraid?"

Training Aids

Delivery Notes

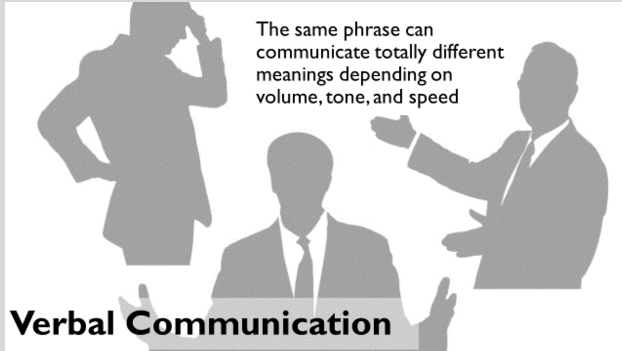
Thank the volunteer and ask participants for other examples of communication through body language.

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.]

Slide 130



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

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.

Share some examples with officers:

Demonstration: "Who left this trash 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?
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 officers, "What do these inflections in volume, speed, and tone mean for you on the job and in the heat of a crisis?"

Training Aids

Delivery Notes

Slide 131

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

You could facilitate a large group discussion by asking:

How do you communicate differently with a 7-year-old child than with a 17-year-old youth?

Follow discussion with a review of the slide, emphasizing the following:

Don't necessarily assume that an officer 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."

Slide 132

Initial Approach

- If practical, monitor youth's behavior prior to approaching
- Assume a calm, non-threatening manner
- Consider personal space issues
- Introduce yourself

Obviously it is only possible to monitor behavior prior to approach if the youth is not engaging in high-risk behaviors.

If possible, officers should spend a moment observing the youth and gathering impressions. The officer's calm manner will set the tone for the interaction.

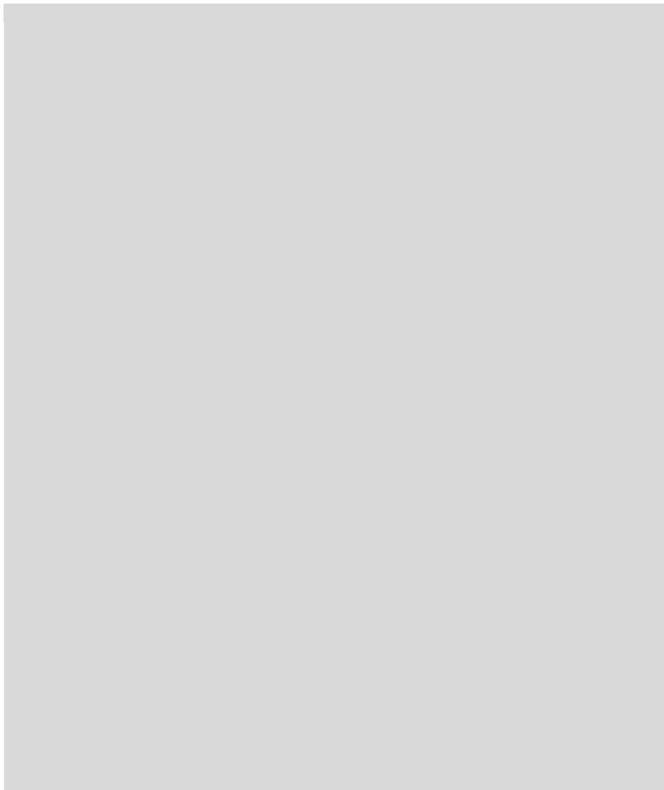
Depending on the state of the youth, allowing greater personal space may be necessary, at least initially.

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 officer comes within eight feet of the boy, he rapidly becomes agitated and angrily tells the officer, "Back off! Give me some space." When the officer complies, the boy's agitation level decreases and he continues to talk about the traumatic encounter. The officer 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 officer doesn't back off, the boy's agitation may rapidly escalate.

Training Aids



Delivery Notes

The entire crisis may then center on him feeling pressured and needing space.

Training Aids

Delivery Notes

Slide 133

Introduction

"I'm ______, an officer with the _____. Police Department, and I would like to help you."

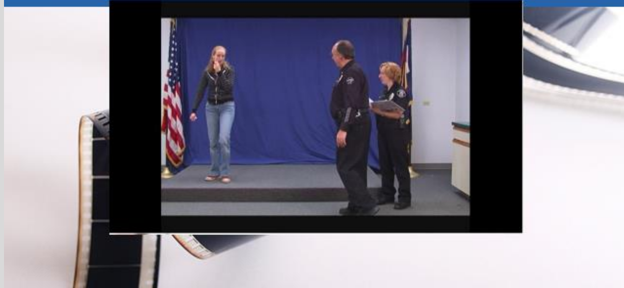
"My name is _______ and I'm from ______ Police Department. I'd like to talk to you about what has happened today. I understand there is a problem and I'd like to help."

Remind officers that they should not assume that the youth knows they are there to help, which is why a clear introduction is important. This slide presents a couple of ways of doing this.

Training Aids

Delivery Notes

Slide 134



Purpose: To display the initial approach as well as de-escalation techniques.

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

Time: *9:07 minutes*

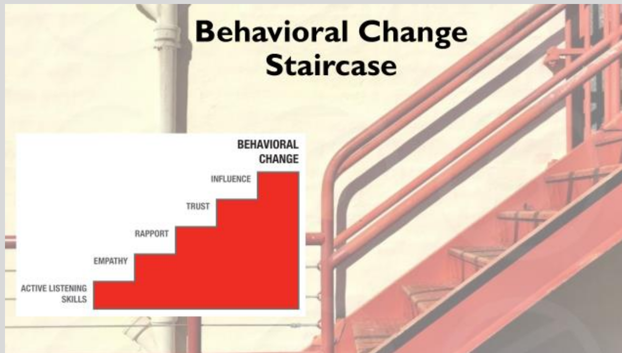
Video Information: *Developed by the National Center for Youth Opportunity and Justice*

Note to Trainer: *The video is extensive, so depending on time, you may want to focus on the initial approach and then move on to the remaining content.*

Training Aids

Delivery Notes

Slide 135



Introduce active listening as the next topic of training.

Active listening is the starting point to changing behavior.

Officers 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.

Because of the active listening skills used, including empathy, rapport develops. This leads the youth to begin to trust the officer who is intervening. At that point, the officer 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."

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.

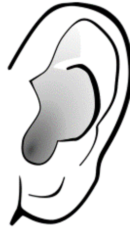
Training Aids

Delivery Notes

Slide 136

Active Listening

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



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.

Active listening is a true skill. Practicing and further developing this skill can help officers become familiar with the youth with whom they come in contact and can be a powerful tool for them to rely on during times of crisis.

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.

Slide 137

Discuss barriers to active listening.

Avoid arguing or 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 kids."

Avoid minimizing 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."

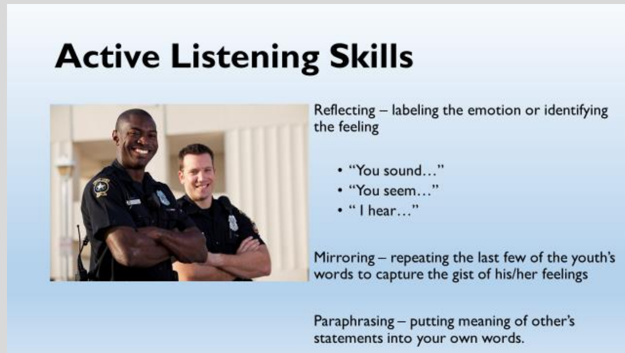
Avoid jumping to conclusions. Don't tell the youth what you think the problem is.
Avoid: "You know, I think you are depressed" or "I think you are making too big of a deal about this."
Instead say: "Tell me more about what you are feeling" or "Can you think of anything you might change about how you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

Avoid 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?"

Training Aids	Delivery Notes
	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.

Training Aids | Delivery Notes

Slide 138



When a listener is able to reflect the speaker's feelings, the listener is perceived as being empathetic and understanding.

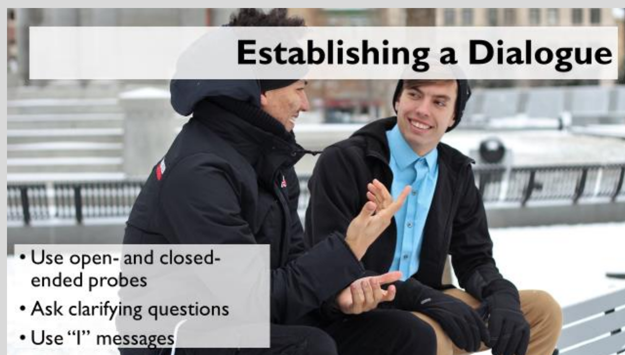
Active listening skills are the fundamentals to establishing a dialogue with a youth.

Provide examples of mirroring:
"The worst day of your life…?
"You just feel like smashing something?"
"You never want to see her again?"

Provide an example of paraphrasing in the context of understanding the youth's story:

"Let me just make sure I understand what you're saying; it seems [summary of situation in your own words]…"

Slide 139



Officers 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, on the other hand, 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 officer should switch to open-ended questions as soon as possible.

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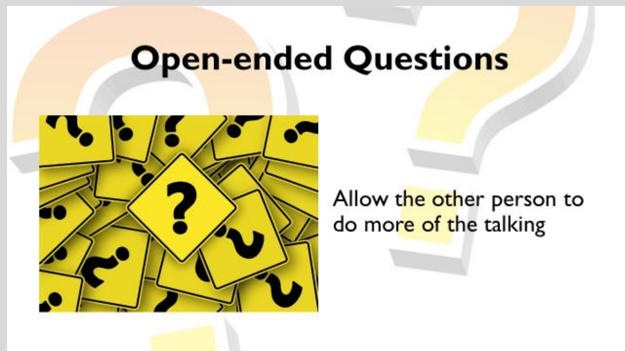
Delivery Notes

Slide 140



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 about what needs to occur in order to stabilize the situation.

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 and next steps."

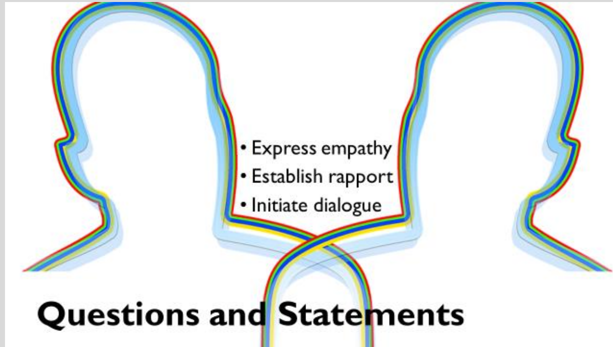
You could ask participants for examples of an open-ended probe questions.

If none are forthcoming, provide examples, such as:

- "Sarah, what led up to this?"
- "Jim, how did this all start?"
- "Sam, what happened in the deli this morning?"
- "Tell me what happened here."

Training Aids | **Delivery Notes**

Slide 141



Clarifying questions and statements help lead to 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 142

"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 "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."

Slide 143

By expressing empathy, an officer may increase his/her rapport (and make a better connection) with the youth.

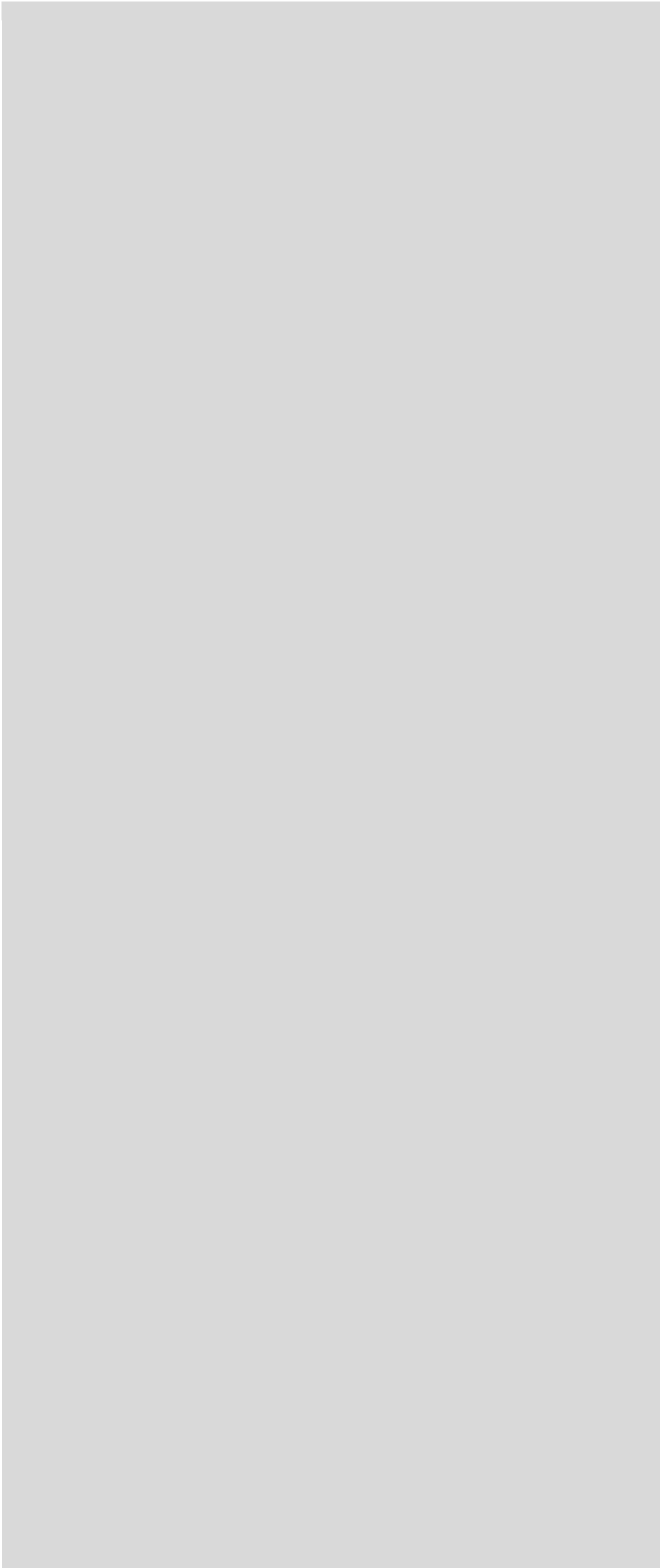
Describe paraphrasing as a strategy for putting the youth's story and emotions in your own words. Paraphrasing your statements in this manner will help lead you to achieving empathy.

"You sound angry."
"You seem really excited."
"I hear you saying you feel frustrated."

If likely to be relevant to officers participating in the training, broach the topic of how there may be an ethnic/linguistic/cultural difference between the officer and the youth/family in crisis.

For example, if the officer is white and the youth/family are of color, or the officer is Asian and the youth/family are Hispanic, how might the officer respond if the youth/family interject a comment or observation about the differences between the officer and the youth/family? An officer may increase the likelihood of establishing or maintaining empathy by:

Acknowledging the ethnic/linguistic/cultural difference commented upon by the youth or family member ("Yes, I appreciate that I am ________ and you are_________.")
Stating openness to information ("If there is something that you think I need to know, please tell me now.")
Stating intent to resolve the crisis situation ("But, what is most important is that we resolve this situation without anybody getting

Training Aids	Delivery Notes
	hurt. That is my goal and our responsibility and that's what we need to do together here today.")

Training Aids

Slide 144

Listen, Listen, Listen

- That's a stupid rule!
- I can't do that. What would my friends think?!?
- 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."

Delivery Notes

You don't want to miss a chance to accurately reflect what is being said. Listening for the problem the youth is trying to solve is like reading between the lines.

Listen for responses that could help prompt an empathetic discussion. 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: "That's a stupid rule!"
Officer: "You sound pretty angry right now."

Youth: "I can't do that. What would my friends think?!"
Officer: "Sounds like you are struggling with how to handle your friends' reactions if you changed."

Youth: "This sucks. I don't see what good talking about it is going to do now."
Officer: "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

Training Aids

Delivery Notes

Slide 145

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 or she said without jumping to another question."

What can you tell me about your most difficult day at work ever?
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?"

Training Aids

Delivery Notes

Slide 146

Influence: Slow Down

- Youth are impulsive and often fail to think before they act
- Slowing down gives youth the opportunity to:
  - Talk about their feelings
  - Think through options
  - Weigh consequences
- TIP: The passage of time, above any other intervention, tends to de-escalate crisis

Point out to participants that one of the hallmarks of crisis intervention is that officers "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 officer, it may be rejected by youth until they feel properly heard.

Encouraging youth to consider and weigh consequences: Help youth to practice thinking through the steps *Stop, Talk, Wait, then Act.* Acknowledge and praise positive responses.

Slide 147

Influence: Calming Techniques

- Modeling
  - Attempt to calm youth by displaying your own calmness
  - Speak slowly and evenly
- Allow venting
- Be empathetic
- Provide actual techniques for calming down
- Provide reassurance
- Avoid saying "relax" or "calm down"

Officers should first attempt to connect with youth by being empathetic.

However, it may be necessary to 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 officer'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. 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 and reflecting have already been discussed as strategies for signaling that youth have been heard.

It is also important to watch for signs indicating whether or not the venting (or "unloading") is being helpful. Signs to watch for include:

- The youth seems to be listening to the officer.
- The youth is slowing down (arms and legs are moving less, breathing is slowing).
- The youth is maintaining eye contact without being threatening.

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Slide 148

Delivery Notes

Remind officers that they have two ears and only one mouth – and thus, they should listen at least twice as much as they talk.

An officer can make a difference in a youth's life simply by listening without judgement and accepting/reflecting the youth's experience without inserting the officer's own opinion.

Officers should avoid repeating what youth has undoubtedly already experienced: an adult quickly telling them what to do. Even if the course of action is obvious to the officer, youth will reject it if they feel they have not been heard first.

Youth in crisis (especially younger ones) often don't know the answer to "why?" questions. Asking WHAT or HOW questions will be more helpful.

Training Aids | **Delivery Notes**

Slide 149

Remind officers that there is a high likelihood that they or their colleagues may 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.

Continue reviewing the 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 150

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.

Slide 151

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.

A 13 year-old boy walks into the mall after curfew. He is immediately approached by the mall security, who asks about his parent/guardian.

Volunteer 1: The 13 year-old boy who begins to pace and wring his hands. He eventually starts to yell "everyone hates me, my parents don't care and all of my friends are texting nasty things about me"

Volunteer 2: The mall security, who gets the boy to sit down. They eventually call the local police department for assistance

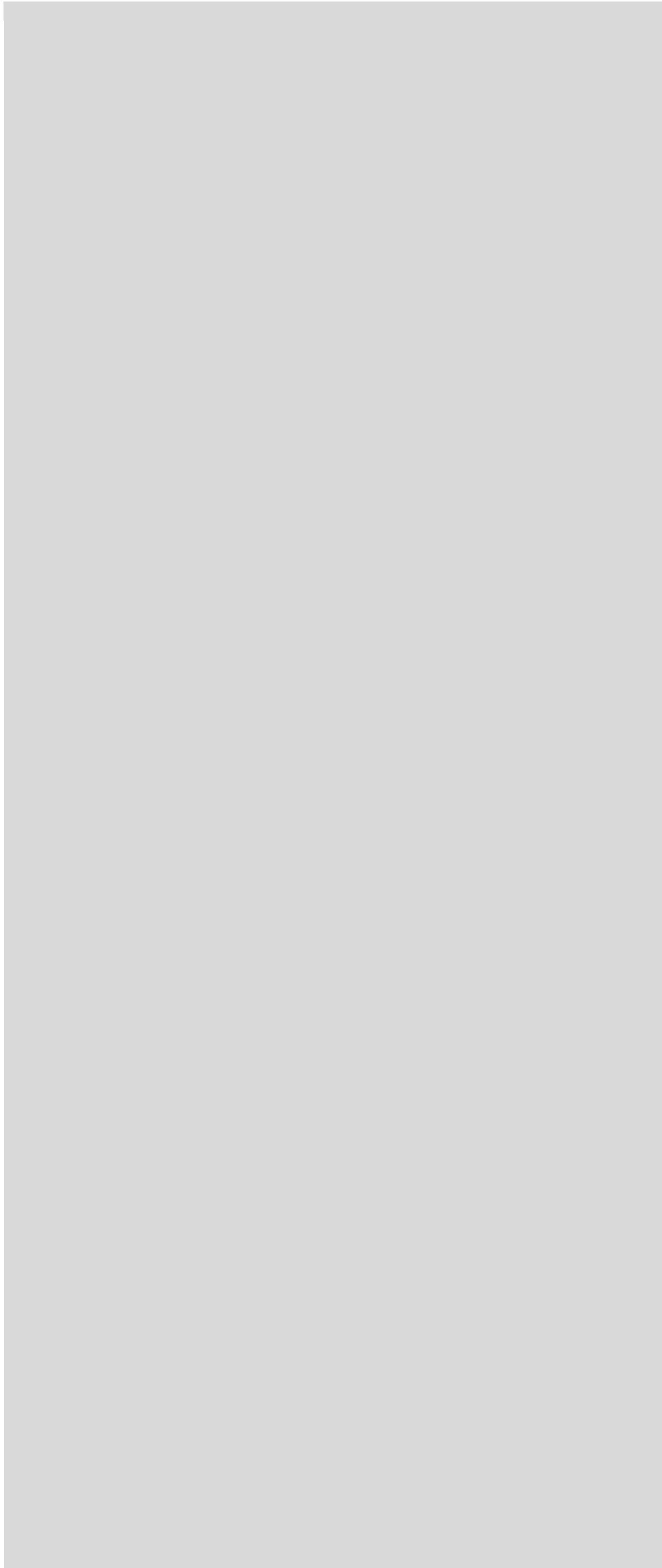
Volunteer 3: The officer who has been called for assistance

Volunteers should demonstrate how emotions, behaviors, and verbalizations can quickly change within a short amount of time.

Facilitate discussion by asking what went well in the role play and what could be improved.

Ask officers:

- Do you have any immediate thoughts about how to approach a youth in this state?
- How or if the approach might be different if it were a white officer responding to an African-American family or and African-American officer responding to a white family.

Training Aids	Delivery Notes
	Conclude activity by reviewing the approaches suggested on the slide.

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Delivery Notes

Slide 152

Review the approaches suggested on this slide with the training audience.

Frustrated and emotionally distraught describes an unstable state. Emotions – and therefore behaviors and verbalizations – can be quite variable within a short amount of time. Typical emotions can vary from depression to anger to anxiety.

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Delivery Notes

Slide 153

The second role play depicts hostile and aggressive behavior, including physical aggression, verbal aggression, and vandalism.

It calls for three volunteers.

Volunteer 1: A 15-year-old male came home at 1:00 am and his parents asked, "where have you been"? The parents also confronted him about money missing from their room. The teenager then shoved his mother against a wall and after his father intervenes the teenager went to his room and broke household items. He began to swear at his parents, saying, "I'll do what I want with my life".

Volunteer 2: The parent of the young teenage boy, who reported their son's recent patterns of staying out late and associating with youth they don't know

Volunteer 3: The responding officer

Volunteers should demonstrate how emotions, behaviors, and verbalizations can quickly change within a short amount of time.

Facilitate discussion by asking what went well in the role play, what could be improved, and what they would have done in the similar situation.

Refer to the approaches suggested on the next slide. Is it consistent with what occurred in the role play? If not, is there a good rationale for any variation?

Slide 154

- Identify yourself and your purpose
- Isolate
- Listen
- Be empathetic
- Set limits and provide alternatives
- Maintain eye contact
- State directives firmly
- Be ready to be friendly if behavior changes
- Use diversions

Hostile/Aggressive Behavior: Approach

The scenario on the slide fits the general scenario of hostile/aggressive behavior, including physical aggression, verbal aggression, and vandalism.

Review the information on the slide if further explanation is required refer to the Content Note below.

Engage officers in discussion about an approach to this situation.

Points to highlight during the discussion include:

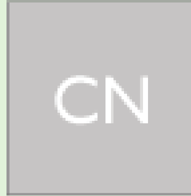
- As always, safety is paramount. Only a minimal amount of physical aggression can be tolerated prior to intervention. However, verbal aggression can be defused.
- A youth's ability to remain calm is largely determined by the level of calm shown by adults in charge. Authority is not derived from being loud and aggressive. On the contrary, the officers 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 officer 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.

Key Note:

Training Aids

Delivery Notes

- **Youth cannot engage in problem solving until they have their bodies under control.**



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 officers 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.*

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Delivery Notes

Slide 155

Substance use-induced behavior can look similar to the behavior exhibited by frustrated/emotionally distraught youth and hostile/aggressive youth.

However, substance use can lead to more impulsive and potentially dangerous acts. Firm limits need to be imposed.

Training Aids

Delivery Notes

Slide 156

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 officers 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 officers, 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.

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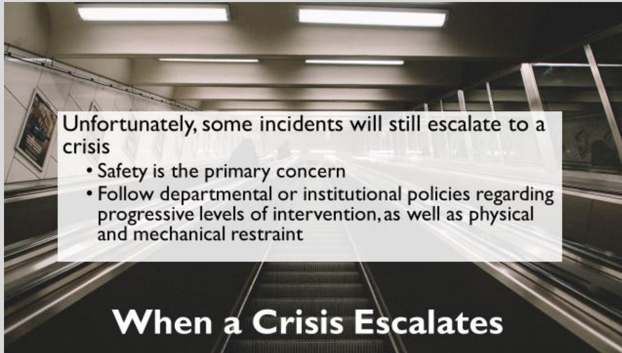
Delivery Notes

Slide 157



Despite best efforts toward prevention and de-escalation, a crisis sometimes develops.

The first priority, of course, is to maintain safety of the youth, officers, and others nearby.

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, officers 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.

Officers 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 officers demonstrate can be important coaching tools after the crisis is resolved.

Slide 158

Crisis Follow-up: Learning New Skills

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

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 officers 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, officers 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.

Training Aids

Slide 159

Delivery Notes

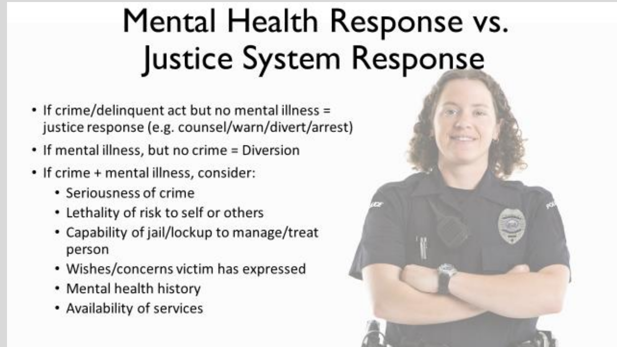
Helping youth talk about the crisis and what led up to it is an important follow-up component.

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, officers should remember to express support and understanding and look for signs of youth's progress. Crisis follow-up efforts will go a long way to averting or reducing another crisis.

Training Aids | **Delivery Notes**

Slide 160

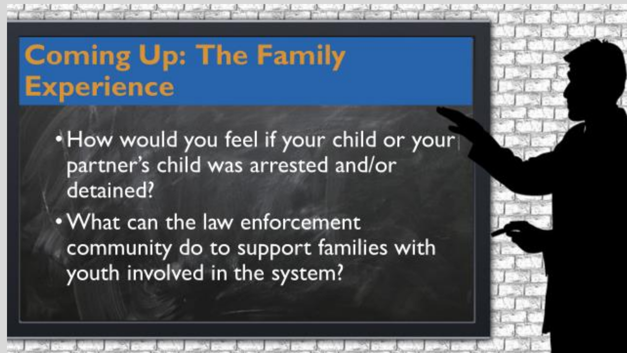


Reiterate that CIT programs stress diversion to evaulation and treatment facilities, whenever possible.

The first two points on the slide are straightforward. The last one is more challenging –That is, when both crime and mental disorder are present, there are various factors that need to be considered in determing the law enforcement response, as deliniated on the slide.

Remind officers that the choice does not always have to be arrest versus diversion; officers can divert initially (when a youth needs further evaluation), but still hold a youth accountable via the legal system if warranted by the incident.

Slide 161



Briefly review the objectves of the next module. Depending on the time, this may be a good spot to take a break.

Supporting Materials
Case Study

Instructions

If time allows, you may want to ask participants to problem-solve a case study, either as one large group or divided into two teams. Each case study has elements of communication and de-escalation skills, problem-solving, officer safety, and use of resources imbedded in the potential responses. Facilitate discussion with the groups regarding how and why each type of response was conducted.

Case Study #1

A call comes in through dispatch that a large group of kids is hanging out at a vacant convenience store parking lot. The reporting party stated the kids are loud and that they are of all ages and all sizes. The caller is sure they are doing drugs and other things that are horrible. The caller became upset when she reported that she also heard someone, probably a girl, screaming. The caller is sure the girl was being hurt – maybe even raped.

When you arrive on the scene, you observe a group of boys standing around a car and rocking it. They are shouting or chanting and there is a trick bicycle lying on the ground near the car. You can't see into the car, and when you approach the scene, a girl on a bench starts screaming that you arrived too late.

One small boy watches you intently and seems to want to talk to you. Another female, perhaps age 14 or 15, is walking in circles and asking for help from "my god."

Useful Information

- This parking lot is known for drug sales and gang involvement. A local gang who engages in its own interpretation of "voodoo" practices has recently been tagging the area.
- The girl praying has a history of running away; she has been found several times lying down on the railroad tracks. One officer recognizes her upon arrival.
- The boy seems fearful and appears glued to the bench, yet his eyes follow you and he seems to be mouthing something you can't hear from your current position.

General Questions

1. What is your first priority?
2. How do you approach the car?
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, if any, difference might it make in this crisis-response situation if the youth involved are of recent Caribbean origin and have maintained a tradition of voodoo practice? What might an officer want to know in advance about this tradition and practice or how the youth have implemented their own "interpretation" of this traditional practice?

Case Study #2

You are assigned to a school. You have been contacted by a student running down the hall who states that the teacher is crying and Debra is out of control in the classroom. You respond to the classroom and find the teacher sobbing at her desk while Debra, a 13-year-old student, is standing on the chair at her desk screaming that the teacher was involved in a porn movie and that the students are all actors. Debra screams that no one is real and they must all stop talking. Someone has broken the cubbies in the room and 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 reporting CIT officer.
- The teacher has a history of depression which she shared with you during a disturbance in her class last year.
- The principal has been notified and is expected to respond, but she has not arrived yet.
- The former reporting CIT officer was criticized in the past by school staff and parents for being "too aggressive" in a crisis situation which was investigated and founded. 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?

Supporting Materials

Association for Conflict Resolutions Newsletter

For Mediators and Arbitrators – In This Corner: Behavioral Change Stairway Model

by Jeff Thompson, Lynn Kinucan

Supporting Effective Agreement

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 yourself 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 HostageNegotiation 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

December 2013

View this article at:
www.mediate.com/articles/ThompsonJbl20131304.cfm

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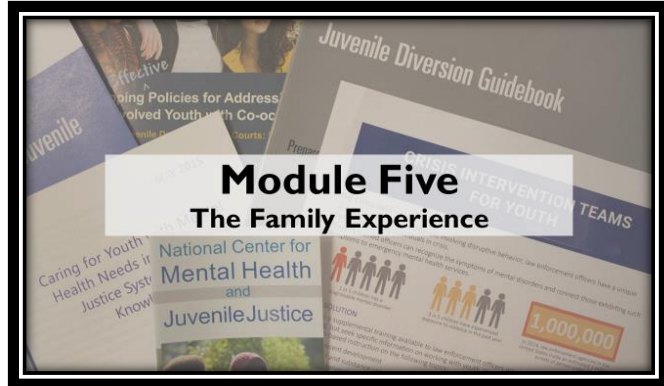
Module Five:
The Family Experience



Time 45 minutes

Slides 17

Purpose
To provide officers with an understanding of what a family experiences when living with a child who has a mental health condition and who becomes involved with the juvenile justice system.

Learning Objectives
At the end of this segment, officers will be able to:

- Be aware of the experience of living with and caring for a child or youth with a behavioral health condition
- Understand ways in which the law enforcement community can support families who are caring for children with behavioral health needs and who come in contact with the police

Activities

- Family Stressors
- What Would You Want to Know?
- *Video Activity: In Their Own Words*

Additional Materials

- Suggested Outline for a Presentation by a Family Member or Parent Representative

Module Outline

1. Objectives
2. Types of Families
3. Family Stressors
4. The Family's Role
5. What Can Officers Do to Support Families?

Training Aids | **Delivery Notes**

Slide 163

Module Objectives

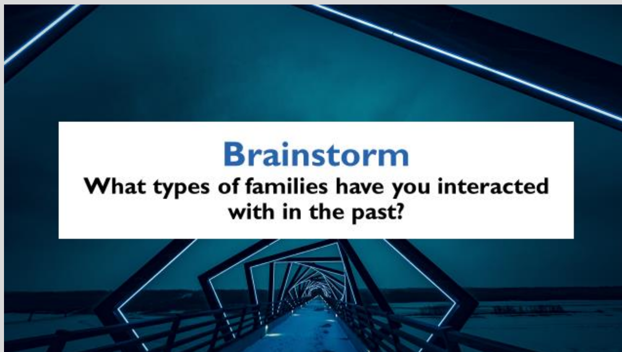
At the conclusion of this module officers will…

- Be aware of the experience of living with and caring for a child or youth with a mental health disorder.
- Understand ways in which the law enforcement community can support families who are caring for children with mental health needs and who come in contact with the police.

This brief unit is designed to sensitize officers 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.

Slide 164



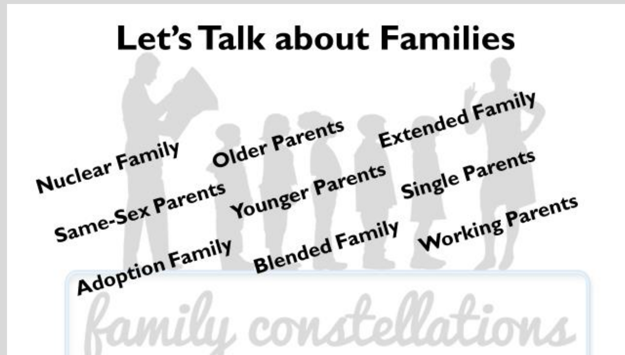
First let's discuss families in general. What types of families have you interacted with in the past?

The next slide will display different types of families.

Training Aids

Delivery Notes

Slide 165



Like those of us in this room, youth come from traditional two-parent families; from households with a single parent; and from extended families sharing a house.

Some youth have parents who are young; others' parents are older. Older siblings or grandparents may be raising youth. Some parents are gay or lesbian.

Youth 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 youth come from blended families; some from adopted families; and some from foster families.

Slide 166

While there is no single defining type of family, the one thing shared by almost all families of children involved with police or the justice system is increased stress related to the contact.

We all have stressors in our lives. What creates stress for you?

Review the items raised and see how they compare with the items on the next slide.

Training Aids

Delivery Notes

Slide 167

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 use. 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.

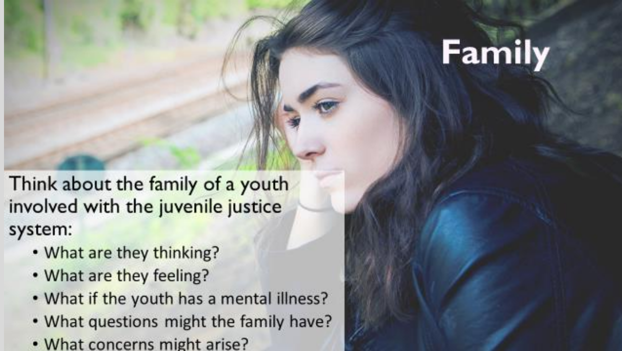
A child's involvement with police can add substantially to a family's stress level.

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.

Training Aids

Slide 168



Delivery Notes

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 their child's problems. 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.

On the other hand, some parents may even feel relief when cops are involved.

You could ask participants:

"What would it be like living with a youth with such severe mental health conditions that police intervention is requested and/or required?"

Training Aids

Delivery Notes

Slide 169

Bias still exists in how parents of children with mental health conditions are viewed.

Remind officers that the less-than-optimal interactions between troubled youth and their parents that they've observed are likely a consequence, not a cause, of the mental health condition.

Emphasize that in most situations, officers should not place the burden of the blame on the parents.

Slide 170

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 youth and parents can feel hopeless.

Training Aids

Delivery Notes

Slide 171

Parents may feel embarrassed 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, while others may be relieved that the police are now involved.

Remember, people without resources need help and sometimes officers are the help. 911 is a rapid response system for many people.

Slide 172

Remember, parents may present differently than how they feel.

Despite the problems that officers see during crisis, the family is and will remain the primary emotional, social, cultural, and spiritual support of a youth.

Training Aids

Delivery Notes

Slide 173

Put yourselves in the place of a parent or family member whose child has been recently arrested or detained?

- What would you want to know?
- Who would you call?
- What concerns might you have?
- What questions would you ask?

What if it was you or your partner's child?

Training Aids

Delivery Notes

Slide 174

Purpose: To briefly depict the experiences of families with youth in the juvenile justice system.

Facilitate discussion by asking:

"What can the law enforcement community do to build stronger relationships and partnerships with families and community/family advocacy organizations?"

Time: 3:50 minutes

Start the video by clicking on the image on the slide.

Video Information: *The Family Experience: In Their Own Words, from the National Center for Youth Opportunity and Justice*

Training Aids | **Delivery Notes**

Slide 175

Lead a brief (1-2) minute activity by having the officers brainstorm some ways to support families.

The upcoming slides will provide more ways in which officers can help youth experiencing trauma.

Slide 176

Conclude unit with practical strategies for encouraging family involvement.

Encourage officers 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 officers want to partner with them to provide the best care for their child. Let them know that the officers may be calling on them to convey vital information.

Training Aids

Delivery Notes

Slide 177

Remember that this may be a time of crisis in the family. The officer 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 in 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 you hear.

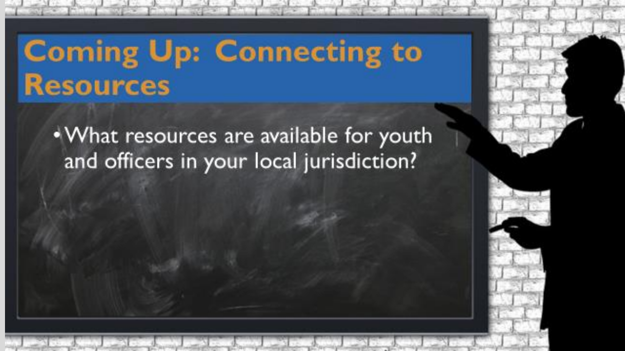
Whenever possible, empower families to make decisions – this is essential to continuing and strengthening family functioning.

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.

Training Aids

Delivery Notes

Slide 178



Briefly explain that the next module is created to provide officers with a better understanding of resources available in their area.

Depending on the time, this may be a good spot to take a break.

Supporting Materials

Suggested Outline for a Presentation by a Family Member or Parent Representative

The following outline includes topics and issues that could be addressed as part of a presentation by a parent or family member in Unit 5.

First Evidence of “Problems” (or “Symptoms” of Mental Illness)

- How old was your child when you first realized something was “wrong”?
- What was it that you first noticed?
- Did others (teachers, friends, neighbors, relatives) point things out to you?

Attempts to Get Help

- How did you know where to first seek help?
- Who did you contact for help?
- Was that initial effort successful?
- What is your biggest frustration with “the system?”
- Have you ever felt that others blamed you for causing your child’s problems?

Drugs and Alcohol

- To what extent have drugs and/or alcohol complicated your child’s mental health?

Impact of Mental Illness on the Family

- How has mental illness impacted your family life either now and/or previously?
    - Daily routines
    - Family functions (holidays, family reunions, etc.)
    - Other areas
- If your child has attempted suicide or tried to injure him/herself, will you please share that experience from your perspective?

Hospitalizations

- How many times has your child been hospitalized?
- What has been most helpful about that? Least helpful?

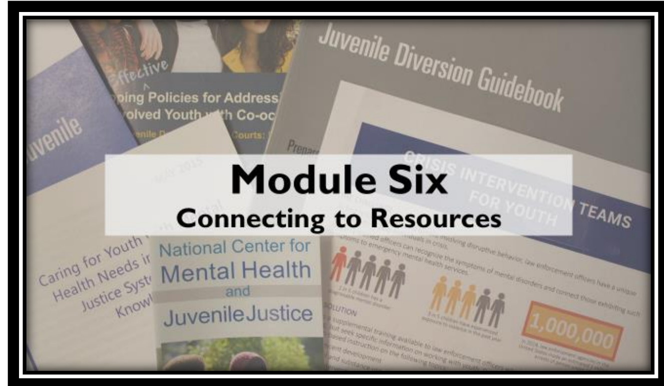
Interactions with the Police

- Have you ever called the police for help with your child?
- How quickly did they respond?
- What has been the most helpful thing the police have done in their interactions with you and/or your child?
- What has been most upsetting/not helpful?
- Have the police ever had to physically restrain your child?
- Has your child ever been arrested?
- Do you think your child's mental illness contributed to him/her committing a crime?
- What was the outcome of the arrest?

Current Status

- How is your child doing now?
- Does your child "accept" or acknowledge that he/she has a mental illness?
- What sort of treatment (therapy? medication? other?) is your child in now?
- Are you and/or other family members part of the treatment?
- Do you have any other comments about your child's current functioning and/or your family's current status?

Module Six: Connecting to Resources



Time 45 minutes

Slides 11

Purpose
To provide officers with information about community services and resources available to youth with mental health needs.

Learning Objectives
At the end of this segment, officers should have access to local contact lists of:

- Emergency mental health service providers who accept youth referrals from law enforcement
- Non-emergency community mental health service providers who accept youth referrals from law enforcement
- Other community services and supports

Activities

- None

Additional Materials

- None

Module Outline

9. Objectives
10. Mental Health Emergency Services
11. Non-psychiatric Emergency Services
12. Outpatient Services
13. Other Services
14. Support Groups
15. Community Resource Panel
16. Post-course Assessment

Training Aids

Delivery Notes

Slide 180

Review all that has been covered thus far in the training: adolescent development and behavioral health conditions, crisis intervention, and the family experience.

Introduce the final unit on local resources and services.

Training Aids

Slide 181

Module Objectives

Officers should have access to local contact lists of…

- Emergency mental health service providers who accept youth referrals from law enforcement
- Non-emergency community mental health service providers who accept youth referrals from law enforcement
- Other community service and supports

Delivery Notes

This session could be led by either someone who is very knowledgeable about local resources or a panel of 3-4 representatives from local agencies, such as:

- *local mental health clinics*
- *specialized mental health service providers*
- *emergency mental health 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 an expert on local resources.

Training Aids

Delivery Notes

Slide 182

This slide will help participants develop a list of local providers of emergency mental health services that are accessible to officers 24/7.

Generating this list will remind officers 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. Officers 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.

Training Aids	Delivery Notes

Slide 183

Officers should be aware of local emergency services that are geared toward children and youth, such as shelters for homeless or runaway youth.

Respite centers provide youth and guardians time to problem-solve escalating issues with a little space and often a mediator.

Slide 184

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.

Officers 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).

Slide 185

Other Services

Other services for youth that may be available include:

- *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 or substance use issues, or developmental disabilities. This knowledge may be especially useful in cases involving youth who had previously stayed at one of the residences. Officers can help transition youth out of these highly structured environments and back into the community environment. This point of transition is difficult for many youth, families, and communities, including schools.*
- *Mental health courts recognize that routine adjudication for those individuals with behavioral health conditions is often not effective, so instead they focus 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.*

Training Aids	Delivery Notes
Slide 186	*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 for specific issues. This slide provides examples of various support groups.*
Slide 187	*This is the part of the module where an expert on local resources or a panel of 3-4 representatives from local agencies could present.* *Help facilitate the panel presentation by steering panelists away from information that repeats the contributions of other panelists, and by politely keeping each panelist within their time limits.* *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 officer and the youth.*

Training Aids	Delivery Notes
Slide 188	*Conclude the session by thanking participants for their attention and input, then ask for and address any remaining questions.*
Slide 189	*Finally, ask participants to complete both the post-course assessment and the training evaluation.*