Evidence-Based Informed Intake: A Resource for Pennsylvania Juvenile Court Judges

Juvenile Justice Academy
2025 Agenda - Hilton Harrisburg

Sunday, May 18th

3:00 – 6:00 Registration
5:00 – 6:00 Reception
6:00 – 7:00 Dinner
7:00 – 8:00 Welcome & Opening Session
- What it Means to be a Juvenile Court Judge

Monday, May 19th

7:00 – 9:00 Registration
8:00 – 9:00 Breakfast
9:00 – 12:00 Welcome & Morning Session
- Evidence Based Practices
- Risk, Need, Responsivity
- Structured Decision Making
- EBP Informed Intake

12:00 – 1:00 Lunch
1:00 – 3:00 Afternoon Session
- The Case Plan
- Practical Application of Evidence Based Intake Practices
- A Case Study w/ Interactive Exercise

3:00 – 4:00 Interactive Team Activity
6:00 – 7:00 Dinner
7:00 – 8:00 Evening Session
- A Conversation with Lived Experience in the Juvenile Justice System

Tuesday, May 20th

8:00 – 9:00 Breakfast
9:00 – 10:30 Morning Session
- Partnerships & Funding opportunities
- JCJC Updates

10:30 – 11:45 Facilitated Discussion
11:45 – 12:00 Concluding Remarks
12:00 – 1:00 Lunch

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BEST PRACTICES FOR AN EVIDENCE-BASED INFORMED INTAKE[1]

WHAT IS EVIDENCE-BASED PRACTICE (EBP)?

"Evidence-based practice" refers to applying research findings to our work with youth, their families, and the communities in which we live. It is the progressive, organizational use of direct, current scientific evidence to guide and inform efficient and effective services. It utilizes research evidence and demonstrates outcomes to confirm that Pennsylvania's juvenile justice system can achieve and effectively implement its Balanced and Restorative Justice (BARJ) mission. In the juvenile justice context, research has demonstrated that the proper implementation of EBP can lead to significant reductions in juvenile delinquency and recidivism.

KEY CONCEPTS IN EBP

i. THE RISK, NEED, AND RESPONSIVITY PRINCIPLES

a) The risk principle helps identify who should receive juvenile justice interventions and treatment. The need principle focuses on what about the young person must be addressed. The responsivity principle emphasizes the importance of how treatment should be delivered, with behavioral and cognitive-behavioral skill-building techniques being the most effective. The responsivity principle explains that better outcomes will result from adequately matching a young person's characteristics (e.g., culture, cognitive ability, maturity, and gender) with service characteristics (e.g., location, structure, length, dosage, methodology, and facilitator traits).

ii. STRUCTURED DECISION-MAKING

a) Structured decision-making in the juvenile justice system ensures that all youth are treated equally under similar circumstances. The use of structured decision-making tools helps system professionals make consistent, appropriate, effective, and fundamentally fair decisions. Structured decision-making tools facilitate consistent, evidence-based, objective, and fair decisions at various critical junctures throughout the juvenile justice system.

- Examples of these tools include, but are not limited to, the Pennsylvania Detention Risk Assessment Instrument (PaDRAI), the Massachusetts Youth Screening Instrument (MAYSI~2), the Child Trauma Screen (CTS), and the Youth Level of Service/Case Management Inventory™ (YLS) Risk/Needs Assessment.

iii. EVIDENCE-BASED INFORMED INTAKE

a) In general, intake decision-making guidelines should be designed to protect the community, hold youth accountable, and address the needs of the victims of juvenile crime while helping juvenile offenders to grow into law-abiding and productive adults. An evidence-based informed intake involves the use of structured decision-making tools designed to help system professionals make consistent, appropriate, effective, and equitable decisions. These tools, based on research results, provide a protocol and framework that every worker can use in every case.

[1]This resource was developed for Pennsylvania Juvenile Court Judges using the following sources: Juvenile Justice System Enhancement Strategy (JJSES) Monograph, Advancing Balanced and Restorative Justice Through Pennsylvania's Juvenile Justice System Enhancement Strategy Monograph, Pennsylvania Juvenile Delinquency Benchbook, Pennsylvania Detention Risk Assessment Instrument Handbook, Massachusetts Youth Screening Instrument: Second Version (MAYSI~2) Training Manual, Lang, J.M.& Connell, C.M. (2017). Development and Validation of a Brief Trauma Screening Measure for Children: The Child Trauma Screen. Psychological Trauma: Theory, Research, Practice, and Policy, Youth Level of Service/Case Management Inventory™ (YLS) User's Manual, Evidence-Based Practice in Juvenile Justice Bench Card, MAYSI~2 Bench Card, CTS Bench Card, and YLS Bench Card.

Evidence-Based Practice in Juvenile Justice

Evidence-Based Practice (EBP) is at the core of Pennsylvania's **Juvenile Justice System Enhancement Strategy's (JJSES) Statement of Purpose**, which states:

We dedicate ourselves to working in partnership to enhance the capacity of Pennsylvania's juvenile justice system to achieve its balanced and restorative justice mission by:

- *Employing **evidence-based practices** with fidelity at every stage of the juvenile justice process;*
- *Collecting and analyzing the data necessary to measure the results of these efforts; and, with this knowledge,*
- *Striving to continuously improve the quality of our decisions, services and programs.*

EBP is the application of evidence from sound research studies to inform decision-making within processes and systems. Such an approach is common within professions such as medicine, engineering, education, etc. During the past 30 years, a significant body of knowledge has been empirically established regarding which practices, interventions, and treatment approaches work most effectively to reduce recidivism with juvenile offenders.

The use of research evidence enables juvenile justice professionals to determine "what works and what doesn't work".[1] Researchers have identified a set of principles through **meta-analysis** that, if applied to juvenile justice interventions, can reduce recidivism. These principles are referred to as the **Risk-Need-Responsivity (R-N-R),** plus **Treatment Principles:**

- The ***Risk*** principle tells us ***Who*** to target. In order to most effectively use resources and have a greater ability to reduce recidivism, high and moderate risk juveniles should be targeted for interventions.
- The ***Need*** principle tells us ***What*** to target. Research has shown that there are certain dynamic risk factors for recidivism or "criminogenic needs" that, if targeted with effective interventions, will reduce recidivism.
- The ***Responsivity*** principle tells us ***How*** we target supervision and intervention. It accounts for a juvenile's traits, learning styles and cognitive functioning which can affect the ability to respond most effectively to the intervention.
- The ***Treatment*** principle tells us ***Which*** programs should be used based on a juvenile's risk, needs and responsivity. Certain interventions or programs have demonstrated that they are effective in reducing recidivism. Other interventions or programs have proven to be ineffective, if not harmful.

[1]*Latessa, Edward J., Ph.D., From Theory to Practice: What Works in Reducing Recidivism?, University of Cincinnati*

The following eight tenets for *effective intervention with juveniles* incorporate the Risk-Need-Responsivity, plus Treatment principles, and are essential considerations as departments and agencies in Pennsylvania's Juvenile Justice System transform their operations into evidence-based organizations.

1. **Assess risk and needs using actuarial instruments** – Use assessments to guide case decisions by applying actuarial and statistically valid tools that describe the *who*, the *what* and the *how* of supervision and intervention.
2. **Enhance intrinsic motivation** – Prepare juveniles for interventions and treatment and keep them engaged by using Motivational Interviewing, strength-based approaches, and incentives and sanctions.
3. **Target interventions** – Focus upon the identified criminogenic factors that are proven to be linked to future delinquency. Enhance protective factors that serve as barriers to future delinquency and address responsivity factors.
4. **Develop skill through directed practice** – Use cognitive behavioral interventions and techniques to help moderate and high risk youth learn thinking patterns, skills and behaviors that can reduce their risk of recidivism. Train juvenile probation officers and service providers to deliver and/or reinforce, in the community and family, pro-social skills that youth have learned in treatment groups.
5. **Increase positive reinforcement** – Use incentives to encourage pro-social attitudes and behavior. Research has shown that a ratio of four to six positive affirmations to every message of disapproval yields the greatest result in having the desired behavior persist.
6. **Engage ongoing support in natural communities** – Strengthen the influence of pro-social communities in juveniles' lives and support the ability of families to assist youth as they learn pro-social values, attitudes, beliefs, and skills. Involve families as partners whenever possible.
7. **Measure relevant processes and practices** – Ensure that the department or agency is measuring and documenting key indicators that inform individual staff and the department as a whole whether practices, interventions and programs are performing as intended and have the desired effect. The identification and collection of this type of information is crucial for evidence-based organizations.
8. **Provide measurement feedback** – Use the analysis of data to provide feedback, evaluate, and make adjustments. Outcomes are more likely to improve if feedback is offered to individuals responsible for providing service, developing policy and managing staff.

Pennsylvania's Juvenile Justice System's use of the Youth Level of Service (YLS), Motivational Interviewing, Case Planning Principles, Cognitive Behavioral and Skill Development Interventions, Standardized Program Evaluation Protocol (SPEP) and other aspects of the Juvenile Justice System Enhancement Strategy (JJSES) are Evidence-Based Practices (EBPs), and are grounded in the best research available in the field of juvenile justice.

STRUCTURED DECISION-MAKING TOOLS OF AN EVIDENCE-BASED INFORMED INTAKE

i. **A Detention Risk Assessment Instrument or the PaDRAI.** The use of a validated Detention Risk Assessment Instrument (DRAI) to inform decisions about detention helps ensure that these decisions are structured, consistent, and racially and ethnically neutral. The PaDRAI is a concise, structured decision-making instrument used to assist in the critical decision of whether to securely detain a youth, release to an alternative to detention (ATD), or release to the custody of a parent or responsible adult during the period that the youth is awaiting their juvenile court hearing. The instrument is designed to assess the risk of youth to 1) commit additional offenses while awaiting their juvenile court hearing and/or 2) fail to appear for their scheduled juvenile court hearing.

   a) **How a juvenile court judge should use the PaDRAI:** A judge should use the PaDRAI to make fair, objective, and evidence-based decisions about whether a youth should be detained before a hearing or released with supervision. The PaDRAI helps ensure that detention is used only when necessary, striking a balance between public safety, court appearance rates, and the youth's well-being.

      1) Review the risk score and factors

         - Most DRAI classify youth into categories like low, moderate, or high risk for failing to appear in court or committing a new offense.
         - The judge should align detention decisions with the recommended response based on the score.

      2) Consider ATD for low- and moderate-risk youth

         - Low-risk youth: may be released to a parent or guardian or placed in a non-secure ATD (e.g., electronic monitoring, reporting centers).
         - Moderate-risk youth: may need additional supervision, such as curfew checks, house arrest, or structured community services.

      3) Justify detention for high-risk youth

         - High-risk youth: detention may be appropriate if they pose a serious public safety risk or a high flight risk.
         - The judge should ensure that the decision aligns with established legal standards and is not influenced by subjective bias.

      4) Weigh other factors beyond the risk score

         - The PaDRAI is a guidance tool, not a mandatory ruling.
         - The judge should consider family circumstances (Is there adult supervision available?); mental health, trauma, or substance use issues (Would detention worsen their condition?); special needs or disabilities (Would detention be harmful or inappropriate?); and legal factors (e.g., pending charges, prior failures to appear, or probation violations).

      5) Use detention as a last resort

         - Research shows that unnecessary detention increases recidivism and harms youth development. If the youth can be safely supervised in the community, that should be the preferred option.
         - Regularly review the youth's status to determine if continued detention is necessary.

b) **What a juvenile court judge should ask themselves:**

1) What was the circumstance under which PaDRAI was completed?
2) What was the indicated decision?
3) Were aggravating or mitigating factors considered?
4) Was an override necessary?
5) Were ATDs considered?

c) **What a juvenile court judge should be aware of:**

1) Over-detaining youth based on subjective concerns (e.g., "gut feeling" rather than risk factors).
2) Ignoring racial or socioeconomic disparities – ensure fair application across all youth.
3) Failing to consider community-based alternatives that may be more effective and less harmful.
4) Results should not be presumed to describe a youth's risk of reoffending or failing to appear at a court hearing beyond the initial consideration for secure detention at the time when the PaDRAI was administered. Some factors may persist longer, but some PaDRAI results might represent temporary states that change over time.

1

PENNSYLVANIA DETENTION RISK ASSESSMENT INSTRUMENT
Revised 4.5.22

Docket #

Previous Sanctions Used:

Youth's Name: _____ DOB: _____ Town of Residence: _____

JID #: _____ Decision by: PO _____ Judge

Gender: Male ☐ Female ☐ (self reported)

PaDRAI Completion Date: _____ Time: _____ ☐ AM ☐ PM

*PaDRAI Type:

1. **Most Serious New Alleged Offense (most recent Pre-Adj "open" charges)** - *Specify:*

Felony I	15	
Felony II or Felony Drug -Ungraded	12	
Felony III	7	=
Misdemeanor I	5	
Misdemeanor II or Misdemeanor Drug - Ungraded	3	
Misdemeanor III or Ungraded	1	
NO New Charge	0	

2. **Most Serious Additional Non-related Charges (on same allegation as above) or other Pending Allegations** *(include Allegations Pending Court Action or Allegations Pending at Intake- These are OPEN, Pre-ADJUDICATION)* - *Specify:*

Felony I	10	
Felony II or Felony Drug Ungraded	7	
Felony III	5	=
Misdemeanor I	4	
Misdemeanor II or Misdemeanor Drug Ungraded	3	
Misdemeanor III or Ungraded	1	
NO Additional Non-related Charges	0	

3. **Current Status (Pre-Adj Status is captured in #1, since charges are still "open")**

Placement	7	
Aftercare Supervision (within 2 months of release from out of home placement)	5	
Formal Probation	4	=
Pre-Adjudication Alternative to Detention	3	
Consent Decree	2	
Informal Adjustment	1	
NONE of the above	0	

4. **Prior Adjudications or Consent Decrees** *(within the past 18 months/both open and closed cases)*

Multiple prior findings for Felony Offenses (all gradings)	6	
One prior findings for a Felony Offense (all gradings)	4	=
Multiple findings for Misdemeanor Offenses (all gradings)	3	
One prior findings for a Misdemeanor Offense (all gradings)	1	
NO prior findings	0	

5. **History of Warrants for Failure to Appear for Court Hearing(s)** *(active within past 12 months)*

Two or more warrants for failure to appear in past 12 months	3	
One warrant for failure to appear in past 12 months	1	=
NO warrants for failure to appear in past 12 months	0	

6. **History of Escape/AWOL/Runaway from Delinquency Placement** *(within past 12 months)*

One or more escapes from secure confinement or custody	4	
One or more instances of AWOL from non-secure, court-ordered, out of home placement	3	=
Two or more Runaways from home or voluntary out of home placement (For more than 24 hours)	1	
NO History of escapes/ AWOLs in past 12 months	0	

DETAIN = 15+

ATD = 10 - 14

RELEASE = 0 - 9

INDICATED PADRAI DECISION (WHAT DOES THE TOOL SAY TO DO) =_____ TOTAL SCORE = ____

2

PENNSYLVANIA DETENTION RISK ASSESSMENT INSTRUMENT
Revised 4.5.22

Mandatory Detention (MUST be detained)

- ☐ Bench Warrant
- ☐ Judicial Order – Please add Order details here: _____

Discretionary Warrant: MITIGATING FACTORS
(Please check the ONE primary factor below that informed your decision then describe rational in detail on next page)

- ☐ Parent willing/able to provide supervision
- ☐ Juvenile has no prior record
- ☐ Juvenile marginally involved in the offense
- ☐ Facts alleged are less serious than the offense charged
- ☐ Juvenile is 13 years of age or less
- ☐ New charge referred is not recent
- ☐ Juvenile is adjudicated dependent and C&Y agency has placement custody
- ☐ Juvenile has significant MH/MR problems or is in MH/MR placement
- ☐ Juvenile doing well on supervision absent this arrest
- ☐ Other – Graduated Response
- ☐ Other (examples: Attends work/school/counseling regularly, etc): _____

OR

Discretionary Warrant: AGGRAVATING FACTORS
(Please check the ONE primary factor below that informed your decision then describe rational in detail on next page)

- ☐ Parent/guardian refusal and no other resources available
- ☐ Parent /guardian unavailable
- ☐ Juvenile has significant substance abuse problems
- ☐ Juvenile has a history of violence in the home or against family members
- ☐ Victim of current offense resides in the home
- ☐ Unsuccessful ATD history (within the past 12 months)
- ☐ Juvenile refuses to participate/cooperate with ATD
- ☐ Victim / witness intimidation
- ☐ Other – Graduated Response
- ☐ OTHER:

Do not use "OTHER" for substance abuse issues or when there is a judicial order requiring detention for any violations.

3

PENNSYLVANIA DETENTION RISK ASSESSMENT INSTRUMENT
Revised 4.5.22

Written Explanation, including any Additional Information must be provided for ANY Discretionary Warrant Not to be used for Judicial Order explaination.

Supervisory Approval is required for ALL Discretionary Warrants.

Approving Supervisor: _____

ACTUAL DECISION:

RELEASE ☐ **ALTERNATIVE (ATD)** ☐ **SECURE DETENTION** ☐

- ☐ Shelter
- ☐ Evening/Day Reporting Center
- ☐ Electronic Monitoring
- ☐ Supervised In-Home Detention
- ☐ House Arrest
- ☐ Expedited Case Processing
- ☐ Other, Specify: _____

- ☐ Serious Threat to Self/Others
- ☐ Mandatory

JPO's original recommendation to the court:

ii. **A Mental/Behavioral Health Screening Tool or the MAYSI~2.** The MAYSI~2 is a brief, behavioral health screening tool designed for juvenile justice programs and facilities. The tool is a self-report inventory consisting of 52 yes-or-no questions. The questions ask the youth if they have experienced various thoughts, feelings, or behaviors in the past few months. The MAYSI~2 provides scores on six primary scales: alcohol/drug use, angry/irritable, depressed/anxious, somatic complaints, suicide ideation, and thought disturbance (boys). Each scale has two levels of cutoff scores: caution (clinically significant) and warning (top 10%). MAYSI~2 scores are used to determine whether a youth is "screened out" or "screened in." The term "screened out" means that the youth does not require further follow-up. The term "screened in" means the youth has been identified as needing further follow-up.

a) **How a juvenile court judge should use the MAYSI~2:** A judge should handle MAYSI~2 information carefully and responsibly. The MAYSI~2 results should be considered as one component of a broader evaluation, which might include psychological evaluations, interviews with the youth, family members, probation officers, and other relevant sources.

1) Understand the purpose of the MAYSI~2

- It is vital to treat the MAYSI~2 as a screening tool, not a definitive diagnosis. Mental health issues identified by the tool may not be the sole explanation for a youth's actions. The judge should ensure that the MAYSI~2 results are considered in the context of the youth's social, familial, educational, and emotional needs. Judges should consider the totality of the situation and not just the mental health information when making decisions about the youth.

2) Order further evaluation when necessary

- If the MAYSI~2 screening suggests potential mental health concerns, the judge should ensure that further evaluation or treatment is ordered if necessary. The judge may request a more thorough psychological evaluation to assess the youth for a diagnosable mental health condition that requires treatment.

3) Incorporate mental health needs into dispositional decisions

- If mental health issues are identified, the judge may use the MAYSI~2 information to guide decisions about appropriate placements, treatment, or services for the youth. This might include directing the youth to mental health services, counseling, or inpatient care. A judge may use the MAYSI~2 results to help determine whether diversion from formal court processes to a treatment-based program is appropriate.
- The information could also influence dispositional decisions, such as recommending community-based treatment options (therapy, counseling, psychiatric care), specialized probation or diversion programs with mental health support, limiting detention or placement if symptoms could worsen in a confined setting, and coordinating with mental health professionals to create an individualized case plan.

4) Ensure proper mental health support in detention or probation

- If the youth remains in detention, the judge should confirm mental health services are available, order continuous monitoring for suicide risk if necessary, and consider alternative placements (e.g., residential treatment) if appropriate.

5) Ensure confidentiality

- As with all sensitive information, the judge must ensure that the MAYSI~2 results are treated with confidentiality. The judge should ensure that only authorized individuals (like attorneys, service providers, and relevant court personnel) have access to the results and that the information is not used inappropriately in the court process.

b) **What a juvenile court judge should ask themselves:**

1) Was a caution or warning indicated on any scale?
2) Was a second screening administered?
3) Was further assessment recommended?
4) Were the results of the MAYSI~2 shared and explained with the youth and parent(s)/ guardian(s)?
5) Were the results of the MAYSI~2 considered in the dispositional recommendation?

c) **What a juvenile court judge should be aware of:**

1) Using MAYSI~2 as a standalone diagnosis – it's only a screening tool, not a full psychological evaluation.
2) Ignoring high-risk indicators – failing to act on flagged concerns could put the youth at risk.
3) Automatically detaining youth based on results – mental health concerns should lead to treatment-focused decisions, not just punitive measures.
4) Results should not be presumed to describe a youth's mental or emotional condition beyond approximately 30 days after the results are obtained. Some conditions may persist longer, but some screening results might represent temporary emotional states that change over time.

MAYSI-2 BENCH CARD

Engaging youth in evidence-based screening for behavioral health needs at system contact has become standard practice nationwide. System contact includes a broad spectrum of settings, including diversion programs, juvenile probation, juvenile detention, and residential placements. Identifying a youth's behavioral health needs, such as mental health, substance use, trauma symptoms, suicide ideation, and related issues, is important at initial system contact. Behavioral health screening is the first step for identifying youth who need immediate attention and further assessment for behavioral health needs.

Purpose

The Massachusetts Youth Screening Instrument (MAYSI-2) is a brief, behavioral health screening tool designed for juvenile justice programs and facilities. The tool is a self-report inventory of 52 yes or no questions. The questions ask the youth if they have experienced various thoughts, feelings, or behaviors in the past few months. It identifies youth ages 12 through 17 years old who may have important, pressing behavioral health needs. The MAYSI-2 provides scores on six primary scales: alcohol/drug use, angry-irritable, depressed-anxious, somatic complaints, suicide ideation, and thought disturbance (boys). Each scale has two levels of cut-off scores: caution (clinically significant) and warning (top 10%). It is written on a fifth-grade reading level and is available in both English and Spanish. The screen measures symptoms at a point in time and produces a "snapshot" of what might be the temporary moods and emotions of a youth. The screening results are not valid for determining a youth's needs over a long period of time.

Policy Development

Prior to a department or facility administering the MAYSI-2, it is recommended that a formal policy be adopted outlining training, administration, response, and stakeholder engagement. It is important to communicate with community providers and make necessary connections for possible referrals. A provider equipped to handle crisis intervention and emergency services should be informed of the department's intention to begin administering the MAYSI-2 and advised of potential referrals. A community resources capacity assessment could also be sent to other providers who might receive referrals for non-emergency behavioral health assessments.

Administration

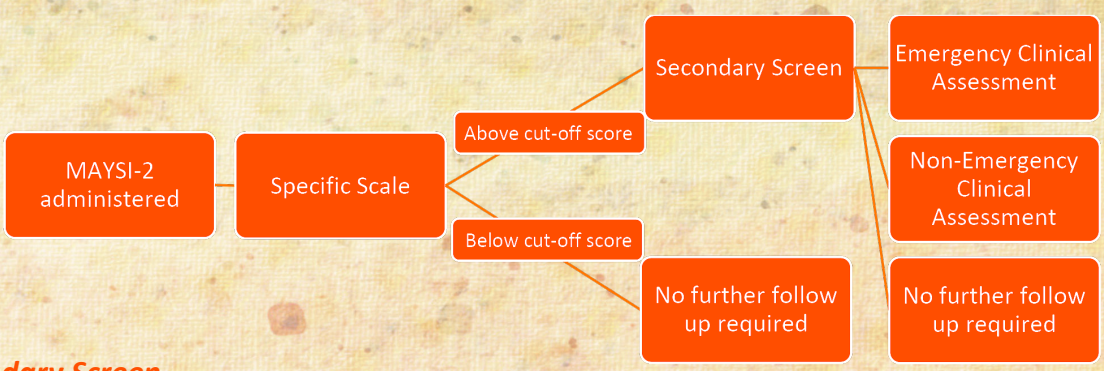
Administering and using the MAYSI-2 does not require training as a professional clinician. Probation officers or facility intake staff can administer the MAYSI-2 after reviewing the manual, attending a training, and understanding what the tool can and cannot do. Screening refers to a process of identifying youth who may have behavioral health problems to address and those that are unlikely to have behavioral health problems as they enter system contact. Typically, this is done by non-mental health professionals, including intake probation staff. Assessment refers to a process by which youth who might have mental health problems are referred for a more detailed clinical evaluation. Clinical evaluations are done by behavioral health professionals to more accurately determine the youth's actual behavioral health needs.

Screened In

MAYSI-2 scores are used to determine whether a youth is "screened out" or "screened in." The term "screened out" means that the youth does not require further follow up. The term "screened in" means the youth has been identified as needing further follow up.

MAYSI-2 BENCH CARD

Screened In vs. Screened Out



Secondary Screen

These are forms that correspond to each MAYSI-2 scale which guide the screener in asking a few more questions when a youth scores above the cut-off on a scale. This should be performed in a conversational style, and the screener should record the youth's responses. The purpose is to determine whether a youth requires an emergency clinical assessment, a non-emergency comprehensive behavioral health assessment, or no follow up at all.

Emergency Clinical Assessment

Emergency clinical assessments involve scheduling an immediate interview with a behavioral health professional qualified to make an individual assessment. These types of assessments could be performed by an on-call psychiatric or psychological consultant, a behavioral health social worker or psychologist, or by arrangement with local youth community behavioral health services. This may result in a referral for emergency behavioral health services (e.g., medication, inpatient care, etc.).

Non-Emergency Comprehensive Mental Health Assessment

If the condition does not appear to present an immediate threat, the youth may be scheduled for assessment by a behavioral health professional. This would determine whether the youth may have special behavioral health needs or for planning disposition (something the MAYSI-2 does not do). Some juvenile justice systems have diversion options for youth with behavioral health disorders, and a further mental health screening may identify youth who are eligible for diversion.

What Not To Do with MAYSI-2 Scores

The MAYSI-2 does not produce a diagnosis. It does not substitute the opinions of behavioral health professionals. It is intended to alert the screener as to which youth need professional behavioral health assessments. The scores should not be trusted to be valid for youth beyond four weeks after administration. Many things in a youth's life may cause changes to their moods and stress levels. MAYSI-2 scores should not be used as a sole or primary basis for making long-range treatment plans for a youth. The results should never be used as part of the adjudication process. If others must be told that a youth has a serious behavioral health need, this can be done without providing the actual answers or scores.

For more detailed information, please see the website of the National Youth Screening & Assessment Partners at: www.nysap.us

MASSACHUSETTS YOUTH *SCREENING INSTRUMENT: SECOND VERSION*

MAYSI ~ 2

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March 2, 2000
(Updated July 2003)

MAYSI ~ 2
Brief Overview

The MAYSI-2 is designed to assist juvenile justice agencies in identifying youths 12-17 years old who may have special mental health needs. It is intended for use at any entry or transitional placement points in the juvenile justice system (e.g., intake probation, pretrial detention, state youth authority reception centers). Development of the MAYSI-2 was guided by the need for a tool that:

- can be administered routinely to all youths in probation intake interviews or within 24-48 hours after their admission to juvenile justice facilities
- requires no more than 15 minutes to administer
- alerts staff to a youth's potential mental/emotional distress and certain behavior problems that might require an immediate response--for example, immediate monitoring, additional questioning of the youth, request for a clinical consultation, or further detailed assessment for longer-range treatment planning
- can be scored and interpreted quickly without the expertise of a mental health professional

The MAYSI-2 is a computerized self-report inventory of 52 questions. Youths answer "yes" or "no" concerning whether each item has been true for them "within the past few months." Youths are read the items via the computerized voice program (the MAYSI-2 also has a fifth grade level of readability). Administration requires about 8-10 minutes and may be accomplished individually or in groups. MAYSIWARE provides a Spanish language version.

Youths' answers contribute to 7 scales for boys and 6 scales for girls *(see next page)*. Each scale has 5-9 items. Scoring requires a count of the "yes" responses to the items that contribute to a given scale. There is no MAYSI "total score." Scores on each scale are compared to cut-off scores that are suggested in this manual or that have been decided as a matter of policy by an agency or juvenile justice system. Scores above a scale's cut-off suggest that the youth may be in need of closer attention by staff, precautionary monitoring, brief counseling, or referral for mental health services (depending on policies set by one's agency).

MAYSI ~ 2
SCALES

Alcohol/Drug Use	- Frequent use of alcohol/drugs - Risk of substance abuse or psychological reaction to lack of access to substances
Angry-Irritable	- Experiences frustration, lasting anger, moodiness - Risk of angry reaction, fighting, aggressive behavior
Depressed-Anxious	- Experiences depressed and anxious feelings - Risk of impairments in motivation, need for treatment
Somatic Complaints	- Experiences bodily discomforts associated with distress - Risk of psychological distress not otherwise evident
Suicide Ideation	- Thoughts and intentions to harm oneself - Risk of suicide attempts or gestures
Thought Disturbance	- (Boys only) Unusual beliefs and perceptions - Risk of thought disorder
Traumatic Experiences	- Lifetime exposure to traumatic events (e.g., abuse, rape, observed violence). Questions refer youth to "ever in the past," not "past few months." -Risk of trauma-related instability in emotion/perception

What are an Agency's Responsibilities?

By ***responsibilities*** we mean the juvenile justice system's obligation to respond to the mental health needs of youths in its custody. National and local standards or laws typically require that juvenile justice facilities attend to the mental health needs of youths admitted to their facilities. These requirements exist for two general reasons: (a) for the welfare of the youth who is in the system's care, and (b) for the protection and safety of the youth, other youths in the facility, staff, and the community.

What are the Potential Responses?

By ***responses*** we mean the types of intervention that conceivably might be employed when youths are identified as having possible mental health needs. There are several types of interventions that facilities can implement in response to youths whom a screening tool identifies as possibly having special mental health needs:

- ***Secondary Screening*** that can disconfirm or provide further evidence that the youth has the mental or emotional problem that the instrument has identified. Sometimes additional observation raises new information that reduces the urgency of the case (it is a "false alarm'), while at other times it will suggest that the results of the screening instrument should be heeded. Secondary screening activities may be of several kinds:

    - ***Monitoring***, in which staff exercise greater vigilance and attention to youth in order to make relevant observations

    - ***Interviewing and collateral contacts***, in which staff engage in discussions with the youth, or with the youth's family and/or past service providers. This focuses on exploring the reasons for the youth's responses on relevant items of the MAYSI-2, as well as outside information that contradicts or is consistent with what the youth reported on the instrument

- ***Clinical Consultation***, in which staff seek expertise from clinical professionals who can intervene to provide brief evaluations or emergency care

- ***Evaluation Referral***, in which staff arrange for a more comprehensive psychiatric or psychological evaluation to determine the nature and source of the youth's self-reported distress or disturbance.

- ***Therapeutic or Security Intervention***, in which staff act to protect the youth or others from potential consequences of the youth's condition, or to transfer the youth to a setting that can provide appropriate psychiatric services to meet the youth's immediate needs.

What Resources Does the System Provide for Responding?

By ***resources***, we mean the financial and administrative support that is required to make the necessary responses or interventions. Juvenile justice agencies must provide the resources to engage in these responses to youths' mental health needs when to do so is necessary for meeting their responsibilities for a youth's welfare and the safety of others.

Weighing the "Three R's"

The MAYSI cut-off scores that an agency decides to set for use by juvenile justice staff will reflect the agency's weighing of all three of these issues. ***The choice of a cut-off score will affect what proportion of youths the agency identifies in relation to its responsibilities, which in turn will define the resources that are needed to respond in a way that meets those responsibilities.***

Difficult decisions must be made when resources are scarce. In such cases, the main questions are how to increase resources, and in the meantime, how to use existing resources in ways that will best meet the system's responsibilities. Several observations about the MAYSI scales may be of help in addressing the latter question.

A key to beginning to resolve the dilemma of Caution vs. Warning cut-offs noted earlier is to recognize that some agency responses may be expensive while others are relatively low-cost. What we call "secondary screening" may be relatively inexpensive. In the form of staff monitoring, it is performed in the routine course of one's duties in juvenile justice facilities, and it can be intensified for specific youths with little cost and little additional effort on the part of staff. Low cost is also involved in requiring that staff sit down and discuss a youth's answers to critical questions that created the "high" scores on the MAYSI-2. The answers might prove to be exactly what they seem, or the youth may have had reasons for responding "yes" that were unrelated to the problem areas the MAYSI-2 assesses.

While Caution cut-offs identify a significant number of youths who must receive a response, the cost of secondary screening as the prescribed response is relatively low. Therefore, most systems should be able to afford the use of Caution cut-offs to activate secondary screening, to determine whether more active intervention is necessary. An agency's sense of its "responsibilities" will determine which of the three criteria it will use in conjunction with Caution cut-offs: above the cut-off on "at least one scale," "at least two scales," or on "certain critical scales."

When Caution cut-offs are used in this way, the agency may wish to have in place a policy that allows or requires more extensive intervention (for example, clinical consultation) when secondary screening indicates the need for it.

Warning cut-offs might be used in a different way, to signal the potential need for more extensive responses such as clinical consultation or referral for comprehensive psychological evaluation. When the availability of these more expensive resources cannot currently be increased, one wishes to use them wisely, expending the resources on youths who are most likely to be in serious need, and using them up on as few "false alarms" as possible. In such cases, the higher Warning cut-off may be more consistent with the agency's concerns for meeting its obligations, because it does a better job of using the more expensive intervention for youths who actually need it.

iii. **A Trauma Screening Tool or the CTS.** The CTS is a brief, empirically based screen for child traumatic stress. The CTS is neither a comprehensive screening tool nor a clinical assessment. It does not screen for all types of trauma exposure, all symptoms of Post-Traumatic Stress Disorder (PTSD), or other traumatic stress reactions. It is not intended to promote lengthy discussions about a youth's exposure to trauma or reactions. Rather, it is intended to assist professionals in determining the presence of trauma and the need for further assessment/evaluation.

a) **How a juvenile court judge should use the CTS:** When a juvenile court judge receives trauma screen information, they should approach it with sensitivity and use it to guide decisions that support the best interests of the youth while addressing any trauma-related needs. Trauma can significantly influence a youth's behavior and decision-making, so the judge should understand that trauma may contribute to the youth's actions or attitudes. Recognizing the role of trauma in the youth's life helps avoid viewing the youth's behavior solely through a punitive lens and allows for a more compassionate and rehabilitative approach. A trauma screen is a screening tool, not a comprehensive evaluation, and it typically only identifies signs or symptoms of potential trauma.

1) Review the screening results

- The CTS typically assesses exposure to traumatic events (e.g., abuse, neglect, violence, accidents, loss of a caregiver) and symptoms of trauma (e.g., nightmares, hypervigilance, emotional numbness, trouble concentrating).
- The judge should ensure that the results are considered alongside other assessments, including psychological evaluations, interviews, and the youth's history, to obtain a more comprehensive understanding of the youth's situation.

2) Order further evaluation when necessary

- If the trauma screen suggests significant trauma or emotional distress, the judge may order further assessments. This could involve more detailed psychological evaluations, trauma-focused therapy, or assessments from a trauma specialist to better understand the depth of the trauma and its potential effects on the youth's behavior and development.

3) Incorporate trauma needs into dispositional decisions

- In cases where trauma has a significant impact, the judge may consider this when determining dispositions. If the youth has experienced significant trauma, the judge should prioritize rehabilitation over punishment, ensure access to trauma-informed services, avoid unnecessary detention, and consider adjusting probation conditions.
- Rather than sending the youth to detention, the judge may consider placement in a therapeutic or trauma-informed setting, referral to a trauma-informed treatment program (e.g., cognitive behavioral therapy), or alternatives such as diversion programs or restorative justice initiatives.
- Trauma often intersects with other issues, such as family problems, mental health issues, and educational struggles. The judge should consider a holistic approach that addresses the youth's emotional, mental, familial, and educational needs. This can involve coordinating trauma-informed services to help the youth heal and develop more positive coping strategies. The judge could also consider ordering support for the youth's family.

Providing family-based interventions and resources can help the youth feel supported and understood in their home environment.

4) Apply a trauma-informed approach in court interactions
    - The judge should support a trauma-informed approach and ensure courtroom practices avoid retraumatization of the youth. This means working with attorneys, probation officers, and other stakeholders to engage in trauma-informed practices such as creating an environment that feels safe for the youth, avoiding aggressive questioning or dismissing emotional responses, and ensuring that decisions are made with the understanding that trauma affects behavior.
5) Ensure confidentiality
    - Since trauma information can be deeply personal and sensitive, the judge should ensure that any trauma screen results are kept confidential and shared only with appropriate individuals, such as treatment providers, attorneys, and other court personnel directly involved in the case.

b) **What a juvenile court judge should ask themselves:**

1) Was a second screening administered?
2) Was further assessment recommended?
3) Were any referrals made as a result of the trauma screen?
4) Is the youth safe?
5) Were the trauma screen results considered in the dispositional recommendation?

c) **What a juvenile court judge should be aware of:**

1) Ignoring trauma symptoms – untreated trauma can lead to recidivism.
2) Assuming all trauma-exposed youth need the same intervention – responses should be individualized.
3) Over-relying on the CTS alone – it's a screening tool, not a full diagnostic assessment.
4) Results of a trauma screen should not be considered valid beyond approximately 30 days after the results are obtained. Some conditions may persist longer, but some screening results might represent temporary emotional states that change over time.

CHILD TRAUMA SCREEN BENCH CARD

Many youths suffer from trauma in silence and alone. Screening is a way to identify youth who are experiencing high levels of distress and may need additional support to overcome trauma exposure. Screening is also important to facilitate discussions with youth and caregivers about trauma, to provide information about traumatic stress, and to offer a range of resources to families, including evidence-based treatment when indicated.

Purpose

The Child Trauma Screen (CTS) is intended to be used as a very brief, empirically based screen for child traumatic stress. It can be administered by trained clinical and non-clinical staff, including intake staff, child welfare workers, juvenile probation officers, clinicians, medical providers, and school personnel. The CTS is intended for youth 6-17 years of age; is available in English, Spanish, Portuguese, and Chinese; and is free to use. The CTS can be used as a stand-alone screen or in conjunction with the MAYSI-2 behavioral health screen.

The goals of the CTS are to:

- Identify youth who are likely to be suffering from trauma exposure and would benefit from being referred for a more comprehensive trauma-focused assessment by a trained clinician.
- Function as an engagement tool for professionals working with youth, allowing them to briefly discuss the youth's exposure to trauma and trauma-related reactions and to support the youth/caregiver.

The CTS is neither a comprehensive screening tool nor a clinical assessment. It does not screen for all types of trauma exposure, all symptoms of Post-Traumatic Stress Disorder (PTSD), or other traumatic stress reactions. It is not intended to promote lengthy discussions about a youth's trauma exposure or reactions. Rather it is intended to assist professionals in determining the presence of trauma and the need for further assessment/evaluation.

Policy Development

Prior to a department or facility administering the CTS, it is recommended that a formal policy be adopted outlining training, administration, response, and stakeholder engagement. It is important to communicate with community providers and make necessary connections for possible referrals. A community resources capacity assessment can be sent to providers who might receive referrals for non-emergency trauma assessments or trauma-focused treatment.

Administration

Administering and using the CTS does not require training as a professional clinician. Probation officers or facility intake staff can administer the screen as an interview (best practice) or self-report. Youth and caregiver versions of the screen are available. The in-person interview provides an opportunity to engage the youth/caregiver directly, observe non-verbal responses, express support for disclosures, and inform the youth/caregiver about trauma. For any administration, it is important that the results of the CTS are reviewed with the youth/caregiver immediately following completion. It is recommended that staff administering the CTS receive brief training in trauma screening.

CHILD TRAUMA SCREEN BENCH CARD

Adverse Childhood Experiences

Abuse
- Emotional
- Physical
- Sexual

Neglect
- Emotional
- Physical

Household
- Domestic Violence
- Substance Abuse
- Mental Illness
- Parental Separation/ Divorce
- Incarcerated Parent

Screened In

Studies suggest that the optimal cut scores for Reactions Total on the CTS are 6 or greater on the youth screen. For consistency, a cut score of 6 or greater on the caregiver screen should also be used. This cut score indicates a high likelihood that the youth may be suffering from clinically significant levels of PTSD symptoms. In these cases, a clinical trauma assessment by a clinician trained in evidence-based, trauma-focused assessments and/or treatments should be considered. Should the results of the CTS suggest specific trauma reactions (i.e., cut score ≥6), the CTS Secondary Screen questions should be asked, with the responses to these questions used to inform referral decisions.

Secondary Screen

The CTS secondary screen should be performed in a conversation style and the screener should record the youth's responses. A decision on whether to refer a youth for further trauma assessment should be guided by the CTS score, answers to the CTS secondary screen, and review of other relevant information from the intake (e.g., other screening results, collateral records, past/current treatment, evidence of other traumatic events not acknowledged on the CTS). Staff administering the screen should be aware that a youth's responses during the CTS secondary screen may trigger a requirement of a mandatory report of child abuse or neglect.

What Not To Do with CTS Scores

When it is necessary to communicate concerns to parents/caregivers or to clinicians, the specific screening scores should not be provided. Parents/caregivers can simply be told the "screening raised some concern about possible stress reactions," or for referral to a clinician, "the trauma screen indicated a history of possible traumatic event exposures and current trauma reactions."

For more detailed information, please see the website of the Child Health and Development Institute at: www.chdi.org

CHILD TRAUMA SCREEN

Child Report (Age 7+)

Child ID: _____ Date Completed: _____ Administered By: _____

Gender: ☐ Male ☐ Female Age: _____

EVENTS: Sometimes, scary or very upsetting things happen to people. These things can sometimes affect what we think, how we feel, and what we do.

		Yes	No
1.	Have you ever seen people pushing, hitting, throwing things at each other, or stabbing, shooting, or trying to hurt each other?	☐	☐
2.	Has someone ever really hurt you? Hit, punched, or kicked you really hard with hands, belts, or other objects, or tried to shoot or stab you?	☐	☐
3.	Has someone ever touched you on the parts of your body that a bathing suit covers, in a way that made you uncomfortable? Or had you touch them in that way?	☐	☐
4.	Has anything else very upsetting or scary happened to you (loved one died, separated from loved one, been left alone for a long time, not had enough food to eat, serious accident or illness, fire, dog bite, bullying)? *What was it?* _____	☐	☐

REACTIONS: Sometimes scary or upsetting events affect how people think, feel, and act. The next questions ask how you have been feeling and thinking recently.

How often did each of these happen in the last 30 days?		**Never/ Rarely**	**1-2 times per month**	**1-2 times per week**	**3+ times per week**
5.	Strong feelings in your body when you remember something that happened (sweating, heart beats fast, feel sick).	0 ☐	1 ☐	2 ☐	3 ☐
6.	Try to stay away from people, places, or things that remind you about something that happened.	0 ☐	1 ☐	2 ☐	3 ☐
7.	Trouble feeling happy.	0 ☐	1 ☐	2 ☐	3 ☐
8.	Trouble sleeping.	0 ☐	1 ☐	2 ☐	3 ☐
9.	Hard to concentrate or pay attention.	0 ☐	1 ☐	2 ☐	3 ☐
10.	Feel alone and not close to people around you.	0 ☐	1 ☐	2 ☐	3 ☐

Notes:

CHILD TRAUMA SCREEN – SECONDARY SCREENING

Secondary Screening

1. When did you start feeling this way? ☐ N/A

2. How long have you been feeling this way? ☐ N/A

3. How often have you been feeling this way (e.g., every day, a few days per week, a few days a month)? ☐ N/A

4. Was there a time when you weren't feeling this way? How long did that time last? ☐ N/A

5. Has anything happened recently to make the problem(s) worse? ☐ N/A

6. Have you found anything that helps with these problems? ☐ N/A

7. Is there anything else you would like to tell me about these problems? ☐ N/A

Recommendation/Next Step

iv. **YLS.** The YLS is an actuarial-based assessment tool that assists juvenile justice professionals in identifying risk, need, and responsivity factors. The YLS is a valid and reliable risk instrument that assesses risk for recidivism by measuring 42 risk/need factors over the following eight domains: prior and current offenses, family circumstances/parenting, education/employment, peer relations, substance abuse, leisure/recreation, personality/behavior, and attitudes/orientation. Ultimately, a youth is assigned an overall risk level of Low, Moderate, High, or Very High, based on the aforementioned domains and other factors gathered through a structured interview/information-gathering process. The assessed risk level is used to inform juvenile justice professionals of the level of supervision and intervention targets.

a) **How a juvenile court judge should use a YLS assessment:** A judge should use the YLS as a tool to guide disposition, case planning, and rehabilitative decisions. The YLS assesses a youth's risk of reoffending and identifies criminogenic needs, helping the judge make informed, individualized decisions.

1) Assess risk level
   - Low-risk youth: consider diversion programs, community service, or probation with minimal supervision to avoid unnecessary system involvement.
   - Moderate to high-risk youth: consider structured interventions, therapy, or intensive probation while ensuring they receive support tailored to their needs.
2) Identify criminogenic needs
   - The YLS highlights specific factors contributing to delinquency (e.g., family issues, substance abuse, peer influences).
   - The judge should prioritize addressing these needs in disposition and rehabilitation plans.
3) Determine the appropriate level of supervision and services
   - A judge should ensure that the level of supervision matches the youth's risk level (e.g., high-risk youth may require intensive services, while low-risk youth should avoid excessive supervision).
4) Guide dispositional decisions
   - Judges may use the YLS results to determine whether to impose probation, community-based interventions, or placement in a residential treatment program.
   - Ensure that interventions align with evidence-based practices to reduce recidivism.
5) Monitor progress and adjust plans
   - The YLS is not a one-time assessment; reassessments should inform case modifications as the youth's needs change.

b) **What a juvenile court judge should ask themselves:**

1) Was the YLS completed with input from the youth and parent(s)/guardian(s)?
2) Were the youths' top criminogenic needs identified?
3) Were the youths' strengths identified?
4) Were the youths' responsivity factors identified?
5) Were the results of the YLS shared and explained with the youth and parent(s)/guardian(s)?
6) What was the identified risk level?
7) Was an override necessary?

8) Were the results of the YLS considered in the dispositional recommendation?
9) Were any referrals made as a result of the YLS?

c) **What a juvenile court judge should be aware of:**

1) Over-relying on the score alone – the YLS should be used in conjunction with judicial discretion, legal considerations, and input from probation officers, psychologists, and other service providers.
2) Placing low-risk youth in intensive programs – this can increase recidivism rather than reduce it.
3) Ignoring protective factors – some youth may have strong support systems that can aid in rehabilitation.
4) Except for the Prior and Current Offenses domain, which spans a lifetime period of observation, the initial YLS assessment should consider the youth's current situation, or the conditions present during the previous 12 months. The recommended EBP timeframe for an initial YLS assessment is between 90 days from the receipt of the written allegation and 30 days post the disposition date. Reassessments should take place at intervals of six months from the last assessment, or at the occurrence of a life-changing event (i.e., new arrest, court hearing, or violations of probation). The recommended EBP timeframe for a closing YLS assessment is between 30 days prior and 30 days post the case closing date.

Youth Level of Service Case Management Inventory

The Youth Level of Service/Case Management Inventory (YLS/CMI) is an actuarial based assessment tool that assists juvenile justice professionals with the identification of risk/need/responsivity factors. Research has shown that addressing these factors can promote long term behavior change (Andrews & Bonta, 2006). This protects the community and facilitates the development of competencies that make it possible for youth to become productive, connected, and law-abiding members of the community. The YLS is designed to aid probation officers in assessing youth in a fair, objective and evidence-based manner. The tool measures 42 risk factors organized around the eight domains listed below.

8 Domains for Identifying Risk

Prior and Current Offenses/Dispositions	*Family Circumstances*	*Education/ Employment*	*Peer Relations*
Substance Abuse	*Leisure/ Recreation*	*Personality/ Behavior*	*Attitudes/ Orientation*

The **eight** risk domains are made up of static and dynamic risk factors.

- Static risk factors are those that have occurred in the past and cannot be changed (Prior and Current Offenses/Dispositions).
- Dynamic risk factors, also called criminogenic needs, are those linked to recidivism that can be improved to reduce the likelihood of reoffending (remaining seven domains).

The YLS Provides an Overall Score that Indicates a Youth's Risk to Recidivate

Low	Moderate	High	Very High
Female 0-8	*Female 9-19*	*Female 20-28*	*Female 29-42*
Male 0-9	*Male 10-21*	*Male 22-31*	*Male 32-42*

Strongest Predictors of Reoffending Behavior

Although Prior and Current Offenses/Dispositions, a static risk factor, is the primary predictor of reoffending behavior; the following four dynamic risk factors are also strong predictors of recidivism. When present, these domains must be prioritized for interventions and treatment in order to maximize risk reduction potential.

- Attitudes/Orientation (Thinking/Beliefs)
- Personality/Behavior
- Peer Relations
- Family Circumstances

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Responsivity Factors

Responsivity factors are individual characteristics that can impact how youth react to services. Initial identification can occur through the YLS and additional screening and assessment instruments. This information should be used in the development of the case plan to individualize interventions. Responsivity factors can include, but are not limited to:

- *Learning Disabilities*
- *Motivation*
- *Trauma Experiences*
- *IQ*
- *Mental Health*
- *Cultural Issues*
- *Gender*

YLS and Case Plan Connection

The YLS lays the foundation for the youth's case plan. Youth that score moderate or high on the YLS should identify goals, activities, and interventions to develop competencies and reduce risk/need in their identified YLS domains. The case planning process should be collaborative and include a discussion between the probation officer, the youth, and their family on the YLS results and the selection of identified needs to be addressed.

Best Practice Principles to Remember

- **Overrides -** Overrides should not exceed 5-10% of the total YLS assessments completed in a given year.
- **Assessment Sharing -** The YLS is most effective when the results of the assessment are shared with the youth, their family, the courts, providers, and other relevant stakeholders.
- **Strengths -** The YLS allows for identification of the youth's strengths, which should be considered when case planning.
- **Item Selection Justification -** The probation officer should provide justification for scoring decisions for each item that is selected, or not selected, in the comment section of each domain.
- **Booster Training**- Booster Training should occur a minimum of twice a year, to ensure fidelity of the tool.
- **Quality Assurance/Continuous Quality Improvement -** jurisdictions should develop QA and CQI practices to ensure policy adherence. This includes but is not limited to inter-rater reliability, data collection and analysis, and fidelity of the tool. Fidelity monitoring shall occur through Master Trainer oversight.
- **Service Matrix -** Service Matrices are used in conjunction with the YLS to help categorize services according to risk level and each criminogenic need. This helps match the needs of youth with proper services.

The Foundation for Behavior Change is Sound Risk Identification

YLS/CMI SCORING:

PO Name:

Youth Name:

Part I

YLS Date:

1. Prior and Current Offenses		**Score:**	**Prior Comments**
Three or More Prior Convictions	a	☐	
Two or More Failures to Comply	b	☐	
Prior Probation	c	☐	
Prior Custody	d	☐	
Three or More Current Convictions	e	☐	
Low (0) Moderate (1-2) High (3-5)	**Total**		

2. Family Circumstances/Parenting		**Score:**	**Family Comments**
Inadequate Supervision	a	☐	
Difficulty Controlling Behavior	b	☐	
Inappropriate Discipline	c	☐	
Inconsistent Parenting	d	☐	
Poor Relations: Father-Youth	e	☐	
Poor Relations: Mother-Youth	f	☐	
Strength		☐	
Low (0) Moderate (1-2) High (3-5)	**Total**		

3. Education/Employment		**Score:**	**Education Comments**
Disruptive Classroom Behavior	a	☐	
Disruptive Behavior on School Property	b	☐	
Low Achievement	c	☐	
Problems with Peers	d	☐	
Problems with Teachers	e	☐	
Truancy	f	☐	
Unemployed/Not Seeking Employment	g	☐	
Strength		☐	
Low (0) Moderate (1-2) High (3-5)	**Total**		

4. Peer Relations		**Score:**	**Peer Comments**
Some delinquent acquaintances	a	☐	
Some delinquent friends	b	☐	
No/Few Positive Acquaintances	c	☐	
No/ Few Positive Friends	d	☐	
Strength		☐	
Low (0) Moderate (1-2) High (3-5)	**Total**		

5. Substance Abuse		**Score:**	**Substance Comments**
Occasional Drug Use	a	☐	
Chronic Drug Use	b	☐	
Chronic Alcohol Use	c	☐	
Substance Abuse Interferes with Life	d	☐	
Substance Abuse Linked to Offense	e	☐	
Strength		☐	
Low (0) Moderate (1-2) High (3-5)	**Total**		

6. Leisure/Recreation		Score:	Leisure Comments
Limited Organized Activities	a	☐	
Could Make Better Use of Time	b	☐	
No Personal Interests	c	☐	
Strength		☐	
Low (0) Moderate (1-2) High (3-5)	**Total**		

7. Personality/Behavior		Score:	Personality Comments
Inflated Self-Esteem	a	☐	
Physically Aggressive	b	☐	
Tantrums (Temper)	c	☐	
Short Attention Span	d	☐	
Poor Frustration Tolerance	e	☐	
Inadequate Guilt Feelings	f	☐	
Verbally Aggressive, Impudent	g	☐	
Strength		☐	
Low (0) Moderate (1-2) High (3-5)	**Total**		

8. Attitudes/Orientation		Score:	Attitudes Comments
Antisocial/Pro-Criminal Attitudes	a	☐	
Not Seeking Help	b	☐	
Actively Rejecting Help	c	☐	
Defies Authority	d	☐	
Callous, Little Concern for Others	e	☐	
Strength		☐	
Low (0) Moderate (1-2) High (3-5)	**Total**		
TOTAL YLS/CMI SCORE:			

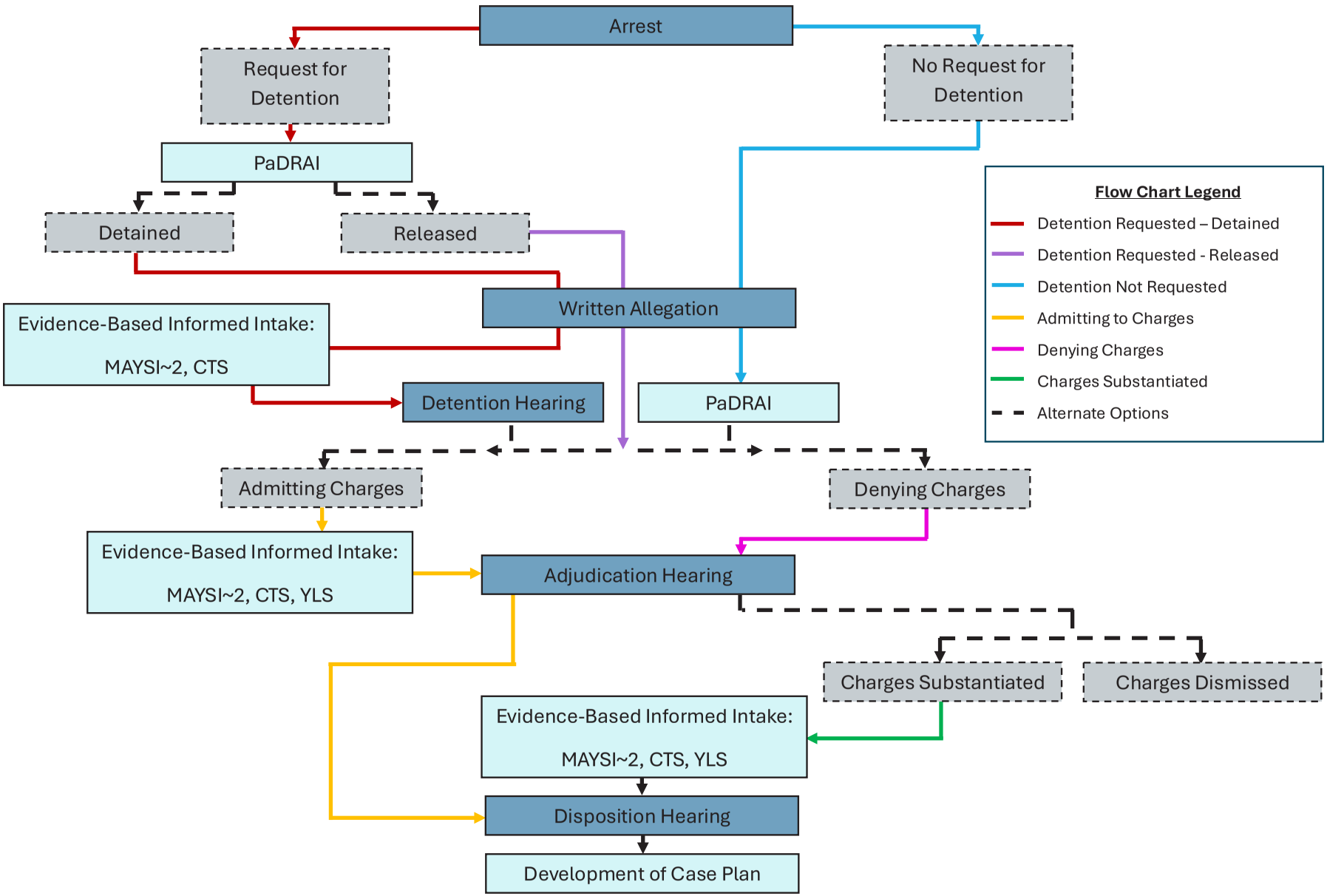
TOP 3 CRIMINOGENIC NEEDS:	1.	
(Rank in order of priority)	2.	
	3.	

PART III: Assessment of Other Needs **Family/Parents**	**Pt. 1**	**PO Rating**	**Family/Parents Responsivity Comments**
Chronic History of Offenses			
Emotional Distress/Psychiatric			
Durg/Alcohol Abuse			
Marital Conflict			
Financial/Accommodation Problems			
Uncooperative Parent(s)			
Cultural/Ethnic Issues			
Abusive Mother			
Abusive Father			
Significant Family Trauma (Specify)			
Other (Specify)			

PART III: Assessment of Other Needs Pt. 2 Youth	PO Rating	Youth Responsivity Comments
Adverse Living Conditions		
Anxious		
Communication Problems		
Cruelty to Animals		
Cultural/Ethnic Issues		
Depressed		
Diagnosis of Conduct Disorder/Oppositional Defiant Disorder		
Diagnosis of Psychosis		
Engages in Denial		
Fetal Alcohol Spectrum Disorder (FASD)		
Financial/Accommodation Problems		
Gang Involvement		
Gender Issues		
Health Problems		
History of Assault on Authority Figures		
History of Bullying		
History of Escape		
History of Fire Setting		
History of Running Away		
History of Sexual Assault/Physical Assault		
History of Weapon Use		
Inappropriate Sexual Activity		
Learning Disabled		
Low Intelligence/Developmental Delay		
Low Self-Esteem		
Manipulative		
Parenting Issues		
Peers Outside of Age Range		
Physical Disability		
Poor Problem-Solving Skills		
Poor Social Skills		
Pregnancy		
Protection Issues		
Racist/Sexist Attitudes		
Self-Management Skills		
Shy/Withdrawn		
Suicidal Ideation/Attempts or Self-Injury		
Third Party Threat		
Underachievement		
Victim of Bullying		
Victim of Neglect		
Victim of Physical/Sexual Abuse		
Witness of Domestic Violence		
Other Mental Health Issues (Specify)		
Other (Specify)		

PART IVI: Your Assessment of Risk Level	Comments
Low (Males: 0-9) (Females: 0-8)	
Moderate (Males: 10-21) (Females: 9-19)	
High (Males: 22-31) (Females: 20-28)	
Very High (Males: 32-42) (Females: 29-42)	

EVIDENCE-BASED INFORMED INTAKE FLOW CHART



*Please note: County practices may differ slightly, but generally follow this flow chart and must comply with the Rules of Juvenile Court Procedure and the Juvenile Act.

Case Planning

The Case Plan is the blueprint for working with the youth while under the Court's supervision, and it is recommended for all youth that score overall moderate risk or higher on the Youth Level of Service (YLS). The Case Plan is designed to target strategies and interventions that address the top criminogenic needs identified by the YLS and incorporate Balanced and Restorative Justice (BARJ) goals. The Case Plan will evolve as the youth moves through supervision, and should build upon the youth's strengths and needs to reduce their likelihood of recidivism and support behavior change. The case plan process is highly collaborative and requires active involvement from the youth, the family, the probation officer, and other stakeholders from start to finish.

Best Practices Principles to consider when developing the Case Plan:

- *Dynamic: Review regularly*
- *Youth and family engagement*
- *Top two or three criminogenic needs*
- *Building rapport and professional alliance*
- *Incorporating responsivity factors*
- *Moderate and high risk youth*

- *SMART goals and activities*
- *Stages of Change*
- *Recognize: triggers, drivers, barriers and strengths*
- *Standard court ordered terms and conditions not included*

Responsivity Factors:

The Case Plan also considers responsivity factors when developing the youth's activities. The following examples of responsivity factors must be considered in the development of the Case Plan to enhance the youth's ability to succeed; *(Please note that these are only a few examples, and there is a full list provided on the YLS 2.0 in the responsivity section. This is not an exhaustive list.)*

- Mental Health
- Victim of Bullying
- Learning Style
- Motivation
- Gender Considerations
- Witness of Abuse
- Developmental Age
- Trauma
- Intellectual Disabilities
- Culture/ethnic Issues
- Engages in Denial
- Manipulation

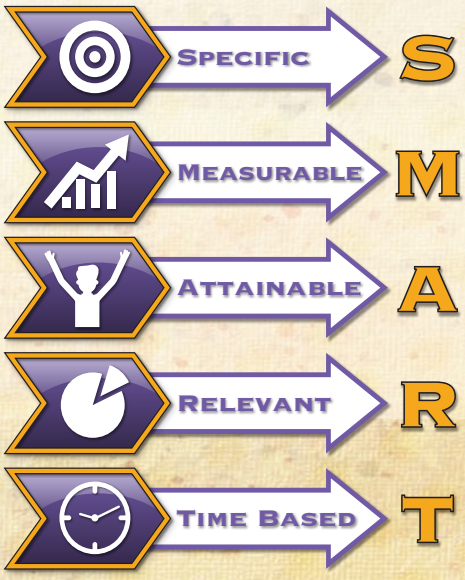
Skill Deficits/Skill Development:

Criminogenic needs are broad and may include several different skill deficits/development areas of focus. Identify specific skill deficits/development that contribute to the problem behavior. Establish activities that will model, teach, and reinforce the new desired skill. In order to determine the skill deficit; ask 'What skill could the youth be lacking in order to achieve this goal?' or 'What possible skill the youth could learn in order to achieve this goal?'. Below are a few examples of skill deficits/development areas.

- Problem Solving
- Decision Making
- Controlling Emotions
- Avoiding Trouble
- Reducing Impulsivity
- Group/Peer Pressure
- Communication
- Anger Control

Goals and Activities:

Case Plan goals must be developed with the youth, their families or their identified support system, and service providers. The juvenile's strengths should be emphasized while triggers and barriers are addressed to ensure the greatest impact on reducing their risk to recidivate. The Case Plan goals should be continually updated and the activities should be tracked and modified based upon the youth's progress or lack thereof. Each activity should follow the **SMART** format.



Graduated Response:

Graduated response systems provide empirically based strategies to influence a youth's behavior. When properly administered, graduated response systems offer effective methods to promote and reinforce near-term achievement of goals identified in the Case Plan. Reponses should be incremental, proportionate, and predictable to encourage desired behaviors, and to discourage undesired behaviors of youth under probation supervision. *(Please see the Graduated Response System Bench Card for more information.)*

Stages of Change:

When a person begins their journey towards change they move through a series of five stages (*Pre-Contemplative, Contemplative, Preparation, Action, Maintenance*). The stages of change are often portrayed in a circular manner because an individual can move back and forth between the stages as the change occurs. It is important to consider a youth's current place in the Stages of Change model when selecting interventions to address the needs that have been identified. A youth's place in the Stages of Change model can have an impact on their success of the applied intervention(s). *(Please see the Motivational Interviewing Bench Card for more information.)*

Evaluating Progress:

Case Plans should be reviewed with the juvenile and the family on a regular basis and updated to reflect the completion of goals or progress towards completion (positive or negative). It is important that Case Plans are collaborative, and that the goals are focused on the juvenile's need area(s). Case plans are designed to be constantly updated and adjusted to ensure that there is a reduction in the identified risk area(s). The Case Plan has designated areas for dates relevant to the juvenile's progress, and should be updated according to your specific counties policy on their success of the applied intervention(s).

The *Case Plan* builds upon the juvenile's strengths and needs to reduce their likelihood of recidivism while supporting their behavior change.

Field Based Case Plan Template

Juvenile Name: **Youth Identifier #:** **PO Name:** **PO Contact #:**

OVERALL TOTAL RISK LEVEL: Low ☐ Mod ☐ High ☐ Very High ☐ **Date:**

INITIAL:

	Low	Mod	High	Strength		Low	Mod	High	Strength	*Prioritize Top 3*
1. Prior and Current Offenses/Dispositions:	☐	☐	☐	☐	5. Substance Abuse:	☐	☐	☐	☐	1.
2. Family Circumstances/Parenting:	☐	☐	☐	☐	6. Leisure/Recreation:	☐	☐	☐	☐	2.
3. Education/Employment:	☐	☐	☐	☐	7. Personality/Behavior:	☐	☐	☐	☐	3.
4. Peer Relations:	☐	☐	☐	☐	8. Attitudes/Orientation:	☐	☐	☐	☐	

OVERALL TOTAL RISK LEVEL Low ☐ Mod ☐ High ☐ Very High ☐ **Date:**

Reassessment or Closing: *(Circle one)*

	Low	Mod	High	Strength		Low	Mod	High	Strength
1. Prior and Current Offenses/Dispositions:	☐	☐	☐	☐	5. Substance Abuse:	☐	☐	☐	☐
2. Family Circumstances/Parenting:	☐	☐	☐	☐	6. Leisure/Recreation:	☐	☐	☐	☐
3. Education/Employment:	☐	☐	☐	☐	7. Personality/Behavior:	☐	☐	☐	☐
4. Peer Relations:	☐	☐	☐	☐	8. Attitudes/Orientation:	☐	☐	☐	☐

By signing this case plan, you acknowledge and agree that you and your child, with the assistance of the juvenile probation officer, have created the goals and activities outlined in this document. _____ **AND** _____

Note: Identify why any initials may be missing

(youth Initials) *(parent initials)*

Specific **M**easurable **A**chievable **R**ealistic **T**ime Limited

Primary Driver

Risk/Criminogenic Need:	Attitudes/Orientation	Personality/Behavior	Peer Relation
Family/Parenting	Substance Abuse	Education/Employment	Leisure/Recreation

Skill Deficit:	
Goal:	Triggers Barriers *(circle one)*

Activity/Action Step:

1.	Date:

Not Yet Started	Started	Making Progress	Completed	Removed/Revised

Activity/Action Step:

2.	Date:

Not Yet Started	Started	Making Progress	Completed	Removed/Revised

Activity/Action Step:

3.	Date:

Not Yet Started	Started	Making Progress	Completed	Removed/Revised

Activity/Action Step:

4.	Date:

Not Yet Started	Started	Making Progress	Completed	Removed/Revised

Specific **M**easurable **A**chievable **R**ealistic **T**ime Limited

Second Driver

Risk/Criminogenic Need:	Attitudes/Orientation	Personality/Behavior	Peer Relation
Family/Parenting	Substance Abuse	Education/Employment	Leisure/Recreation

Skill Deficit:	
Goal:	Triggers Barriers *(circle one)*

Activity/Action Step:

1.	Date:

Not Yet Started	Started	Making Progress	Completed	Removed/Revised

Activity/Action Step:

2.	Date:

Not Yet Started	Started	Making Progress	Completed	Removed/Revised

Activity/Action Step:

3.	Date:

Not Yet Started	Started	Making Progress	Completed	Removed/Revised

Activity/Action Step:

4.	Date:

Not Yet Started	Started	Making Progress	Completed	Removed/Revised

Specific **M**easurable **A**chievable **R**ealistic **T**ime Limited

By signing this document, I agree that I have reviewed the case plan with the juvenile probation officer assigned to the case.

Juvenile and Parent Signature **Date**

_____ _____/_____/_____
Juvenile and Parent Signature **Date**

_____ _____/_____/_____
Juvenile and Parent Signature **Date**

_____ _____/_____/_____
Juvenile and Parent Signature **Date**

_____ _____/_____/_____
Juvenile and Parent Signature **Date**

_____ _____/_____/_____
Juvenile and Parent Signature **Date**

_____ _____/_____/_____

Specific **M**easurable **A**chievable **R**ealistic **T**ime Limited

GLOSSARY

PENNSYLVANIA'S JUVENILE JUSTICE SYSTEM EVIDENCE-BASED PRACTICES

Case Plan: A document developed in collaboration with the youth, family, and juvenile probation officer designed to target strategies and interventions that address the youth's top criminogenic needs identified by the Youth Level of Service (YLS). Case plans identify goals and activities that are to be completed during the period of probation supervision.

Child Trauma Screen (CTS): A brief, empirically-based screen for child traumatic stress. The CTS is used to identify youth who are likely to be suffering from trauma exposure and would benefit from being referred for a more comprehensive trauma-focused assessment by a trained clinician.

Effective Practices in Community Supervision (EPICS): A model of community supervision that utilizes structured sessions to target criminogenic needs through evidence-based interventions. Sessions include a check-in, review, intervention, and homework.

Graduated Responses (GR): The use of incentives and sanctions/interventions, delivered in a structured and systematic manner, to encourage and reinforce positive behaviors and to discourage negative behaviors with consequences that hold youth accountable.

Massachusetts Youth Screening Instrument (MAYSI~2): A brief, behavioral health screening tool designed for juvenile justice programs and facilities. The tool is a self-report inventory consisting of 52 yes-or-no questions. The questions ask the youth if they have experienced various thoughts, feelings, or behaviors in the past few months. The MAYSI~2 provides scores on six primary scales: alcohol/drug use, angry/irritable, depressed/anxious, somatic complaints, suicide ideation, and thought disturbance (boys).

Motivational Interviewing (MI): A collaborative, goal-oriented style of communication that focuses on the language of change and assists youth in resolving their ambivalence about change. It is designed to strengthen internal motivation for, and commitment to, a specific goal by eliciting and exploring the person's reasons for change within an atmosphere of acceptance and compassion.

Pennsylvania Detention Risk Assessment Instrument (PaDRAI): A concise, structured decision-making instrument used to assist in the critical decision of whether to securely detain a youth, release to an alternative to detention (ATD), or release to the custody of a parent or responsible adult during the period that the youth is awaiting their juvenile court hearing.

Youth Level of Service/Case Management Inventory™ (YLS) Risk/Needs Assessment: An actuarial-based assessment tool that assists juvenile justice professionals in identifying risk, need, and responsivity factors. The YLS is a valid and reliable risk instrument that assesses risk for recidivism by measuring 42 risk/need factors over the following eight domains: prior and current offenses, family circumstances/parenting, education/employment, peer relations, substance abuse, leisure/recreation, personality/behavior, and attitudes/orientation.

GLOSSARY

TOOLS AND INTERVENTIONS

Aggression Replacement Training® (ART): A group-facilitated, evidence-based, cognitive behavioral intervention that reduces aggressive behavior by teaching youth social skills, anger control, and moral reasoning.

Brief Intervention Tools (BITS): Structured, time-limited interventions designed to help juvenile justice professionals address problematic behaviors with youth. BITS provide short, focused sessions that encourage youth to reflect on their behavior, set goals, and build the necessary skills to facilitate behavior change.

Carey Guides: Structured tools used to assess and guide the development of youth within the juvenile justice system. These guides are designed to help probation officers by providing a framework for evaluating and addressing the needs of juveniles in a way that promotes rehabilitation and reduces recidivism.

Dialectical Behavior Therapy (DBT): A type of psychotherapy that helps individuals regulate emotions, improve interpersonal relationships, and manage distress by teaching skills in mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.

Four Core Competencies (4CC): Enables juvenile justice professionals to establish a professional alliance, facilitate case planning, promote skills practice, and ensure the effective use of rewards and sanctions to facilitate long-term behavior change and reduce recidivism.

Moral Reconation Therapy® (MRT): A cognitive-behavioral treatment program designed to enhance moral reasoning, improve decision-making, and foster positive behavioral changes.

National Curriculum and Training Institute (NCTI) Youth Crossroads®: Evidence-based curricula, delivered to youth in a group format designed to target specific interventions that address criminogenic needs. Certified facilitators guide participants through the curricula using workbooks and interactive exercises to assist youth in developing prosocial skills.

National Institute of Correction's Thinking for a Change (T4C): An integrated cognitive behavioral change program that teaches youth cognitive restructuring, social skills, and problem-solving skills. Facilitated in a group, participants use workbooks and are assigned homework.

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS): A manualized, empirically supported group treatment designed to improve the emotional, social, academic, and behavioral functioning of youth exposed to chronic interpersonal trauma and/or other types of trauma.

The Change Companies® Forward Thinking Journals: A cognitive-behavioral series that uses evidence-based strategies to assist youth involved in the juvenile justice system in making positive changes to their thoughts, feelings, and behaviors.

Inclusive Language: Considerations for Use

Created with support and reviewed by individuals on the spectrum.

Words matter and using respectful and inclusive language can make a big difference. The goal of inclusive language is to respect people across race, class, gender and ability. This is also true when discussing Autism Spectrum Disorder.

Each autistic person experiences the world in a different way. This includes how they think, interact with the sensory world around them, communicate, and more. Being respectful of these differences through the use of inclusive language can have a positive impact on everyone.

It is also important to avoid ableist language. Ableist language assumes disabled people are not as good as nondisabled people. This is harmful as it excludes, devalues, and ignores disabled people.

Below are some common phrases that can be adjusted to be more inclusive. These phrases are preferred by many in the autism community, but autistic individuals may have specific preferences that are different from these examples. As with anyone, asking an autistic person their preferences should take priority.

INSTEAD OF…..	TRY THIS…
autism symptoms	autistic characteristics/traits/features
person with autism	autistic person
deficit	difference
treatment	supports/services/strategies/accommodations
person with a disability	disabled person
suffers from autism	impact/effect of autism
normal	neurotypical/non-autistic/person without autism
typical person/typical peer	non-autistic person/typically developing peer

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Instead of…..	Try this…
differently abled	disabled
different ability	disability
mental retardation	intellectual disability
high functioning	low support needs
low functioning	high support needs
autism as a “puzzle”	autism as a part of neurodiversity *(people interact and experience the world differently)*
cure	supports/accommodations/quality of life outcomes
disorder	condition/disability
non-verbal	non-speaking
special interests	focused interests
at risk for autism	increased likelihood of autism
burden of autism	impact/effect of autism

Here are some examples of what NOT to say or assume:

“You don’t look autistic”.

Autism is a broad spectrum and impacts everyone differently and because you can’t “see” autism, it may surprise you when someone discloses they are autistic. This is not a compliment. You should respect the individual who shares their diagnosis and if you need to say anything, ask if there is any way you can support or accommodate them in that moment.

“You seem normal.”

Again, each autistic individual is unique and the word normal is offensive. If you are surprised by someone who shares their autism diagnosis rather than comment, you could explain that you know very little about autism and ask how you can support or accommodate them.

“You must be good at math/music/art”.

This perpetuates an often misunderstood stereotype. Ask instead, “What are your interests?”

“What’s it like to be autistic?”

Instead you could ask, “From your experience where can accommodations and the disability experience be improved, where are people and places doing a good job?”

Asking a question about the autistic person to a parent, caregiver or support professional when the autistic individual is standing right there. Presume competence.

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WHAT AM I TELLING YOU?

A GUIDE FOR JUSTICE PROFESSIONALS ABOUT INDIVIDUALS ON THE AUTISM SPECTRUM

Created with support and reviewed by individuals on the spectrum.

WHAT YOU SEE/HEAR	WHAT YOU THINK	WHAT AM I TELLING YOU?
Little to no eye contact	Something to hide Trying to be deceptive	Eye contact makes me anxious and is difficult for me. I cannot look at you if you want me to hear and understand you. I may need a break from eye contact.
Aloof, inappropriate comments Outbursts or monotone speech	No remorse, rude Not listening, not paying attention	I do not understand the social implications of how I am speaking to you. I tell it like it is.
Mimicking what you are saying	He is mocking me or not taking me seriously	I have to repeat what you say to try to comprehend it and sometimes repeating things helps me calm down.
Unusual facial expressions and body language Excessive movement	Using drugs or other substances, has an intellectual disability, or appears rude	Autism causes my body to behave and react differently. I am trying to listen to you and do what you ask but sometimes my body won't let me. It is more difficult for me to communicate using "typical" facial expressions and body language.
No immediate response or no response at all	Not listening, not caring	I heard you but I need extra processing time. Please slow down, allow me time to answer your question before asking again, and repeat yourself as necessary.
Plugging my ears, closing my eyes	Non-compliance	It is too bright and loud in here, my senses are overloaded and my flight or fight response is in overdrive. Please give me some time to calm down.
Not wanting to be touched	Hiding Something	Even the lightest touch hurts me. Please warn me if you are going to touch me.
Refusing to comply	Deceptive, Uncooperative	My world is very chaotic. Routine helps make the world calmer. When my routine is disrupted I become very agitated and anxious. Please give me time to adjust to the change.
Very agreeable, admits to anything	Guilty	Making friends is hard. I have learned that doing what others want makes having friends easier. Sometimes I agree or admit to things because I have been told that that is the way to get along with other people.
Repeating the same directions numerous times	Not Listening	I learn better by seeing. Can you please show me what you want me to do?

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The ASERT Collaborative is funded by the Office of Developmental Programs, PA Department of Human Services.

4/05/21

Signs of Autism: a guide for justice system professionals

Repetitive Behaviors

- Flapping, flicking, spinning, rocking
- Focuses on one topic/detail that is unrelated to the conversation
- Scripting or repeating sounds
  - (e.g. repeat lines of a television show or movie)

Individual History

- Reported history of other developmental delays/diagnoses
- History/current substance use/abuse
  - due to social desirability, self-medicating
- Other concerns about individual's development
- Does not display age-appropriate knowledge of sex and sexual boundaries

Mental Processes

- Displays poor impulse control
  - (e.g. constantly touching an object despite being told/given consequences)
- Processing delay/Unable to follow a chain of commands
  - (e.g. put your coat on the chair, sit down, and put your phone on the table)

Social Communication

- Flat vocal affect
  - (e.g. voice stays at one tone with little to no inflection)
- Unusual facial grimaces
- Avoidance of eye contact or blank stare throughout conversation
- Individual has no friends or is socially isolated
- May appear stubborn, defiant, or non-compliant with requests
- Atypical or stiff body language flat facial expressions.
- Overly literal interpretation of questions
- Increased aggravation/anxiety during interview
- Overly agreeable
- Appears to have a lack of sympathy or empathy

Sensory Behaviors

- May be sensitive to touch
  - especially if unexpected
- Overwhelmed by sensory environment
  - (e.g. covers ears, eyes, nose)

Key Signs

Have a question about autism? Contact the ASERT Resource Center at 877-231-4244

- Lack of Eye Contact
- Flapping, Flicking, Spinning
- Sensitive to Touch
- May Appear Stubborn/Resistant
- Scripting Words, Phrases, Noises
- Processing Delays

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Ten Things Every Juvenile Court Judge Should Know About Trauma and Delinquency

By Kristine Buffington, Carly B. Dierkhising, and Shawn C. Marsh

INTRODUCTION

The majority of youth who develop a pattern of delinquent behaviors and experience subsequent juvenile court involvement have faced both serious adversities and traumatic experiences. Research continues to show that most youth who are detained in juvenile detention centers have been exposed to both community and family violence and many have been threatened with, or been the direct target of, such violence (Abram et al., 2004; Wiig, Widom, & Tuell, 2003). Studies also demonstrate that youth who have multiple exposures to violence or victimization are at higher risk for mental health problems, behavioral problems, substance abuse, and delinquent behaviors (Ford, Chapman, Hawke, & Albert, 2007; Ford, Elhai, Connor, & Frueh, in press; Saunders, Williams, Smith, & Hanson, 2005; Tuell, 2008).

The mission of the juvenile court is complex. The court is tasked with protecting society, safeguarding the youth and families that come to its attention, and holding

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Authors' Note: The authors would like to thank the judicial officers, clinical experts, staff, and system consumers who reviewed this article for their time and thoughtful input that made this a better product.

Editor's Note: This article was published in 2010 as a Technical Assistance Bulletin by the National Council of Juvenile and Family Court Judges. This project was supported by Grant No. 2007-JL-FX-0007 awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions in this document or program are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice or the National Council of Juvenile and Family Court Judges.

Juvenile and Family Court Journal 61, no. 3 (Summer)

delinquent youth accountable while supporting their rehabilitation. In order to successfully meet these sometimes contradictory goals, the courts, and especially the juvenile court judge, are asked to understand the myriad underlying factors that affect the lives of juveniles and their families. One of the most pervasive of these factors is exposure to trauma. To be most effective in achieving its mission, the juvenile court must both understand the role of traumatic exposure in the lives of children and engage resources and interventions that address child traumatic stress. Accordingly, the purpose of this article is to highlight ten crucial areas that judges need to be familiar with in order to best assist traumatized youth who enter the juvenile justice system.

1. A Traumatic Experience is an Event That Threatens Someone's Life, Safety, or Well-Being.

Trauma can include a direct encounter with a dangerous or threatening event, or it can involve witnessing the endangerment or suffering of another living being. A key condition that makes these events traumatic is that they can overwhelm a person's capacity to cope, and elicit intense feelings such as fear, terror, helplessness, hopelessness, and despair. Traumatic events include: emotional, physical, and sexual abuse; neglect; physical assaults; witnessing family, school, or community violence; war; racism; bullying; acts of terrorism; fires; serious accidents; serious injuries; intrusive or painful medical procedures; loss of loved ones; abandonment; and separation.

2. Child Traumatic Stress Can Lead to Post Traumatic Stress Disorder (PTSD).

While many youth who experience trauma are able to work through subsequent challenges, some display traumatic stress reactions. The impact of a potentially traumatic event is determined, not only by the objective nature of the event, but also by the child's subjective response to the event; something that is traumatic for one child may not be for another. The degree to which a child is impacted by trauma is influenced by his or her temperament; the way the child interprets what has happened; his or her basic coping skills; the level of traumatic exposure; home and community environments; and the degree to which a child has access to strong and healthy support systems.

Rates of PTSD in juvenile justice-involved youth are estimated between 3%-50% (Wolpaw & Ford, 2004) making it comparable to the PTSD rates (12%-20%) of soldiers returning from deployment in Iraq (Roehr, 2007). PTSD is a psychiatric disorder defined in the DSM-IV-TR, and several conditions or criteria must be met for an individual to receive the diagnosis. These criteria include: having been exposed to a threatening event, experiencing an overwhelming emotional reaction, and developing symptoms causing severe distress and interference with daily life. Further, individuals also must experience a sufficient number of the following three symptoms for more than one month: *avoidance* (i.e., avoiding reminders of the trauma); *hyperarousal* (i.e., being emotionally or behaviorally agitated); and *re-experiencing* (e.g., nightmares or intrusive memories). Because the PTSD diagnosis was developed initially to describe an adult condition, the definition is not a perfect fit for what professionals often see with children and youth who have experienced trauma.

It is also important to understand that not all youth who are impacted severely by traumatic stress develop PTSD. Some youth may experience partial symptoms of PTSD, other forms of anxiety or depression, or other significant impairments in their ability to meet the demands of daily life (e.g., emotional numbness or apathy).

3. Trauma Impacts a Child's Development and Health Throughout His or Her Life.

Traumatic experiences have the potential to impact children in all areas of social, cognitive, and emotional development throughout their lives. Trauma that occurs early in life, such as infancy or toddlerhood, strikes during a critical developmental period. The most significant amount of brain growth occurs between birth and two years of age. Exposure to child abuse and neglect can restrict brain growth especially in the areas of the brain that control learning and self regulation (DeBellis, 1999). Exposure to domestic violence has also been linked to lower IQ scores for children (Koenen, Moffitt, Avshalom, Taylor, & Purcell, 2003). In addition to critical periods of brain development, it is during early childhood that children develop the foundations for their future relationships. When young children are cared for by parents who protect them, interact with them, and nurture them, they can learn to trust others, develop empathy, and have a greater capacity for identification with social norms (Putnam, 2006). Loss of a caregiver or being parented by a significantly impaired caregiver can disrupt children's abilities to manage their emotions, behaviors, and relationships. Youth who experience traumatic events may have mental and physical health challenges, problems developing and maintaining healthy relationships, difficulties learning, behavioral problems, and substance abuse issues (Ford et al., 2007; Saunders et al., 2005). In other words, what occurs in the lives of infants and young children matters a great deal and can set the stage for a child's entire life trajectory.

The experience of either **acute trauma** (a single traumatic event limited in time; see Figure 1), or **chronic trauma** (multiple traumatic events) can derail a child's development if proper supports or treatment are not accessed (Garbarino, 2000). It is not likely just one traumatic event will lead a youth to become violent or antisocial, rather it is both a series and pattern of traumatic events—occurring with no protection, no support, and no opportunities for healing—that places youth at the highest risk (Garbarino, 2000). It is this pattern of chronic trauma that affects many youth who come before the juvenile court system. Research also suggests that the impact of trauma can persist into adulthood and can increase risk of serious diseases, health problems, and early mortality (Felitti et al., 1998). Given that child traumatic stress can impact brain development and have such a profound influence throughout a person's lifespan, it is essential for courts and communities to work together to prevent traumatic events where possible (such as child abuse and neglect) and to provide early interventions to treat traumatic stress before a youth becomes entrenched in a pattern of maladaptive and problematic behavior.

4. Complex Trauma is Associated with Risk of Delinquency.

The effect of trauma is cumulative: the greater the number of traumatic events that a child experiences, the greater the risks to a child's development and his or her emotional

Acute Trauma: "A single traumatic event that is limited in time. An earthquake, dog bite, or motor vehicle accident are all examples of acute traumas" (Child Welfare Committee (CWC)/National Center for Child Traumatic Stress Network (NCTSN), 2008, p. 6).
Chronic Trauma: "Chronic trauma may refer to multiple and varied (traumatic) events such as a child who is exposed to domestic violence at home, is involved in a car accident, and then becomes a victim of community violence, or longstanding trauma such as physical abuse or war." (CWC/NCTSN, 2008, p. 6).
Complex Trauma: "Complex trauma is a term used by some experts to describe both exposure to chronic trauma—usually caused by adults entrusted with the child's care, such as parents or caregivers—and the immediate and long-term impact of such exposure on the child." (CWC/NCTSN, 2008, p. 7).
Hypervigilance: "Abnormally increased arousal, responsiveness to stimuli, and scanning of the environment for threats" (Dorland's Medical Dictionary for Health Consumers, 2007). Hypervigilance is a symptom that adults and youth can develop after exposure to dangerous and life-threatening events (Ford et al., 2000; Sipprelle, 1992). The American Psychiatric Association's diagnostic criteria manual (DSM-IV-TR) identifies it as a symptom related to Post Traumatic Stress Disorder (American Psychiatric Association, 2000).
Resiliency: "A pattern of positive adaptation in the context of past or present adversity" (Wright & Masten, 2005, p. 18).
Traumatic Reminders: "A traumatic reminder is any person, situation, sensation, feeling, or thing that reminds a child of a traumatic event. When faced with these reminders, a child may re-experience the intense and disturbing feelings tied to the original trauma." (CWC/NCTSN, 2008, p. 12).

FIGURE 1. Key Definitions

and physical health. Youth who experience **complex trauma** have been exposed to a series of traumatic events that include interpersonal abuse and violence, often perpetrated by those who are meant to protect them. This level of traumatic exposure has extremely high potential to derail a child's development on a number of levels. Youth who are victimized by abuse, and are exposed to other forms of violence, often lose their trust in the adults who are either responsible for perpetrating the abuse or who fail to protect them. Victimization, particularly victimization that goes unaddressed, is a violation of our social contract with youth and can create a deep disregard both for adults in general and the rules that adults have set (Cook, Blaustein, Spinazzola, & van der Kolk, 2003; Cook et al., 2005). Distrust and disregard for adults, rules, and laws place youth at a much greater risk for delinquency and other inappropriate behaviors.

Danny, a runaway who was interviewed in a residential treatment program, expressed anger and frustration with the fact that the juvenile court's first response was to quickly issue punitive consequences for his delinquent behavior, while being very slow to act and protect him from the physical abuse that he was suffering at the hands of his parent. He asserted that courts need to ask the questions, "Why is this kid running away? Why is he acting out like this?" It does not go unnoticed by youth when their safety and well-being are not addressed but their delinquent behavior is. These kinds of paradoxes and frustrations can increase the likelihood that youth will respond defiantly and with hostility to court and other professionals who are in positions of authority. System professionals would benefit from recognizing that imposing only negative or punitive

consequences will likely do little to change the youth's patterns of aggression, rule breaking, and risky behaviors because such a response does not address the impact of traumatic stress on the child. By recognizing and addressing the role of trauma in the lives of youth, the court and other systems can become more effective in meeting the needs of the justice-involved youth and the needs of the community.

5. Traumatic Exposure, Delinquency, and School Failure are Related.

Academic failure, poor school attendance, and dropping out of school are factors that increase the risk of delinquency. Success in school requires confidence, the ability to focus and concentrate, the discipline to complete assignments, the ability to regulate emotions and behaviors, and the skills to understand and negotiate social relationships. When youth live in unpredictable and dangerous environments they often, in order to survive, operate in a state of **hypervigilance**. Clinical dictionaries typically describe hypervigilance as abnormally increased physiological arousal and responsiveness to stimuli, and scanning of the environment for threats. Individuals who experience hypervigilance often have difficulty sleeping and managing their emotions, and because they often see people or situations as a threat they are more likely to react in aggressive or defensive ways. The mindset and skills involved in hypervigilance fundamentally conflict with the skills and focus needed to succeed in school academically, socially, and behaviorally.

Unfortunately, school performance and attendance issues (whether trauma related or not), can be exacerbated by involvement in the juvenile justice or child protection systems. Studies in New York City and the State of Kentucky found that after being released from juvenile justice facilities, between 66%-95% of youth either did not return to school or dropped out (Brock & Keegan, 2007). Youth may experience absences due to waiting for records to transfer, a delay in specialized services, inadequate educational planning, and poor service coordination between school systems, child welfare agencies, and juvenile justice systems. Also, it may be easier for youth to act out or give up than to continue failing in school. It is essential that the juvenile justice system works with other community partners to ensure that youth have the supports they need to attend and succeed in school. Without these supports and resources, uneducated youth face further adversities such as poverty, unemployment, and ongoing justice system involvement.

6. Trauma Assessments Can Reduce Misdiagnosis, Promote Positive Outcomes, and Maximize Resources.

"Sixty-percent of youth involved in the juvenile justice system suffer from diagnosable mental health disorders" (Wood, Foy, Layne, Pynoos, & James, 2002, p. 129). Many of these youth have extensive histories of mental health treatment that may also include the use of psychotropic medication. Often youth who are exposed to chronic or complex trauma receive a diagnosis of Attention Deficit Disorder, Oppositional Defiant Disorder, Conduct Disorder, or other mental health disorders. These diagnoses are predominantly based on observable behaviors and symptoms. When there is a lack of

thorough assessment, youth are provided treatment based on these behavioral diagnoses, without addressing the traumatic experiences that are contributing to the symptoms. In order to avoid this disconnect, trauma screenings and standardized assessments should be implemented at intake and at other points of contact. There are a number of assessments that assist in both identifying and tracking trauma histories, such as the Traumatic Events Screening Inventory (Daviss et al., 2000; Ford et al., 2000) and the Child Welfare Trauma Screening Tool (Igelman et al., 2007). There are also validated, standardized assessment tools that assist with identifying both mental health and behavioral symptoms and disorders related to traumatic experiences such as the UCLA Posttraumatic Stress Disorder Reaction Index (Steinberg, Brymer, Decker, & Pynoos, 2004) and the Trauma Symptom Checklist for Children (Briere, 1996). With such a strong body of knowledge and tools available, and so much at stake for youth and society, it makes good sense and is also ethically imperative to use evidence-based assessment tools to make accurate diagnoses that can inform appropriate responses and treatment for trauma-exposed youth.

7. There Are Mental Health Treatments That Are Effective in Helping Youth Who Are Experiencing Child Traumatic Stress.

A number of evidence-based practices (EBPs) are available to courts and communities for treating youth who are impacted by trauma (see Figure 2). EBPs are practices that have been evaluated through rigorous scientific studies and have been found to be effective. It is a service provider's ethical responsibility to provide the highest standard of care and to use evidence-based practices whenever possible. It is also imperative that referrals for treatment be made to service providers that use trauma-focused EBPs, so that youth may receive both the best care and the most positive outcomes. The Centers for Disease Control indicates that the most effective treatments for traumatic stress are cognitive behavioral treatment models (Centers for Disease Control, 2008). Typically, trauma-focused, evidence-based treatments include the following components: psychoeducation, caregiver involvement and support, emotional regulation skills, anxiety management, cognitive processing, construction of a trauma narrative, and personal empowerment training. Judges can and should discuss the availability of EBPs with their treatment providers and advocate for the development of trauma-specific programming. (Please visit www.nctsnet.org for a list of evidence-based trauma treatments and respective evidence, treatment components, and target populations.)

8. There is a Compelling Need for Effective Family Involvement.

Youth who do not have helpful and consistent family support are at higher risk of violence and prolonged involvement in the court system (Garbarino, 2000). If juvenile courts are to enhance their success in rehabilitating juveniles who commit delinquent acts, they need to maximize opportunities to engage and partner with their caregivers. This means working to develop meaningful involvement of biological parents, extended family members, kinship caregivers, adoptive families, foster parents, and others.

There are a variety of treatments that research suggests are effective in working with youth who have experienced trauma. A comprehensive list of such treatments and supporting documentation is available at http://www.nctsn.org/nctsn_assets/pdfs/CCG_Book.pdf. Some of the more common evidence-based treatments, however, include (in no particular order):

Cognitive Behavioral Intervention for Trauma in Schools (CBITS): Tested with youth who have experienced violence and complex trauma. CBITS is provided in a group format in schools, residential programs, and other similar environments.

Trauma Affect Regulation: Guide for Education and Therapy (TARGET-A): TARGET-A shows evidence of effectiveness with youth who are in correctional facilities, residential settings, and community-based programs. This model can be practiced in group, individual, and family formats, which helps both youth and families to better understand trauma and stress, and to develop skills that help them to think through, and regulate, their emotional, cognitive, and behavioral responses to stress triggers.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): Youth (and their parents, possibly) are taught to process the trauma; manage distressful thoughts, feelings, and behaviors; and enhance both personal safety and family communication. It can be provided over a relatively short period of time in virtually any setting.

Sanctuary Model: The Sanctuary Model promotes system change based on the creation and maintenance of a nonviolent, democratic, productive community to help individuals heal from trauma. The model provides a common language for staff, clients, and other stakeholders, and can be adapted to several settings and populations.

FIGURE 2. Evidence-Based Treatments for Working with Youth Who Have Experienced Trauma

Families may need education about traumatic stress and treatments that work so they can be more supportive of their children, and for some families, this education will help them address their own traumatic experiences. Kinship caregivers, foster parents, and adoptive families often regret not being involved sooner in a child's life so they could have prevented earlier traumatic events. Often out-of-home caregivers need more information about what specific traumatic events or adversities a child may have experienced prior to becoming part of their family so they can make sense out of the child's behaviors and find helpful ways to respond.

There can be obstacles and challenges to achieving successful family involvement. Sometimes families avoid interactions with the court system because of feelings of shame and fears of being criticized. Therefore, courts might wish to engage families in ways that can help them feel more valued, respected, and invited to participate in the court processes and their child's rehabilitation. Practical and economic issues can also play a significant role in limiting family involvement, including: too much distance from the child's home to the juvenile correction center, lack of reliable transportation, language and cultural barriers, and feelings of being overwhelmed and intimidated about interacting with a large public institution. When courts collaborate with community organizations and families, they may be able to find some practical ways to locate the resources that enable increased family participation. The best strategy to improve family

involvement and partnerships is for the courts to take the time to ask them for guidance and solutions.

9. Youth Are Resilient.

Resiliency is the capacity for human beings to thrive in the face of adversity—such as traumatic experiences. Research suggests that the degree to which one is resilient is influenced by a complex interaction of risk and protective factors that exist across various domains, such as individual, family, community, and school. Accordingly, most practitioners approach enhancing resiliency by seeking both to reduce risk (e.g., exposure to violence) and increase protection (e.g., educational engagement) in the lives of the youth and families with whom they work. Research on resiliency suggests that youth are more likely to overcome adversities when they have caring adults in their lives. Through positive relationships with adults, youth experience a safe and supportive connection that fosters self-efficacy, increases coping skills, and enhances natural talents. Parents and other important familial adults can help increase their children's ability to heal from trauma and promote prosocial behaviors by spending time at home together, talking, sharing meals, and "setting clear boundaries for behavior and reasonable disciplinary actions" (National Youth Violence Prevention Resource Center, 2007). Further, schools, courts, and communities can enhance resiliency by providing opportunities for youth to make meaningful decisions about their lives and environment, as well as investing in recreational programs, arts, mentorship, and vocational programs. The Search Institute, in Minneapolis, Minnesota, has developed a variety of tools to identify and promote developmental assets (www.search-institute.org).

10. Next Steps: The Juvenile Justice System Needs to be Trauma-Informed at All Levels.

Trauma-informed systems of care understand the impact of traumatic stress both on youth and families, and provide services and supports that prevent, address, and ameliorate the impact of trauma. It is essential that juvenile courts work to provide environments that are safe and services that do not increase the level of trauma that youth and families experience. For example, a trauma-informed juvenile justice system understands that youth who are chronically exposed to trauma are often hypervigilant and can be easily triggered into a defensive or aggressive response toward adults and peers. Such a juvenile justice system makes system-level changes to improve a youth's feelings of safety, reduce exposure to **traumatic reminders**, and help equip youth with supports and tools to cope with traumatic stress reactions. The provision of or referral to evidence-based trauma-informed treatment is essential within a trauma-informed system, as youth are less likely to benefit from rehabilitation services if the system they are involved in does not respond to their issues of safety and victimization.

Trauma-informed systems require successful and respectful partnerships between youth, families, professionals, and other stakeholders. To help sustain and ensure effectiveness of a trauma-informed juvenile justice system, data needs to be collected,

evaluated, and used to determine the quality, fidelity, and effectiveness of the system changes. For example, there needs to be supervision and evaluation to ensure that trauma-informed interventions are being practiced the way they were designed in the particular evidence-based treatment model. Clinical outcome measures need to be used at least pre- and post-treatment to determine if a decrease in symptoms and/or increase in healthy coping have occurred during and after completion of the therapy model. Often juvenile detention centers have looked at rates of aggression, self-injury, and restraint and seclusion as data to help determine if the trauma-informed treatments are effective or in need of modification. All stakeholders need to be regularly informed on the status and quality of the outcomes of the system change efforts (Fixsen, Blase, Naoom, & Wallace, 2007). There are many resources that describe trauma-informed care in various service systems, such as juvenile justice, that can help guide interested systems through a transformation process.

SUMMARY

Juvenile courts can benefit from understanding trauma, its impact on youth, and its relationship to delinquency. Research has repeatedly shown that the majority of youth in the juvenile justice system have experienced traumatic events; the juvenile court is disadvantaged if this fact is overlooked. By becoming trauma-informed, juvenile justice personnel aid the juvenile court in its mission of protecting and rehabilitating traumatized youth while holding them responsible for their actions. Rehabilitation resources also can be maximized by utilizing effective assessment and treatment strategies that reduce or ameliorate the impact of childhood trauma. Ultimately, such efforts will help promote improved outcomes for youth, families, and communities most in need of our help.

RESOURCES

For more information about trauma, delinquency, or other issues of interest to juvenile and family courts, please contact the National Child Traumatic Stress Network (NCTSN) at info@nctsn.org or the National Council of Juvenile and Family Court Judges (NCJFCJ) at (775) 784-6012; e-mail jflinfo@ncjfcj.org. Other resources are available online at:

- www.safestartcenter.org/cev/index.php
- www.ojjdp.ncjrs.gov
- www.search-institute.org
- www.nctsnet.org
- www.ncjfcj.org

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ADDITIONAL RESOURCES FOR REFERENCE AND REVIEW

Essential Elements of a Trauma-Informed Juvenile Justice System

https://www.nctsn.org/resources/essential-elements-trauma-informed-juvenile-justice-system

Assessing Exposure to Psychological Trauma and Posttraumatic Stress Symptoms in the Juvenile Justice Population

https://www.nctsn.org/sites/default/files/resources/fact-sheet/assessing-exposure-to-psychological-trauma-and-posttraumatic-stress-symptoms-in-the-juvenile-justice-population.pdf

Center for Trauma Recovery and Juvenile Justice (CTRJJ) Science & Services Spotlights

https://health.uconn.edu/trauma-recovery-juvenile-justice/science-and-services-spotlight/

Behavioral Health Screening Resources

https://www.nysap.us/resources-by-topic#behavioral-health-screening

Risk Screening & Assessment Resources

https://www.nysap.us/resources-by-topic#risk

Youth Protective Factors Study: Effective Supervision and Services Based on Risk, Strengths, and Development

https://www.umassmed.edu/lawandpsychiatry/law-and-psychiatry-research/NIJ-Youth-Protective-Factor-Study/