TEXAS JUVENILE JUSTICE DEPARTMENT

Responsivity Assessment Manual

FOR TREATMENT PLANNING & TREATMENT DELIVERY FOR JUSTICE-INVOLVED ADOLESCENTS

RESPONSIVITY ASSESSMENT MANUAL

FOR TREATMENT PLANNING & TREATMENT DELIVERY FOR JUSTICE INVOLVED ADOLESCENTS

by

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This manual was developed for treatment planning and progress monitoring *only*.
This guide is not intended to address an adolescent's risk to re-offend,
The purpose of this guide is to support the effective delivery of rehabilitative treatment programs,
in both institutional- and community-based settings.

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RESPONSIVITY: WHAT IS IT?

To reduce a person's risk of re-offending, treatment programs must use three important principles: [1]

- The **risk principle** tells us *who should receive treatment* (higher risk = more treatment)
- The **need principle** tells us *what topics to address in treatment* (i.e., "dynamic risk factors")[2]
- The **responsivity principle** tells us *how treatment should be delivered*

This manual focuses on the **responsivity principle**: that is, how to design a treatment program, and create individual treatment plans, that improve treatment participation and maximize treatment benefit. Though initially developed for adults, there is research[3] that supports the application of the risk-need-responsivity principle to juvenile justice and rehabilitation efforts, with some accommodation for the differences in cognitive, emotional and social development between adolescents and adults. This manual will therefore explain how to assess an adolescent youth's[4] responsivity needs, and how to incorporate responsivity needs in treatment planning and delivery.

What is "responsivity" and why does it matter? Responsivity refers to how the youth responds to treatment, and how the treatment program responds to the youth.. **Anything that might get in the way of treatment is considered a "responsivity need."** If a youth's responsivity needs are ignored, then the youth might not be able to participate in treatment, or treatment may not have a positive impact – in which case, treatment will "fail" (which means resources have been wasted, and the youth risk to re-offend has probably not changed).

Here are some very basic examples of responsivity needs, and how a treatment program might respond to each need:

- A youth who has trouble hearing may need a sign-language interpreter during therapy sessions.
- A youth who cannot read will need non-written treatment materials and assignments.
- A youth with ADHD may need medication in order to concentrate during therapy sessions.
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- A youth with a trauma history may not respond to a therapist who is very confrontational, and may require additional time to develop trust in their therapist.

These are just a few examples - effective treatment programs will consider every client's individual learning style, physical and cognitive abilities, familial history, and anything else that might get in the way of treatment delivery.[5]

When thinking about your youth's responsivity needs, the basic question is:
What might prevent the youth from participating in treatment?
(and/or)
What might be preventing the youth from making treatment progress?

[1] Gendreau, P., & Andrews, D.A., (1990). Tertiary prevention: What the meta-analysis of the client treatment literature tells us about "what works". *Canadian Journal of Criminology*, 32, 173-184.
[2] This manual assumes the reader has a basic understanding of "dynamic-risk factors" (DRFs) and how these are incorporated into treatment planning and delivery. For those readers who are unfamiliar with DRFs, please refer to the "recommended readings" section at the end of this manual, for additional information on dynamic risk factors/criminogenic needs.
[3] e.g., Brogan, L., Haney-Caron, E., NeMoyer, A., and DeMatteo, D. (2015). Applying the Risk-Needs-Responsivity (RNR) Model to Juvenile Justice. *Criminal Justice Review*;40(3):277-302. doi:10.1177/0734016814567312.
[4] In this manual, the term "client" is used to refer to the adolescent who is receiving treatment. Some programs may use other terms such as "resident," client," or "inmate."
[5] Serin, R., & Kennedy, S. (1997). Treatment readiness and responsivity: Contributing to effective correctional programming. Available from the Department of the Solicitor General Canada, www.psepc-sppcc.gc.ca.

Program-specific factors that may impact responsivity: The focus of this manual is on how to assess a youth's *individual* responsivity needs. However, in order to understand how a person's individual needs might "get in the way" of treatment, it is also important to consider exactly how therapy is delivered in your treatment program.

The **responsivity principle** suggests that effective treatment programs will consider a youth's individual characteristics, as well as the interaction between those characteristics and aspects of the program itself, such as:

- treatment techniques that are used
- therapist characteristics
- therapist style
- mode of treatment
- therapeutic environment

Research on treatment programs for adolescents that work (to reduce criminal re-offending) tend to have the following things in common:

- They incorporate the "risk-need-responsivity" principles (RNR)
- They have a clear treatment structure and well-defined treatment goals
- They are evidence-based (i.e., based on research/science)
- They use cognitive-behavioral and skill building techniques (CBT; other examples include Dialectical Behavior Therapy, Trauma Focused CBT, Motivational Interviewing, Relapse Prevention)
- They use assessment instruments at intake (to help inform treatment needs)
- Treatment targets multiple youth-specific needs (i.e., "dynamic risk factors")
- They focus on reward of positive or desired behaviors, rather than punishing negative behaviors[6]
- They involve adolescents in activities that encourage them to think clearly and rationally about what to do or believe and make independent decisions to prepare to for adult roles.
- They have professionally trained staff with extensive clinical experience
- They use a variety of treatment techniques (e.g., skills training, role-plays, cognitive-restructuring)
- They engage in core therapeutic practices (effective modeling, reinforcement, motivational interviewing, open-ended questioning, encouraging emotional expression, etc.)
- They promote positive therapist-youth relationships/therapeutic alliance
- Therapists exhibit empathy, genuineness, warmth, respect, support, confidence, flexibility, and use of humor
- They involve a trustworthy, influential parent or caregiver figure who is involved and concerned with the adolescent's success
- They attend to the treatment environment and incorporate family, friends, community institutions and centers, so that adolescents are involved in a group of peers where they feel included, that models and encourages prosocial thinking and behavior.
- They help staff work together, through in-service trainings, self-evaluation, and outside resources
- They undergo program audits and evaluation
- They replicate and reinforce interventions and opportunities for adolescents to apply skills in multiple settings or "systems" (including multisystemic therapy (MST) and functional family therapy (FFT) approaches)
- They are based on ethical principles and standards of practice (e.g., APA, AP-LS, ATSA)

[6] Including specific avoidance of programming that is built primarily on models of deterrence (focus on negative consequences/ "scared straight") or discipline (imposed regimen and structures/ "boot camp")

RESPONSIVITY NEEDS: HOW TO IDENTIFY THEM

Identifying and assessing individual responsivity needs can be complicated. Here are some general guidelines:

- Identifying responsivity needs requires a detailed, individualized assessment of the client. There are a number of methods to do this using standardized instruments. For example, the Neurosequential Model of Therapeutics (NMT) provides a detailed process by which to collect key information. Without an adequate assessment, a provider can overlook a responsivity need, or they might assume something is due to the client's "personality" or "willingness to comply." For example, if a client doesn't complete a homework assignment, the provider might mistakenly see this as the client being "antisocial" and not following the rules – when actually the client didn't understand the homework assignment, because they read at a first-grade level.

- Responsivity needs usually occur often, over a period of time, and/or they are severe. A minor issue or condition is unlikely to be a responsivity need, even if it interferes with treatment once or twice (for example, if the youth has flu and doesn't come to group for two days, that would not be considered a responsivity need). A responsivity need would be something that impacts treatment on more than one or two occasions (for example, if the youth had Crohn's Disease, this might impact their treatment on a daily basis). However, providers should also pay attention to patterns of "minor" issues that may suggest something else is going on (for example, if the youth has the "flu" every Thursday before group, this may be a red-flag for an actual responsivity need).

- Responsivity needs can be long-term (chronic), short-term (acute), or both. For example:
  (1) If a youth has been diagnosed with a learning disability, which makes it hard for them to read, this is a long-term, or "chronic" responsivity need;
  (2) If a youth receives a head injury that results in a temporary condition, which makes it hard for them to read, this is a short-term, or "acute" responsivity need;
  (3) If a youth can only read to a first-grade level, but some of your assignments require an fourth grade reading level, then this situation may include both a chronic responsivity need and an acute responsivity need.

- Chronic conditions/characteristics are not always responsivity needs. Responsivity needs result from the *interaction* between certain characteristics, and the situation in which the youth is placed. *Don't assume that a chronic condition or characteristic is also a responsivity need.* For example, not all developmentally delayed youth will have difficulty reading, writing, or comprehending materials in a way that significantly impacts treatment.
  - ✓ *Ask the youth to discuss their strengths, limitations, and experiences with the condition/trait.* Discuss the treatment program with the youth(you could use the table on page 3), to include treatment strategies, duration, and frequency – as well as your own characteristics/style as a therapist - to try figure out how the youth's condition/trait might impact their treatment participation. The youth might also be able to help come up with some specific strategies, depending on what has/has not worked for them in the past.

- Youth characteristics/behaviors may be a dynamic risk-need, a responsivity need, or both. To distinguish responsivity issues from dynamic risk-needs, it is important to consider how the behavior/characteristic of the youth is related to their sexual offense behavior (dynamic risk-need) versus how it impacts their ability to participate in treatment (responsivity need).

For example:

(1) a youth has a history of feeling rejected by their same-aged peers, and acting out sexually with younger children when they feel socially rejected [social rejection = a dynamic risk need];
(2) the youth may not act out sexually when they are feeling socially rejected, but if they fear they might be rejected by their peers, they isolate in their room and avoid being around others [social rejection = responsivity need];
(3) when they feel socially rejected, the youth isolates from their peers, and seeks attention from younger children against whom they might sexually offend [social rejection = responsivity need and dynamic risk need]).

- Responsivity needs can change over time, as they progress in treatment. Youth may enter treatment without any obvious responsivity needs, but later in treatment, such needs may develop as the demands of the program change. For example, the youth might begin another group that requires a lot more homework. In some cases, the underlying condition/trait may remain relatively unchanged, but how it interacts with the treatment program may fluctuate. For example, a youth's learning disability may not interfere with their ability to complete simple written assignments, but they may have more difficulty as the assignments get longer and more complicated. Therapists re-evaluate and update treatment goals and interventions as needed throughout the course of treatment.

ADDRESSING RESPONSIVITY NEEDS IN TREATMENT

The most common responsivity needs usually fall into one the following categories:

- Physical/Sensory
- Cognitive/Learning Style
- Emotional & Behavioral Health
- Motivation for Change
- Trauma-related
- Other

In this manual, there is a section for each of these categories, that includes a description of the responsivity need, and how to evaluate the severity of the need. Please note that the categories provided in this manual represent the most common areas in which responsivity needs occur, but there may be responsivity needs that are not included in this manual. Remember: Anything that might get in the way of treatment delivery is a "responsivity need."

Sometimes, specific behavioral targets may be indicated for certain responsivity needs. For example, a youth with significant mental health needs may need short-, medium-, and long-term goals to reduce the impact of their mental health symptoms on treatment delivery. In such cases, the following model can be employed (additional examples are included in each responsivity need section):
LONG-TERM TREATMENT GOALS: These are goals that the youth, provider, and/or program are expected to pursue while the youth's in treatment. For example: *By the time the youth completes treatment, they will have 100% attendance for six months. Youth will follow recommendations of their treatment team.*
QUARTERLY TARGETS: These represent intermediate behavioral goals to be achieved each quarter, that would move the therapist/program/youth closer to the Long-Term Treatment Goal(s). For example: *By the end of this quarter, youth will increase attendance in group therapy sessions by 50 percent. Youth will*

consult with a mental health professional (MHP) and comply with treatment recommendations. Treatment team will *incorporate MHP recommendations.*

DAILY/WEEKLY TASKS: These are specific tasks, activities, homework assignments, etc., that the youth does during sessions and in-between sessions, on a day-to-day, or week to week basis. These tasks are designed to move the youth closer toward their Quarterly Target(s). For example, *create a diary card/skills tracker to track treatment participation.*

REMEMBER:

- ✓ The primary purpose of these interventions is **to increase the youth's engagement in treatment**.
- ✓ Responsivity needs can also be addressed through **changes made by the therapist/treatment program,** as well as changes to the youth's behavior.

Physical/Sensory

The basic construct: This need area refers to the impact of physical disabilities, sensory impairments or integration/processing issues, or medical conditions on a youth's treatment participation (examples include being visually impaired, hearing impaired, mobility impaired, or having a chronic illness). These conditions may impact the youth's ability to comfortably or safely interact with their physical environment (for example, sitting, standing, speaking, listening) – which could impact their ability to actively engage in treatment.

In determining the potential impact on treatment, consider:

- ✓ Can the youth get to the building? Climb up stairs?
- ✓ Can they hear? How well?
- ✓ Can they see? How well?
- ✓ Can they control their movement? How well?
- ✓ Are they in physical pain? Where?
- ✓ Can they sit for extended periods of time?
- ✓ Are there frequent requests for changes in or preferences for a certain location (room, seat), clothing, food, or hygiene product(s)?
- ✓ their reactivity to, complains about, or stubborn insistence about temperature, light or sound levels, clothing or food textures, etc.?
- ✓ Can they sit for extended periods of time?
- ✓ Does their focus, engagement, or stamina decline noticeably after short periods or before the end of a session or class?
- ✓ Are they able to attend to their own activities of daily living? (e.g. getting dressed, bathing, toileting)
- ✓ Is there an emotional or behavioral problem because of their physical or sensory issue? (e.g., self-consciousness, anxiety, avoidance, defensiveness, embarrassment, low self-esteem)

Physical/Sensory

Examples of *Considerations for Treatment Delivery* for youth with physical/sensory responsivity needs:

- *Youth with a sensory deficit:* A visual impairment will make it difficult for them to participate in treatment techniques that require sight, such as reading assignments and written activities. When possible, written materials will be audio recorded for youth, and they will be provided with a[device to listen to the recorded materials. Other group members may also assist youth as needed, such as by reading materials out loud to them.

- *Youth with a substantial medical diagnosis:* Ongoing management of [medical condition/diagnosis] will require coordination/collaboration with a medical professional regarding symptom management, physical/support needs, appointments, medication management, and progress in managing illness.
- *Youth with a physical disability*: Given that a youth uses a wheelchair, his group and individual therapy sessions will take place in Classroom B, which is wheelchair accessible and closest to an accessible restroom.

Examples of *Long-Term Treatment Goals* for youth with physical/sensory responsivity needs:

- Maintain independent management of illness/condition while in treatment
- Develop skills to independently manage illness/condition
- Appropriately use professional support to continue to manage physical limitation/illness
- Consistently implement accommodations to reduce impact of physical/sensory issue on treatment participation/engagement/focus

Examples of *Quarterly Targets* for youth with physical/sensory responsivity needs:

- Attend all scheduled appointments with medical professionals
- Take all medications as prescribed
- Comply with physician recommendations for diet and exercise
- Increase knowledge about illness and its management
- Reduce group absences related to medical condition (e.g., medical appointments, illness)
- Create a list of thoughts/attitudes, feelings, and external factors that encourage avoidance of illness or management of illness
- Increase group participation

Physical/Sensory

Examples of *Daily/Weekly Tasks* for youth with physical/sensory responsivity needs:

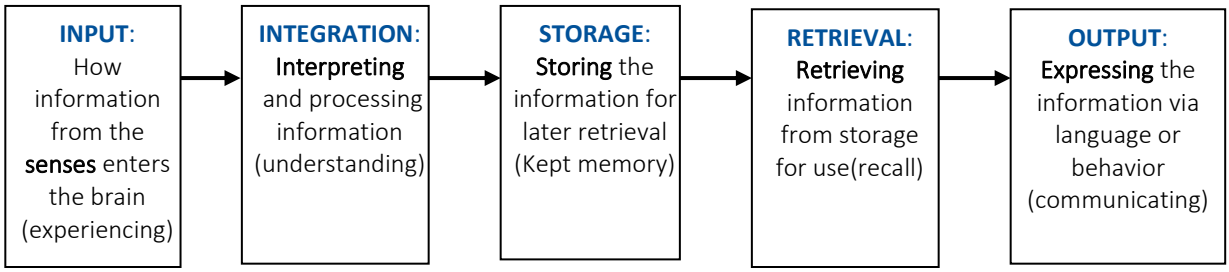
1. Will complete assessment with appropriate medical provider
2. Work with therapist/group to develop strategies for implementing recommendations from provider/physical therapist
3. Recommended accommodation will be implemented for each group and individual session
4. Attend 75 percent of scheduled medical appointments for next three months
5. Increase group attendance to 75 percent within two weeks
6. Participate in problem solving group exercise to develop appropriate exercise regimen
7. Comply with exercise regimen for three of seven days for two weeks
8. Identify positive aspects of managing illness in a written assignment (or individual sessions)
9. Identify positive aspects of exercise (or going to doctor, or taking meds) in written assignment
10. Identify ways to reward self for following doctor's recommendations
11. Keep weekly/daily log of thoughts, attitudes, feelings about management of illness/attending appointments/taking medications, etc. for four weeks
12. Prepare a 5-minute presentation for the group regarding your illness, including common causes, symptoms, course, treatment, and long-term and short-term effects of non-management.
13. Examine attitude re: management of illness and identify replacement attitudes
14. Provide feedback in group at least four times per week for next two weeks
15. Document group content/feedback for at least two sessions each week for next month.

Cognitive/Learning Style

The basic construct: This area refers to the impact of cognitive impairment on treatment participation. The word "cognitive" includes anything that has to do with *thinking* - such as attention, concentration, memory, planning, reasoning, understanding, and language. If a person has problems with their cognitive abilities, it can be difficult for them to pay attention, concentrate, organize materials, make plans, think ahead, problem solve, store information, recall information, or communicate.

Cognitive/Learning Style

When a person is trying to process new information, their brain follows several steps:



Cognitive problems can get in the way of any of these steps, making it difficult for a person to experience, understand, store, recall, or communicate that information. Cognitive problems might be caused by an underlying medical or mental health diagnosis (e.g., Autism, ADHD, Learning Disorder), or they can be due to differences in learning style.

Unlike other treatment needs that can be managed through "talk" therapy or medications, cognitive deficits are often addressed by making changes to a person's environment, brain rehabilitation/training, and the use of behavioral techniques and practical aides (for example, using day planners, calendars, reminder cards, notebooks, electronic reminders, etc.).

Further, most adolescents are pretty adept at learning new behaviors by watching or imitating others (e.g., social learning), particularly peers; considering both developmental changes (as adolescents spend increasing amounts of time with peers as they begin to individuate from parents/parental figures) and neurological changes (as adolescent brain functioning is more susceptible to stimulation and reward from peers) that occur during this developmental stage. Considering and incorporating this learning process into interventions is often a key component for juvenile rehabilitation programs in general, but may be emphasized or serve as an individual intervention to address a cognitive limitation or difficulty learning through instruction methods that emphasize reading/writing skills (by instead emphasizing "hands on" demonstration or role-plays to learn new skills in a group setting, for example). However, programmatic emphasis on social learning can also lead to difficulties for adolescents with social deficits or who struggle to accurately "read" or interpret social cues or non-verbal social behaviors that may also require specialized accommodations or interventions to support their effective participation in aspects of treatment.

Cognitive/Learning Style

Some cognitive abilities that are often assumed by treatment programs:

- Ability to remain focused and sustain attention for hours at a time
- Ability to read, write, and speak English, often at a high-school level.
- Detailed recall of events that took place a long time ago (i.e., offending history timeline, full disclosures of offense behaviors, offense "cycle" etc.)
- Ability to pay attention, listen, remember, process, apply, and communicate information to multiple sources, for sustained periods, several times a week (i.e., group therapy)
- Ability to learn new words and phrases (e.g., legal-jargon, dialectic," "cognitive distortion")
- Ability to understand, remember, and apply lots of new information (e.g., cognitive restructuring, Relapse Prevention, dynamic risk factors)
- Ability to complete written assignments, which are often long and complicated
- Ability to apply attitudes, concepts, and skills from one situation, to a variety of other situations (also known as "skill generalization")
- Ability to think flexibly and abstractly (For example: challenging cognitive distortions, developing "insight," considering other people's perspectives, empathizing with others, etc.)
- Ability to recognize, recall, be influenced by, and respond to the behaviors, comments, and experiences of others (also known as "social learning")
- Ability to express oneself, and recognize and communicate inner thoughts and feelings to others in a variety of ways (written, oral, non-verbal social cues/behaviors)
- Ability to process information at a rate similar to peers in a group, to "keep up" with instruction/activities in the group
- Ability to accurately recognize and understand expressions of or input provided by others (e.g., feedback) in various ways (written, oral, non-verbal social cues/behaviors).

Cognitive/Learning Style

Examples of *Considerations for Treatment Delivery* for youth with cognitive/learning responsivity needs:

- Given youth's difficulty paying attention/concentrating, the following approaches will be used to help the improve the youth's participation in treatment:
  - ✓ Providing a solitary, quiet room in the treatment building to reduce distractions, and allow for breaks during treatment assignments
  - ✓ Involving them in hands-on activities during group sessions (monitoring group activities, role-plays, and other active tasks), and limiting how much they have to read, write, and passively listen to verbal information.
  - ✓ Increasing individual sessions to review materials to provide additional professional attention in a distraction-free environment.
  - ✓ Apply mindfulness skills to manage distractions
  - ✓ Work together to develop strategies that may help with attention or hyperactivity that impacts attention (allow for fidgeting, drawing, during session; employ physical activities as part of treatment sessions, etc.).
  - ✓ Consultation with other professionals/consultants for additional methods of managing attention/concentration difficulties (i.e., medication)

- Youth's noted difficulty understanding verbal material (written and auditory) will be addressed through the following modifications to treatment:
  - ✓ Assignment to a specialized treatment group with similar learning limitations

- ✓ Presentation of verbal material in brief, simple formats
- ✓ Presentation of concepts with graphical representations where possible (e.g., infographics, charts, etc.).
- ✓ Periodic assessment of their understanding of group/written/homework (e.g., asking them to summarize what another group member just said, explain the homework assignment, etc.).
- ✓ Reductions of homework assignments into brief, simpler segments (i.e., break down homework assignments into single tasks/concepts, use graphical organizers or charts/diary cards for skills practice/homework sheets)
- ✓ Use of "buddy system" or peer supports to assist them with verbal material/assignments.
- ✓ Ongoing monitoring to determine need for additional psychological assessment

Cognitive/Learning

Examples of *Long-Term Treatment Goals for* youth with cognitive/learning responsivity needs:

- Reduce impact of cognitive impairment or limitation on treatment participation
- Increase use of specific strategies to enhance strengths in the areas of visual or handson learning or, auditory memory, etc.

Examples of *Quarterly Targets* for youth with cognitive/learning responsivity needs:

- Identify treatment situations and tasks in which youth have difficulty
- Increase understanding of cognitive strengths, limitations, and appropriate interventions
- Develop methods of increasing attention/focus, and/or reducing distractibility
- Consult with medical/neuropsychological professional to improve understanding of difficulties, and/or develop interventions to improve treatment delivery
- Learn/apply new cognitive skills
- Develop methods for addressing memory deficits and/or reducing the impact of forgetfulness
- Practice using (daily planner, notebook, etc.), assess effectiveness in variety of situations
- Discuss beliefs/attitudes/feelings about poor reading/spelling skills
- Increase completion and/or timeliness of written assignments
- Practice telling others when having difficulty with a task, or understanding verbal instructions
- Develop alternatives to reading/writing assignments
- Participate in an educational program to improve reading/writing/spelling skills
- Consistently implement recommended accommodations or accommodations as specified

Examples of *Daily/Weekly Tasks* for youth with cognitive/learning responsivity needs:

1. Identify reasons it is difficult to ask other people for support, or telling other people about your cognitive problems
2. Identify ways to overcome this, and role-play/practice this
3. Participate in psychological evaluation/consultation
4. Attend scheduled medical appointments
5. Participate in feedback/intervention planning session with treatment team
6. Primary therapist will consult with medical doctor/neuropsychologist
7. Practice cognitive skills/complete cognitive skill assignments on a daily basis for next two weeks. Progress to be discussed in individual sessions.
8. Discuss emotional response, beliefs, attitudes, related to cognitive/learning disability with group.
9. Review homework in individual sessions to improve/review issues related to the thoroughness and quality of assignments
10. Complete one Mindfulness exercise per day (e.g., counting sounds, observing thoughts, body scan)

Emotional & Behavioral Health

The basic construct: This area refers to the impact of mental health symptoms and behavioral disorders on an individual's treatment participation. In order to develop effective interventions, the emphasis should be on identifying observable behaviors/symptoms and how these may interfere with treatment, rather than focusing on the underlying diagnosis. For example, if a youth has a fear of public speaking, interventions would focus on increasing the youth's ability to speak during group, but wouldn't focus on targeting the diagnosis of social anxiety.

Examples of mental health symptoms/behaviors that may interfere with treatment:

- Mistrust of the therapist, that is related to clinical paranoia
- Rigid insistence on unrealistic interventions or goals, that is related to grandiosity or delusions
- Compulsive rituals or perfectionism that led to tardiness/poor attendance or difficulty completing assignments in a timely fashion
- Avoidance of group interaction, speaking in group, etc. that is due to general/social anxiety
- Confusion/inattention, that is related to mood instability (or anxiety, trauma, psychosis, etc.)
- Minimal attendance, participation, and/or engagement in sessions, that is due to depression
- Repeated threats of/attempts to harm self
- Impulsive/compulsive statements or behaviors that disrupt and/or distract treatment sessions
- Poor hygiene that is upsetting to other members of group or distracts/disrupts treatment

Emotional & Behavioral Health

Examples of *Considerations for Treatment Delivery* for youth with mental & behavioral health responsivity needs:

- Youth's significant history of suicidal ideation, planning, and attempts requires ongoing assessment and intervention. Given the nature of treatment, it is anticipated that youth will periodically experience feelings of guilt, shame, embarrassment that may lead to increased feelings of hopelessness and suicidal ideation. Accordingly, their response to treatment will be assessed/monitored and reviewed with them regularly, particularly with regard to feelings of hopelessness, helplessness, and suicidal ideation. Ongoing monitoring of these issues will include a structured assessment, including [institutional suicidality assessment protocol]. Youth will be expected to be actively involved in improving their understanding of their risk factors, symptomatology, and effective interventions for managing their depression and suicidal ideation, as well as developing a plan to help other people identify their risk factors. Youth are expected to continue their medications.

- Youth presents with somewhat blunted affect and reports irritability, consistent with depressive symptoms. He also has a history of conduct problems, such as stealing and acting out physically. Currently, these problems do not appear to be interfering with his ability to participate in treatment; however, his psychological and behavioral functioning will continue to be monitored and modifications will be made to his treatment plan as indicated. There is no current indication of suicidal or aggressive/homicidal ideation, intent, or plan.

- Youth has symptoms of anxiety, particularly with regard to social activities, that may interfere with treatment delivery. Accordingly, treatment interventions designed to increased her social

contacts and activities will be developed collaboratively and with the use of progressive exposure techniques (e.g., imaginal exposure, gradual in-vivo exposure).

Emotional & Behavioral Health

Examples of *Long-Term Treatment Goals for* youth with emotional & behavioral health responsivity needs:

- Reduce impact of behavior/symptoms on treatment participation

Examples of *Quarterly Targets* for youth with emotional & behavioral health responsivity needs:

- Therapist will establish collaborative relationship with treatment team and supervisory staff
- Decrease barriers to use of psychotropic medications
- Develop understanding of situations, thoughts, attitudes, behaviors, feelings, etc. that contribute to suicidal ideation
- Reduce disruptive behaviors in group
- Increase use of adaptive, appropriate statement/behaviors in group
- Learn and practice Interpersonal Effectiveness skills in weekly group and individual sessions
- Learn and practice Distress Tolerance skills in weekly group and individual sessions

Examples of *Daily/Weekly Tasks* for youth with emotional & behavioral health responsivity needs:

1. Identify the frequency, intensity, duration, and setting(s) for target behavior(s) or symptoms
2. Identify which behaviors are disruptive and why
3. Identify precursors to behaviors, and/or situations/thoughts/feelings that exacerbate behaviors
4. Identify time periods, situations, internal experiences in which behaviors did not occur
5. Identify the incentives (rewards) and disincentives (punishments/consequences) for disruptive behaviors
6. Identify incentives for non-disruptive behavior in group sessions
7. Discuss with primary therapist/and develop written list of possible methods of managing barriers to accessing/receiving medications
8. Identify, with help of primary therapist, difficulties with taking medications consistently at appropriate times in individual sessions
9. Solicit feedback from group members in next group session regarding differences in behavior, demeanor, statements in the time period surrounding recent experience of suicidal ideation

Motivation for Change

The basic construct: "motivation or readiness to change" refers to a youth's desire to change their thoughts, attitudes, beliefs, and behavior, and can include the concept of "motivation" for treatment. The desire to change is a complex and dynamic process, influenced by many different factors. Youth may express readiness to change in some areas, but not others (e.g., the youth may be willing to address their impulsive behaviors, but denies needing treatment for deviant thought patterns). Responsivity needs arise when a youth's level of motivation/readiness impairs or limits their meaningful treatment participation.

It is important to consider external/environmental issues when conceptualizing responsivity needs in this area, and not rely solely on youth attitudes or behaviors indicating poor interest or "buy in" to their goals/ the treatment process. Many youth who present for treatment may be ready to change their thoughts, attitudes, behaviors - but they may also have reservations about participating in treatment in general (or in this program in particular). The interplay of being court ordered to therapy/treatment is an important consideration as well. Finally, family or support system dynamics may also be important to consider as part of barriers to change (e.g., family role is/all family problems based on the "bad seed" or

youth; support system doubts change/doubts that program, "system," or mental health interventions will produce any real change, etc.).

Examples of external features to consider:

- Therapeutic alliance/rapport
- Other responsivity issues/needs (i.e., mental health issues, physical illnesses, family/support system issues, etc.).
- Recent programmatic/systemic changes, staff turnover
- Youth's legal situation/circumstances
- Recent losses or setbacks (including changes in family, peer, or other important sources of support)
- Changes to the group structure, format, or members/environment
- Nearing treatment termination or community transition (i.e., "senioritis")
- The intensity, duration, frequency of treatment interventions currently using
- Lack of clear expectations or time frames (to the youth) for advancement, completion or earning/reinstatement of privileges
- Offender comprehension and access to accurate information

Motivation for Change

Examples of *Considerations for Treatment Delivery* for youth with motivation for change responsivity needs:

- Youth appears fairly unmotivated to make changes to their thoughts or behaviors, either in general, or with respect to any deviance; and adamantly denies a need for treatment. At the same time, youth did indicate a strong desire to be considered for release to the community. Youth's attitudes toward treatment and their need /willingness to change has clear implications for treatment implementation and expectations, to include the following:
  - ✓ Exploratory, supportive, and insight-oriented treatment approaches are contraindicated; treatment techniques that utilize behavioral monitoring, skill building, role-plays, and interpersonal interaction are likely to be the most effective.
  - ✓ Treatment will initially occur solely in an individual session format, to reduce youth's opportunity distraction/externalization, and increase their ability to focus and work on/toward their treatment goals. Because participating in a cooperative group format and exhibiting related appropriate social/interactional skills are essential to youth's treatment, they are expected to gradually integrate into a treatment group later in the course of their treatment program.
  - ✓ It is anticipated that cognitive techniques will be implemented later in the course of treatment after they have had time/opportunity to adjust to the treatment environment and expectations, and have developed a working alliance with their primary therapist.
  - ✓ Given youth's tendency to externalize their responsibility for their difficulties, related treatment goals and skill development will be behaviorally based (vs. insight-oriented discussions), independently manageable, and generated by youth(vs. their therapist or the group) to maximize their effectiveness.
  - ✓ Treatment interventions that focus on "overcoming denial," full disclosure of deviant activity, or empathy/remorse and moralistic concerns are unlikely to be effective in producing meaningful changes to youth's thoughts, attitudes, or behaviors. Instead, treatment efforts will target identification of problematic behaviors, any patterns these behaviors represent, and the causes of or needs that those behaviors fulfill, in order to identify appropriate behaviors and activities that will similarly meet those needs.

Motivation for Change

Examples of *Considerations for Treatment Delivery* for youth with motivation for change responsivity needs:

- Although acknowledging the problematic nature of their offense behavior, and issues with anger and substance abuse, youth does not appear to believe they have any particular issue with "deviancy," nor do they consider themselves at any significant risk to re-offend. To improve their engagement and benefit from treatment interventions and individualized goals targeting these issues, initial goals and interventions will focus on other risk/needs identified for youth they appear motivated to address (e.g., maintaining sobriety, emotional regulation). However, youth will be expected to participate in group sessions in which other group members, at various stages of treatment and with different needs, actively work on and discuss violent behavior problems. At the same time, youth will discuss their observations of this process and their progress, and as well as their own issues/discomfort in individual sessions with this therapist. It is anticipated that the youth's success in achieving treatment goals in other areas, combined with their exposure to/discussion of the behavioral difficulties of others, may increase their comfort with various treatment techniques and the treatment process overall and improve their motivation/readiness to address/change.

Examples of *Long-Term Treatment Goals for* youth with motivation for change responsivity needs:

- Develop/improve working therapeutic alliance with youth
- Establish and maintain openness to treatment and/or readiness to change related to identified dynamic risk/needs
- Establish and maintain increases in opportunity for treatment benefit
- Establish and maintain consistent treatment attendance and/or participation
- Reduce negative/ambivalent attitude(s) toward treatment, to include the program, staff, and/or other participants

Examples of *Quarterly Targets* for youth with motivation for change responsivity needs:

- Identify reservations/issues related to therapist, group, and/or treatment participation
- Develop skills to realistically appraise concerns/issues/experiences related to poor treatment attendance/participation/engagement
- Identify barriers to treatment progress
- Increase treatment attendance and participation
- Develop skills/interventions to manage counterproductive behaviors (e.g., defensiveness) and emotional reactivity to distressing thoughts/concerns (e.g., fear of prolonged detention).
- Develop methods of responding to/managing "real" potential detriments of treatment participation, and/or increased engagement
- Monitor/assess youth's willingness to consider alternative perspectives, new/previously dismissed treatment goals, and acknowledgement of dynamic risk/needs or other need to monitor behaviors, etc.
- Assess quality/content of therapeutic relationship
- Identify barriers to development of therapeutic alliance, and/or youth trust in therapist/program
- Participate in motivational interviewing/enhancement group

Motivation for Change

Examples of *Daily/Weekly Tasks* for youth with motivation for change responsivity needs:

1. Create written list of reservations/issues with participating in treatment and present list in next group session.
2. Identify, through discussion in next two individual sessions, issues/areas you believe you need to work on, including how you think you behave/look now, and how you think you would like to behave/look in the future, or at the end of treatment to work toward your "life worth living"
3. Identify core values/beliefs related to treatment (in general) in particular through written assignment and/or discussion in individual/group sessions for next two weeks
4. Practice interpersonal effectiveness skills with other group members for at least one hour, twice per week for next four weeks
5. Identify at least one positive treatment experience/outcome each week for next four weeks
6. Identify positive aspects/negative consequences of discussing/working on a particular issue in treatment, in written document and/or individual sessions within two weeks
7. Practice mindfulness skills in group/individual sessions that discuss issues related to sexual deviancy and keep log of their effectiveness for each session for next two weeks.
8. Practice emotional regulation skills in group/individual sessions and keep log of their effectiveness for each session for next two weeks
9. Develop list of advantages/disadvantages with regard to participating in treatment (or a particular treatment protocol/technique such as covert scripts), including input from primary therapist, other group members, friends, and family; present in individual session in three weeks.
10. Discuss/identify goals for participating in treatment, and what you perceive as barriers to/supports for obtaining those goals in individual sessions for next two weeks.
11. Identify/discuss ways in which current behaviors [*specifically identify these*] will lead to attainment of long-term goals in individual session next week.

Trauma - Related

The basic construct: Rates of childhood exposure to traumatic and adverse experiences are very high. These averse childhood experiences (ACES), can include physical, emotional, and sexual abuse, neglect, household dysfunction (such witnessing substance use, criminal behavior, severe mental health issues, or abuse of family members or experiencing out of home placements), substantial poverty and lack of basic needs (inconsistent or inadequate housing, basic utilities, food, clothing, etc.), and community dysfunction (including witnessing/experiencing community violence and chronic bullying.These experiences have long-term, deleterious effects on physical and emotional cognitive and brain development, and interpersonal and social functioning and relationships, that can also impact a youth's ability to consistently engage in and benefit from juvenile justice and treatment interventions.

Trauma-related issues can arise that impact or disrupt the treatment process at any time. First, it is common for trauma-related symptoms to wax and wane, with circumstances in the environment and levels/types of stressors. In addition, a history of adverse and traumatic experiences may not be known at the onset of treatment, despite through intake assessments. A number of barriers to reporting these experiences, felt by both the youth and their family, may have existed preventing disclosure in the past (e.g., concerns about stigmatization, and experience of repercussions, involvement of government agencies or criminal or immigration proceedings; fear, shame and stress with disclosure, etc.), In addition, for many youth and their families, lack of adequate resources and access to healthy environments and medical or mental health care can also mean that symptoms and difficulties went unrecognized, particularly in cased of intergenerational and developmental trauma and adversity.

Examples of trauma-related symptoms/behaviors that may impact treatment success:

- Mistrust of/aggressive displays with others
- Strong negative beliefs about self/others that reduces treatment engagement, effort, completion of assignments (e.g., feels worthless and gives up easily/doesn't try due to presumed failure)
- Repeated or severe boundary violations or issues with providers, staff, peers
- Avoidance of group attendance/activity due to anxiety
- Emotional reactivity or outbursts
- Repeated somatization of distress that disrupts treatment engagement or participation (e.g., frequent stomach distress that results in missing treatment activities, frequent presentation for medical care instead of treatment activities)
- Increases in self-harm or reckless/self-destructive behaviors
- Difficulty with certain treatment tasks or assignments due to interference from symptoms; such as sleep disturbances, panic attacks, depressive episodes, etc.
- Intense concerns regarding the distress or safety of family members or over-protectiveness of peers that disrupts treatment
- Hoarding or stealing of resources due to insecurity, and resultant disciplinary processes that disrupt treatment

Trauma - Related

Assessing the impact of trauma and stressor related difficulties on meaningful treatment participation focuses on recognizing and understanding how aspects of the treatment program, structure, and participants are/might be interacting with a particular youth's adverse experience or symptoms. Further, managing this responsivity need does not necessarily focus on treating trauma-related symptoms in the individual (though this may be a component), but on reducing the specific disruptions of/interference with the treatment process, which may involve focus on the specific youth, and/or the various aspects of the treatment environment, including providers and professional and personal community supports. Therefore, interventions will likely include consideration of trauma-informed practices within the program at all levels, including:

- Adequate knowledge and training – Do the personal and professional supports involved with the youth have sufficient knowledge and training of trauma-related symptoms to understand and recognize these symptoms and their impact? Does the youth have this information? Is there access to a trauma specialist on the team/within the program, so these staff and support persons can consult, ask questions, or obtain additional information or training as needed? Is there a procedure or means of referring for a trauma screening or assessment when further symptom treatment is needed?
- Creating a safe environment – Considering all the 'environments' a youth is in each day, are there any safety concerns that are not/can be addressed? Meeting rooms, living units, restrooms; one-onone or group meetings or activities; safety scans/checks/monitoring locations. How are disclosures and information regarding traumatic and diverse experiences handled within the program; do those methods avoid inadvertent over disclosure, re-traumatization/boundary violations, confidentiality, or safety concerns? Consider that a sense of safety will be relative or unique to the individual and their experiences, and can include physical, psychological/emotional, and social threats.
- Supporting healthy relationships and connections to others – Does the program and environment support stable relationships with healthy, prosocial supports? Is there high turnover, frequent changes to living units, group membership or inconsistencies in community supports? Do the program, practices, and/or environment promote establishing and maintain healthy boundaries?

Is there adequate oversight and structure to ensure the interactions between peers are prosocial and safe? Are staff and support persons adequately trained to respond to outbursts or behavioral issues in ways that avoid or reduce re-traumatizing the individual? Are there restorative practices that focus on repair and relationship building available/incorporated within the program – for instance, are staff, supports, and participants learning and practicing repair skills and healthy conflict management? Is there a consistent, appropriate response to issues and conflicts that arise?

- Teaching and supporting emotional regulation skills - Does the setting or activity provide opportunities to learn and practice healthy emotional coping skills? Are there allowances or procedures for the time and support this may require? Do those procedures rely on goals and rewards for using skills or regulating emotions, or are they inadvertently punitive or punishing? Do those involved have the adequate knowledge and training to understand and recognize trauma-related symptoms, and support the implementation and development of these skills with the youth?

Trauma - Related

Because traumatic and adverse experiences can have such wide-ranging effects and negative outcomes in various domains of functioning, it is possible (even likely) that trauma-related problems will overlap with other responsivity domains (e.g., cognitive limitations, emotional and behavioral health needs, family dysfunction). In such cases, the domain in which you describe the responsivity need should once again be the one with the most practical/therapeutic utility to you and those delivering treatment services or interventions.

This item may be assessed using file review, collateral data, behavioral observations, clinical interview data, psychological assessment referral/ instruments.

Trauma - Related

Examples of *Considerations for Treatment Delivery* for clients with trauma-related responsivity needs:

- Youth has engaged in several aggressive outbursts in group this month, including yelling and one incident of throwing a chair across the room. During an individual meeting, youth ultimately reported a previously undisclosed history of sexual abuse, with increasing distress and nightmares following the introduction of a new group member. Youth has been referred for an assessment with the team trauma specialist, and further consultation to develop appropriate interventions are expected to occur. With discussion regarding his sense of safety and inclusiveness, youth indicated that he would like to continue to attend his regular group. He reported that now that he has disclosed, he does not experience the same high levels of distress with the new group member present. However, youth will work with his primary therapist to develop brief interventions/strategies for managing distress should these arise in group as he completes the trauma related assessment.

- Youth has presented with a number of treatment-interfering behaviors related to a history of trauma. In particular, he experiences nausea and vomiting with exposure to routine life stressors, and either stays in his room or seeks urgent medical care and treatment. These episodes occur at least weekly, and result in his absence from treatment activities, social activities with mentors and peers, or difficulty completing out of session assignments and skills practice. Overall, treatment interventions will include assisting youth with understanding trauma-related symptoms and how these may result in somatization, and learning skills to cope and reduce his experience of symptoms. Youth's caregiver will also receive psycho-education regarding trauma, its symptoms and means of supporting youth in recognizing when symptoms occur and helping them use coping skills. Youth will work with his individual therapist to improve their understanding of when these symptoms occur (e.g., behavioral chain analysis), and developing alternative responses (which may also include changes to the environment or processes if safety issues or 'triggers/cues' are contributing to his experience of symptoms).

Examples of *Long-Term Treatment Goals* for youth with trauma-related responsivity needs:

- Reduce impact of trauma-related behavior/symptoms on treatment attendance, contribution, engagement and/or benefit
- Increase use/application of trauma informed interventions within youth's treatment program

Trauma - Related

Examples of *Quarterly Targets* for youth with trauma-related responsivity needs:

- Modify group setting to increase sense of safety
- Refer to trauma-specialist for comprehensive assessment and/or therapy (i.e., TF-CBT or EMDR).
- Develop understanding of situations, thoughts, attitudes, behaviors, feelings, etc. that contribute to avoidance behaviors
- Reduce disruptive behaviors in group
- Increase use of healthy coping or regulation strategies/behaviors in group
- Improve knowledge and understanding of traumatic and adverse experiences and their effects
- Learn/develop skills for improving affect regulation
- Reduce boundary violations in group setting

Examples of *Daily/Weekly Tasks* for youth with trauma-related responsivity needs:

1. Attend affect regulation group for six weeks
2. Primary therapist will consult with trauma specialist to obtain additional information and/or develop trauma-specific interventions for youth in accordance with trauma therapy protocols (i.e., TF-CBT or EMDR).
3. Primary therapist will coordinate with case manager to establish consistency in routine and environment
4. Caregivers to participate in psychoeducation on trauma and interventions
5. Youth will take 20-minute walk daily with peer mentor, and practice grounding exercises for five minutes prior to treatment meetings
6. Complete assessment with trauma-specialist
7. Learn about healthy boundaries, and practice setting and maintaining boundaries with others in weekly group and individual sessions for next four weeks to address disruptive behavior
8. Primary therapist and youth will develop list of situations and circumstances that lead to symptoms through weekly behavioral chain analysis for next four weeks

9. Primary therapist and youth will explore/identify situations, processes, persons that feel threatening to youth, and collaborate on ways to increase sense of safety
10. Will meet with community supports and family members twice this month to discuss methods of establishing and maintaining a safe environment for youth during activities
11. Use diary cards to monitor practice of coping skills, and review in group or individual sessions weekly

Other Responsivity Need(s)

The basic construct: The "other" responsivity need area is meant to capture highly unique situations or characteristics of the program, therapist, or youth, that negatively impact the youth's treatment participation, engagement, and benefit.

Like the prior responsivity domains, the needs described/addressed in this area should be relevant to the youth's ability to participate meaningfully in treatment. Capturing such features accurately and usefully in this section can be a difficult task; be sure to get input from other professionals when considering "other" potential responsivity needs.

POTENTIAL "OTHER" AREAS TO CONSIDER

- Changes to therapist(s)
- Roommate/living unit changes
- Treatment/community transition
- Death of loved one/withdrawal of support
- Divorce/break-up
- Sudden changes in financial status
- Loss of privileges or significant changes to correctional/institutional procedures
- Facing parole/conditional release
- Loss of freedom/liberty
- Loss of access to/restricted used of technology (and related social, leisure outlets/status)
- Access to adequate food/nutrition
- Access to medical care/physical needs
- Ability to achieve restful sleep
- Need for employment/income
- Family discord/stressors in family
- Limited family support or contact
- Intergenerational health/trauma/mental health and substance use issues
- Lack of resources of family impacting their participation/source of stress for youth
- Loss of friendships/relationship discord with peers/peer groups
- Need to complete other institutional programming requirements
- Current grievance with/complaints against treatment/supervision staff
- Sexual/physical assault by a peer (or threat of assault)
- Pending legal matters

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Other Responsivity Need(s)

Examples of *Considerations for Treatment Delivery* for youth with "other" responsivity needs:

- Significant address of/progress in the dynamic risk/need areas identified for youth are likely complicated by their significant term of incarceration. Accordingly, youth will participate in treatment interventions that assist them with identifying the unique challenges they will face in transitioning to community after such a protracted incarceration period, and how those challenges may amplify their dynamic risk/needs, in addition to developing skills and resources for successfully managing those challenges in the community. In addition, many of youth's dynamic risk/needs may be more appropriately assessed and addressed in the context of community treatment. As these issues arise, they will be addressed accordingly in treatment, and be summarized in related documentation.

- Youths experiencing significant anxiety and frustration around the ambivalence in their future created by uncertainty of release from program and stalled release/transition planning. Accordingly, initial treatment efforts will focus on assisting them in the practical and emotional management of this issue to reduce their anxiety and allow them to focus on other aspects of their treatment (i.e., identified dynamic risk/needs).

- Due to an anticipated extended absence of this therapist, youth will be transitioning to a new group and primary therapist during the next quarter. To limit the potential impact of this change, youth will participate in discussion of the change and its implications in group sessions (prior to the transition), and develop methods of managing negative repercussions of the change. Youth will also participate in transitional sessions involving this therapist and their new primary therapist to facilitate continuity of care, and to gradually acclimate youth.

Other

Examples of *Long-Term Treatment Goals for* youth with "other" responsivity needs:

- Reduce impact of [other responsivity needs] on treatment attendance/contribution/ engagement/benefit

Examples of *Quarterly Targets* for youth with "other" responsivity needs:

- Develop list/description of thoughts/attitudes, feelings, and external environmental features that encourage discomfort, or avoidance of treatment intervention (i.e., homework assignment, class, role-play, etc.)
- Identify barriers to treatment progress
- Increase treatment attendance and participation
- Develop skills/interventions to manage counterproductive behaviors (e.g., defensiveness) and emotional reactivity to distressing thoughts/concerns (e.g., fear of civil commitment).
- Identify distractors/issues that impair treatment focus/engagement
- Express/process feelings related to recent event(s) and implications for future goals
- Develop skills/methods of managing implication(s) of recent event(s)

Examples of *Daily/Weekly Tasks* for youth with "other" responsivity needs:

1. Identify/discuss ways in which current behaviors [*specifically identify these*] will lead to attainment of long-term goals in individual session next week

2. Identify alternative methods for meeting short-term needs/goals without impacting treatment progress/engagement/participation
3. Identify and compare benefits of current behavior to continued treatment participation/engagement/benefit with regard to long-term goals
4. Identify methods of overcoming barriers, and role-play/practice methods in two individual sessions at end of month
5. Practice mindfulness skills (role-play in group and utilize outside of treatment) to manage impact of recent event(s) and keep log of their effectiveness for each session for next two weeks.
6. Practice distress tolerance skills (role-play in group and utilize outside of treatment) to manage impact of recent event(s) and keep log of their effectiveness for each session for next two weeks.
7. Practice emotional regulation skills (role-play in group and utilize outside of treatment) to manage impact of recent event(s) and keep log of their effectiveness for each session for next two weeks.
8. Practice interpersonal effectiveness skills (role-play in group and utilize outside of treatment) to manage impact of recent event(s) and keep log of their effectiveness for each session for next two weeks.
9. Increase group attendance to 75% within two weeks
10. Participate in practical problem-solving group exercise to manage recent issue/event(s)
11. Provide feedback in group at least four times per week for next two weeks
12. Document group content/feedback for at least two sessions each week for next month.
13. Work with case manager/family support liaison to increase sources of support for family to increase their participation/contact with youth