Youth with Mental Health Disorders in Custody: What You Need to Know

Participant Guide
How to Use the Participant Guide

In this Participant Guide for Youth with Mental Health Disorders in Custody: What You Need to Know, you will find materials needed to take notes on presentations and to participate fully in both group and individual activities.

You should keep this Participant Guide after the training session has concluded and use it as a reference and a resource as you return to your work. You may also be asked to discuss the content and the significance of this training with your supervisor and/or other staff members.
Welcome

Slide 2

1) “Rome wasn’t built in a day.”
2) “A journey is not a destination.”
3) “….this is all good information but what do you want me to do differently?”
4) Behavior is best understood and managed in “context”

Slide 3

Participants will be able to:

• Better understand youth in custody with mental health disorders & identify effective strategies to use when working with them.
• Describe the essential elements of a Juvenile Corrections Approach, a Treatment-Oriented Approach & Trauma-Responsive Approach as they relate to the effective care of youth in custody.
• Identify potential ways staff mental health can be impacted by working in a juvenile justice facility and some potential ways to minimize the effect on their personal and professional lives.
Mental Health Disorders

Slide 4

Agenda

• Introduction, Prevalence, Definitions
• Mental Health Screening & Assessment
• Common Mental Health Disorders Among Youth in Custody
• Trauma Among Youth in Custody
• Head Injury Among Youth in Custody
• 3 Approaches to Working with Youth in Custody w/ Mental Health Disorders
• Effective Strategies for Youth in Custody w/ Mental Health Disorders
• Your Mental Health

Slide 5

63-92% of youth in Juvenile Confinement settings meet criteria for Mental Health or Substance Use Disorder

Slide 6

“A mental health disorder is a condition that impacts an individual's thoughts, feelings or behavior (or a combination of all three) and that causes the individual significant distress or difficulty in functioning.”

(National Institute of Mental Health)
COMMON MENTAL HEALTH DISORDERS

- Mood Disorders (e.g., Depression, Bipolar)
- Attention-Deficit/Hyperactivity Disorder
- Conduct Disorder
- Substance Use Disorders
- Posttraumatic Stress Disorder
- Anxiety Disorders
- Learning Disorders
- Intellectual Disability

CO-MORBIDITY
Suffering from more than one Mental Health Disorder at the same time

CO-OCCURRING
Suffering from one or more Mental Health Disorders AND one or more Substance Use Disorders at the same time

CO-MORBIDITY AND CO-OCCURRING
Suffering from both more than one Mental Health Disorder and one or more Substance Use Disorders at the same time
Slide 13

1) What trauma they experienced

2) What behaviors you recognize from the video

3) How will you use today’s information with him/her and others

Slide 14

Head Injury/Brain Trauma

Slide 15

Studies show that 1 in 4 to almost 1 in 5 incarcerated youth suffer from traumatic brain injury

Most are un-identified

(Crane et al. 2001; Perron and Ybarra 2008)
Slide 16
Difficulty.....
• Planning ahead
• Accurately judging situations
• Controlling their emotions
• Prioritizing what’s important
• Controlling their behavior

Mental Health—Desktop Guide to Quality Practice for Working with Youth in Confinement (Boesky, 2014)

Slide 17
Therefore.....
• Following rules or directives
• Delaying immediate gratification
• Behaving appropriately
• Regulating their emotions
• Learning from consequences or past mistakes

Mental Health—Desktop Guide to Quality Practice for Working with Youth in Confinement (Boesky, 2014)

Slide 18

Mental Health Disorders 8 2/15
Effective Management Strategies and Treatment Interventions for Youth in Custody with Mental Health Disorders

Slide 23

Basics

- Provide safety
- Provide structure, consistency, predictability
- Adequate staffing
- Treat youth as individuals
- Clear understandable rules
- Home-like environment
- Welcoming/transparent

Slide 24

ALL Youth with Mental Health Disorders

- Provide praise
- Assist in problem-solving
- Allow youth to ask clarifying questions
- Be professional, helpful and validating
- Teach youth calming skills
- Offer alternate ways of thinking in response to thinking errors
Slide 25

All Youth with Mental Health Disorders (2)

- Provide prompts/reminders
- Provide clear limits and behavioral expectations
- Teach and reinforce skills
- Provide reinforcement and consequences ASAP
- Notify youth of any negative consequences
- Support youth during times of stress and transition

Slide 26

Giving sanctions, or threatening to do so, does little to change the behavior of youth who have difficulty understanding abstract and future events or consequences.

Slide 27

All Youth with Mental Health Disorders (3)

- Reasonable expectations
- Provide substance abuse treatment as needed
- Interventions that focus on anger, stress, thinking, social skills
- Listen, support, de-escalate
- Exhibit patience, creativity, flexibility
- Teach and coach practical coping skills
Slide 28

Formal Mental Health Treatment

- Ongoing, long-term, relapse
- CBT—appropriate level
- Protective factors
- Individualized plans, goals
- Co-occurring, integrated, equal
- Psychotropic medication
- Modified anonymous groups

Slide 29

WHO ME?
- No energy/always tired
- Cynical
- Feeling disconnected or isolated from others
- Headaches, stomachaches, pain, or illness
- Restless
- Worried, tense, or on-edge
- Feeling trapped or overwhelmed
- Numb
- Irritable or short fuse
- Upset stomach or nausea
- Difficulty managing emotions
- Repeatedly making poor decisions

Slide 30

WHO ME?
- Not caring about anything or anyone
- Sudden feeling that something bad is going to happen
- Trouble falling or staying asleep/Nightmares
- Difficulty concentrating
- Finding it difficult to get up in the morning
- Sweaty or damp and clammy hands
- Lack of emotional response
- Feeling hopeless
- Not enjoying things you used to enjoy
**Slide 31**

**Vicarious Trauma**

The process of change that happens because you care about other people who have been hurt, and feel committed or responsible to help them.

Over time this process can lead to changes in your psychological, physical, and spiritual well-being.

- Headington Institute

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**Slide 32**

**For More Information.......**

- Mental Health" Chapter—Desktop Guide to Quality Practice for Working with Youth in Confine: www.desktopguide.info

- Juvenile Offenders With Mental Health Disorders: Who Are They & What Do We Do With Them (2nd Edition) www.aca.org or Amazon.com

- Additional NCYC/NSPJS Training “Suicide Prevention Among Youth in Custody: What You Need to Know” & “Behavior Management of Youth in Custody”
Case Study Tomiko’s Story

Tomiko is in his middle teen years and was arrested for Robbery 1 and Sexual Assault, in that he approached a woman as she walked to her car from her place of employment and demanded that she give him her wallet and jewelry at knifepoint. The woman complied at which time Tomiko reached under the woman’s dress running his hand over the woman’s under garments. The woman screamed. Tomiko ran from the scene still clutching a hunting knife with a five inch blade in his hand. A passing police cruiser on routine patrol saw Tomiko running down the street with the knife in his hand and stopped him. Tomiko was found to have cash, credit cards and jewelry on his person. While questioning Tomiko as to where he got the items in his possession the officer received a call to respond to the scene of a reported robbery two blocks from where he was questioning Tomiko. The officer responded with Tomiko in the patrol car. The woman at the scene identified Tomiko as her assailant and Tomiko was arrested. Tomiko has gang tatts, a history of truancy, neglect, sexual abuse, physical abuse, was knocked unconscious at age 9 by mother’s boyfriend, coma for two days, mother died of OD, in various prior placements Tomiko diagnosed with Oppositional Defiant Disorder, Conduct Disorder and Depression, staff report Tomiko to be sullen, uncooperative, manipulative and aggressive.
EFFECTIVE MANAGEMENT STRATEGIES AND TREATMENT INTERVENTIONS FOR YOUTH IN CUSTODY WITH MENTAL HEALTH DISORDERS

ACTIVITY

• **(TELL)** Youth should FEEL “SAFE” physically, psychologically, morally/ethically, socially. Physical safety is freedom from physical harm, Psychological is safety in one’s own thoughts i.e., not thinking hurtful or destructive thoughts, Moral/ethical safety speaks to things like fairness, honesty and integrity within the staff and the program, Social safety is safety with peers and in groups. Youth are not likely to engage in treatment or change their behavior if they do not feel “safe.”

• **(TELL)** STRUCTURE, CONSISTENCY, PREDICTABILITY should be emphasized in all programming and treatment activities

• **(TELL)** Adequate numbers of qualified trained staff should be available to address juvenile’s safety, programming and treatment needs. Including juvenile justice, mental health, educational, medical and recreational staff, as well as other important professionals in your facility.

• **(TELL)** Individual youth’s strengths or special needs should always be considered

• **(SHOW)** Rules should be clear and youth should always know what is expected of them.

• **(TELL)** Units should be more HOME-LIKE than correctional or institutional in look and feel.

• **(SHOW)** Direct-care staff and other facility professionals should make youth, their parents and other caregivers feel WELCOME, be engaging during their interactions, and keep them informed regarding their child and their child’s treatment.
• **(SHOW)** Always provide praise and recognize even small accomplishments.

• **(TELL)** Assist in problem-solving to reduce hopeless, helpless feelings. Effective problem solving should be taught and modeled to help create a mentally healthy environment.

• **(SHOW)** Always give time to think and allow for clarifying questions when interacting with youth who have Mental Health Disorders.

• **(TELL)** All the adults in the environment should interact with the youth and each other in a professional, helpful and accepting manner. While a firm tone is often necessary a harsh tone should never be used.

• **(TELL)** Teach youth ways to calm themselves down when upset. Emotion management skills should be taught and regularly modeled in the environment.

• **(TELL)** When youth exhibit thinking errors or cognitive distortions. Never ridicule youth in custody, instead offer ideas in a supportive manner about alternate ways of thinking.

• **(SHOW)** Provide prompts, reminders or assistance when youth are off-task. It’s important to help youth develop skillful behavior patterns through coaching and providing reminders.

• **(TELL)** Clear limits and clear behavioral expectations are vitally important and need to be reinforced consistently.
• **(TELL)** Identify, teach and reinforce skills that can help youth behave more effectively. Catch kids doing things correctly and reinforce their success.

• **(TELL)** To be most effective reinforcement or a negative consequence should be applied as soon as possible after the behavior.

• **(SHOW)** Especially during times of stress and transition youth need lots of support and validation as well as careful monitoring for any self-injurious behavior.

![All Youth with Mental Health Disorders (3)]

- Reasonable expectations
- Provide substance abuse treatment as needed
- Interventions that focus on anger, stress, thinking, social skills
- Listen, support, de-escalate
- Exhibit patience, creativity, flexibility
- Teach and coach practical coping skills

• **(TELL)** The treatment of youth with MHDs is often a long, difficult process with many ups and downs as medication and other interventions are combined in an attempt to benefit the individual’s ability to function. Patience, understanding and encouragement are required from the adults in the environment to support the treatment process.

• **(TELL)** Substance use greatly impacts many of the youth we work with and substance abuse treatment must be provided.

• **(TELL)** Provide interventions focused on managing anger, reducing stress, thinking before they act, correctly perceiving social cues and empathizing with others. Interventions that teach these types of skills combined with regular modeling of these types of skills in the environment provide the best opportunity for developing and using more skillful behaviors.

• **(SHOW)** Listen, provide support, help youth de-escalate when upset, and assist them in developing more adaptive thoughts/behaviors, especially when “triggered”. Coaching the use of skillful behaviors in “real time” difficult situations is very important in a treatment environment.

• **(TELL)** Exhibit patience, creativity and flexibility with youth suffering from mental health disorders. As stated earlier the treatment of youth with MHDs is often a long and difficult process, staff working this difficult population must exhibit a great deal of patience, creativity and flexibility.

• **(SHOW)** Youth with mental health disorders need to learn practical coping skills in mentally healthy environment supported by well-trained supportive staff.
## Case Study Devin

<table>
<thead>
<tr>
<th>Youth Name:</th>
<th>Devin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Facility:</td>
<td>ABC Center</td>
</tr>
<tr>
<td>Legal Status:</td>
<td>JD</td>
</tr>
</tbody>
</table>

Sentence: 12 months Sale of Controlled Substance. Devin stole prescription medication from grandmother and other relatives and sold to other students at his school.

Prior Placement? Yes
Timpkins Residential Center

**Summary of Mental Health Screen:**
Youth appears stable, oriented appropriately, shows a full range of affect consistent with situation and thought content. Thought process is logical, organized, coherent, non-delusional. Suicidal ideation and self-abusive impulses are reported in the present and by recent history. Last reported incident of Self Injurious Behavior approximately two weeks ago, once the behavior starts youth reports he cannot stop. Devin reports that he has command auditory hallucinations telling him to hurt himself sometimes. He was not able to identify a pattern or sequence for the hallucination in the current interview. He does not have to comply with the voice all the time and frequently does not. However there are other times he gives in to the voice and impulse to self mutilate and once started he cannot stop.
Youth appears to have symptoms of hallucinations, mood disorder, suicidal ideation, self-injurious behavior and anger management problems.

**MENTAL HEALTH HISTORY**
The youth reports a history of psychiatric hospitalizations prior to this placement. Youth was placed in the Res. Ctr. Mental Health Unit but did not complete the treatment program. He was transferred for safety & security reasons.

**History of Suicidality:** Self reported and documented history of suicidal ideation with verbalizations and plans to take his own life. In the past six months the most frequent and troubling behavior has been his Self-Injurious Behavior. The SiB is not life threatening at this time but it is compulsive. Devin most frequently scratches and rubs his left arm causing minor injury. This behavior occurs approximately twice per month.

**History of Violence:** No. Devin is oppositional at times. He is verbally threatening and profane at times, all as a function of poor affect regulation skills and abilities, but he is not physically violent.

**History of Physical, Emotional, Sexual Abuse:**
Victim of sexual abuse at age 12.
Abandoned by mother as an infant to the care of his grandparents.
History of interpersonal conflict and discord with grandmother.
EDUCATION:

Devin is classified with Multiple Educational Disabilities. No intelligence testing is available, clinical impression of cognitive skills is within the average range.

Woodcock Johnson testing: Reading = 10.6, Math = 6.7.

ALCOHOL AND/OR OTHER DRUG USE:

History of marijuana abuse prior to placement.

History of alcohol dependence prior to placement.

History of prescription medication abuse.

FAMILY/LEGAL GUARDIAN:

Permanency Plan is for youth to be released to the home of his grandparents.
Case Study Luther

Youth Name: Luther  
Current Facility: URH Center
Legal Status: JD
Sentence: Assault 12 months

Prior Placement:
Luther had previously been a resident at Tyler Residential Center, which included a period of time at the Tyler Mental Health Unit. Luther was placed at Brubaker Residential Treatment Facility, where he remained for approximately a year, before being returned to Tyler for increasingly aggressive behavior which began around the time that the Residential Treatment Facility was making plans to return Luther to home.

Summary of Mental Health Screen:
Luther is alert and oriented to his surroundings. Mood is reported as “good”, but affect is restricted. Luther acknowledges a lengthy history of trauma experiences, but declines to speak of these issues. Luther acknowledges that he feels anxious and tense frequently, but especially so now because of his current living situation in Wormwood Cottage, as he feels threatened by a number of gang member residents. Luther states that he currently does not feel safe. Speech and thought processes are clear and appropriate. Luther denies current suicidal/homicidal thoughts. Luther denies hallucinations and paranoid thinking at this time.

Prior Treatment Interventions Attempted:
Luther was admitted to the Tyler Mental Health Unit, where he disclosed that he was a victim of sexual abuse. He was discharged from the MHU back to the generic program at Tyler approximately one month later. Luther was at Brubaker RTF for approximately one year. When living at home with his biological parents who both receive services from ARC for developmental disabilities, Luther was seen weekly by an ARC worker in the home. Luther had been classified as multiply disabled by his home school district’s Committee on Special Education, and had received special education services.

Mental Health History:
Luther spent approximately one year at an RTF, during which time he made progress. Luther is now more inclined to speak to a staff member when feeling distressed, and is aware of pro-social coping strategies to reduce and/or manage his anger. He had done well in the RTF until RTF staff began talking to him about returning home.
History of Suicidality: Yes.
Upon his initial admission to Tyler, Luther had a history of suicidal ideations and self-injurious behaviors. Luther became frustrated in the past and punched a glass window, which resulted in a cut to the artery in his wrist. Luther has also injured his hand/knuckles by punching walls when angry. Luther has engaged in head-banging. Luther has also engaged in the self-induction of vomiting.

History of Violence: Yes.
Luther has a significant history of aggression towards peers and staff. He has bitten people and punched them in the face. He has threatened to hurt people. However, Luther is neither aggressive nor violent on a consistent basis. Also, he has been reported to have flashbacks when in a restraint.

History of Physical, Emotional, Sexual Abuse: Yes.
Luther has been subjected to significant physical and emotional abuse by his family members. He was treated for burns approximately four to five years ago. He has witnessed domestic violence in the home from early childhood. He alleges that he was sexually abused by two older female relatives.

EDUCATION:
Luther was classified with multiple disabilities by the Tyler CSE. Luther was assessed with the Woodcock-Johnson which resulted in a reading grade equivalent score of 2.0 and a math grade equivalent score of 3.2. His Fullscale IQ on the WISC-III was 68 which is in the “intellectually deficient” range. The Vineland Adaptive Behavior Composite score was 71, plus or minus 7, which is in the moderately low range of adaptive functioning. Luther’s test results demonstrated that his level of intellectual functioning was in the borderline range.

ALCOHOL AND/OR OTHER DRUG USE: No
There is a parental history of substance abuse. Father has been incarcerated on drug-related charges.

FAMILY/LEGAL GUARDIAN: Mother
Case Study Daisy

Youth Name: Daisy  
Current Facility: Mayberry Girls Secure

Legal Status: JD
Sentence: 12 months Extension of Placement pending

Prior Placement: Yes
Daisy was a resident of Long Lake’s Mental Health Unit before she was transferred to Mayberry Girls Secure.

Summary of Mental Health Screen:
When evaluated, Daisy was fully oriented, and cooperated with evaluation. She reported her mood as “good”. Speech flowed smoothly; no impediment noted. Eye contact was fair. Judgment was adequate for session. No psychotic process was noted. She denied suicidal/homicidal ideation. She reported being upset with herself over self-inflicted scratches on her arms and thighs.
Daisy continues to experience much difficulty in getting along with her peers. She is eager to make friends, sometimes siding with negative peers, but shutting down completely when rebuffed. She is easily insulted and returns perceived slights with insults of her own. She generally has a good relationship with her counselor and some of her unit staff.

Additional Information:
Daisy was on the Mental Health Unit at Long Lake for 6 months. While Daisy made some progress, in that the frequency of her violent acting out behavior decreased and she became more cooperative in treatment, the severity of her most recent violent behavior necessitated her transfer to Mayberry Girls Secure. Additionally, it is reported that she continues to display self-injurious behavior and it is believed that she requires more intensive structure and supervision than a generic mental health unit can provide.

PRIOR TREATMENT INTERVENTIONS ATTEMPTED:
Daisy was initially placed in a Residential Treatment Center and then transferred to the MHU at Long Lake. Daisy was transferred to Mayberry due to violent acting out behavior i.e. assaulting staff. While at Long Lake, Daisy received individual and group therapy, and medication management. It is unclear at this time exactly which medication was prescribed for Daisy while at Long Lake. Daisy reports that she often outright refused to take the medication or “cheeked” it to please her counselor and then spit it out later because it made her feel “sleepy and sick”. Her counselor, her therapist, medical staff, and Facility Director have been involved in special programs and various behavioral interventions to help her stop the self- injurious behavior.
while at Long Lake. She has shown the most improvement when she is involved in making a contract, although she needs much encouragement and support from staff and others to follow through.

**MENTAL HEALTH HISTORY:**
No records available at this time

**History of Suicidality:** Yes.
Much of self-injurious behavior was reported by the resident as not intended to be suicide attempts but she has occasionally tied objects around her neck and made suicidal threats.

**History of Violence:** Yes
Daisy has a history of fights in school and was moved from Residential Treatment Center to Long Lake due to aggressive behavior. During a programmed gardening activity at Long Lake Daisy assaulted a male staff member with a shovel which resulted in the staff member being hospitalized.

**History of Physical, Emotional, Sexual Abuse:**
Details are unknown as Daisy is very reluctant to discuss abuse, especially sexual abuse. She does admit to physical abuse by her father, with whom she was sent to live at age 11. She demonstrates characteristics of previous trauma, such as hyper vigilance, flashbacks, exaggerated startle response.

**EDUCATION:**
WASI – Full Scale IQ 98-Average.

**ALCOHOL AND/OR OTHER DRUG USE:** Yes.
Sometimes admits to previous use of marijuana but denied this to substance abuse counselor and refused treatment.

**FAMILY/LEGAL GUARDIAN:** Mother
Case Study Tonya

Youth Name: Tonya
Legal Status: JD
Sentence: 12 months Assault
Prior Placement? No

Summary of Mental Health Screen:
Tonya presents as hopeless, isolative, quiet, yet cooperative with the interview. She acknowledges sleep/appetite disturbance and depressed mood for the past several months. Affect appears congruent with mood. She acknowledges feeling suicidal since she was sexually assaulted by her mother’s boyfriend. She maintains, “Today I am going to kill myself.” Tonya feels alienated from her mother and the rest of her family. Tonya claims that her mother did not believe her when she told her that her mother’s boyfriend had sexually assaulted her. No background information is available. Tonya was admitted to VGR last night on personal safety watch for suicidal ideations. She was placed on suicide watch upon admission by the facility psychologist, and remains on suicide watch status due to high risk of self-injury. There is no evidence of a psychotic process. Speech/thought processes are clear and appropriate.

Additional Information:
Tonya is actively suicidal at this time. She reports that she has felt suicidal for months, including the two month period that she was hospitalized at Aster County Medical Center for suicidal feelings. Tonya is in need of intensive therapy to resolve feelings of unworthiness, betrayal and low self-esteem, seemingly stemming from the rape. Family work could be initiated to reduce her feelings of alienation and to work towards reuniting her with her family.

PRIOR TREATMENT INTERVENTIONS ATTEMPTED:
Tonya reported that she has received some counseling after the sexual assault incident, including counseling at Aster County Medical Center.

MENTAL HEALTH HISTORY:

Psychiatric or Mental Health Service(s) History: Yes.
Tonya was hospitalized at Aster County Medical Center for two months earlier this year due to suicidal thoughts/feelings, according to self-report. Contact was made with Aster County Child Protective Services who verified that Tonya has been suicidal for months, that she had been
hospitalized for suicidality recently, and that the CPS case against the mother’s boyfriend had been indicated. Criminal charges were never brought against the boyfriend, however, for reasons unknown to the CPS worker.

**History of Suicidality:** Yes.
Suicidality seems to have begun since the sexual assault. Tonya has verbalized suicidal intent and has made plans to hurt herself.

**History of Violence:** Yes.
Tonya assaulted a staff at her previous placement, which caused him to become unconscious, resulting in his hospitalization. Tonya has been aggressive on other occasions as well.

**History of Physical, Emotional, Sexual Abuse:** Yes.
Tonya alleges that she was sexually assaulted by her mother’s 44 year old live-in boyfriend. CPS verifies that an investigation into the matter was held, and the case was found to be indicated. No criminal charges have been filed against the perpetrator at this time. The man has been told to stay away from Tonya. However, he lives near her mother, and was seen in the mother’s home last week by a CPS worker who thought that he was there allegedly to bring food to the family.

**EDUCATION:** No information is available at this time.

**ALCOHOL AND/OR OTHER DRUG USE:**
Unknown

**FAMILY/LEGAL GUARDIAN:** mother

**OTHER SPECIAL CONDITIONS and/ or SERVICE NEEDS:**
CPS contact in Aster County is Jane Smith who has been involved in the case.
Case Study Kirk

Youth Name:  Kirk  
Current Facility:  Star Gate Residential Center

Legal Status:  JD
Sentence: 12 months

Prior Placement? Yes.
Ashland — was transferred to Star Gate from Ashland due to appearing disorganized, vague and sometimes delusional. At Ashland he was manifesting unusual behaviors, such as spitting at staff, spitting on his bunk, pulling the fire alarm, refusing to eat because staff “are going to poison me”, and frequently stating, “I’m a space alien—I need to get back to my ship”. At Ashland he attempted to dislocate his finger.

Summary of Mental Health Screen:
Kirk presents as somewhat guarded and slowed in speech and movement. Hygiene is less than adequate. While he denies having hallucinations, Kirk reports that he would not admit to hallucinations even if he were experiencing them. Kirk reports that he has been having trouble with his thinking and his memory. Response time is slow. Kirk speaks in single words or simple phrases/sentences without elaborating. He denies any suicidal thoughts or feelings at present. He reports that he is now interested in trying medication because he feels he needs help with his thinking. Last week he had refused medication, and stated that he would just stay in his room and not come out until his release from the facility.

Additional Information:
Kirk’s mental status appears to be deteriorating. For two days in a row Kirk had fights which resulted in a recommendation from Dr. McCoy that he be placed in the Modified Service Program. During that same timeframe Kirk rushed into the room of another resident without provocation and started punching him repeatedly while shouting “he’s a Klingon”. The resident was sound asleep. Since his admission to MSP, Kirk’s hygiene has declined, and at times he refuses to go to the dining hall to eat. He continues to have a slow response time, and reports that he is having trouble with his thinking and memory. He reports that at times he cannot remember what he is supposed to be doing, or where he should be going, even though he knows that he should know these things.

PRIOR TREATMENT INTERVENTIONS ATTEMPTED: Kirk was hospitalized at Rigel Seven Hospital previously, but did not comply with his medication regimen over time. Kirk was noncompliant with outpatient therapy/intensive case management at the Venus Family Institute.
MENTAL HEALTH HISTORY: Yes.
Kirk reports that a year or two ago was hospitalized for psychiatric reasons at Rigel Seven Hospital. Kirk also reports that he was hospitalized at Star Fleet Hospital for approximately four months last year. Reasons for the hospitalizations are unclear.

History of Suicidality: No.
Kirk has reported in the past that he has engaged in self-mutilation, but without intent to die.

History of Violence: Yes.
Kirk was arrested for possessing a fake gun with the intent to scare people sufficiently so that they would leave him alone. Mother reported that she has heard Kirk threaten to kill other people in the house, and then say that he would already be dead when they were killed. Kirk allegedly has cut his face in the past with hair clippers in order to prove to people in the community that he was bad so that no one would mess with him.

History of Physical, Emotional, Sexual Abuse: None.

EDUCATION:
Kirk scored a WASI Two Subtest Scale IQ of 91, which is in the average range. Kirk was held back in fourth grade. Kirk was not attending school prior to his placement as he was afraid that his peers would hurt him.

ALCOHOL AND/OR OTHER DRUG USE: Yes. Kirk has used marijuana extensively. He reports that he started using marijuana at the age of 11.

FAMILY/LEGAL GUARDIAN: mother
Case Study Juan

Youth Name: Juan

Current Facility: Holyfield Center

Legal Status: JD

Sentence: Assault 12 months

Prior Placement:
Juan had previously been a resident at Sunnybrook Residential Center.

Summary of Mental Health Screen:
Juan appears distracted but oriented to his surroundings. He says he is confused as to why he got “shipped” to Holyfield. Mood is reported as “mad” and he fidgets and wrings his hands frequently. Juan denies any history of trauma experiences and says, “You talkin’ about trauma? Hell no, sometimes you just got to man the f--- up”. Juan acknowledges that he feels angry most of the time and adds, “Who the f--- wouldn’t be pissed in a place like this.” Juan states that he does feel safe adding, “It’s these other mother f------ that got to worry about feeling safe”. Juan denies current suicidal/homicidal thoughts and denies hallucinations and paranoid thinking at this time.

Prior Interventions Attempted:
Juan was admitted to the Sunnybrook Residential Center where, starting at Intake, he was said to display “significant aggressive behavior toward staff and peers”. The behavior management system, treatment plans and staffing patterns at Sunnybrook proved to be inadequate to meet Juan’s needs.

Mental Health History:
Juan has been uncooperative during previous attempts to provide a mental health assessment including an assessment ordered by the placing judge.

History of Suicidality: Yes.
Juan reports that he was hospitalized once for an intentional drug overdose. He would not elaborate and no record of the hospitalization is currently in his file.

History of Violence: Yes.
Juan has a significant history of aggression towards peers and staff. He fights with little provocation and responds poorly and aggressively to attempts to stop fights by staff. He routinely threatens to hurt people and he has been reported to “blackout” when responding violently in a restraint or a physical altercation.

History of Physical, Emotional, Sexual Abuse: Yes.
Juan appears to have been subjected to significant physical and emotional abuse by his family members. He has witnessed domestic violence in the home from early childhood.
**EDUCATION:**

There are no educational records for Juan at this time.

**ALCOHOL AND/OR OTHER DRUG USE:** Yes

As previously indicated Juan states that he used drugs to attempt suicide. Juan also reports that he routinely used alcohol, marijuana and other drugs. There is a parental history of substance abuse.

**FAMILY/LEGAL GUARDIAN:** Aunt
Self-Care Plan

Physical
• Engage in self-care behaviors
• Physical activity – exercise, dance, strenuous manual labor
• Reconnecting with one’s body – massage, yoga
• Take care of oneself physically; use physical means to find adrenalin highs
• Maintain a high-energy level through proper diet, sleep, exercise

List the Physical components of your self-care plan:
________________________________________________________________________
________________________________________________________________________

Psychological
• Identify triggers which may cause you to experience vicarious traumatization
• Consider therapy if personal issues and past traumas seem to get in the way
• Develop and use self-soothing techniques
• Set and keep boundaries for self and others
• Maintain an ability to see gray
• Engage in healthy activities
• Listen to music
• Spend time in nature
• Take a vacation
• Read for pleasure
• Balance work, play and rest
• Engage in creative endeavors
• Dream
• Journal
• If possible modify your work schedule to fit your life

List the Psychological components of your self-care plan:
________________________________________________________________________
________________________________________________________________________

Social
• Identify personal and social resources and use them
• Engage in social activities outside of work
• Emotional support from colleagues, family and
• Garner emotional support from family and friends
• Spend time with children, pets
List the Social components of your self-care plan:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Organizational / Work Setting

• Accept stressors as real and legitimate, impacting individuals and group as-a-whole
• Work in a team
• Create a culture to counteract the effects of trauma
• Consider developing Assaulted Staff Action Program
• Alter physical setting to be more secure, safe, and soothing
• Establish a clear value system within your organization
• Develop clarity about job tasks and personnel guidelines
• Encourage democratic processes in decision-making and conflict resolution
• View problems as a problem for the entire group, not just an individual problem
• The general approach to the problem is to seek solutions, not assign blame
• Express support clearly, directly and abundantly through tangible behavioral response like providing resources – helping with paperwork, making phone calls, providing backup
• Communicate openly and effectively
• Expect a high degree of cohesion
• Expect considerable flexibility of roles
• Join with others to deal with organizational bullies
• Eliminate any subculture of violence and abuse

List the Organizational components of your self-care plan:

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