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

Facilitator Guide
The NCYC/NPJS Youth Care Curriculum Series is made up of a collection of modules designed to develop or enhance the skills and knowledge of those working with youth in secure settings. Modules in the series are designed to support individual professionals and the cultures in which they operate to embrace best practices in the field of juvenile justice.

Youth with Mental Health Disorders: What You Need to Know is one training module in this series. Because youth care work is a dynamic process, concepts from other topic areas, which are detailed elsewhere in the series, may be introduced in this module. Youth care workers may benefit from participation in all the training modules in the series.

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Course Description:
With the downsizing of juvenile justice facilities, those who remain in custody are among the most disturbed and challenging youth in the nation. Participants will learn about a balanced, blended approach to meet the needs of this difficult population. This training explores the impact of trauma and mental disorders among confined youth, and provides some practical “do’s and don'ts” for effectively managing them in facilities. The impact on staff who work with this very troubled population will also be covered.

Learning Objectives

In this workshop, you will:

• Better understand youth in custody with mental health disorders and identify effective strategies to use when working with them
• Describe the essential elements of a Juvenile Corrections Approach, a Treatment-Oriented Approach and a Trauma-Responsive Approach as they relate to the effective care of youth in custody.
• Identify potential ways staffs’ mental health can be impacted by working in a juvenile justice facility and some potential ways to minimize the effect of this on their personal and professional lives.
Target Audience:  
Youth Care Workers – staff providing direct services to youth in a confinement setting and Supervisors (recommended)

Number of Participants:  
Minimum 12
Maximum 25-30

Level of training:  
Basic or In-service

Total Course Time: Approx. 8 hours (6 hours of learning plus 1.5 hours for lunch and breaks)

Recommended content areas prior to taking this course:  
• Understanding Adolescent Brain Development Through Current Research (2014), National Partnership for Juvenile Services, www.npjs.org or a similar training course covering current research on adolescent development and brain research
• Behavior Management (2014), National Partnership for Juvenile Services, www.npjs.org or a similar training course on managing youth behavior in a confinement setting

Instructional Methods/Techniques:  
Lecture, small group discussions, large group discussions, role plays, small group activities, examples

Class Preparation  
Large room with table groups (4-6 per table)

Required materials

1. Printed Facilitators Guide  
2. Participant Guide for each participant  
3. PowerPoint slides  
4. Laptop or computer  
5. Projector or LCD Flip Chart and stand  
6. Flip chart Pad (Post-it type is recommended)  
7. Markers (flip chart and dry erase)  
8. Masking Tape  
9. Prepared newsprint charts as needed  
10. Supplies required for training activities  
11. NPJSpeaks Dr. Lisa Boesky Video Segments  
   Segment #1: “Alma’s Story”  
   Segment #2: “James’s Story” Segment #3: “Sean’s Story”
Other:
This is an interactive training session with frequent group discussion, small group activities and individual written assignments. The facilitator guide will provide anticipated responses and instructions for structured activities. In order to complete all the input, practice and processing of information, it will be necessary to stick to the timeline provided. Discussion is welcomed but should be guided by the facilitator as needed to accomplish this.

BEFORE the learning event Agency/program administrators should:

- Review the resource: Lisa Boesky, Ph.D.: Juvenile Offenders With Mental Health Disorders Who They Are, And What Do We Do With Them
- Read Chapter 11, “Mental Health” by Dr. Lisa Boesky in The Desktop to Quality Practice for Working with Youth in Confinement available at www.desktopguide.info.
- Attend the beginning of each learning event to tell staff why this topic is important to your program and how they will be expected to use the concepts and skills they are learning in their work. [OPTION: Create a 3- to 5-minute video to be shown to staff at the beginning of each session.]

Facilitator should:

- Review the resource: Lisa Boesky, Ph.D.: Juvenile Offenders With Mental Health Disorders Who They Are, And What Do We Do With Them
- Read Chapter 11, “Mental Health” by Dr. Lisa Boesky in The Desktop to Quality Practice for Working with Youth in Confinement available at www.desktopguide.info.
- Read the entire Facilitation Guide, prepare necessary materials and rehearse presentations and activities.
- Review NPJSpeaks Dr. Lisa Boesky Video Segments
  Segment #1: “Alma’s Story”  
  Segment #2: “James’s Story”  
  Segment #3: “Sean’s Story”
  Coordinate with the agency or program administrator to attend the beginning of each learning event, share the importance of this topic to the program and how staff will be expected to use the concepts and skills they are learning in their work. [OPTION: Work with the administrator to create a 3- to 5-minute video to be shown to staff at the beginning of each session.]
- Arrange for a room large enough to hold the expected number of participants at tables of 4-6 people each, with room to move around between the tables and chairs. You will also need a table for materials and a table for the cut-down tool/sheet practice space.
- Model in your facilitation style the kind of empowering strategies youth workers could be using with youth. That is, encourage participants to ask questions and share opinions, even when they are not supportive of the content of this program. Encourage higher-level thinking and evaluation of their own attitudes and beliefs. Recognize risk-taking in trying out new ideas and behaviors. Support their learning efforts.
At the BEGINNING of the learning event Facilitator should:

- Make sure the room is arranged in table groups of 5-6 people and that no seats have their backs to the front of the room so everyone will easily be able to see you and the visuals.
- Arrange for a table for materials, if needed.
- Greet each participant as they arrive and welcome him/her to the workshop
- Pass around a sign-in sheet for names and emails for follow up.

AFTER the learning event Facilitator should:

- Review the feedback forms for any patterns
YOUTH WITH MENTAL HEALTH DISORDERS: WHAT YOU NEED TO KNOW

DO: Have Slide 1 “Title and Welcome” slide up as participants enter the training room.

Introduction (15 minutes)

SAY: Welcome to this workshop “Youth with Mental Health Disorders in Custody: What You Need to Know.”

SAY: Please let me know the first thing that comes to your mind when I ask you the next (3) questions:

ASK: What is most FRUSTRATING when working with youth in custody with Mental Health Disorders? (LOOK FOR: they don’t listen, don’t follow rules, get aggressive, mess up the schedule, pretend they’re going to kill themselves)

ASK: What is most FRIGHTENING about working with youth in custody with Mental Health Disorders? (LOOK FOR: they really could kill themselves, they’re unpredictable, they can be assultive)

ASK: What is most REWARDING about working with youth in custody with Mental Health Disorders? (LOOK FOR: you can really help them, many don’t have healthy role models, you can see positive changes in their behavior, some of them are really nice and helpful)

SAY: Thank you so much for your answers. Your experience with the youth we are going to talk about today is clear.

DO: Introduce self and training team.

SAY: We have asked you to sit in assigned seats in hopes of putting professionals from various professions around the same table. Some of you may have slightly different—or very different—roles when interacting with the youth in this facility. This arrangement will be useful in this training during various activities that we’ll ask you to carry out as part of the learning. This arrangement also acknowledges the fact that effectively managing juveniles with Mental Health Disorders in confinement settings requires a collaborative approach where each of the functions and the people who carry out those functions are viewed and valued as essential parts of the effort.
Youth with Mental Disorders

**SAY:** You may or may not work closely with the other people at your table, so take 5 minutes and introduce yourself to them, making sure to talk about your role at the facility and with the youth who reside here. Please also include in your introduction one interesting “non-work” related thing about yourself.

**DO:** After 5 minutes call the group back to order and ask, “Did any interesting things that you didn’t know about each other come up?” Get a few responses, then move on.

**SAY:** At the onset the creators of this curriculum would like to acknowledge some things: **DO:** Show slide 2

![Image](image.png)

**DO:** Click to first bullet, “Rome wasn’t built in a day”

**SAY:** Any attempt to comprehensively cover all of the aspects of Mental Health Disorders (Mental Health Disorder), diagnosis, treatment, trauma, signs and symptoms, associated behaviors etc. in adolescents during an eight hour training experience would be impossible. That would require what we not so fondly refer to as a “Data Dump”. I would just stand here and lecture tons of data and information at you all day— and you would probably only remember 10%—IF you stayed awake. While we have a great deal of information to share we hope to focus on information that will be most useful to direct care workers.

**DO:** Click to second bullet, “A journey not a destination”

**SAY:** At the end of this day we hope to have provided you with some insight into this complex and fascinating topic. However, There will be much more to learn.

**DO:** Click to third bullet, “this is all good information but what do you want me to do differently”

**SAY:** All too often this question is asked following a training like this that offers a great deal of information. The short answer is we want you to **continue to provide** the safety, structure, consistency, fairness, empathy and effective behavior management techniques that are required to manage our population. AND it is our hope that you will provide those necessary features of a well-run juvenile justice facility with an understanding of the ways that mental health disorders, brain injury and trauma can impact a youth’s behavior. Because...
DO: Click to fourth bullet, “behavior is best understood and managed in context”

SAY: Context refers to the situation or conditions in which something happens. Let’s look at “situations.” Hearing a youth loudly screaming “Ahhhhhh” would be very worrisome if coming from your facility’s library or bathroom. But, not so concerning if the same youth is visiting a haunted house or riding on a roller coaster.

ASK: Can the “situation” or “context” a youth is in impact their behavior? *(Look for: YES.)*

ASK: Could being INCARCERATED impact a youth’s mental health? *(Look for: yes.)*
ASK: Can THE SPECIFIC UNIT a youth is placed on impact their mental health—positively or negatively? *(look for: Yes)*

ASK: Are there certain STAFF MEMBERS that can impact a youth’s mental health—positively or negatively? *(Look For: yes!)*

SAY: We also said “context” could be the “condition” in which something happens. Imagine working with a youth who is not following your directions, not completing a task you have required them to do, and when you raise your voice to let them know you are serious, they stomp their feet and yell inappropriate things.

ASK: If that youth has a “condition” such as a brain injury or a very low I.Q., could that CONDITION impact the youth’s ability to follow directions, control their own behavior, and manage their emotions? *(Look For: Yes)*

SAY: This does not mean that we “excuse” unacceptable behavior. Accountability is important. And having a Mental Health Disorder does not change that. However, HOW corrective measures and rewards are applied must take into account “context”.

ASK: Do you have any comments or questions before we go over the learning objectives and agenda for the day?

DO: Show and READ slide “Participants Will Be Able To”

SAY: Here’s what we intend to work toward today and our Agenda is how we intend to get there.
DO: Show and READ slide “Agenda”

Prevalence & Definitions (20 minutes)

ASK: What percentage of youth in Juvenile Confinement do you think are diagnosed with a Mental Health Disorder?

DO: Get a few responses then show slide “Prevalence”

SAY: Studies of youth in custody have found 63% to 92% met formal criteria for a mental health or substance use disorder. When one of the studies removed Conduct Disorder and Substance Use Disorders, ALMOST HALF OF ALL YOUTH still met criteria for a Mental Health Disorder.

SAY: It will come as no surprise to many of you, that you work with a very disturbed population with many complex issues that contribute to major difficulties in managing their behavior.

DO: Show and READ slide “Mental Disorder” definition.
**SAY:** According to the *National Institute for Mental Health*:

“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.”

As with many diseases or conditions, mental health disorders are severe in some cases and mild in others.

**SAY:** Knowing **which** Mental Health Disorders are most common among your population would likely be helpful in developing more effective management strategies.

**DO:** Show and READ slide of “Common Mental Health Disorders among Incarcerated Youth”.

**SAY:** Although no national statistics are currently available regarding the **exact rate** of incarcerated youth diagnosed with specific Mental Health Disorders, it is clear that youth detained or incarcerated in juvenile justice facilities suffer from many more Mental Health Disorders than youth in the general population— and their Mental Health Disorders can be serious and debilitating.

**SAY:** Adolescents with Mental Health Disorders often suffer from **more than one disorder at the same time**. This is referred to as **co-morbidity** and it is the rule rather than the exception among juvenile offenders.

**DO:** Show slide “Co-morbidity” and “Co-occurring Disorders”

**SAY:** Also on our slide we have another term **co-occurring disorder**
**DO:** READ definition of “Co-occurring Disorder” from the slide.

**ASK:** Do you think some of the youth you work with might use alcohol or other drugs to “self-medicate” an underlying mental health disorder? *(Look for: YES!)* **SAY:** I do too.

**SAY:** Co-morbidity and Co-Occurring Disorders are VERY common among the youth that you work with, which makes “managing” them and “treating” them even more challenging.

**DO:** Show slide “Cover of DSM-5”

**SAY:** The “Diagnostic and Statistical Manual of Mental Health Disorders”—Fifth Edition (DSM-5) is a classification and diagnostic tool for mental health disorders. It is published by the American Psychiatric Association—and the most recent version was released in 2013. The DSM-5 lists EVERY mental health disorder affecting children, adolescents and adults—from ADHD to Depression to Schizophrenia. It is not the ONLY way to classify mental health disorders, but is the most COMMON way mental health professionals do it in the United States.

**ASK:** How many of you have seen the DSM? *(Look for: show of hands).*  
**ASK:** Does anyone in the room OWN a version of the DSM? *(Look for: show of hands)*

**SAY:** In this training we will be talking about the various symptoms associated with some of the most common mental health disorders seen among youth in custody. Even though these symptoms and disorders come directly from the DSM-5, it should never be used as a “checklist.” For example, if a youth is restless, has difficulty sitting still and is forgetful—it would be unethical for him or her to be diagnosed with ADHD purely based on those symptoms.

Mental Health Disorders are complex and clinicians must take into account a youth’s history, as well as biological, psychological and social factors that may be playing a role in their thoughts, mood or behavior.

**SAY:** Genetics play a role in a youth’s mental health, the way a youth was raised plays a role, a youth’s coping skills play a role......AND we alluded to this earlier......**being in your facility** could play a role.

**ASK:** What ways could being detained/incarcerated NEGATIVELY impact a youth’s mental health? **Think about it from a youth’s perspective.** *(LOOK FOR: increased stress, no privacy, fear of other residents, staff may be harsh, no contact with support system, confusion)*
ASK: Could being detained/incarcerated ever POSITIVELY impact a youth’s mental health?  
(LOOK FOR: some youth they feel safer, can get their medication, get treatment, people who care about them))

SAY/ASK: We cannot change a youth’s genetics, we cannot change the way a youth was raised—but can we impact their “experience” while they are in our care? (Look for: YES)

ASK: Can we teach them new coping skills while they are in our care? (Look for: Yes)

SAY: These are some of the things we will be covering today.

MENTAL HEALTH SCREENING & ASSESSMENT (? Minutes)

SAY: Some of you are probably thinking that if as many as 92% of our youth have a mental health or substance use disorder —and some of those youth may have BOTH or have two or more mental health disorders, how do we know who has what? How do we identify the youth AND the disorder they have? One way is to use MENTAL HEALTH SCREENING & ASSESSMENT.

DO: Show slide “Mental Health Screening”

SAY: A Mental Health Screening is generally defined as a brief procedure, 30 minutes or less, that is used to detect youth who may have a mental health disorder and are in need of further evaluation. Screening is often conducted by non-mental health staff or in some cases may be completed by the youth on their own.

SAY: A mental health screening is not designed to provide a mental health diagnosis but can help identify youth with possible symptoms of mental health disorders. Every youth who enters your facility should have a mental health screening during the intake process.

ASK: Does anyone know what screening tool is used at your facility? (Look for: MAYS1, MH-JDAT, a list of questions the mental health/nursing staff have in their office)

ASK: Who administers your mental health screening tool? (LOOK FOR: intake officer, nurse, QMHP)
ASK: What kind of information does it ask for? (Look for: it asks about suicide, depression, drug use, anger issues, and trauma.)

SAY: Okay so that’s mental health screening; it’s a pretty quick process, every youth should be screened, it is not designed to provide a mental health diagnosis—but it is designed to let us know which youth we need to pay CLOSER attention to. It tells us which youth need a closer look with regard to a possible Mental Health Disorder.

SAY: “Mental Health Assessments” on the other hand are much more comprehensive, often take hours to complete, generally occur after the youth has been identified as having a possible Mental Health Disorder— and go more in depth on issues covered in the mental health screening.

SAY: The results of a mental health assessment can provide the foundation for treatment planning— both while the youth is at the facility and when they transition back to the community.

ASK: Who administers Mental Health assessments at your facility? (Look for: psychologist, MH contract provider, I don’t know, we don’t do MH assessments.)

ASK: What kinds of information could unit staff, teachers, and recreation staff provide to the professional completing a Mental Health assessment to help them get a more complete picture of the youth? (Look for: the youth’s behavior on the unit, in school and at Rec, things we’ve heard the youth say, behavior changes that we’ve seen.)

ASK: How could the information from a MH assessment help you do your job more effectively? (Look for: we could better understand some of the reasons that the youth acts the way they act, we could contribute more to the overall work that’s going with the kid if we understand more about the youth, we could keep everyone safer).

SAY/ASK: What would be the best way for information to be communicated to staff that work with youth, without completely compromising a youth’s privacy? (Look for: we could just get the recommendations, we only need general information we don’t need the specifics, supervisor can give us highlights, unit log can have recommendations for us to follow)

SAY: Both mental health “screening” and mental health “assessments” largely rely on youth telling the person administering the screen or assessment about their thoughts, behaviors, challenges and successes.
ASK: What are some of the downsides of relying on what we call “self-report” information from detained or incarcerated youth? (Look for: They lie, they fake symptoms to get meds, they don’t report symptoms because they’re embarrassed.

ASK: What are some other ways the professional conducting a Mental Health “assessment” can gather important information about youth? (Look for: ASK the staff who are with the youth 24/7, ask the teachers, use psychological tests that suggest whether or not the youth is giving accurate information, ask the parents.)

FAMILY INVOLVEMENT and TRANSITION TO THE COMMUNITY (? Minutes)

SAY: I want you to imagine a youth who came into your facility and had a mental health screening. The screening revealed the possibility of a mental health disorder. On the unit, the youth’s behavior was disruptive with angry outbursts resulting in several restraints. The youth was then referred to a Qualified Mental Health Professional (QMHP) for a mental health “assessment.” The assessment revealed a mental health disorder that when left untreated, is often characterized by overreacting with angry outbursts—and sometimes physical aggression. A treatment plan was developed that included psychotropic medication and skill-building to help the youth regulate his emotions and more effectively manage his behavior.

SAY: As long as we’re imagining, lets imagine the plan seems to be working well, he responded to treatment, his behavior stabilized, and the youth is fully participating in school and on the unit.

ASK: What’s missing? (Look for and add if not offered; including and engaging the family in the treatment plan and planning for transition to the community)

SAY/ASK: Think about the youth and families you work with. What are some of the challenges or frustrations we could potentially run into when we include and engage youths’ parents or other caretakers in their mental health care? (Look for: “these kids’ families ARE the problem”, “they don’t want to work with us, they don’t trust us”, “most of these kids don’t have families”, involving them can make things worse, these kids are doing okay until a phone call or visit from their parents, they don’t care about these kids, etc.)

Trainer Note: It is suggested that the trainer validate the underlying frustration and acknowledge the probability that not every family will be willing to engage and point out that some will, some are very concerned and looking for ways to change the direction their child is heading. Some may want to help their child, but don’t know how or have their own issues they are dealing with.
ASK: What would be some of the benefits of having parents or other caretakers involved in the work we’re doing with youth who have Mental Health Disorders? (Look for: The MH assessment would be more complete with the family’s input, the kid is more likely to buy into a treatment plan that includes suggestions and involvement from the family, if it’s solely our plan for the kid both the kid and the family are less likely to be invested in the plan than they will be if the plan includes their goals and suggestions, the skills the kid has learned while in facility will need to be supported by the family if we expect the kid to continue using them when he/she is transitioned.)

GROUP ACTIVITY

DO: Put participants in groups of 4-5, if they are not already sitting together at a table.

SAY: Take (5) minutes in your table groups to come up with a list of all the things that you can do to encourage or engage parents or other caregivers in programming and treatment for youth with Mental Health Disorders. Make sure that someone in your table group records the group’s ideas and someone is willing to report the list out to the large group.

Trainer Note: As indicated on the Trainer Prep document, whenever possible the table groups should be intentionally arranged in advance to include a representative(s) from each of the disciplines involved in programming for youth, i.e. direct care/unit staff, education staff, supervisory staff, clinical staff (QMHP), administrative staff, medical staff, etc.

DO: After (5) minutes conduct the “report outs” (LOOK FOR: make regular contact with the family; offer progress reports; provide praise when possible; ask the family about the youth, their behavior, their history, their opinion of the what the youth needs; when possible, schedule events that include a meal with family)

ASK: A few minutes ago we mentioned “transition” back to the community, what are a few of the reasons we should be concerned about transition back to the community—especially for youths with Mental Health Disorders? (Look for: some medications can have serious side effects if you just stop taking them so provisions for continuing the medication would be necessary; if the kid can’t get the medication they need they might begin to self-medicate with street drugs and alcohol; the skills the kid has learned will need to be supported in the community if we expect the kid to continue using them; Mental Health treatment is often a long term process and will likely need to continue; youth will need stable place to live, a school to attend or a job, and possibly new friends.)

ASK: When do you think transition planning should begin? (Look for: It should be part of the treatment plan, at intake.)

SAY/ASK: Many times facilities wait until a month or even a few days before a youth leaves? Why can that be problematic? (LOOK FOR: setting kids up for services/appointments can take a long time, there are usually long waiting lists, it’s hard to find placements for mentally ill youth, there may be no place for them to go, working with schools/vocational programs takes time)
**GROUP ACTIVITY**

**DO:** Put participants back into their groups if they are not seated at a table.

**SAY:** Take (5) minutes in your table groups to make a list of the things that need to happen in order for a youth with a Mental Health Disorder to have a chance for a “successful transition” back to the community. This time we’ll ask the person in your table group with the most number of years of experience to list the group’s ideas and the person with the least number of years of experience to report the list.

**DO:** After (5) minutes conduct the “report outs”

*(LOOK FOR: set up resources for continuation of treatment, including medication; transport to and from appointments; set up educational and/or vocational plan; if willing offer family services)*

**SAY:** Earlier we said that behavior is best understood and managed in the “context” in which it occurs. Managing confined youth with mental health disorders is complex. Many of the youth you work with have at least one Mental Health Disorder, with some suffering from 2 or more, plus a Substance Use Disorder. There are stressors youth can be exposed to in custody that can exacerbate their symptoms if we do not mitigate or remove them.

**SAY:** We need to identify youth with Mental Health Disorder, effectively manage them, engage their families, provide treatment, and ensure key services are set up for them in the community prior to their release. Given the intensity of this work, we also need to purposefully engage in some form of Self-Care to maintain our OWN wellness and stability. We’ll talk more about that at the end of the day. Next we’ll take a closer look at some of the Mental Health Disorders we’ve been referring to.

**Mental Health Disorders (60 minutes)**

**“PREPARING” FOR GROUP ACTIVITY**

**DO:** As indicated in the Trainer Prep document, prior to the start of the training, prepare seven (7) sheets of flip chart paper, label each sheet with the terms below and post them around the room:
Sheet 1: Psychosis
Sheet 2: Attention-Deficit/Hyperactivity Disorder (ADHD)
Sheet 3: Major Depression
Sheet 4: Persistent Depressive Disorder
Sheet 5: Bipolar Disorder
Sheet 6: Disruptive Mood Dysregulation Disorder
Sheet 7: Posttraumatic Stress Disorder
Sheet 8: Generalized Anxiety Disorder
Sheet 9: Learning Disorders or Intellectual Disability (previously known as Mental Retardation)
Sheet 10: Conduct Disorder

**DO:** When participants have completed the lists and sit back down to engage in a discussion with their partner, discreetly go through each of the 10 sheets as quickly as possible CIRCLING the symptoms that are CORRECT. Ignore those that are not listed as “correct” — do not cross them out. The correct answers are listed below under each Mental Health Disorder. These are taken directly from the DSM-5, which you can tell the group if they question your source.

**GROUP ACTIVITY**

**SAY:** Posted around the room you will notice flipchart paper with some of the more common Mental Health Disorders found among juveniles in custody. For the next 5 minutes we want you to come to the front of the room, pick up a marker, and go to each of these labeled newsprints and write down any signs or symptoms that you know are associated with that Mental Health Disorder. I/We know most of you are not “mental health professionals,” so if you don’t know what to write, feel free to take a guess. Think about the youth you work with, people that you know, TV shows or movies you’ve seen, or stories you’ve heard on the news. This is all anonymous, so don’t be concerned if you don’t get it right.

**DO:** After 5 minutes call the large group back to order and ask them to return to their seats.

**SAY:** As you were doing this activity, many of you likely thought of some specific individuals. I’d like you to turn to the person sitting closest to you and for the next few minutes, discuss some “real” people you know (children, teens or adults) who have some of the symptoms you wrote down. If it is someone from your personal life, you do not need to say who it is, but describe the behaviors you have seen and the diagnosis that individual has received or you believe they SHOULD receive.

**TRAINER NOTE:** As participants are talking with their partners, very quickly go to each of the 10 newsprints and LOOK FOR the symptoms that match the symptom listed in the lesson plan below. CIRCLE the symptoms that are CORRECT. Ignore those that are not listed in this lesson plan below— do NOT cross them out. Focus on what is “correct.”

**DO:** Using the information that follows, “Symptoms of Mental Health Disorders,” trainer stands by EACH flipchart page, reads the CIRCLED symptoms listed, validating the correct responses and makes any additions to the content when needed. After reviewing each “section” of circled symptoms, ask the participants about “management strategies” and “treatment interventions” specific to each disorder.
Symptoms of Mental Health Disorders

SHEET #1—Symptoms of “PSYCHOSIS”

DO/SAY: Let’s start with Sheet #1—“Psychosis”—and review the symptoms you wrote down.

SAY: Psychosis is not one particular disorder. Youth who have Schizophrenia are “psychotic.” But youth who have severe Depression or Bipolar Disorder can become “psychotic” as well. So can youth who use large amounts of drugs.

DO: Review the “circled” key features of Psychosis on the flipchart paper. Explain what the terms mean if it is not clear. Add any of the 5 KEY SYMPTOMS BELOW, if not listed, and very briefly describe them.

1) **Hallucinations**—vivid and clear experiences where youth hear things other people don’t hear (“hearing voices”) or see things other people don’t see. Rarely, they may taste things that aren’t there, smell things other people don’t smell, or feel something on or underneath their skin that is not there. Hearing voices is most common.

2) **Delusions**—beliefs that are not true, and sometimes not even possible, but a youth is convinced that it is absolutely true and rigidly holds that belief, despite everyone else believing the opposite—or clear cut proof that it is not true. Youth may have bizarre delusions; believe people are after them, or that they have special talents or powers.

3) **Disorganized Thinking (Speech)**—during conversations youth may switch quickly from topic to topic or talk in ways that make little to no sense. Their thinking and speech is so severe that it prevents them from effectively communicating with others.

4) **Grossly Disorganized or Abnormal Behavior**—youth may exhibit childlike silliness, random agitation, strange movements, strange facial expressions, not speak at all, or continuously repeat what others say.

5) **Negative symptoms**—little to no eye-contact, not speaking at all or completely flat tone of voice, no emotional expression, no socializing, or no interest in engaging in most or all activities.

**DO: AFTER DISCUSSING SYMPTOMS OF PSYCHOSIS—Move to discussion about management strategies/treatment interventions for Psychosis**
SAY: We are talking about “Psychosis” FIRST to draw a contrast between THIS type of disorder and most of the others disorders that we’ll talk about today. Being detained or incarcerated if very stressful for youth who are “psychotic”. In addition, the disruption to that setting can be extreme. An entire unit can easily be affected by one psychotic youth. The majority of juvenile justice facilities were not designed to—and do not have the capacity to—manage and effectively treat youth suffering with psychosis. But, they are entering and residing in our facilities, so we must find a way.

ASK: What are some treatment interventions and management strategies that might be helpful (or given your experience managing these youth you have already found helpful) for youth experiencing psychotic symptoms while in custody?

(look for: Medication, help youth maintain orientation to time and place, if youth asks about his/her hallucinations answer honestly, i.e. No, I don’t hear that voice, No, I don’t see what you’re describing, quiet environment, structure, clear expectations, low stress, making sure they’re safe, work with QMHP to develop ways of coping with their illness)

**Trainee Note:** If trainees are struggling to come up with answers or one person repeatedly offers answers, SAY: “Let’s look at the circled symptoms again—what would a youth with THOSE symptoms need at your facility? What could we provide him or her that would be helpful? Or what should we definitely NOT do so we don’t make things worse?”

*Do this for any of the Mental Health Disorders, if applicable.*

**Youth Who Look “Crazy” vs. Those Who Don’t**

SAY: Here is a major point. People experiencing psychosis are sometimes referred to in common language as “crazy” or “insane”. That’s because they often look and act as if they are not in touch with reality—and they may not be. Their symptoms are severe enough that their mental disorder is evident, most people could observe the youth and say, “something’s not right with that kid” or “they need professional help”. We DO NOT see a lot of these youth in juvenile confinement settings. But, as we mentioned—and some have you have experienced—due to the severity of their condition, when we do have these youth in our care, they are extremely challenging to manage in custody and require hard work and creative strategies from professionals of all disciplines.

SAY: In contrast, the majority of the youth in juvenile confinement settings that DO HAVE mental health or substance use disorders do not necessarily look or act “insane” or “crazy”. They are in touch with reality and are not experiencing hallucinations or delusions. However, they DO HAVE mental health symptoms that interfere with their ability to be successful—or sometimes even behave within acceptable limits—on the unit, at school, or socially.

SAY: When talking about youth in custody specifically, their mental health symptoms less often make them look “crazy” or “insane” and more often make them look “bad,” “mad”, “defiant,” “uncooperative,” or “violent.” Plus, some detained or incarcerated youth have a Mental Health Disorder AND are defiant, uncooperative and violent. Accurate diagnosis and effective treatment of a youth’s Mental Health Disorder, along with the best features of an effective juvenile justice setting are two essential steps toward long-term improvement.
DO: GO TO SHEET #2—SYMPTOMS OF ADHD

SAY: Many youth in juvenile detention and correctional facilities have ADHD. Let’s review the symptoms you wrote down.

- **Inattention**—a) careless mistakes, no attention to detail, b) difficulty paying attention or staying focused, c) doesn’t seem to be listening when talking to them, d) doesn’t follow through on instructions, doesn’t finish their schoolwork/chores/assignments—or starts tasks and gets sidetracked and doesn’t finish them e) difficulty organizing tasks/messy/disorganized/poor time management f) avoids or dislikes tasks where have to pay attention for long time g) loses things h) easily distracted—by things going on around them or their own thoughts) forgets to do what expected to do

- **Hyperactivity/Impulsivity**—a) fidgety, often tapping hands or feet, squirms in seat b) gets us from seat when should be seated c) runs or climbs when inappropriate, d) too loud during leisure activities, e) difficulty sitting still for extended periods, f) talks excessively, g) blurts out answers or cannot wait their turn in conversation, h) difficulty waiting for their turn in line or other situations l) interrupts or butts in on conversations, games, or activities/uses things that belong to others without asking permission/takes over what someone else is doing

SAY: Adolescents with ADHD usually have problems with “paying attention” and “being disorganized” OR problems feeling “restless” and “being impulsive though some youth, including those in juvenile justice facilities, often have both.

ASK: Given what we know about youth in ADHD—think about the types of struggles they would have in your facility. What are some treatment interventions and management strategies that might be helpful for detained or incarcerated youth with ADHD?

(Look for: Post rules, give single step instructions, repeat typical expectations prior to situations, offer action oriented tasks, lots of structure, individual attention, medication, working with QMHP on skill-building and thinking before they act)
SEEING ONESELF IN THE DISORDERS

**SAY:** Some of you may see yourself or other people you know in one or more of the disorders we are talking about because you or they have some of the symptoms listed. We ALL have mental health symptoms—it’s part of being human. It is when these symptoms cause significant distress or negatively impact your ability to function at work, home, or in relationships that you should be concerned. And the same is true with the youth we work with. Not every hyper youth has ADHD. Not every youth who is bummed out and disinterested in unit activities has Major Depression. We talked earlier about how diagnosing Mental Health Disorders must be comprehensive, taking into account a multitude of factors and gathering information from a variety of individuals. No one should ever use a checklist of symptoms to make a diagnosis.

- **DO:** Go to Sheet #3 Major Depression on the wall and review the “circled” items or irritable mood most or all of the time for 2 weeks for more
- Losing interest or pleasure in activities they used to enjoy/ Social withdrawal from friends, family, etc.
- Significant weight loss or weight gain
- Sleeplessness (insomnia) or excessive sleeping (hypersomnia)
- Physical movement that is excessively slow (psychomotor retardation) OR excessively fidgety (agitation)
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think, concentrate, or make decisions
- Recurrent thoughts of death of suicide or suicide attempts

**DO:** Go to Sheet #4—PersistenT DepressivE Disorder on the wall and review “circled” symptoms

**SAY:** This disorder was a “Bonus” because the name of this disorder is new to the DSM-5.
- Depressed or irritable most of the day, on most days FOR AT LEAST A YEAR
- Poor appetite or overeating
- Difficulty sleeping or excessive sleeping
- Low energy or fatigue
- Low self-esteem
- Poor concentration or difficulty making decisions
- Feelings of hopelessness

**SAY:** For those of you who were familiar with previous editions of the DSM this is the new term for the diagnosis dysthymia. *(Trainer note: Dysthymia is pronounced, “dis” as in you don’t dis me man, “thigh” as in the upper part of your leg, “mea” as in mama mea that’s a spicy meatball!)*

**SAY:** It also includes what used to be called “Chronic Depressive Disorder”—as you can see, the symptom are similar to Major Depression, but this condition is much more CHRONIC in nature—symptoms last for at least a year in young people.
**DO: GO TO SHEET #5—BIPOLAR DISORDER** on the wall and review “circled” symptoms

**SAY:** Bipolar Disorder is name we use for what used to be called “Manic-Depression”. Let’s first review the symptoms of “Mania”—and then we’ll talk about the “Depression” part. Youth with Bipolar Disorder experience a “Manic” episode, with one or more episodes of “Depression” occurring sometime before or afterwards.

- Elevated, expansive, or irritable mood—although some youth with Bipolar Disorder in the community are “too happy”, most youth in juvenile justice facilities with are “too irritable”—they may be agitated or even aggressive
- Inflated self-esteem
- Decreased need for sleep
- Pressure to keep talking
- Feeling that thoughts are racing or moving quickly from topic to topic in conversation
- Distractibility
- Feeling that they need to be doing something constantly or moving around incessantly with no true purpose
- Excessive involvement in risky activities that have a high potential for painful consequences

**SAY:** These symptoms represent the “manic” part of Bipolar Disorder. The “Depression” part is everything we talked about a few minutes ago.

**DO:** Walk over to SHEET #3 “Major Depression” paper on the wall and just point to list.

**SAY:** Youth with Bipolar Disorder typically experience both Mania and Depression—usually at different times, but some youth can experience them simultaneously.

**GO TO SHEET #6—DISRUPTIVE MOOD DYSREGULATION DISORDER (DMDD) on** wall and quickly review symptoms you circled for at least a year, youth must have:

- Severe recurrent temper outbursts (verbal rages or aggression towards people or property) that are WAY out of proportion (how intense they are or how long they last) to the situation or what provoked the youth
- Occurring 3 or more times per week
- Mood between temper outbursts persistently irritable/angry most of the time

**SAY:** Having a “Mental Health Disorder,” especially a “MOOD DISORDER” such as Major Depression, Persistent Depressive Disorder, PMDD and Bipolar Disorder is a MAJOR risk factor for Suicide. And suicide is the leading cause of death among youth in custody.

**SAY:** The sponsors of this training, the National Center for Youth in Custody and the National Partnership for Juvenile Services also have a training titled “Suicide Prevention Among Youth in Custody: What You NEED to Know.” It is a very interactive and engaging training on the key issues you need to know to identify and manage suicidal youth in your facility.
ASK: Okay, back to the “Mood Disorders”—we reviewed the symptoms of Major Depression, Persistent Depressive Disorder, PMDD and Bipolar Disorder—What are some “treatment interventions” and “management strategies” that might be helpful for youth who suffer from one of these particular disorders while they are at your facility? (Look for: Respond to feeling of hopelessness and helplessness with problem solving steps, point out positive events and growth, provide praise, encourage recreational activities, psychotropic medication, develop coping skills with QMHP, clear expectations, swift consequences, don’t overwhelm them)

DO: After discussing “Mood Disorders”, go back over to the “Major Depression” and “Persistent Depressive Disorder” pages—SHEETS #3 and #4

SAY: I’d like to focus on “Major Depression” and “Persistent Depressive Disorder” again for a moment. As your list shows (NOTE: most lists will validate this point) we usually think of depressed people as mostly “sad”, but many people experience Depression through “irritability.” “Irritability” is much more common among Depressed youth in juvenile confinement settings—our youth often appear as “mad kids” who have short fuses and are angry all the time. When Depression shows up as irritability, a short fuse, or a general angry demeanor— they also appear as “bad kids” who become verbally and physically aggressive with little to no provocation.

ASK: So here’s a major question—Is it possible to “punish” the Mental Health Disorder out of a youth? (LOOK FOR: No)

SAY: It would actually be unethical and in some instances illegal, to try. However, if we have a youth with Depression and his/her symptoms include “irritable most of the time” and his/her irritability looks like “mad and bad” behavior, i.e. verbally and physically aggressive, and our ONLY response is to punish the “mad and bad” behavior, that punishment not only will not make the “mad and bad” go away, it will likely frustrate the youth AND the staff because it doesn’t work— and ultimately may result in making things worse!

SAY: On the other hand if a youth received a Mental Health screening at Intake, that indicated a need for an in-depth mental health assessment, that assessment would hopefully help identify the Depression and a treatment plan would be developed.

SAY: Cognitive-behavioral therapy has been shown to be effective in reducing symptoms of Depression among adolescents, including the “mad” or irritable feelings. If medication is necessary, an anti-depressant can be prescribed. Cognitive-behavioral therapy can also help youth learn more skillful behavior options to replace the “bad” type behavior responses the youth has been displaying.

ASK: What do you think the direct care staff’s role would be in this process we’re describing? (Look for and validate or “Say” if not offered: Staff would observe for the beneficial effects and any side effects of the prescribed medication, i.e. “the youth doesn’t seem so angry all the time” or “the kid doesn’t seem so irritable but she complains of her mouth being dry all the time”. Staff would also remind, coach and reward the use of skillful behaviors that the kid was developing in the cognitive behavior therapy sessions.)
MEDICATION

SAY: As long as we’re talking about “medication”—Please STAND UP if you think the youth we work with are prescribed too much medication? Okay, please sit down.

SAY: Now, please STAND UP if you think more of the youth we work with should be placed on medication? Okay, please sit down.

SAY: Please STAND UP if you are not really sure if there is too much medication or not enough medication being prescribed to treat the youth in your care. Okay, please sit down.

SAY: There are many reasons why youth may be prescribed medication when they do not need it or ARE NOT prescribed medication when they do. So, you are likely all correct to some degree. What is important for you to know is that mental health medication—“psychotropic” medication—impacts the brain and nervous system.

SAY: Many of the disorders we are discussing today are “brain” disorders and the prescribed medication may increase, decrease or balance out a youth’s brain chemistry. Medication may or may not be needed to treat a youth’s Mental Health Disorder. Even if it IS needed, medication is never enough. Youth in juvenile justice facilities still need to learn SKILLS—coping skills, social skills, emotion regulation skills, among others.

SAY: Similar to someone who has heart disease. They can take heart medication—but that is not enough. They still need to exercise, eat right, and keep their stress to a minimum. The medication can be an important part of their treatment—but should never be the sole treatment. In fact, some individuals with heart disease have avoided surgery—just by making lifestyle changes. Many youth with mental health disorders, particularly those with mild conditions can decrease their symptoms without the use of medication, if working closely and effectively with you and the QMHPs.

DO: GO TO SHEET #7—POSTTRAUMATIC STRESS DISORDER (PTSD) on wall and highlight “circled” items

- Exposure to actual or threatened death, serious injury or sexual violence (directly, witnessing, learning it happened to loved one)
- “Intrusion” symptoms related to the event (repeated upsetting memories, nightmares, flashbacks, dissociation—loss of awareness)
- “Avoidance” symptoms (avoiding or tries to avoid memories, thoughts, or feelings associated with the event or avoids or tries to avoid reminders of event—people, places, situations, activities)
- Negative changes in “thoughts” or “mood” (can’t remember important parts of the event, exaggerated negative beliefs about themselves/others/world—“I’m a horrible person” “you can’t trust anyone ever”, repeated and distorted beliefs about the event so youth blames themselves, repeated feelings of fear, anger, guilt, shame, loss of interest in important activities, feeling detached or different from others, inability to experience positive emotions like happiness, joy, love
• Major changes in “arousal” or “reactivity” (irritability, angry outbursts, aggression—all with little to no provocation, reckless/destructive behavior, constantly scanning the environment, startle easily, difficulty concentrating, insomnia or restless sleep

SAY: PTSD is no longer classified as an “Anxiety Disorder,” but because they share some similarities, I’d like to talk about “Generalized Anxiety Disorder,” one of the most common Anxiety disorders.

DO: GO TO SHEET #8—GENERALIZED ANXIETY DISORDER on wall and highlight “circled” symptoms:

SAY: “Anxiety Disorders” have at their core: excessive fear, worry and anxiety—of something bad happening now or potentially happening in the future.

- Excessive anxiety or worry
- Difficulty controlling their worry
- Restlessness/Feeling on edge
- Being easily fatigued
- Sleep disturbance
- Difficulty concentrating/mind going blank
- Irritability
- Muscle tension

ASK: What are some treatment interventions or management strategies that might be helpful for youth for youth with “Posttraumatic Stress Disorder” or “Generalized Anxiety Disorder while detained or incarcerated?” (Look for: Simple rules, clear instructions, a structured environment, teach and encourage self-soothing skills, use a calm reassuring approach, medication, learning coping skills with QMHP, empathy from staff, low pressure situations, extra support if something reminds them of a traumatic event)

DO: GO TO SHEET #9—LEARNING DISORDERS & INTELLECTUAL DISABILITIES on wall and highlight “circled” items

- Difficulty with reasoning, problem-solving, planning, judgment, learning from experience,
- Unable to meet standards for independence and social responsibility (Intellectual Disability)
- Difficulty reading, understanding what is read, spelling, writing, mathematics—these skills are much lower than one would expect for their age and negatively impact their schooling, work, or behavior on the unit
- Misunderstanding of instructions and directions
- Poorly developed social skills – they often are seen as rude or bossy
- Choice of peer groups that share their disabilities
- Little commitment to school
ASK: What are some treatment interventions or management strategies that might be helpful for youth with Learning Disorders or an Intellectual Disability while residing in your facility? (Look for: Give clear one step at a time instructions, allow for questioning of instructions to provide understanding, create opportunities to celebrate small successes at school, structure, break down large tasks into small ones, write things down for them, give lots of reminder)

GO TO SHEET #10—CONDUCT DISORDER on wall and highlight “circled” symptoms
SAY: Youth with Conduct Disorder repeatedly violate the rights of others or violate society’s rules or norms. This is much more serious than youth being “oppositional” or “defiant”—they are typically breaking the law or hurting others.
• Aggressive towards people and/or animals (bullying, threatening or intimidating others; initiates physical fights; used a weapon/object to harm others; stolen while confronting a victim; forced someone into sexual activity)
• Destroy property (deliberately destroyed other people’s property, fire setting to cause damage)
• Deceitful/theft (broken into house, building or car; lies/cons others to get favors or avoid obligations; stolen items of value without confronting victim—shoplifting, forgery, etc.)
• Serious violation of age-appropriate rules (stays out all night against parental rules, running away from home, truancy)

ASK: What are some management strategies and treatment interventions that might be helpful for youth with Conduct Disorder while they reside in your facility? (Look for: Set clear specific limits, provide immediate consequences for behavior, teach emotion management and conflict resolution skills, be aware of and manage your own emotions, have them assessed for other mental health disorders.)

SAY: Conduct Disorder is one of the most common diagnoses given to youth in custody. Some individuals believe ALL youth in custody have Conduct Disorder because they are locked up. This is absolutely not true. Do some—or possibly many —youth in your facility exhibit the symptoms listed on the Conduct Disorder sheet? Yes.

SAY: BUT—What is behind a youth hurting animals or other people? WHY do they run away from home or not go to school? Very few youth meet criteria for JUST Conduct Disorder—they typically have a co-occurring Substance Use Disorder and/or one or more additional Mental Health Disorders (such as a Learning Disorder, ADHD, Depression, Bipolar Disorder or others).

ASK: (rhetorically) For example, how many of you know youth who stole things, threatened others, got into fights, and skipped school (ALL symptoms of Conduct Disorder) primarily because of their heavy use of alcohol or other drugs?

SAY: The benefit of mental health assessments is better understanding WHY youth with Conduct Disorder do what they do. Is it related to their upbringing, what’s been role-modeled, how they have been treated, or what they experienced as a young child? Or is it related to another Mental Health Disorder or a Substance Use Disorder? Has it been present from a very young age, despite a positive
childhood and upbringing? The answers to these types of questions help clinicians more accurately diagnose these quote/unquote “bad youth” and direct them to the type of treatment they truly need.

DO: At the END OF THE ABOVE ACTIVITY after ALL of the flip chart sheets have been discussed......

SAY: As you can see there is overlap among the various Mental Health Disorders—these conditions are not as clear-cut as we would like them to be. And that is especially true when talking about juveniles in custody.

SAY: If you are interested in additional information, the book “Juvenile Offenders with Mental Health Disorders: Who Are They & What Do We Do With Them” has a chapter on each of the mental health disorders plus “Suicide” and “Self-Injury”—and describes what each disorder specifically looks like among the population we work with and gives specific “do’s and don’ts when working with juveniles in custody with each of the different disorders.

TRAUMA (60 minutes)

SAY: There is another feature present among many youth in confinement settings that can profoundly impact virtually every aspect of their lives—and that is TRAUMA. As we talk about “Trauma”—I encourage you to think about how experiencing chronic and repeated trauma could result in a young person engaging in many of the behaviors you wrote on the lists posted on the wall.

The way we’re going to learn about trauma is to show several video clips of psychologist Dr. Lisa Boesky (Bo-S-Key), who is a national expert on juvenile offenders with mental health disorders, including those who have experienced multiple traumas. After each video clip we’ll stop and discuss the major points that Dr. Lisa covered in the clip.

DO: SHOW VIDEO CLIP #1—“ALMA/TRAUMA AMONG YOUTH IN CUSTODY”

DO: (With a group of EXPERIENCED workers) ASK: Does anyone recall working with any youths who had stories similar to Alma’s? Would anyone care to share a youth’s trauma story that you recall?

DO: (With a group of NOT EXPERIENCED workers) ASK: Have you known anyone in your life that has had experiences similar to Alma’s? Would anyone care to share that trauma story?

ASK: What were some of the main points that Dr. Lisa spoke about? (Look for:
  - Trauma is the rule not the exception, most youth in custody had one traumatic event, over half experienced 6 or more traumatic events
  - Many events occurred during childhood, youths not good at processing disturbing events, attachment figures often caused the trauma, hurt people, hurt people
• Interpersonal traumas tend to have the most negative impact on youth, many Mental Health Disorders are associated with trauma, neglect can be as harmful as physical and sexual abuse

• More trauma, more damage

• Trauma effects youth’s brain, can change the structure of brain, wired for survival, and may see threats were none exist.

• Most youth in custody NOT diagnosed with trauma, most screening/assessments don’t include trauma specific measure, boys under report physical and sexual abuse, trauma often misdiagnosed as other Mental Health Disorder

ASK: Does this fit with your experience with the youth in your facility? Why or Why Not? (LOOK FOR: validation that many youth they work with have these trauma histories, that some of youths’ current “bad” behavior probably stems from trauma, validation about how youth’s brain changes can make them impulsive, emotional, difficult-to-mange)

ASK: How is the information related to trauma’s impact on the “brain” specifically relevant to your work with youth in custody? (LOOK FOR: it helps us to understand why they act the way they do, they are always revved up, they are overly-aware of threats, that’s why they see us as the “bad” guys, that’s why they over-react to small things, they aren’t always doing negative things on purpose)

DO: SHOW VIDEO CLIP #2—“JAMES/TRAUMA IMPACT/RE-TRAUMATIZATION

DO: (With a group of EXPERIENCED workers)

ASK: Does anyone recall working with youths who had stories similar to James’? Would anyone care to share a youth’s trauma story that you recall?

DO: (With a group of NOT EXPERIENCED workers)

ASK: Have you known anyone in your life that has had experiences similar to James? Would anyone care to share that trauma story?

ASK: What were some of the key points that Dr. Lisa spoke about in this 2nd clip? (Look for: Trauma impacts a person’s beliefs about themselves, others, and the world, Reactive vs. Proactive Aggression, Re-traumatization)

ASK: What are some of the implications of this information in terms of how we manage youths in our facilities? (Look for responses like: It sounds like she’s saying we can’t use physical restraint, can’t use isolation, can’t search kids, can’t use a safety smock when they’re suicidal, I think she’s the one who’s crazy. Does she know what these kids have done to get in here? Who does she think we’re dealing with here a bunch of Eagle Scout choir boys?)
DO: *(In response to concerns like those above, the trainer should respond with something like):*

SAY: No one, including Dr. Lisa, is saying we can’t use physical restraint or search youth or use a safety smock—or even in extreme cases use some form of isolation. What IS being suggested is that the decision to use measures like physical restraint and isolation to manage behavior should be carefully weighed against the probability of re-traumatization, and should only be used when all other attempts to manage the behavior have been exhausted. And searches will continue to occur and should be carried out in a sensitive professional manner. Further we’ll continue to do everything we can to keep suicidal youth safe. What is being suggested is that we do those things in a manner that reflects our knowledge of trauma and its impact on young people.

**DO: SHOW VIDEO CLIP #3—“SEAN/NEXT STEPS” INDIVIDUAL/GROUP ACTIVITY**

AFTER THE LAST VIDEO CLIP.......While participants are still together in the large group........

SAY: I would like you each individually to think of a youth you work with who you believe—or you know for sure—has experienced significant trauma. On your handout, please write down 1) what trauma the individual experienced 2) what behaviors you recognize in them based on what was discussed in the video we just watched and 3) how you will use the information from today’s video to more effectively interact with him or her, as well as other “traumatized” youth.

**NOTE:** If participants have not begun working with youth yet, ask them to think of “someone they know”

**DO:** Show Slide with the 3 Trauma-Related Questions

**DO:** After participants have individually answered the questions, put them back into their groups if they are not already at a table.

SAY: Please give each person in your group 2 minutes to share their answers to the 3 questions you just wrote down.

**DO:** After 8-10 minutes, reconvene the large group and thank them for their work
HEAD INJURY/BRAIN TRAUMA (10 MINUTES)

DO: Show slide “Head Injury/Brain Trauma”

SAY: Many incarcerated juveniles have had experiences in which damage to their brain could have occurred.

ASK: What are some of those experiences? (LOOK FOR & INCLUDE IF NOT STATED: physical fights, car accidents, blow to the head, shaken as a baby, falling from trees or down stairs, excessive drug use, being beat up, sports injuries).

SAY: Some incarcerated youth experienced trauma to their brain before birth—during pregnancy.

ASK: What are some of the causes of trauma to the brain during pregnancy? (LOOK FOR & INCLUDE IF NOT STATED that the mother: used alcohol and drugs, did not receive appropriate prenatal care, was malnourished, was infected with an illness, gave birth prematurely before the youth’s brain was developed, experienced complications (i.e. decreased oxygen to baby’s brain)

DO: SHOW & READ slide on the Prevalence of Traumatic Brain Injury

DO: Show and READ Slide Titled “DIFFICULTY”
**SAY:** When incarcerated juveniles incur damage to the front part of the brain—where “executive functioning” resides—they often have difficulty: planning ahead, accurately judging situations, controlling emotions, prioritizing what’s important, controlling their behavior.

**DO:** Show and READ Slide Titled “THEREFORE”

**SAY:** Therefore, these youth: have a hard time following rules or directives, delaying immediate gratification, behaving appropriately, regulating their emotions, and learning from consequences/past mistakes.

**ASK:** Has anyone here ever worked with a youth who has shown many of the behaviors I just mentioned— and you suspect they were exposed to alcohol or drugs when their mother was pregnant or had damage to the head from using drugs or being hit? Who would be willing to tell us how challenging it is to manage that type of youth? (LOOK FOR: don’t follow rules, punishment doesn’t make a difference, nothing seems to work)

**ASK:** When working with these incredibly challenging youth in confinement, how do we typically respond to the behaviors just mentioned? (LOOK FOR: provide consequences, isolation, loss of privileges).

**SAY:** Accountability for noncompliance is necessary. However, if we are to understand behavior in context and the context is a traumatic brain injury, then we have to understand that in some cases, a youth may not be ABLE to make a “better choice” without external support— and threats of sanctions or providing punishments won’t necessarily change that. Regardless of how many unpleasant consequences you provide to a youth whose negative behavior stems from head trauma or a brain injury—if that is ALL you do, you will not likely stop that behavior from occurring in the future. We’ll talk more about what you can do as we address strategies in a little bit.

**SAY:** We’ve talked about Mental Health Disorders and Trauma and Brain Injury. We’ve established that many youth in custody have been diagnosed with more than one MHD and nearly all youth in custody have a history of trauma. We are going to refer to all the different disorders we’ve discussed, the experiencing of repeated or multiple traumas, as well as brain injury under the umbrella term “Mental Health Disorders” as we move forward to talk about strategies and interventions.
A Balanced Blended Approach (45 Minutes)

**DO:** Display SLIDE “Three Approaches” with all (3) approaches listed

**SAY:** Now we are going to explore three (3) philosophies or approaches to managing youth in custody. Each approach has aspects that will be of **benefit** to youth with Mental Health Disorders in juvenile confinement settings. Each has aspects that could be **counterproductive**, or **potentially harmful**, for youth with Mental Health Disorders in juvenile confinement settings. I’ll tell you up front that it is the belief of the creators of this training—and my belief as well—that the greatest benefit for youth with Mental Health Disorders in juvenile confinement settings will result when these three approaches are used together in a **balanced, blended and carefully strategized manner**.

**SAY:** First let’s very briefly define what we mean by these terms. In all fairness—each approach is broader and deeper than we are about to describe, so the following statements are an attempt to use a “rough sketch” to illustrate some of the thinking behind them. For the sake of training, we will be making them more black & white than they are.

**DO:** Display SLIDE “Juvenile Corrections”

**SAY:** The “**JUVENILE CORRECTIONS**” approach basically says: “You’re choosing to be bad” and “You need to make better choices.” It’s our job to show you the consequences of your actions so you will make better choices in the future.” You either didn’t learn to do the right thing or you learned to do the wrong thing based on your lack of role models or the harmful role models you had. If we can make this place unpleasant enough, or we can tell you how to turn your life around, you will make better choices and not come back. Safety, structure and accountability are paramount, rewards are used to reinforce compliance with program expectations, and sanctions are used to deter “bad behavior”.
**DO:** Display SLIDE “Treatment-Oriented”

**SAY:** The “TREATMENT-ORIENTED” approach often includes the traditional mental health approach which basically says, “You’re not well, you’re ill, you’re sick, you need treatment”. We understand the reasons you do the bad things you do, it’s because there is something wrong with you, you have a mental health disorder or a substance use disorder— or both— and you need treatment to “fix” it. Sometimes it’s their brain chemistry that isn’t well or an addiction or disease that needs to be treated. Treatment may include medication to impact brain chemistry, cognitive-behavioral talk therapy to help the youth understand how their thinking impacts their behavior, and skill-building to help the youth better manage their emotions and behaviors. This approach typically stresses treatment of a diagnosed mental health or substance use disorder or other identified “deficit” to deter future “bad behavior.”

**DO:** Display SLIDE “Trauma-Informed”

**SAY:** The “TRAUMA-RESPONSIVE” approach basically says, “You have been victimized or injured, you need to heal”. Instead of asking, “What’s wrong with you?” or “What disorder do you have?” It asks, “What HAPPENED to you that causes you to think and act this way?” We understand why you do the bad things you do—it’s because you have been hurt and hurt people, hurt people. You do bad things because others have done bad things to you and injured you in unthinkable ways. Because of this, you feel unworthy of good things so you’re sometimes destructive to yourself and to others. Intervention focuses on safety in all aspects of the youth’s life. Safety in relationship with others, (social safety), safety within one’s own thoughts, (psychological safety), safety in the effectiveness and fairness of the rules, expectations policies, and people in the system the youth is involved with, (moral/ethical safety) and of course physical safety. Talk therapy focuses on how past events impact youth today, medication is not a primary mode of intervention (and used only when absolutely necessary), and other modes of therapeutic interventions may be used to deter future bad behavior.
SMALL GROUP ACTIVITY

DO: Display SLIDE “Three Approaches” with all (3) approaches listed and leave up throughout Small Group Activity

SAY: We’re going to do a SMALL GROUP ACTIVITY to explore the “benefits” and “potential liabilities” of each of these approaches when working with youth in a juvenile confinement setting.

DO: Distribute Case Study #1 “TOMIKO” to each participant.

SAY: With these (3) approaches in mind please take a few minutes to read Tomiko’s Story.

SAY: Each group will be assigned one of the 3 approaches—some groups may be working on the same “approach”. Your group’s task will be to develop a list of the 1) BENEFITS and 2) POTENTIAL DETRIMENTS or PROBLEMS that Tomiko would encounter if ONLY your assigned approach, as described above, was applied.

DO: Assign each table ONE of the (3) approaches. (NOTE: Depending on how many participants are in the room, some groups will work on the “same” approach, but those groups will do so independently from one another. Write the words 1) BENEFITS and 2) POTENTIAL DISADVANTAGES OR PROBLEMS on the trainer Flip Chart.

SAY: In your small groups you will have 4 minutes to develop (2) lists. One list will be the BENEFITS of your “assigned” approach for Tomiko, the other list will be potential DISADVANTAGES or PROBLEMS that your assigned approach might have for Tomiko. Please choose a “recorder” to list your benefits and potential disadvantages on Newsprint and a “reporter” to report your list back to the large group.

DO: After 4 minutes RECONVENE the large group and conduct the report outs. If two groups have the same “approach”, have them follow each other during the report out.

TRAINER NOTE: What we’re trying to establish with this activity is that each of the approaches can “benefit” Tomiko. Each of the approaches can have “detrimental” aspects for Tomiko. To have the greatest benefit, Tomiko would be exposed to a balanced, blended, strategically planned approach that provided structure, safety, predictability, accountability, mental health and substance abuse treatment, skill-building, trauma-responsive care and opportunities to begin recovery in a mentally and emotionally healthy environment.

LOOK FOR the following answers or similar from each of the groups:
**BENEFITS of the “JUVENILE CORRECTIONS” Approach**

Provides safety, structure, predictability and accountability. Offers reinforcement for compliance. And accountability for negative behavior. Safety essential for “treatment” to occur—youth rarely open to treatment or behavior change if they do not feel “safe.”

**DETRIMENTS of the “JUVENILE CORRECTIONS” Approach**

Can be Harsh, can create a punitive environment may have the unintended consequence of a worsening of Tomiko’s symptoms. For example; if a brain injury occurred from being knocked out Tomiko might be punished for things he may have great difficulty doing or understanding, the behaviors that led to a diagnosis of Conduct Disorder may actually be stemming from untreated Depression or Trauma and will likely make it difficult for him to comply with program expectations in terms of relationships with staff and peers, plus unaddressed issues stemming from his trauma history will likely show up in behaviors that go against program expectations which will likely result in repeated sanctions and may unintentionally contribute to additional trauma.

**BENEFITS of the “TREATMENT-ORIENTED” Approach**

Accurate diagnosis of mental health disorders can lead to comprehensive treatment plan, medication can mitigate the symptoms of the disorder, skill building will aid in program compliance and offer a better possibility of healthy relationships with staff and peers. Tomiko will receive treatment to address his harmful use of alcohol/drugs. There is an “effort” to understand what drives Tomiko’s negative behaviors and why Tomiko behaves the way he does. (Behavior in Context)

**DETRIMENTS of the “TREATMENT-ORIENTED” Approach**

Detriments of the “Treatment-Oriented” Approach: Often the focus on the treatment plan to address the mental health or substance use disorder seems to not include sufficient measures to address the need for program compliance resulting in less safety, structure and predictability while in custody. Historically, the treatment-oriented approach has often mis-diagnosed symptoms of trauma in our population of youth as Depression, a personality disorder or most commonly—Conduct Disorder. In juvenile justice settings, there can be an over-reliance on medication and an under-reliance on talk therapy and skill-building.

**BENEFITS of the “TRAUMA-RESPONSIVE” Approach**

Tomiko’s history of trauma is recognized and validated. The relationship of his trauma history to his behavior patterns are pointed out offering the youth a sense of connection with the helpers in the environment. The behaviors that Tomiko displays are more clearly understood by staff as to what drives those behaviors and the purpose those behaviors serve for Tomiko. (Behavior in Context). The likelihood of him being over-diagnosed or mis-diagnosed is reduced. As is the risk that he may be medicated when it is not necessary. Rather than receiving standard “substance abuse” treatment, it can be individualized to Tomiko—without addressing the possibility that he is self-medicating or numbing himself against trauma-related symptoms, substance abuse treatment would likely have little impact.
DETREGENTS of the “TRAUMA-RESPONSIVE” Approach

Sometimes perceived by staff as providing an “excuse” for bad behavior thereby providing a reason for not holding youth accountable for their behavior, requires extensive training and system adjustments, including possible changes to current policies. Responses to “bad behavior” like physical restraint and isolation come under scrutiny and are labeled as potentially re-traumatizing for youth so Staff often feel disempowered to respond effectively to serious acting out behavior.)

ASK: What was it like to do this activity? Was it difficult to see Tomiko from different points of view?

(LOOK FOR: eye opening, didn’t see the value in other approaches before, didn’t see any drawbacks in our approach until now)

SAY: In your table groups take 5 minutes to discuss the following questions:

1) How would BLENDING and BALANCING the benefits of all three (3) approaches in a STRATEGIC manner to address Tomiko’s issues be beneficial for Tomiko?
2) What would that approach look like?
3) How would you mitigate the “drawbacks” of each approach in that plan?

Make sure someone at your table jots down the group’s ideas, and that you choose someone to report out to the large group.

DO: After (5) minutes conduct “report outs”—THEN ask the following questions.

NOTE: Write the following SENTENCES on the Flip Chart to remind participants of the questions:
   1) How would blending and balancing the approaches be beneficial?
   2) What would that approach look like?
   3) How would you mitigate the “drawbacks” of each approach?

ASK: Are there youth in your facility that would benefit from a balanced blended approach like we’ve been talking about? Get a few responses

ASK: what would need to happen for your facility to move in that direction? Get a few responses. Thank the group for their work.

EFFECTIVE MANAGEMENT STRATEGIES & TREATMENT INTERVENTIONS (60 Minutes)

DO: Show slide “Effective Management Strategies and Treatment Interventions for Youth in Custody with Mental Disorders”
SAY: This section of the training, is based on information from the “Mental Health” chapter of the “Desktop Guide to Quality Practice for Working with Youth in Confinement” a national online resource sponsored by the National Center for Youth in Custody, the National Partnership for Juvenile Services, and the National Institute of Corrections—and written by Dr. Lisa Boesky. I will provide information about this resource and other resources related to “Youth in Custody with Mental Health Disorders” at the end of the training.

SMALL GROUP ACTIVITY-SHOW AND TELL

SAY: In your Participant Manuals you will find a series of slides and descriptions of Effective Management Strategies and Treatment Interventions for youth in custody with Mental Health Disorders. Each table will be given one of those slides to work with. You will notice that each Strategy/Intervention is labeled either “Show” or “Tell”. Where you see the word “Show”, your task will be to show, through the use of a brief skit, what this Strategy/Intervention would look like when used on your unit. Where you see the word “Tell”, next to the Strategy/Intervention, your task will be to describe what the skill would look like when used on your unit. Each skit and description should be no more than 60 seconds in length. You will have 7 minutes to develop your responses in your small groups.

DO: Assign each table group 1 of the 4 slides and corresponding descriptions. Allow 7 minutes prep time then conduct report outs/skits. During report outs, display the slide that coincides with each report out. Explain and expand on responses as necessary. Total time for this activity is 60 minutes.

DO: Show slide “Basics”
• (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.

Click slide “All Youth With Mental Health Disorders”

• (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.

**DO:** Show slide of “ALL Youth with Mental Health Disorders (2)

![Slide](image)

• **(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.
**ASK:** Which of these strategies would be most helpful for youth who are suffering from a head injury/brain trauma? (Look for: All of them)

**SAY:** Display Slide – It’s important to remember......

Click to slide, “ALL Youth with Mental Health Disorders (3)”

- **(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.

**SAY:** You did a fantastic job. Give yourselves a hand.
**DO:** Start the applause.

**FORMAL MENTAL HEALTH TREATMENT**

**SAY:** In addition to the ALL the strategies that we just discussed, youth in custody with Mental Health Disorders also require more targeted “FORMAL MENTAL HEALTH TREATMENT” provided by a Qualified Mental Health Professional (QMHP) who has mental health knowledge, training and experience.

**SAY:** Talk therapy can be an essential treatment piece for incarcerated youth with Mental Health Disorders. Treatment approaches that are “cognitive-behavioral” in nature (focusing on how youth’s thoughts and ways of thinking impact their negative behavior) have been shown to be helpful. Talk therapy that focuses on engaging youth, empathizing with how difficult it is to change one’s behavior, and teaching youth practical, relevant skills are essential—as is addressing trauma, coping skills, and youths’ relationships with their family and peers.

**DO:** Show and READ the slide “Formal Mental Health Treatment” and follow script as indicated below for bullets

![Formal Mental Health Treatment](image)

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

**SAY:** Some key issues related to “Formal Mental Health Treatment” to keep in mind are:
- Mental health treatment is often an ongoing, long-term process; relapse is common and should be planned for
- Cognitive-behavioral therapy should be appropriate for a youth’s intellectual and developmental level.
- QMHPs should focus on developing and strengthening “protective factors”, rather than only reducing mental health symptoms.
• Individualized treatment plans should address specific short- and long-term goals in multiple key areas of youths’ lives,
• Treatment for “co-occurring” mental health and substance use disorders should be integrated and provided by the same treatment provider or by a team of providers who closely communicate and take equal responsibility for intervention goals.
• Psychotropic medication is only used when absolutely necessary
• Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings should be available within the facility and modified for adolescents.

LARGE GROUP ACTIVITY—FORMAL MENTAL HEALTH TREATMENT

DO: Put participants back into their small groups. Give each group a piece of flip chart paper and a large marker.

SAY: I’d like you to take a few minutes in your groups to write down as many answers as you can to the following question:

ASK: As key members of the “treatment team,” what can direct-care staff do to help QMHPs provide effective “formal mental health treatment?”

SAY: The recorder should write down your responses and the reporter will report them to the large group.

DO: Reconvene the large group after 3-4 minutes and have the groups “report out”—with each group focusing on unique answers the groups before them did not mention.

(LOOK FOR or ADD: Be alert to unusual youth behaviors, moods, or statements of concern; communicate concerns about youth to QMHP; make referrals to QMHP; carry out the QMHP’s recommendations)

SAY: Even though most of you are not QMHPs, I hope you can see the valuable role you play in the management and treatment of youth with mental health disorders in your facility.

Case Study Activity (45 Minutes)

SAY: Throughout the training we’ve tried to highlight the complex nature of the issues that challenge youth in custody—and the multitude of ways that those issues complicate our work with them. We’ve talked about interventions and management strategies that provide positive growth opportunities for the youth we work with and suggested a blending of the best features of a “juvenile correctional” approach, “treatment-oriented” approach and “trauma responsive” approach to offer the structure, treatment, and skill-building activities needed to help our youth develop in more positive ways.
LARGE GROUP ACTIVITY—CASE STUDY

SAY: What we’d like to do now is to offer you the opportunity in your table groups to practice applying some of that information you’ve learned using case studies based on actual youth in juvenile detention and correctional facilities.

DO: Place youth in their groups if not already at a table. Distribute A SEPARATE case study to each table— with enough copies for every participant at that table.

SAY: Take a few minutes of “individual” time to read over your case study. Your group will then have 7 minutes to discuss and respond to the questions found at the end of your case study. Please select someone to record your group’s responses to the questions on newsprint and someone to report your group’s work to the large group.

Note: Some of the questions will be specific to the youth’s story and their particular Mental Health Disorder and/or Trauma. ALL will include the following questions:

- What information needs to be shared with all of the staff?
- What information suggests that you should be concerned about the safety of the youth in the case study and/or the safety of others (residents or staff) on the unit?
- What steps will you take to provide safety?
- What interventions and strategies that we discussed earlier will likely be HELPFUL for this youth?
- What interventions or strategies that we discussed earlier should we AVOID with this youth?
- What is the best way to engage or involve the youth’s parents or other caregivers? What potential challenges do you see arising when involving them?
- What are some of the things that will have to be considered for “transitioning” this youth back to the community?

Trainer Note: During the report outs the trainer should be prepared to read each case study to the large group immediately prior to the small group report out on that case study.

DO: After 7 minutes call the group back to order and read the first case study—invite the first small group to “report out” on their work. Following each report, out the trainer asks the large group if they have any questions or suggestions (NOTE: other groups and trainers should fill in any “major” gaps), compliments the group on their work, and leads the group in applauding their colleague’s efforts. Trainer follows the same process for all the small groups.

DO: Following the last small group’s “report” out ASK the following:

ASK: What was it like to do this activity?
ASK: Were the kids described in the case studies similar to the kids in your facility?
ASK: Do you respond to similar cases at your facility in a way similar to your responses in this activity? Why or Why not?
YOUR Mental Health (30 Minutes)

SAY: Now I/we want to take a moment to focus on OURSELVES. Please think about yourself and whether any of these symptoms sound familiar?

DO: Show and READ the (2) slides titled “Who Me?”

- No energy/always tired
- Cynical
- Feeling disconnected or isolated from others
- Feeling trapped
- Numb
- Irritable/Short Fuse
- Upset stomach or nausea
- 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
- Not enjoying things you used to enjoy
- Feeling hopeless
- Difficulty concentrating
- Headaches
- Worried
- Tense/On Edge

SAY: Several times today we’ve talked about the difficulty involved in working with our very disturbed population of adolescents. This work can have a profound impact on those of us who work closely with them and their difficult and complex issues.

ASK/SAY: If you think working with the youth in this facility can be “stressful” please stand up. (LOOK FOR: most of the participants to be standing)

ASK/SAY: Please remain standing if you think working with the youth is the MOST stressful part of your job? (Look for: some youth standing/some sitting down)

NOTE: Briefly acknowledge the dynamics of how many stood up and for which question(s)

SAY: Thank you, everyone can sit down now. Direct-care work in a juvenile justice facility is incredibly challenging— and most people could not do what you do every day. Just look at the high rates of turnover.

SAY: Some staff may be impacted by “Vicarious Trauma”

DO: Show Slide “Vicarious Trauma” and READ the Entire Slide Aloud
DO: Put them back into their table groups. As they are getting seated, write the following (2) questions on FLIP CHART paper.

1) What are the most STRESSFUL parts of working in a juvenile justice facility?
2) What are the BENEFITS of working in a juvenile justice facility?

SAY/ASK: In your groups I would like you to come up with as long of a list as you can for the following (2) questions: (NOTE: point to the questions you wrote on the Flip Chart paper)

ASK: 1) What are the most STRESSFUL parts of working in a juvenile justice facility?
   (Look for: shift work, mentally ill youth, violent youth, ineffective leadership, terrible schedule, mandated overtime, no say in policy, terrible policies, getting assaulted, families that don’t care, youth that don’t care, dirty units, low pay, no respect, having urine thrown at you, being threatened by youth, harassment from colleagues, never going outside, noisy, potential layoff, sleep deprivation, understaffing, lack of training for what I have to do, too much paperwork, not safe since can’t put kids in their rooms anymore)

ASK: 2) What are the BENEFITS of working in a juvenile justice facility
   (look for: make a difference in the lives of young people, paycheck, insurance, pension, different every day, challenging, friendships with colleagues)

DO: AFTER groups finish their two lists, BUT BEFORE they “report back” to the large group, ask them to review their list of stressors and put an asterisk (*) next to the items that they have “control” over.

ASK/SAY: As a group, please review your list of stressors and put an asterisk (*) next to the items that you have “control” over.

(NOTE TO TRAINER: After all groups report out—there will likely be MANY stressors. Most that they do NOT have control over).

SAY: So it looks like there are some pretty good benefits—not only a paycheck and health insurance, but making a difference in the life of youth and friendships with colleagues. Great! (NOTE: highlight all benefits written)
SAY: But it looks like there are A LOT of stressors.

ASK: Are most of them under your control? (LOOK FOR: No.)

ASK: We all need to cope and we do the best that we can. What potential “negative” ways of coping do we see among employees that work in stressful environments? (Look for: drinking, smoking, overeating, physical pain, illness, spending money they don’t have, too much video game playing, withdrawal from family or friends),

ASK? Does it make sense that a stressed out employee would engage in those behaviors? (Look For: Yes)

ASK: How do you think these “negative” coping behaviors impact their health? Their relationships with their spouse? Their friends? Their children? (LOOK FOR: not well, divorce, poor relationship with kids, health problems, die early, sick a lot, get in debt)

ASK: If we can’t change many of the stressors in the “system”—and the system has some benefits that we want—what CAN we change? (Look for: our attitude, how we handle the stress, how we think about things, don’t sweat the small stuff)

SAY: In order to help others, we must first take care of ourselves – the airline motto: “put your oxygen mask on before assisting others” is very relevant to your work with youth in custody.

SAY: Many of us come to the field as “helpers” because WE have faced and overcome our own traumas or problems. This can make us more vulnerable to stress, burn out or vicarious trauma.

SMALL GROUP ACTIVITY

DO: ASK them to go back into their table groups.

ASK/SAY: I/We would like you to go back into your group and this time list what types of “healthy” coping skills staff can engage in to deal with their stress. Don’t think about how realistic they are or not. In an ideal world, what would staff do to take care of themselves so they do not develop the symptoms listed on our slides? (Look for: exercise, eat right, spend time with friends/family, get counseling, go fishing, go to movies, play sports, take vacation days, take sick days when need them, sleep, not get worked up over small things or things can’t change, stop thinking about work when at home, don’t volunteer to work so much overtime)

(NOTE: Do NOT do “report out”. They got enough of the information they needed in their groups to help them with the next activity)
**INDIVIDUAL ACTIVITY**

**DO:** Reconvene large group and distribute “Self-Care Plan” HANDOUT.

**SAY:** Everyone’s level of stress is different and everyone’s preferred ways of coping are different. Only you know what works (and does not work) for you. Please take 5 minutes to complete as much of this self-care plan as you can. Nothing is in stone. You will be taking this with you so you can always change it later. Just write the first thing you can think of—don’t get caught up with how realistic it is at this point. Please be as SPECIFIC as possible regarding what you will do or stop doing.

**DO:** After (5) minutes, **SAY:** Pair up at your table in pairs of 2 or 3 if there is an odd number. Share at least 1 thing you are comfortable sharing with your partner(s) from your “Self-Care” plan.

**DO:** During this activity the trainer should walk around the room offering validating comments on healthy activities that the pairs are discussing.

**SAY:** I heard several great ideas for self-care while you were discussing your plans. Would anyone like to share some of your ideas with the large group? It may give others an idea they had not thought of.

**DO:** Get a few responses.

**SAY:** One of the first things we mentioned this morning was that it is impossible to cover EVERYTHING you need to know about “youth in custody with mental health disorders.” Here are several helpful resources where you can obtain detailed information about working with this challenging population.

**DO:** Show slide “For More Information:

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**DO:** Thank participants for their work. Distribute the evaluations.