## ABUSE

Physical

Emotional

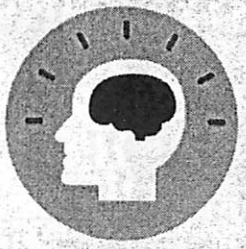
Sexual

## NEGLECT

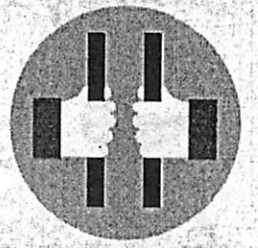
Physical

Emotional

## HOUSEHOLD DYSFUNCTION

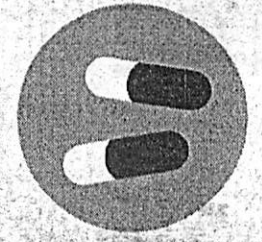


Mental Illness

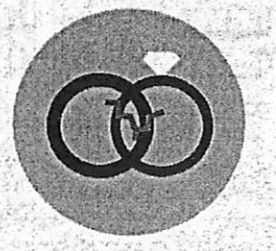


Incarcerated Relative

Mother treated violently



Substance Abuse



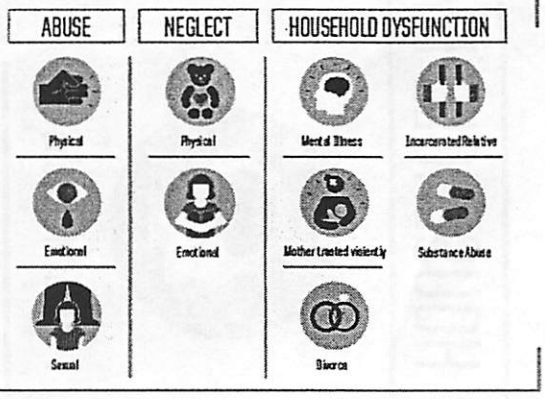
Divorce

# THE TRUTH ABOUT ACEs

## WHAT ARE THEY?

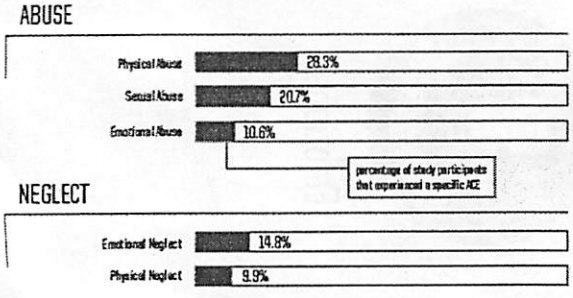
**ACEs are ADVERSE CHILDHOOD EXPERIENCES**

*The three types of ACEs include*

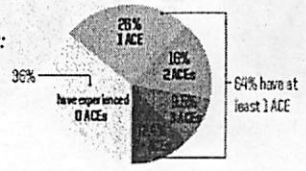



## HOW PREVALENT ARE ACEs?

*The ACE study* revealed the following estimates:*

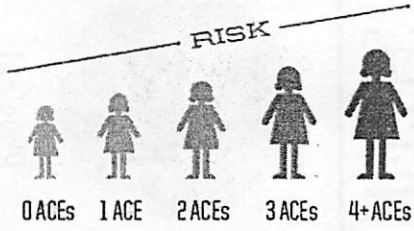



*Of 17,000 ACE study participants:*

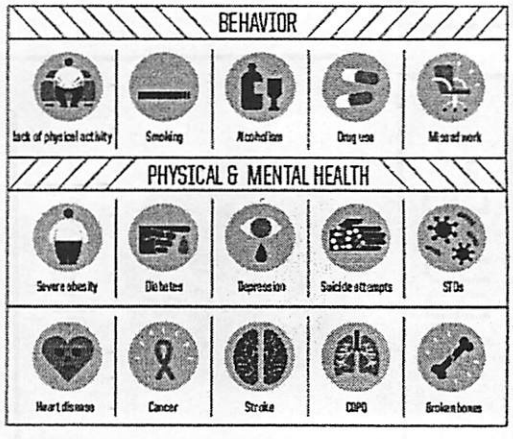



## WHAT IMPACT DO ACEs HAVE?

*As the number of ACEs increases, so does the risk for negative health outcomes*




*Possible Risk Outcomes:*




rwjf.org/aces

Robert Wood Johnson Foundation

*Source: http://www.cdc.gov/ace/prevalence.htm

# Idaho Example Case: State V. Samuel, Justice Bevin

Samuel was born in California in 1999. Samuel's parents had another son eleven months after Samuel was born. Samuel's younger brother was severely autistic and required significant attention. Both of Samuel's parents had prescription drug addictions which led to financial problems, criminal charges, and arrests. Throughout Samuel's childhood the family lived in shoddy, cockroach-infested residences and moved frequently, usually after they had been evicted for not paying rent. Samuel's mother started abusing pain pills following a car accident when Samuel was 4, became suicidal, and was hospitalized several times. Samuel's father became addicted to pain pills after he injured his shoulder at work. Samuel's father began to believe that a "zombie apocalypse" was inevitable. Samuel's mother testified that Samuel's father taught him how to kill zombies by playing violent video games, watching zombie themed movies, and training Samuel to use knives and guns.

Samuel witnessed extreme violence growing up. When Samuel was four he watched his father pour lighter fluid on his mother and threaten to burn her alive because he wanted a settlement check she received from a car accident. When Samuel was six he watched his father intentionally drive over his mother, breaking her collar bone. When Samuel was ten his father pointed a gun at his mother's head, bound her with duct tape, and forced Samuel to urinate on her. Child Protective Services were repeatedly contacted in California but never intervened. By 2013, Samuel's mother had left and Samuel's father moved to Idaho with Samuel and his brother. Samuel had frequent visits to the doctor for insomnia, nausea, migraines, blurred vision, and congestion.

On the evening of March 24, 2014, officers responded to a 911 call at Samuel's residence. Samuel told the operator that his brother and dad had been shot. After officers arrived on the scene Samuel was taken to the police station. After originally telling a different version of the events that evening, i.e., initially blaming his father for killing his brother, Samuel eventually described the following events during a police interrogation.

Samuel's father was on medication when he shot a .45 gun outside, believing that a "zombie apocalypse" had begun. Samuel told his father to go back inside. Once his father went inside he pushed Samuel in the chest and told him to leave. Samuel picked up his father's gun, and when his father pushed him a second time, Samuel shot him in the stomach. Samuel's father then crawled to Samuel's brother's room, leaving a trail of blood on the floor. Samuel did not believe the first shot killed his father and shot him three more times in the head once he reached Samuel's brother's room.

After killing his father, Samuel saw his brother hiding under the bed and told him to get out. His brother did not move. Samuel got a shotgun and shot his brother while he was under the bed. Samuel reloaded the shotgun and continued to shoot his brother. Samuel then dropped the shotgun and started to stab at his brother with a knife. Samuel moved the mattress off of the bed frame and got a machete. Samuel swung the machete at his brother through the gaps in the wood planks of the bed frame. When his brother tried to climb out from underneath the bed, Samuel hit him in the back of the head with the machete. Samuel continued to swing the machete as hard as he could until his brother stopped talking and was quiet. Samuel then called 911.

# Preventing Adverse Childhood Experiences (ACEs):

## Leveraging the Best Available Evidence

National Center for Injury Prevention and Control
Division of Violence Prevention

# Preventing Adverse Childhood Experiences (ACEs):

## Leveraging the Best Available Evidence

2019

Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
Atlanta, Georgia

**National Center for Injury Prevention and Control**
Debra E. Houry, MD, MPH, Director

**Division of Violence Prevention**
James A. Mercy, PhD, Director

**Suggested citation:**

Centers for Disease Control and Prevention (2019). *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

# Contents

# Acknowledgements

We would like to acknowledge the following individuals who contributed to the development, review and support of this publication. First, we give special thanks to Linda Dahlberg for leading the development of this document. Second, we extend our gratitude to the many staff involved in the development of the *CDC Technical Packages to Prevent Violence*. These packages provided the foundation for this document. In particular, we thank the leads of the technical packages to prevent child abuse and neglect (Beverly Fortson, Joanne Klevens, and Melissa Merrick), sexual violence (Kathleen Basile and Sarah DeGue), intimate partner violence (Phyllis Niolon and Megan Kearns), youth violence (Corinne David-Ferdon), and suicide (Deborah Stone and Kristin Holland) for their insights, review, and contributions to this document. We also thank Kathyrn Ports, Christopher Jones, Marilyn Metzler and Tamara Haegerich for generating ideas and offering many useful suggestions. Finally, we thank Alida Knuth for her assistance with graphics and layout and extend our gratitude to Division and Center leadership for their helpful feedback and support.

# What are Adverse Childhood Experiences?

Adverse Childhood Experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years) such as experiencing violence, abuse, or neglect; witnessing violence in the home; and having a family member attempt or die by suicide.[1,2] Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding such as growing up in a household with substance misuse, mental health problems, or instability due to parental separation or incarceration of a parent, sibling or other member of the household.[1,2]

Traumatic events in childhood can be emotionally painful or distressing and can have effects that persist for years.[2] Factors such as the nature, frequency and seriousness of the traumatic event, prior history of trauma, and available family and community supports can shape a child's response to trauma.[2]

# Preventing ACEs is a priority for CDC

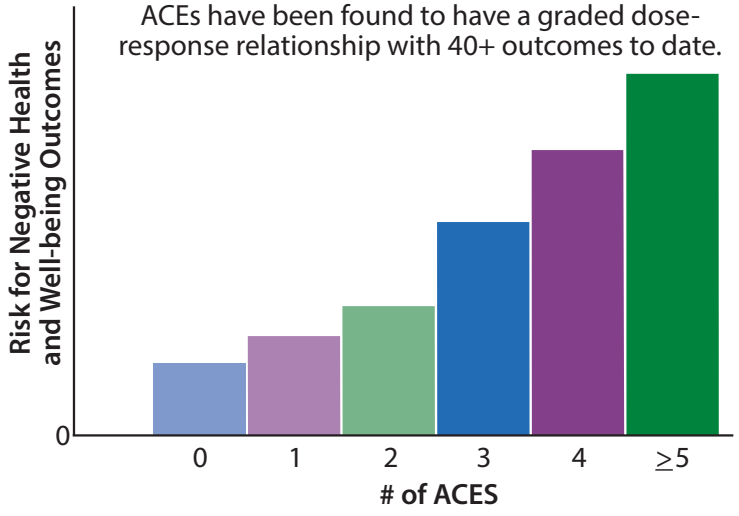
An estimated 62% of adults surveyed across 23 states reported that they had experienced one ACE during childhood and nearly one-quarter reported that they had experienced three or more ACEs.[3] ACEs can have negative, lasting effects on health, wellbeing, and opportunity. These exposures can disrupt healthy brain development, affect social development, compromise immune systems, and can lead to substance misuse and other unhealthy coping behaviors.[4-9] The evidence confirms that these exposures increase the risks of injury, sexually transmitted infections, including HIV, mental health problems, maternal and child health problems, teen pregnancy, involvement in sex trafficking, a wide range of chronic diseases and the leading causes of death such as cancer, diabetes, heart disease, and suicide.[1,10-16] ACEs can also negatively impact education, employment, and earnings potential.[17] The total economic and social costs to families, communities, and society is in the hundreds of billions of dollars each year.[18-21]

## ACEs can have lasting effects on...

**Health** (obesity, diabetes, depression, suicide attempts, STDs, heart disease, cancer, stroke, COPD, broken bones)

**Behaviors** (smoking, alcoholism, drug use)

**Life Potential** (graduation rates, academic achievement, lost time from work)

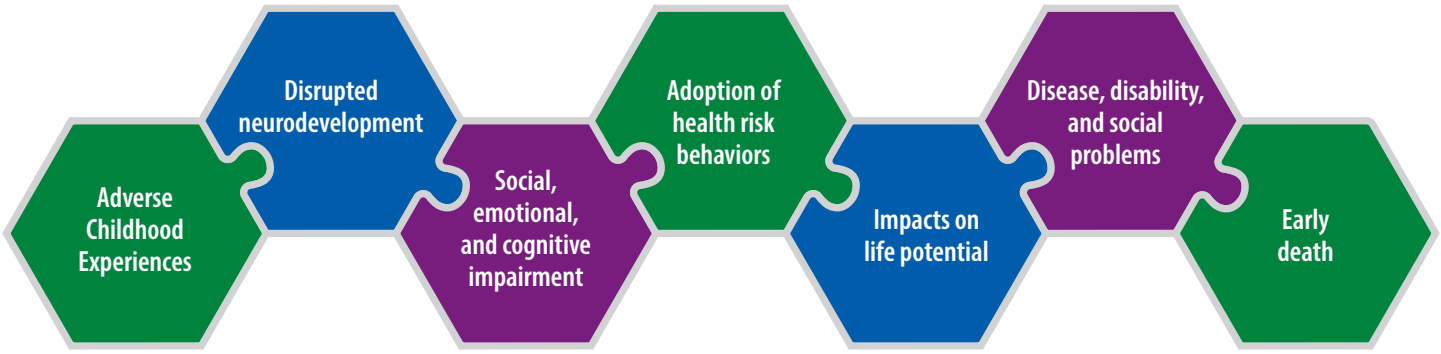



*This pattern holds for the 40+ outcomes, but the exact risk values vary depending on the outcome.

## How ACEs influence health and opportunity

The childhood years, from the prenatal period to late adolescence, are the "building block" years that help set the stage for adult relationships, behaviors, health, and social outcomes. ACEs and associated conditions such as living in under-resourced or racially segregated neighborhoods, frequently moving, experiencing food insecurity, and other instability can cause toxic stress (i.e., prolonged activation of the stress-response system[4]). Some children may face further exposure to toxic stress from historical and ongoing traumas due to systemic racism or the impacts of multigenerational poverty resulting from limited educational and economic opportunities.

A large and growing body of research indicates that toxic stress during childhood can harm the most basic levels of the nervous, endocrine, and immune systems, and that such exposures can even alter the physical structure of DNA (epigenetic effects).[4,5] Changes to the brain from toxic stress can affect such things as attention, impulsive behavior, decision-making, learning, emotion, and response to stress.[5] Absent factors that can prevent or reduce toxic stress, children growing up under these conditions often struggle to learn and complete schooling.[5,22] They are at increased risk of becoming involved in crime and violence,[23,24] using alcohol or drugs,[6,7] and engaging in other health-risk behaviors (e.g., early initiation of sexual activity; unprotected sex; and suicide attempts).[9,13,16,23] They are susceptible to disease, illness, and mental health challenges over their lifetime.[5,14,15] Children growing up with toxic stress may have difficulty forming healthy and stable relationships. They may also have unstable work histories as adults and struggle with finances, family, jobs, and depression throughout life—the effects of which can be passed on to their own children.[5,12,17]




# What can be done to prevent ACEs?

ACEs and their associated harms are preventable. Creating and sustaining safe, stable, nurturing relationships and environments for all children and families can prevent ACEs and help all children reach their full health and life potential. CDC has produced a suite of technical packages to help states and communities take advantage of the best available evidence to prevent violence, including the many types of violence and social, economic, and other exposures in the home and community that adversely affect children.[25-29]

A "technical package" is a select group of strategies to achieve and sustain substantial reductions in a specific risk factor or outcome.[30] Technical packages help communities and states prioritize prevention activities with the greatest potential for impact. A technical package has three parts. The first component is the strategy or the preventive direction or actions to achieve the goal of preventing ACEs. The second component is the approach. The approach includes the specific ways to advance the strategy. This can be accomplished through programs, practices, and policies. The third component is the evidence for each of the approaches in preventing ACEs or its associated risk factors.

Across the CDC Technical Packages there are several strategies that can prevent ACEs from happening in the first place as well as strategies to mitigate the harms of ACEs. The evidence tells us that ACEs can be prevented by:

- Strengthening economic supports for families
- Promoting social norms that protect against violence and adversity
- Ensuring a strong start for children and paving the way for them to reach their full potential
- Teaching skills to help parents and youth handle stress, manage emotions, and tackle everyday challenges
- Connecting youth to caring adults and activities
- Intervening to lessen immediate and long-term harms

## Preventing ACEs

| Strategy | Approach |
|---|---|
| **Strengthen economic supports to families** | • Strengthening household financial security<br>• Family-friendly work policies |
| **Promote social norms that protect against violence and adversity** | • Public education campaigns<br>• Legislative approaches to reduce corporal punishment<br>• Bystander approaches<br>• Men and boys as allies in prevention |
| **Ensure a strong start for children** | • Early childhood home visitation<br>• High-quality child care<br>• Preschool enrichment with family engagement |
| **Teach skills** | • Social-emotional learning<br>• Safe dating and healthy relationship skill programs<br>• Parenting skills and family relationship approaches |
| **Connect youth to caring adults and activities** | • Mentoring programs<br>• After-school programs |
| **Intervene to lessen immediate and long-term harms** | • Enhanced primary care<br>• Victim-centered services<br>• Treatment to lessen the harms of ACEs<br>• Treatment to prevent problem behavior and future involvement in violence<br>• Family-centered treatment for substance use disorders |

These strategies focus on changing norms, environments, and behaviors in ways that can prevent ACEs from happening in the first place. The last strategy focuses on mitigating the immediate and long-term physical, mental, and behavioral consequences of ACEs. By addressing the conditions that give rise to ACEs and simultaneously addressing the needs of children and parents, these strategies take a multi-generation approach to prevent ACEs and ensure safe, stable, nurturing relationships and environments. Together, these strategies are intended to work in combination and reinforce each other to prevent ACEs and achieve synergistic impact.

# Strengthen Economic Supports for Families

Research shows that parents facing financial hardship are more likely to experience stress, depression, and conflict in their relationships and family, all of which compromise parenting and increase the risk for violence and other ACEs.[31,32] Parents facing financial hardship also have fewer resources to invest in their children and face difficult choices when trying to balance work and family responsibilities. About 4 in 10 children under the age of 18 in the United States live in a low-income household* including more than half of African American and Hispanic children.[33] Nearly 1 in 10 children in the U.S. live in deep poverty.[33] Strong evidence consistently links low income to ACE exposures and children's long-term health, educational, and social outcomes.[5,34] Addressing the social and economic underpinnings of ACEs is critical to achieving lasting and sustainable effects.

Policies that **strengthen household financial security** (e.g., tax credits, childcare subsidies, other forms of temporary assistance, and livable wages) and **family-friendly work policies,** such as paid leave and flexible and consistent work schedules, can prevent ACEs by increasing economic stability and family income, increasing maternal employment, and improving parents' ability to meet children's basic needs and obtain high-quality childcare.[27,28] These types of policies can also prevent ACEs by reducing parental stress and depression and by protecting families from losing income to care for a sick child or family member.[27,28] Strengthening economic supports for families is a multi-generation strategy that addresses the needs of parents and children so that both can succeed and achieve lifelong health and well-being.

## Evidence

Tax credits, such as the *Earned Income Tax Credit (EITC)* and *Child Tax Credit (CTC*) help increase income for working families while offsetting the costs of childcare. The *EITC* has been shown to lift families out of poverty[35,36] and has demonstrated impacts on infant mortality, health insurance coverage,[37] school performance,[38,39] maternal stress, and mental health problems.[40] *CTC's* have also been shown to reduce child behavioral problems (e.g., physical aggression, anxiety, and hyperactivity)[41]—factors that are linked to later perpetration of violence toward peers and intimate partners.[26,28]

Parents who receive childcare subsidies tend to access higher quality childcare,[42] which increases the likelihood that children will experience safe, stable, nurturing relationships and environments. Access to affordable childcare also reduces parental stress[43] and maternal depression,[44] which are risk factors for child abuse and neglect[31] and other risk behaviors associated with ACEs.[45]

Research suggests that women who receive paid maternity leave are more likely to maintain their current employment[46] and that access to paid leave may be protective against depression[47] and pediatric abusive head trauma.[48] Paid maternity leave also may be protective against intimate partner violence (IPV),[49] which is another ACE exposure. Apart from the trauma of witnessing IPV, children growing up in homes with IPV are at increased risk for experiencing violence themselves and at increased risk for later involvement in crime and violence.[26,27]

Flexible and consistent work schedules provide parents with a predictable pattern of work (e.g., consistent beginning/ending times to the workday; flexibility in the number of hours worked or location) which makes it easier for parents to access quality childcare. Children whose parents work unpredictable schedules have more cognitive deficits (e.g., with memory, learning, and problem-solving) than children whose parents have more predictable schedules.[50-52] Parents who work irregular shift times are also more prone to work-family conflict and stress,[53] which are risk factors for multiple forms of violence.

*The low-income category includes both the poor and the near poor. Poor is defined as income below 100% of the Federal Poverty Threshold (FPT), and near poor is between 100% and 199% of the FPT. Deep poverty is below 50% of the FPT.


21

# Promote Social Norms that Protect Against Violence and Adversity

Norms are group-level beliefs and expectations about how members of the group should behave.[25,27] Changing social norms that accept or allow indifference to violence and adversity is important in the prevention of ACEs.[25-29] There are a number of norms that can protect against violence and adversity, including those that:

- Promote community norms around a shared responsibility for the health and well-being of all children[27]
- Support parents and positive parenting, including norms around safe and effective discipline;[27]
- Foster healthy and positive norms around gender, masculinity, and violence to protect against violence towards intimate partners, children, and peers;[25,26,28]
- Reduce stigma around help-seeking;[29] and
- Enhance connectedness to build resiliency in the face of adversity.[29]

**Public education campaigns** are one way to shift social norms and reframe the way people think and talk about ACEs, and who is responsible for preventing them.[27] They can help shift the narrative away from individual responsibility to one that engages the community and draws upon multiple solutions to promote safe, stable, nurturing relationships and environments for all children.[27] Such a narrative can also normalize protective factors by enhancing connectedness and reducing the stigma around seeking help with parenting or for substance misuse, depression, or suicidal thoughts.[27,29] **Legislative approaches to reduce corporal punishment** can help establish norms around safer, more effective discipline strategies to reduce the harms of harsh physical punishment, particularly if paired with public education campaigns.[27] **Bystander approaches** and efforts to **mobilize men and boys as allies in prevention** can be used to change social norms in ways that support healthy relationship behaviors.[25,28] Such approaches work by fostering healthy norms around gender, masculinity, and violence with the goal of spreading these social norms through peer networks.[25,28] They also work by teaching young people skills to safely intervene when they see behavior that puts others at risk and reinforcing social norms that reduce their own risk for future perpetration.[25,28]

## Evidence

Research suggests that public education campaigns to help parents understand the cycle of abuse and campaigns specifically targeting child physical abuse positively impact parenting practices, reduce children's exposure to parental anger and conflict, reduce child behavior problems, and improve parental self-efficacy and knowledge of actions to prevent child abuse.[54]

Legislative approaches to reducing corporal punishment are associated with decreases in support of and use of harsh physical punishment as a child discipline technique.[55,56] Experiencing harsh physical punishment as a child increases the risk for involvement in crime and violence in adolescence[57] and later perpetration of violence toward a partner and one's own children.[32] Experiencing harsh physical punishment as a child is also associated with mental health problems, lower academic performance, and lower self-esteem.[58,59]

Bystander approaches and efforts to mobilize men and boys as allies in prevention change the social context for violent and abusive behavior.[25,28] Programs such as *Green Dot* and *Coaching Boys into Men*®, for instance, have been shown to reduce violence against dating partners, negative bystander behaviors (such as laughing at sexist jokes or encouraging abusive behaviors), as well as sexual violence perpetration and victimization.[60-62]

# Ensure a Strong Start for Children

A child's relationship with others inside and outside the family plays a role in healthy brain development, as well as in the development of physical, emotional, social, behavioral, and intellectual capacities.[26,27] Parents may struggle to provide the care and nurturing necessary for children to develop these capacities and thrive for a number of reasons, including health, substance misuse, mental health, financial issues, or access to resources or support. **Early childhood home visitation** can prevent ACEs by providing information, caregiver support, and training about child health, development, and care to families in their homes to build a safe, stable, nurturing and supportive home environment.[26-28] **High-quality childcare** and **preschool enrichment programs with family engagement**[26-28] help children build a strong foundation for future learning and opportunity by improving their physical, social, emotional and cognitive development, language and literacy skills, and school readiness. These approaches also help by strengthening connections between home and school environments, and can be especially beneficial to economically disadvantaged children who may not have educational resources at home or the support to help them learn and thrive.[26-28]

## Evidence

Effective home visiting models,[63] such as the *Nurse Family Partnership Program® (NFP)*, have demonstrated many benefits for children and parents. *NFP* is associated with a 48% relative reduction in rates of child abuse and neglect.[64] Children participating in the program have better cognitive and language development, better academic achievement, fewer behavioral problems, lower rates of substance use, and fewer arrests, convictions, and parole violations by age 19.[65-67] For mothers, *NFP* is associated with better pregnancy outcomes, improved parenting practices, reductions in the use of welfare and other government assistance, greater employment, lower rates of substance use, and reduced exposure to intimate partner violence.[64,65,68,69]

Research suggests that access to affordable, high-quality childcare can buffer against a lower quality home environment and reduce child behavior problems, parental stress and depression, and rates of child abuse and neglect.[27] Difficulties finding quality childcare, for instance, have been linked to self-reported child neglect among mothers with substance use problems.[70] Access to affordable, high-quality childcare may also reduce child abuse deaths associated with having to leave children at home in the care of unrelated adults.[71]

Children enrolled in preschool enrichment programs that actively involve and support parents have better math, language, and social skills as they enter school; require less special education services as they grow older; are less likely to be held back a grade in school; are more likely to graduate high-school and attend college; and are more likely to be employed and have higher earnings as adults.[72-75] In addition to these documented benefits, programs such as *Child Parent Centers* are also associated with lower rates of substantiated reports of child abuse and neglect and out-of-home placements; youth depression and substance use; and arrests for violent and nonviolent offenses, convictions, and incarceration well into adulthood.[73-76]

# Teach Skills

Skill-based learning is an important part of a comprehensive approach to prevent ACEs. Decades of research shows that teaching children and youth skills to handle stress, resolve conflicts, and manage their emotions and behaviors can prevent violence victimization and perpetration, as well as substance misuse, sexually transmitted infections, including HIV, and teen pregnancy.[25,26,28,29] Strengthening parenting skills and promoting nurturing and supportive family environments can build a strong foundation for children and protect them from multiple forms of violence, substance misuse, and other negative health outcomes across developmental periods and into adulthood.[25-29]

There are a number of approaches to teach skills. **Social emotional learning approaches** (also referred to as universal school-based programs when delivered to all students in a particular classroom, grade or school) are widely used across the United States to enhance interpersonal skills.[25,26,28,29] This includes skills related to communication, problem-solving, alcohol and drug resistance, conflict management, empathy, coping, and emotional awareness and regulation. **Safe dating and healthy relationship skill programs** address similar skills within the context of dating and intimate partner relationships with the goal of promoting caring, respectful, and non-violent relationships.[25,28] **Parenting skills and family relationship approaches** cover developmentally appropriate expectations for child behavior; teach behavior management, monitoring, and problem-solving skills; safe and effective discipline; healthy relationship behaviors; and work with parents to enhance parent-child communication and ways to support children and youth.[25-29]

## Evidence

Systematic reviews of the evidence for social emotional learning approaches finds that they significantly reduce peer violence across grade levels, school environments, and demographic groups.[77,78] In addition to impacts on aggression and violent behavior,[79-86] programs such as *Life Skills® Training*, the *Good Behavior Game*, and *Promoting Alternative THinking Strategies® (PATHS)* have demonstrated other benefits as well, including reductions in youth alcohol, tobacco, and drug use, depression and anxiety, suicidal thoughts and attempts, delinquency, and involvement in crime.[80,83-85,87] Social emotional learning approaches are also associated with improvements in reading, writing, and math proficiency, paving the way for future academic success.[79,88]

Unhealthy relationships can start early and last a lifetime, especially for teens who display aggression towards peers, engage in early sexual activity, and witness or experience violence in the home.[25,28] Programs such as ***Dating Matters®, Safe Dates*** and the ***Fourth R***, which teach healthy relationship skills to adolescents, have been shown to significantly reduce teen dating violence.[89-91] ***Dating Matters®*** and the ***Safe Dates*** program are also associated with reductions in peer violence and weapon carrying.[92-94]

The evidence is also strong for skill-based parenting and family relationship approaches in reducing known risk factors for child abuse and neglect and protecting children and youth from multiple forms of violence and other health compromising behaviors.[25-29,79] For instance, programs such as ***The Incredible Years®*** and ***Strengthening Families 10-14*** decrease child behavior problems,[79,95] youth substance use (including prescription opioid misuse),[97-99] physical fighting and involvement in crime;[96] reduce parental stress, depression, and family conflict;[96,100] and improve parenting practices related to child discipline, monitoring and supervision.[100]

# Connect Youth to Caring Adults and Activities

Relationships with caring adults who are positive role models can prevent ACEs and improve future outcomes for young people.[26] Caring adults could include teachers, coaches, extended family members, neighbors or community volunteers. Connecting youth to caring adults and activities helps to ground them, improve their engagement in school, and establish positive networks and experiences.[25,26] It is an important preventive strategy to buffer against parental absence or other difficulties at home, frequent moves, and exposure to negative influences at school and in the community. It can also buffer against the impact of ACEs for youth who have already experienced ACEs.

**Mentoring** and **after-school programs** are ways to connect youth to other caring adults and activities.[26] Mentoring programs pair youth with an adult volunteer with the goal of fostering a relationship that will contribute to the young person's growth opportunities, skill development, academic success, and future schooling and employment outcomes.[26,101] Mentoring programs may be delivered in a school or community setting and to youth of all ages, from early childhood through adolescence.[101]

After-school programs are a way to provide opportunities for youth to strengthen their behavioral, leadership, and academic skills and become involved in positive school and community activities.[25,26] Programs range from those offering tutoring and homework assistance to more formal skill-based programming and structured learning activities.[26] These programs also address other key risk and protective factors for high-risk behavior by providing adult supervision during critical periods of the days, such as between 3:00 to 6:00 p.m., when youth crime and violence peaks.[102] Mentoring and after-school programs can reduce the prevalence of crime, violence, and other adolescent risk behavior and pave the way for positive outcomes in adulthood.[25,26]

## Evidence

Research suggests that mentoring programs improve outcomes across behavioral, social, emotional and academic domains.[103,104] ***Big Brothers, Big Sisters*** is the oldest and best known example of a one-on-one mentoring program.[105] Evaluations of the program show that mentored youth are less likely to skip classes, skip school, initiate drug and alcohol use, or engage in physical fighting.[106] Other benefits include improvements in academic performance, parent-child and student-teacher relationships, and parental trust.[106-108]

Opportunities to develop and practice leadership, decision-making, self-management, and social problem-solving skills are important components of after-school programs with documented benefits.[104,109] One example is the ***After School Matters*** program, which offers apprenticeship experiences in technology, science, communication, the arts, and sports to high-school students.[110] Rigorous evaluations of the program show many program benefits, including improved attitudes toward school, fewer course failures, and higher graduation rates.[111,112] Youth in the program are also less likely to sell drugs or participate in gang activity.[112]

Another example is ***Powerful Voices,*** which helps adolescent girls build confidence and develop individual leadership skills as a way to strengthen their future education and employment outcomes and reduce risk for sexual and other forms of violence.[25] Evaluation results show improvements in girls' job skills, motivation to excel at school, connections to their cultural identity and values, and ability to develop healthy relationships with peers and adults.[113]

# Intervene to Lessen Immediate and Long-term Harms

Children and youth with ACE exposures may show signs of behavioral and mental health challenges. They may be irritable, depressed, display acting-out behaviors, have difficulty sleeping or concentrating, and show other traumatic stress symptoms.[25-28] They may be struggling with school, associating with delinquent peers, and already engaging in other health compromising behaviors (e.g., alcohol use, opioid misuse, high-risk sexual behavior).[25-28] Continued exposure to violence and other adversity increases the risk that these patterns will continue in adulthood potentially affecting their own future and their children's future.[25-28] Timely access to assessment, intervention, and effective care, support, and treatment for children and families in which ACEs have already occurred can help mitigate the health and behavioral consequences of ACEs, strengthen children's resilience, and break the cycle of adversity.[25-29]

There are a number of approaches to lessen the immediate and long-term harms of ACE exposures. **Enhanced primary care** may be used to identify and address ACE exposures with brief screening assessments and referral to intervention services and supports.[27-29] For children, assessments may be used with parents or caregivers to identify risks in the family environment such as parental alcohol or drug use, depression, stress, the use of harsh punishment, as well as intimate partner violence.[27] For adults, assessments may be used to identify a history of ACE exposures to assist with risk mitigation and improve treatment outcomes.[28,29] Follow-up intervention services are tailored to assessment findings and coordinated with local community agencies.

For children and adult survivors of violence, **victim-centered services** can be both lifesaving and helpful in reducing the harms of violence.[25,28] Such services include crisis intervention, hotlines, medical and legal advocacy, housing support, social support, and access to community resources.[25,28] For children of survivors, such services also include meeting their needs around recreation, school supports, and material goods.[28]

**Treatment to lessen the harms of ACEs** may be used to address depression, fear and anxiety, post-traumatic stress disorder (PTSD), problems adjusting to school, work, or daily life, and other symptoms of distress.[25-29] These symptoms can be successfully reduced with therapeutic treatments that are trauma-informed (i.e., delivered in a way that is influenced by knowledge and understanding of how trauma affects a survivor's life and experiences long-term[28]) and tailored to the specific circumstances and needs of children, youth, and families.[2,25-28] **Treatment to prevent problem behavior and future involvement in violence** is another approach to mitigate consequences.[25-28] This includes therapeutic interventions and other supports to address the social, emotional, and behavioral risks associated with ACE exposures.[25-28] Evidence-based treatments are provided by trained clinicians in the home or clinic setting and typically include multiple components (e.g., individual and family counseling, parent training, and school consultation).[25-28] Referrals may come from social services, the juvenile justice system, schools, or other community organizations working with children, youth, and families.[25-28]

Finally, **family-centered treatment approaches for substance use disorders** may be used to simultaneously address substance misuse by parents and the needs of their children with this ACE exposure.[114] Parents with alcohol or drug use problems may have difficulty regulating stress, processing emotions, and fulfilling the many childrearing tasks that are essential for children's healthy social and emotional development.[114] These approaches utilize integrated program models that combine evidence-based treatments for substance use disorders (e.g., medication-assisted treatment for opioid use disorder[115]) with a range of preventive services (e.g., mental health services, parenting education and training, medical and nutrition services, education and employment assistance, childcare, children's services, and aftercare). Programs may be delivered in residential or outpatient settings.

# Evidence

Primary care settings offer a unique opportunity to identify and address ACE exposures. Randomized trials of the *Safe Environment for Every Kid (SEEK)* model (which screens for ACE exposures in the family environment), have demonstrated a number of positive effects including fewer reports to child protective services, fewer reported occurrences of harsh physical punishment by parents, better adherence to medical care, and more timely childhood immunizations.[116] *SEEK* is also associated with less maternal psychological aggression,[117] fewer minor maternal physical assaults,[117] and improvements among providers in addressing depression, substance misuse, intimate partner violence, and serious parental stress.[118]

Women receiving victim-centered services report less abuse from former intimate partners, less depression, decreased feelings of distress, and overall improvements in self-esteem, safety and well-being[119-121] —outcomes that help to ensure safe, stable, nurturing relationships and environments for their children. Many victims of partner violence have a history of ACEs. Victim-centered services in this regard also help women cope with their own history of ACEs and access support.

Effective treatments such as *Trauma-focused Cognitive Behavioral Therapy® (TF-CBT)* have demonstrated many benefits for children, youth, and families with ACE exposures.[25-28] *TF-CBT* effectively reduces symptoms of PTSD, depression, fear, anxiety, shame, and behavioral problems.[122-126] It also reduces parental emotional distress and depressive symptoms and is associated with improvements in parenting behaviors.[125,126] For children who may face treatment barriers, such as stigma and access to services, *Cognitive Behavioral Intervention for Trauma in Schools (CBITS)* is another treatment option that is associated with improvements in symptoms of PTSD, depression, and parent-reported behavioral problems.[127,128]

Children with a history of ACE exposures are at increased risk of becoming involved in crime and violence, using alcohol or drugs, and engaging in other health-compromising behaviors.[25-28] Effective treatments such as *Multisystemic Therapy® (MST)* have demonstrated both short- and long-term benefits in reducing these risks and strengthening protective factors.[129] *MST*, for example, effectively reduces rates of arrests for violent felonies and other crime,[129-132] problematic sexual behavior,[133-135] and out-of-home placements.[136,137] *MST* has also demonstrated beneficial impacts on family functioning, parenting practices, youth substance use, peer relations, academic performance, mental health, involvement in gangs, and sibling criminal behavior.[129,130]

Available evidence suggests that integrated programs that combine evidence-based treatments for substance use disorders (e.g., medication-assisted treatment for opioid use disorder) with a range of preventive services benefit both children and parents and that pairing effective parenting interventions with substance use treatment has benefits that go beyond substance use treatment alone.[138,139] Integrated programs are associated with improvements in child development and emotional and behavioral functioning.[139] They are also associated with positive impacts on maternal mental health, birth outcomes, parent-child attachment, and positive parenting behaviors.[138,140-142]

# Sector Involvement

Public health can play an important and unique role in preventing ACEs. Public health agencies, which typically place prevention at the forefront of efforts and work to create broad population-level impact, can bring critical leadership and resources to bear on this problem. For example, these agencies can serve as a convener, bringing together partners and stakeholders to plan, prioritize, and coordinate prevention efforts.[25-29] Public health agencies are also well positioned to collect and disseminate data, implement preventive measures, evaluate programs, and track progress.[25-29] Although public health can be a lead in preventing ACEs, the strategies and approaches outlined here cannot be accomplished by the public health sector alone.

Other sectors vital to preventing ACEs and mitigating the immediate and long-term harms of ACEs include, but are not limited to, education, government (local, state, and federal), social services, health services, business and labor, public safety, justice, housing, media, and organizations that comprise civil society such as faith-based organizations, youth-serving organizations, domestic violence and sexual assault coalitions, foundations and other non-governmental organizations.[25-29] Collectively, these sectors can make a difference in preventing ACEs by impacting the various contexts and underlying risks that contribute to violence and adversity and by supporting safe, stable, nurturing relationships and environments for all children.

# Monitoring and Evaluation

Monitoring and evaluation are necessary components of the public health approach to prevention. Timely and reliable data are essential for monitoring the extent of the problem, determining how best to utilize resources, and evaluating the impact of prevention efforts. Data are also necessary for program planning and implementation.

Surveillance data can help researchers and practitioners track changes in the burden and consequences of ACEs. There are a number of surveillance systems that collect information related to ACE exposures and consequences at the federal, state, and local levels. For example, the Behavioral Risk Factor Surveillance System (BRFSS) is an example of a surveillance system that provides state data on previous exposure to ACEs among adults aged 18 and older reporting on their childhood. The system also gathers information on a range of health conditions to assess the impact of ACE exposures on health. The Youth Risk Behavior Surveillance System (YRBSS) collects information on multiple forms of violence among high-school students in the United States, including information about lifetime and past year sexual violence victimization, past year physical and sexual teen dating violence victimization, youth violence (including bullying), and suicidal behavior. It also collects lifetime and current use of alcohol and other substances. YRBS data are available at the local, state, and national levels.

Other sources of data include the National Survey of Children's Exposure to Violence (NatSCEV), the National Intimate Partner and Sexual Violence Survey (NISVS), the National Survey of Children's Health (NSCH), and the National Crime Victimization Survey (NCVS). NatSCEV provides self-reported data on violence against children through a nationally representative random-digit dial survey of children (aged 0-9) and youth (aged 10-18). Youth report on their own past year and lifetime victimization experiences across five general areas (i.e., conventional crime, child abuse and neglect, peer and sibling victimization, sexual victimization, and witnessing violence). Caregivers report on these victimizations for children. NISVS collects lifetime and past year information on intimate partner violence, sexual violence, and stalking victimization at both the state and national level, including data on characteristics of the victimization, demographic information on victims and perpetrators, impacts of the violence, age at first experiences of these types of violence, and health conditions associated with the violence. The NSCH is a nationally representative survey that gathers information on the physical and emotional health of children aged 0-17 and the child's family, neighborhood, school, and social context. The survey includes several ACE exposures as well as information on family, school, and neighborhood protective factors. The NCVS gathers information from a nationally representative sample of households on the frequency, characteristics, and consequences of criminal victimization among persons aged 12 and older in the United States.

National, state, and local data are available from other sources as well. The National Child Abuse and Neglect Data System (NCANDS) provides official reports of child abuse and neglect made to Child Protective Services. The National Violent Death Reporting System (NVDRS) is a state-based surveillance system that combines data from death certificates, law enforcement reports, and coroner or medical examiner reports to provide detailed information on the circumstances of violent deaths such as homicide and suicide, including intimate partner violence, mental health problems and treatment, and recent life stressors. Information about violent offenses, victimization, and involvement with the justice system are also available from the Department of Justice's Bureau of Justice Statistics, the Federal Bureau of Investigation's Uniform Crime Reports, and the Office of Juvenile Justice and Delinquency Statistical Briefing Book.

No matter the data source, it is important that routine and ongoing monitoring align with the work of multiple federal, state-level, and local partners and agencies to achieve a more comprehensive understanding of ACE exposures, their consequences, and effective prevention efforts in this area. It is also important to track progress of prevention efforts and to evaluate the impact of those efforts. Evaluation data, produced through program implementation and evaluation, is essential in providing information on what does or does not work to prevent ACEs and associated risk and protective factors.

# Conclusion

ACEs are a serious public health problem with far-reaching consequences across the lifespan. They are also preventable. The strategies outlined here, drawn from the *CDC Technical Packages to Prevent Violence,* are intended to change norms, environments, and behaviors in ways that can prevent ACEs from happening in the first place as well as to lessen the immediate and long-term harms of ACEs. To maximize impact, these strategies and approaches are intended to be used in combination as part of a comprehensive effort to help ensure that all children have safe, stable, nurturing relationships and environments in which to thrive and achieve lifelong health and success. The hope is that multiple sectors, such as public health, health care, education, public safety, justice, social services, and business will use this information as a guide and join CDC in efforts to prevent ACEs.

# Learn More

**CDC's Technical Packages to Prevent Violence**
https://www.cdc.gov/violenceprevention/communicationresources/pub/technical-packages.html

**CDC's *Violence Prevention in Practice*** is a resource to help state and local health agencies and other stakeholders with their violence prevention efforts
https://vetoviolence.cdc.gov/apps/violence-prevention-practice/#!/

# References


1. Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine, 14*, 245-258.
2. What is child trauma? National Child Traumatic Stress Network. (2019). Retrieved from https://www.nctsn.org/what-is-child-trauma/about-child-trauma
3. Merrick, M. T., Ford, D. C., Ports, K. A., & Guinn, A. S. (2018). Prevalence of adverse childhood experiences from the 2011-2014 Behavioral Risk Factor Surveillance System in 23 States. *JAMA Pediatrics, 172*(11), 1038-1044.
4. Shonkoff, J. P., & Phillips, D. A. (eds). (2000). *From neurons to neighborhoods: The science of early childhood development.* National Research Council and Institute of Medicine. Washington DC: National Academy Press.
5. Shonkoff, J. P., Garner, A. S., & Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care and Section on Developmental and Behavioral Pediatrics. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, *129(1),* e232-e246.
6. Dube, S. R., Anda, R. F., Felitti, V. J., Edwards, V. J,. & Croft, J. B. (2002). Adverse Childhood Experiences and personal alcohol abuse as an adult. *Addictive Behaviors, 27*(5), 713-725.
7. Dube, S.R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). Childhood abuse, neglect and household dysfunction and the risk of illicit drug use: The Adverse Childhood Experience Study. *Pediatrics, 111*(3), 564-572.
8. Anda, R. F., Whitfield, C. L., Felitti, V. J., Chapman, D., Edwards, V. J., Dube, S. R., & Williamson, D. F. (2002) Adverse childhood experiences, alcoholic parents, and later risk of alcoholism and depression. *Psychiatric Services, 53*(8), 1001-1009.
9. Hillis, S. D., Anda, R. F., Felitti, V. J., & Marchbanks, P. A. (2001). Adverse childhood experiences and sexual risk behaviors in women: a retrospective cohort study. *Family Planning Perspectives, 33*, 206-211.
10. Leeb, R. T., Lewis, T., & Zolotor, A. J. (2011). A review of the physical and mental health consequences of child abuse and neglect and implications for practice. *American Journal of Lifestyle Medicine, 5*(5), 454-468.
11. Hillis, S. D., Anda, R. F., Felitti, V. J., Nordenberg, D., & Marchbanks, P. A. (2000). Adverse childhood experiences and sexually transmitted diseases in men and women: a retrospective study. *Pediatrics, 106*(1), E11.
12. Chapman, D. P., Anda, R. F., Felitti, V. J., Dube, S. R., Edwards, V. J., Whitfield, C. L. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders, 82*, 217-225.
13. Hillis, S. D., Anda, R. F., Dube, S. R., Felitti, V. J., Marchbanks, P. A., & Marks, J. S. (2004). The association between adverse childhood experiences and adolescent pregnancy, long-term psychosocial outcomes, and fetal death. *Pediatrics, 113(*2), 320-327.
14. Edwards, V. J., Anda, R. F., Dube, S. R., Dong, M., Chapman, D. F., & Felitti, V. J. (2005). The wide-ranging health consequences of adverse childhood experiences. In Kathleen Kendall-Tackett and Sarah Giacomoni (eds.) *Victimization of Children and Youth: Patterns of Abuse, Response Strategies*, Kingston, NJ: Civic Research Institute.
15. Gilbert, L. K., Breiding, M. J., Merrick, M. T, Parks, S. E, Thompson, W. W., Dhingra, S. S., & Ford, D. C. (2015). Childhood adversity and adult chronic disease: an update from ten states and the District of Columbia, 2010. *American Journal of Preventive Medicine, 48*(3), 345-349.
16. Dube, S. R., Anda, R, F., Felitti, V. J., Chapman, D., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction and the risk of attempted suicide throughout the life span: findings from Adverse Childhood Experiences Study. *Journal of the American Medical Association, 286,* 3089-3096.

17. Metzler, M., Merrick, M. T., Klevens, J., Ports, K. A., & Ford, D. C. (2017). Adverse childhood experiences and life opportunities: shifting the narrative. *Children and Youth Services Review, 72,* 141-149.

18. Peterson, C., Florence, C., & Klevens, J. (2018). The economic burden of child maltreatment in the United States, 2015. *Child Abuse and Neglect, 86*, 178-183.

19. Peterson, C., DeGue, S., Florence, C., & Lokey, C. (2017). Lifetime economic burden of rape in the United States. *American Journal of Preventive Medicine, 52*(6), 691-701.

20. Peterson, C., Kearns, M. C., McIntosh, W. L., Estefan, L. F., Nicolaidis, C., McCollester, K. E., Gordon, A., & Florence, C. (2018). Lifetime economic burden of intimate partner violence among U.S. adults. *American Journal of Preventive Medicine, 55*(4), 433-444.

21. Centers for Disease Control and Prevention. (2019). Cost of Injury. Web-based Injury Statistics Query and Reporting System (WISQARS). Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Retrieved from http://www.cdc.gov/injury/wisqars/

22. National Scientific Council on the Developing Child. (2010). *Persistent fear and anxiety can affect young children's learning and development*. Working Paper No. 9. Retrieved from https://developingchild.harvard.edu/wp-content/uploads/2010/05/Persistent-Fear-and-Anxiety-Can-Affect-Young-Childrens-Learning-and-Development.pdf

23. Duke, N. N., Pettingell, S. L., McMorris, B. J., & Borowsky, I. W. (2010). Adolescent violence perpetration: associations with multiple types of adverse childhood experiences. *Pediatrics, 125*(4), e778-86.

24. Fox, B. H., Pereza, N., Cass, E., Bagliviob, M. T., & Epp, N. (2015). Trauma changes everything: examining the relationship between adverse childhood experiences and serious, violent and chronic juvenile offenders. *Child Abuse & Neglect, 46,* 163-173.

25. Basile, K.C., DeGue, S., Jones, K., Freire, K., Dills, J., Smith, S.G., & Raiford, J.L. (2016). *STOP SV: A technical package to prevent sexual violence*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

26. David-Ferdon, C., Vivolo-Kantor, A. M., Dahlberg, L. L., Marshall, K. J., Rainford, N. & Hall, J. E. (2016). *A comprehensive technical package for the prevention of youth violence and associated risk behaviors.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

27. Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). *Preventing child abuse and neglect: a technical package for policy, norm, and programmatic activities.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

28. Niolon, P. H., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T., & Gilbert, L. (2017). *Preventing intimate partner violence across the lifespan: a technical package of programs, policies, and practices.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

29. Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., & Wilkins, N. (2017). *Preventing suicide: a technical package of policies, programs, and practices*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

30. Frieden, T. R. (2014). Six components necessary for effective public health program implementation. *American Journal of Public Health, 104,* 1, 17-22.

31. Stith, S. M., Liu, T., Davies, L. C., Boykin, E. L., Alder, M. C., Harris, J. M., Som, A., McPherson, M., & Dees, J. E. M. E. G. (2009). Risk factors in child maltreatment: a meta-analytic review of the literature. *Aggression and Violent Behavior, 14,* 13-29.

32. Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of risk factors for intimate partner violence. *Partner Abuse*, *3*(2), 231-80.

33. Child Trends Databank. (2019). *Children in poverty*. Retrieved from https://www.childtrends.org/?indicators=children-in-poverty

34. Cooper, K., & Stewart, K. (2013). *Does money affect children's outcomes? A systematic review.* York, UK: Joseph Rowntree Foundation. Retrieved from http://www.jrf.org.uk/publications/does-money-affect-childrens-outcomes

35. Levitie, J., & Koulish, J. (2008). *State earned income tax credits: 2008 legislative update*. Center on Budget and Policy Priorities. Retrieved from http://www.cbpp.org/cms/?fa=view&id=462

36. Waldfogel, J. (2004). Welfare reform and the child welfare system. *Children and Youth Services Review, 26*, 919-929.

37. Arno, P. S., Sohler, N., Viola, D., & Schechter, C. (2009). Bringing health and social policy together: the case of the Earned Income Tax Credit. *Journal of Public Health Policy, 30*, 198-207.

38. Dahl, G., & Lochner, L. (2012). The impact of family income on child achievement: evidence from the Earned Income Tax Credit. *American Economic Review, 102*(5), 1927-1956.

39. Marr, C., Charite, J., & Huang, C. C. (2013). *Earned Income Tax Credit promotes work, encourages children's success at school, research finds*. Center on Budget and Policy Priorities. Retrieved from www.cbpp.org/files/6-26-12tax.pdf

40. Evans, W. N., & Garthwaite, C. L. (2010). *Giving mom a break: The impact of higher EITC payments on maternal health*. NBER Working Paper No. 16296. Retrieved from https://www.nber.org/papers/w16296

41. Milligan, K., & Stabile, M. (2011). Do child tax benefits affect the well-being of children? Evidence from Canadian child benefit expansions. *American Economic Journal: Economic Policy, 3*, 175-205.

42. Michalopoulos, C., Lundquist, E., & Castells, N. (2010). *The effects of child care subsidies for moderate-income families in Cook County, Illinois*. New York, New York: MDRC.

43. Morrissey, T. W., & Warner, M. E. (2007). Why early care and education deserves as much attention, or more, than prekindergarten alone. *Applied Development Science, 11*(2), 47-70.

44. Gordon, R. A., Usdansky, M. L., Wang, X., & Guzman, A. (2011). Child care and mothers' mental health: is high-quality care associated with fewer depressive symptoms? *Family Relations, 60*, 446-460.

45. Wickham, M. E., Senthilselvan, A., Wild, T. C., Hoglund, W. L., & Colman, I. (2015). Maternal depressive symptoms during childhood and risky adolescent health behaviors. *Pediatrics, 135*(1), 59-67.

46. Waldfogel, J. (1997). Working mothers then and now: a cross-cohort analysis of the effects of maternity leave on women's pay. Paper presented at the Annual Meeting of the Population Association of America, New Orleans, LA.

47. Chatterji, P., & Markowitz, S. (2005). Does the length of maternity leave affect maternal health? *Southern Economic Journal, 72*(1), 16-41.

48. Klevens, J., Luo, F., Xu, L., Peterson, C., & Latzman, N. (2016). Paid family leave's effect on hospital admissions for pediatric abusive head trauma. *Injury Prevention, 22*, 442-445.

49. Gartland, D., Hemphill, S. A., Hegarty, K., & Brown, S. J. (2011). Intimate partner violence during pregnancy and the first year postpartum in an Australian pregnancy cohort study. *Maternal and Child Health Journal, 15*(5), 570-578.

50. Morsy, L., & Rothstein, R. (2015). *Parents' non-standard work schedules make adequate childrearing difficult: Reforming labor market practices can improve children's cognitive and behavioral outcomes*. Economic Policy Institute, Issue Brief #400. Retrieved from https://www.epi.org/files/pdf/88777.pdf

51. Han, W. (2005). Maternal nonstandard work schedules and child cognitive outcomes. *Child Development, 76*(1), 137-154.

52. Joshi, P., & Bogen, K. (2007). Nonstandard schedules and young children's behavioral outcomes among working low-income families. *Journal of Marriage and Family, 69*, 139-156.

53. Golden, L. (2015). *Irregular work scheduling and its consequences*. Economic Policy Institute Briefing Paper #394. Retrieved from https://www.epi.org/files/pdf/82524.pdf

54. Poole, M. K., Seale, D. W., & Taylor, C. A. (2014). A systematic review of universal campaigns targeting child physical abuse. *Health Education Research, 29*(3), 388-432.

55. Bussman, K., Erthal, C., & Schroth, A. (2011). Effects of banning corporal punishment in Europe – A five nation comparison. In J. E. Durrant & A. B. Smith (Eds), *Global pathways to abolishing physical punishment* (pp. 299-322). New York: Routledge.

56. Zolotor, A. J., & Puzia, M. E. (2010). Bans against corporal punishment: a systematic review of the laws, changes in attitudes and behaviours. *Child Abuse Review, 19*, 229-247.

57. Dahlberg, L. L., & Simon, T. R. (2006). Predicting and preventing youth violence: developmental pathways and risk. In J. R. Lutzker (Ed.), *Preventing violence: research and evidence-based intervention strategies* (pp. 97-124). Washington, DC: American Psychological Association.

58. Durrant, J., & Ensom, R. (2012). Physical punishment of children: lessons from 20 years of research. *Canadian Medical Association Journal,* 184(12), 1373-1377.

59. Font, S. A., & Caige, J. (2018). Dimensions of physical punishment and their associations with children's cognitive performance and school adjustment. *Child Abuse & Neglect, 75,* 29-40.

60. Coker, A. L., Fisher, B. S., Bush, H. M., Swan, S. C., Williams, C. M., Clear, E. R., & DeGue, S. (2015). Evaluation of the Green Dot bystander intervention to reduce interpersonal violence among college students across three campuses. *Violence Against Women, 21*(12), 1507-1527.

61. Coker, A. L., Bush, H. M., Cook-Craig, P. G., DeGue, S. A., Clear, E. R., Brancato, C. J., Fisher, B. S., & Recktenwald, E. A. (2017). RCT testing bystander effectiveness to reduce violence. *American Journal of Preventive Medicine 52*(5), 566-578.

62. Miller, E., Tancredi, D. J., McCauley, H. L., Decker, M. R., Virata, M. C. D., Anderson, H. A., O'Conner, B., & Silverman, J. G. (2013). One-year follow-up of a coach-delivered dating violence prevention program: a cluster randomized controlled trial. *American Journal of Preventive Medicine, 45*(1), 108-112.

63. Sama-Miller, E., Akers, L., Mraz-Esposito, A., Zukiewicz, M., Avellar, S., Paulsell, D., & DeGrosso, P. (2017). *Home visiting evidence of effectiveness review: Executive summary*. Washington, DC: Administration for Children and Families, U.S. Department of Health and Human Services Retrieved from https://homvee.acf.hhs.gov/homvee_executive_summary_august_2017_final_508_compliant.pdf

64. Olds, D. L., Eckenrode, J., Henderson, C. R., Kitzman, H., Powers, J., Cole, R., Sidora, K., Morris, P., Pettitt, L. M., & Luckey, D. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: fifteen-year follow-up of a randomized trial. *Journal of the American Medical Association, 278*(8), 637-643.

65. Olds, D. L., Henderson, C. R., & Kitzman, H. (1994). Does prenatal and infancy nurse home visitation have enduring effects on qualities of parental caregiving and child health at 25 to 50 months of life? *Pediatrics, 93*(1), 89-98.

66. Olds, D. L., Henderson, C. R., Cole, R., Eckenrode, J., Kitzman, H., Luckey, D., Pettitt, L., Sidora, K., Morris, P., & Powers, J. (1998). Long-term effects of Nurse Home Visitation on children's criminal and antisocial behavior: 15-year follow-up of a randomized controlled trial. *Journal of the American Medical Association, 280*(14), 1238-1244.

67. Eckenrode, J., Campa, M., Luckey, D. W., Henderson Jr., C. R., Cole, R., Kitzman, H., Anson, E., Sidora-Arcoleo, K., Powers, J., & Olds, D. L. (2010). Long-term effects of prenatal and infancy nurse home visitation on the life course of youths: 19-year follow-up of a randomized trial. *Archives of Pediatric and Adolescent Medicine, 164*(1), 9-15.

68. Olds, D. L., Kitzman, H., Hanks, C., Cole, R., Anson, E., Sidora-Arcoleo, K., Luckey, D. W., Henderson C. R. Jr., Holmberg, J., Tutt, R. A., Stevenson, A. J., & Bondy, J. (2007). Effects of nurse home visiting on maternal and child functioning: age-9 follow-up of a randomized trial. *Pediatrics, 120*(4), e832-e845.

69. Olds, D. L., Robinson, J., Pettitt, L., Luckey, D. W., Holmberg, J., Ng, R. K., Isaacs, K., Sheff, L., & Henderson, C. R. Jr. (2004). Effects of home visits by paraprofessionals and by nurses: age 4 follow-up results of a randomized trial. *Pediatrics, 114*(16), 1560-1568.

70. Cash, S. J., & Wilke, D. J. (2003). An ecological model of maternal substance abuse and child neglect: issues, analyses, and recommendations. *American Journal of Orthopsychiatry, 73*, 392-404.

71. Schnitzer, P. G., & Ewigman, B. G. (2005). Child deaths resulting from inflicted injuries: household risk factors and perpetrator characteristics. *Pediatrics, 116*(5), e687-e693.

72. Love, J. M., Kisker, E. E., Ross, C., Constantine, J., Boller, K., Brooks-Gunn, J., Chazan-Cohen, R., Tarullo, L. B., Brady-Smith, C., Fuligni, A. S., Schochet, P. Z., Paulsell, D., & Vogel, C. (2005). The effectiveness of Early Head Start for 3-year-old children and their parents: lessons for policy and programs. *Developmental Psychology, 41*, 885-901.

73. Reynolds, A. J., Temple, J. A., Robertson, D. L., & Mann, E. A. (2001). Long-term effects of an early childhood intervention on educational achievement and juvenile arrest: a 15-year follow-up of low-income children in public schools. *Journal of the American Medical Association, 285*(18), 2339-2346.

74. Reynolds, A. J., Temple, J. A., Ou, S. R., Robertson, D. L., Mersky, J. P., Topitzes, J. W., & Niles, M. D. (2007). Effects of a school-based, early childhood intervention on adult health and well-being: a 19-year follow-up of low-income families. *Archives of Pediatrics and Adolescent Medicine, 161*(8), 730-739.

75. Reynolds, A. J., Temple, J. A., White. B. A. B., Ou, S., & Robertson, D. L. (2011). Age-26 cost-benefit analysis of the Child-Parent Early Education Program. *Child Development, 82*(1), 379-404.

76. Reynolds, A. J., & Robertson, D. L. (2003). School-based early intervention and later child maltreatment in the Chicago Longitudinal Study. *Child Development, 74*(1), 3-26.

77. Hahn, R., Fuqua-Whitley, D., Wethington, H., Lowy, J., Crosby, A., Fullilove, M., …& Task Force on Community Preventive Services. (2007). Effectiveness of universal school-based programs to prevent violent and aggressive behavior: a systematic review. *American Journal of Preventive Medicine, 33*(2), S114-S129.

78. Matjasko, J. L., Vivolo-Kantor, A. M., Massetti, G. M., Holland, K. M., Holt, M. K., & Cruz, J. D. (2012). A systematic meta-review of evaluations of youth violence prevention programs: common and divergent findings from 25 years of meta-analyses and systematic reviews. *Aggression and Violent Behavior, 17*(6), 540-552.

79. Center for the Study and Prevention of Violence. (2019). Blueprints for violence prevention. Boulder, CO: University of Colorado Boulder, Institute of Behavioral Science, Center for the Study and Prevention of Violence. Retrieved from http:// www.colorado.edu/cspv/blueprints/

80. Botvin, G. J., Griffin, K. W., & Nichols, T. D. (2006). Preventing youth violence and delinquency through a universal school-based prevention approach. *Prevention Science*, *7*(4), 403-408.

81. Dolan, L. J., Kellam, S. G., Brown, C. H., Werthamer-Larsson, L., Rebok, G. W., Mayer, L. S., …& Wheeler, L. T. (1993). The short term impact of two classroom-based preventive interventions on aggressive and shy behaviors and poor achievement. *Journal of Applied Developmental Psychology, 14*(3), 317-345.

82. Kellam, S. G., Rebok, G. W., Ialongo, N., & Mayer, L. S. (1994). The course and malleability of aggressive behavior from early first grade into middle school: results of a developmental epidemiologically-based preventive trial. *Journal of Child Psychology and Psychiatry 35*(2), 259-282.

83. Kellam, S. G., Brown, C. H., Poduska, J. M., Ialongo, N. S., Wang, W., Toyinbo, P., …& Wilcox, H. C. (2008). Effects of a universal classroom behavior management program in first and second grades on young adult behavioral, psychiatric, and social outcomes. *Drug and Alcohol Dependence, 95*(1), S5-S28.

84. Petras, H., Kellam, S. G., Brown, C. H., Muthen, B. O., Ialongo, N. S., & Poduska, J. M. (2008). Developmental epidemiological courses leading to antisocial personality disorder and violent criminal behavior: effects by young adulthood of a universal preventive intervention in first- and second-grade classrooms. *Drug and Alcohol Dependence, 95*(Suppl 1), 45-59.

85. Greenberg, M. T., & Kusché, C. A. (2006). Building social and emotional competence: The PATHS curriculum. In S. R. Jimerson & M. Furlong (Eds.), *Handbook of school violence and school safety: From research to practice* (pp. 395-412). Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

86. Crean, H. F., & Johnson, D. B. (2013). Promoting Alternative THinking Strategies (PATHS) and elementary school aged children's aggression: results from a cluster randomized trial. *American Journal of Community Psychology, 52*(1-2), 56-72.

87. Wilcox, H. C., Kellam, S. G., Brown, C. H., Poduska, J. M., Ialongo, N. S., Wang, W., & Anthony, J. C. (2008). The impact of two universal randomized first- and second-grade classroom interventions on young adult suicide ideation and attempts. *Drug and Alcohol Dependence, 95*(Suppl. 1), S60-S73.

88. Schonfeld, D. J., Adams, R. E., Fredstrom, B. K., Weissberg, R. P., Gilman, R., Voyce, C., … & Speese-Linehan, D. (2015). Cluster-randomized trial demonstrating impact on academic achievement of elementary social-emotional learning. *School Psychology Quarterly, 30*(3), 406-420.

89. Niolon, P. H., Vivolo-Kantor, A. M., Tracy, A. J., Latzman, N. E., Little, T. D., DeGue, S., … & Tharp, A., T. (2019) An RCT of Dating Matters®: effects on teen dating violence and relationship behaviors. *American Journal of Preventive Medicine, 57*(1):13-23.

90. Foshee, V. A., Bauman, K. E., Ennett, S. T., Linder, G. F., Benefield, T., & Suchindran, C. (2004). Assessing the long-term effects of the Safe Dates program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. *American Journal of Public Health, 94*(4), 619-624.

91. Wolfe, D. A., Crooks, C., Jaffe, P., Chiodo, D., Hughes, R., Ellis, W., Stitt, L., & Donner, A. (2009). A school-based program to prevent adolescent dating violence: a cluster randomized trial. *Archives of Pediatrics & Adolescent Medicine*, *163*(8), 692-699.

92. Vivolo-Kantor, A. M., Niolon, P. H., Tracy, A., Latzman, N.E., Little, T.D., DeGue, S., … & Tharp, A., T. (2019). Middle school effects of the Dating Matters® comprehensive approach on peer violence, bullying, and cyber-bullying: a cluster-randomized controlled trial. *Prevention Science* (under peer-review).

93. Estefan, L. F., Vivolo-Kantor, A. M., Niolon, P. H., Tracy, A. J., Latzman, N., Little, T. D., … & Tharp, A., T. (2019). Effects of the Dating Matters® comprehensive prevention model on delinquent behaviors in middle school youth: a cluster-randomized controlled trial. *Prevention Science* (under peer-review).

94. Foshee, V. A., Reyes, L. M., Agnew-Brune, C. B., Simon, T. R., Vagi, K. J., Lee, R. D., & Suchindran, C. (2014). The effects of the evidence-based Safe Dates dating abuse prevention program on other youth violence outcomes. *Prevention Science, 15*(6), 907-916.

95. Menting, A. T., de Castro, B. O., & Matthys, W. (2013). Effectiveness of the Incredible Years® parent training to modify disruptive and prosocial child behavior: a meta-analytic review. *Clinical Psychology Review, 33*(8), 901-913.

96. Spoth, R. L., Redmond, C., & Shin, C. (2000). Reducing adolescents' aggressive and hostile behaviors: randomized trial effects of a brief family intervention 4 years past baseline. *Archives of Pediatrics & Adolescent Medicine, 154*(12), 1248-1257.

97. Spoth, R., Redmond, C., & Lepper, H. (1999). Alcohol initiation outcomes of universal family focused preventive interventions: one-and two-year follow-ups of a controlled study. *Journal of Studies on Alcohol, 13,* 103-110.

98. Spoth, R. L., Redmond, C., & Shin, C. (2001). Randomized trial of brief family interventions for general populations: adolescent substance use outcomes 4 years following baseline. *Journal of Consulting & Clinical Psychology, 69*(4), 627-642.

99. Spoth, R., Trudeau, L., Shin, C., Ralston, E., Redmond, C., Greenberg, M., & Feinberg, M. (2013). Longitudinal effects of universal preventive intervention on prescription drug misuse: three randomized controlled trials with late adolescents and young adults. *American Journal of Public Health, 103*(4), 665-672.

100. Webster-Stratton, C. (2016). The Incredible Years® series: a developmental approach. In M. J. Van Ryzin, K. L. Kumpfer, G. M. Fosco, & M. T. Greenberg (Eds.), *Family-based prevention programs for children and adolescents: Theory, research, and large-scale dissemination* (pp. 42-67). New York, NY: Psychology Press.

101. DuBois, D. L., & Karcher, M. J. (Eds.). (2014). *Handbook of youth mentoring*. Second edition. Thousand Oaks, CA: Sage Publications.

102. Sickmund, M., & Puzzanchera, C. (Eds.). (2014). *Juvenile offenders and victims: 2014 national report*. Pittsburgh, PA: National Center for Juvenile Justice. Retrieved from http://www.ojjdp.gov/ojstatbb/nr2014/

103. Tolan, P. H., Henry, D. B., Schoeny, M. S., Lovegrove, P., & Nichols, E. (2014). Mentoring programs to affect delinquency and associated outcomes of youth at risk: a comprehensive meta-analytic review. *Journal of Experimental Criminology, 10*(2), 179-206.

104. Durlak, J. A., Weissberg, R. P., & Pachan, M. (2010). A meta-analysis of after-school programs that seek to promote personal and social skills in children and adolescents. *American Journal of Community Psychology, 45*(3-4), 294–309.

105. Big Brothers Big Sisters of America. (2016). *110 years of history*. Tampa, FL: Big Brothers Big Sisters of America. Retrieved from http://www.bbbs.org/site/c.9iILI3NGKhK6F/b.5960955/k.E56C/Starting_something_since_1904.htm

106. Grossman, J. B., & Tierney, J. P. (1998). Does mentoring work? An impact study of the Big Brothers Big Sisters program. *Evaluation Review*, *22*(3), 403-426.

107. Herrera, C., Grossman, J. B., Kauh, T. J., & McMaken, J. (2011). Mentoring in schools: an impact study of Big Brothers Big Sisters school-based mentoring. *Child Development*, *82*(1), 346-361.

108. Chan C. S., Rhodes, J. E., Howard W. J., Lowe, S. R., Schwartz, S. E. O., & Herrera C. (2013). Pathways of influence in school-based mentoring: the mediating role of parent and teacher relationships. *Journal of School Psychology, 51*(1), 129-142.

109. Gottfredson, D. C., Cross, A., & Soulé, D. A. (2007). Distinguishing characteristics of effective and ineffective afterschool programs to prevent delinquency and victimization. *Criminology & Public Policy, 6*(2), 601-631.

110. After School Matters. (2016). Program information and requirements. Chicago, IL: After School Matters. Retrieved from http://www.afterschoolmatters.org/teens/programs/

111. Goerge, R. M., Cusick, G. R., Wasserman, M., & Gladden, R. M. (2007). After-school programs and academic impact: a study of Chicago's After School Matters. Chicago, IL: Chapin Hall, University of Chicago. Retrieved from http://www.chapinhall.org/sites/default/files/publications/ChapinHallDocument(2)_0.pdf

112. Hirsch, B. J., Hedges, L. V., Stawicki, J. A., & Mekinda, M. A. (2011). After-school programs for high school students: an evaluation of After School Matters. Technical report. Evanston, IL: Northwestern University. Retrieved from http://www.sesp.northwestern.edu/docs/publications/1070224029553e7f678c09f.pdf

113. Powerful Voices. (2011). Outcomes for girls: highlights of our 2011 outcome evaluation results. Retrieved from http://www.powerfulvoices.org/success/2011results.shtml

114. Rutherford, H. J. V., Barry, D., T., & Mayes, L. C. (2018). *Family-focused approaches to opioid addiction improve the effectiveness of treatment.* Society for Research in Child Development, Child Evidence Brief, No. 2 (June). Retrieved from https://www.srcd.org/policy-media/child-evidence-briefs/opioid-addiction

115. American Society for Addiction Medicine. (2015). *National practice guideline for the use of medications in the treatment of addiction involving opioid use*. Retrieved from https://www.asam.org/resources/guidelines-and-consensus-documents/npg

116. Dubowitz, H., Feigelman, S., Lane, W., & Kim, J. (2009). Pediatric primary care to help prevent child maltreatment: the Safe Environment for Every Kid (SEEK) model. *Pediatrics, 123*(3), 858-864.

117. Dubowitz, H., Lane, W. G., Semiatin, J. N., & Magder, L. S. (2012). The SEEK model of pediatric primary care: can child maltreatment be prevented in a low-risk population? *Academic Pediatrics, 12*(4), 259-268.

118. Dubowitz, H., Lane, W. G., Semiatin, J. N., Magder, L. S., Venepally, M., & Jans, M. (2011). The Safe Environment for Every Kid model: impact on pediatric primary care professionals. *Pediatrics, 127*(4), 962-970.

119. Sullivan, C.M. (2012, October). *Domestic violence shelter services: a review of the empirical evidence*. Harrisburg, PA: National Resource Center on Domestic Violence. Retrieved from http://www.dvevidenceproject.org.

120. Wasco, S. M., Campbell, R., Howard, A., Mason, G. E., Staggs, S. L., Schewe, P. A., & Riger, S. (2004). A statewide evaluation of services provided to rape survivors. *Journal of Interpersonal Violence, 19*(2), 252-263.

121. Campbell, R. (2006). Rape survivors' experiences with the legal and medical systems: do rape victim advocates make a difference? *Violence Against Women, 12*(1), 30-45.

122. Cary, C. E., & McMillen, J. C. (2012). The data behind the dissemination: a systematic review of trauma-focused cognitive behavioral therapy for use with children and youth. *Children and Youth Services Review, 34*(4), 748-757.

123. de Arellano, M. A., R. Lyman, D. R., Jobe-Shields, L., George, P., Dougherty, R. H., Daniels, A. S., … & Delphin-Rittmon, M. E. (2014). Trauma-focused cognitive behavioral therapy: assessing the evidence. *Psychiatric Services, 65*(5), 591–602.

124. Mannarino, A. P., Cohen, J. A., Deblinger, E., Runyon, M. K., & Steer, R. A. (2012). Trauma-Focused Cognitive-Behavioral Therapy for sustained impact of treatment 6 and 12 months later. *Child Maltreatment, 17*(3), 231-241.

125. Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(4), 393-402.

126. Deblinger, E., Mannarino, A. P., Cohen, J. A., & Steer, R. A. (2006). A follow-up study of a multisite, randomized, controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(12), 1474-1484.

127. Dorsey, S., Briggs, E. C., & Woods, B. A. (2011). Cognitive-behavioral treatment for posttraumatic stress disorder in children and adolescents. *Child and Adolescent Psychiatric Clinics of North America, 20*(2), 255-269.

128. Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., & Fink, A. (2003). A mental health intervention for schoolchildren exposed to violence: a randomized controlled trial. *Journal of the American Medical Association, 290*(5), 603-611.

129. Multisystemic Therapy Services. (2016). *Multisystemic Therapy (MST) research at a glance: Published MST outcome, implementation, and benchmarking studies*. Mount Pleasant, SC: Multisystemic Therapy Services. Retrieved from http://mstservices.com/files/outcomestudies.pdf.

130. van der Stouwe, T., Asscher, J. J., Stams, G. J. J. M., Deković, M., & van der Laan, P. H. (2014). The effectiveness of Multisystemic Therapy (MST): a meta-analysis. *Clinical Psychology Review, 34*(6), 468-481.

131. Sawyer, A. M., & Borduin, C. M. (2011). Effects of Multisystemic Therapy through midlife: a 21.9-year follow-up to a randomized clinical trial with serious and violent juvenile offenders. *Journal of Consulting and Clinical Psychology, 79*(5), 643-652.

132. Wagner, D. V., Borduin, C. M., Sawyer, A. M., & Dopp, A. R. (2014). Long-term prevention of criminality in siblings of serious and violent juvenile offenders: a 25-year follow-up to a randomized clinical trial of Multisystemic Therapy. *Journal of Consulting and Clinical Psychology, 82*(3), 492-499.

133. Borduin, C. M., Henggeler, S. W., Blaske, D. M., & Stein, R. J. (1990). Multisystemic treatment of adolescent sexual offenders. *International Journal of Offender Therapy and Comparative Criminology, 35*, 105-114.

134. Borduin, C. M., Schaeffer, C. M., & Heiblum, N. (2009). A randomized clinical trial of multisystemic therapy with juvenile sexual offenders: effects on youth social ecology and criminal activity. *Journal of Consulting and Clinical Psychology, 77*, 26-37.

135. Letourneau, E. J., Henggeler, S. W., Borduin, C. M., Schewe, P. A., McCart, M. R., Chapman, J. E., & Saldana, L. (2009). Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial. *Journal of Family Psychology, 23*(1), 89-102.

136. Swenson, C. C., Schaeffer, C., Henggeler, S. W., Faldowski, R., & Mayhew, A. M. (2010). Multisystemic Therapy for child abuse and neglect: a randomized effectiveness trial. *Journal of Family Psychology, 24*, 497-507.

137. Schaeffer, C. M., Swenson, C. C., Tuerk, E. H., & Henggeler, S. W. (2013). Comprehensive treatment for co-occurring child maltreatment and parental substance abuse: outcomes from a 24-month pilot study of the MST-Building Stronger Families program. *Child Abuse and Neglect, 37*(8), 596-607.

138. Niccols, A., Milligan, K., Sword, W., Thabane, L., Henderson, J., & Smith, A. (2012). Integrated programs for mothers with substance abuse issues: a systematic review of studies reporting on parenting outcomes. *Harm Reduction Journal*, 9-14.

139. Niccols, A., Milligan, K., Smith, A., Sword, W., Thabanee, L., & Henderson, J. (2012). Integrated programs for mothers with substance abuse issues and their children: a systematic review of studies reporting on child outcomes. *Child Abuse & Neglect 36*, 308-322.

140. Milligan, K., Niccols, A., Sword, W., Thabane, L., Henderson, J., & Smith, A. (2011). Birth outcomes for infants born to women participating in integrated substance abuse treatment programs: a meta-analytic review. *Addiction Research & Theory, 19*, 6, 542-555.

141. Niccols, A., Milligan, K., Sword, W., Thabane, L., Henderson, J., Smith, A., Liu, J., & Jack, S. (2010). Maternal mental health and integrated programs for mothers with substance abuse issues. *Psychology of Addictive Behaviors, 24,* 466-474.

142. Neger, E. N., & Prinz, R. J. (2015). Interventions to address parenting and parental substance abuse: conceptual and methodological considerations. *Clinical and Psychological Review, 39,* 71–82.

## For more information

To learn more about preventing adverse childhood experiences, call 1-800-CDC-INFO or visit CDC's violence prevention pages at www.cdc.gov/violenceprevention.

National Center for Injury Prevention and Control
Division of Violence Prevention

AK2019

# Suggested questions for parents to ask when choosing a therapist:

1. What type of therapy do you offer? What is it called? Tell me how therapy works, and about the main components of the therapy.

2. How do you decide what type of therapy is best for a particular problem or diagnosis? Do you use standardized measures or questionnaires as part of your clinical assessment?

3. What is your approach to treating anxiety, depression or posttraumatic stress?

4. In what evidence-based treatments have you had training? Tell me a little about the training? Did you receive any type of certification?

5. Do you receive clinical supervision or consultation for the evidence-based therapy that you do?

6. To about how many clients have you delivered the therapy?

7. Where can I learn more about the therapy? Can you direct me to websites or other resources that have information about the therapy? Do you have any materials that describe the therapy?

8. What will be expected of me for the treatment to work the best? How long does it typically last?

9. How do you monitor if the treatment is working? How do you decide when the treatment has worked or has been successful or when it may need to be changed because there is not enough progress?

# *Need help finding the best treatment available for your youth?*

*Scan the bar code:*

*Or follow the link below:*

https://www.siphidaho.org/comhealth/behavioral-health.php

# *Consult the Evidence Based Treatment Resource Guide for Idaho District 6*

**Learn what to ask a provider with questions like:**

- What is your approach to treating anxiety, depression or posttraumatic stress?
- How do you monitor if the treatment is working?
- How do you decide when the treatment has worked or has been successful or when it may need to be changed because there is not enough progress?

**As a consumer of therapy services, you are encouraged to ask questions and find out more about the type of therapy that is offered and the training and the supervision of the therapist. It is up to you to decide what kind of therapy and which therapist you think is best for the situation.**

# MATERIALS IDAHO JUVENILE RULE 16

1. Crossover Youth Practice Model Bannock County
    a. Purpose
    b. Dual Pathway Crossover Youth Practice Model
    c. Crossover Youth Protocols
    d. Crossover Youth Prevention
    e. Data Collection and Analysis
    f. App. A: Crossover Youth Family Guide
    g. App. B: Release of Information
    h. App. C: Family Case Management Plan
    i. Crossover Youth Team Meeting Facilitator Guide
    j. Rule 16 Screening Report/Crossover Youth Report
    k. Crossover Youth/Crossover Youth Prevention Data Sheet
2. Rule 16 (Crossover Youth) Screening Facilitator Guide
3. Rule 16 Screening Report Template
4. Case Management Plan Template
5. Example Rule 16 Report
6. Example Dual Case Management Plan
7. Example Rule 16 Screening Report Prevention
8. Example Rule 16 Screening Report #2
9. Youth Level Services Inventory (YLSI) Example Screening Report

# Bannock County

# Crossover Youth Practice Model

# Table of Contents

## Purpose of the Crossover Youth Practice Model

The purpose of the Crossover Youth Practice Model is to develop and implement a system of care that is responsive to the unique issues of youth and families who are identified as Crossover Youth or at risk of becoming Crossover Youth.

The **primary identified outcomes** of the Crossover Youth Practice Model are reductions in the following areas:

1. The number of youth placed in out-of-home-care
2. The use of congregate care
3. The disproportionate representation of children of color
4. The number of youth crossing over and becoming dually involved.
5. The length of stay in out-of-home-care.

To **effectively achieve the desired outcomes**, the policies and procedures in the model are built on the foundation of the following:

1. Engaging families in a way that recognizes and highlights their strengths and values the contribution of the youth, family, and natural supports in the assessment and planning process.
2. Collaboration between government agencies, private service providers, and community stakeholders working with Crossover Youth and Crossover Prevention Youth that promotes the timely sharing of information, the utilization of evidence-based practices, and a reduction in the duplication of services and conflicting requirements.
3. Cross-training of staff in policies and procedures of the model
4. The collection and analysis of data to aid in the decision-making process and provide quality assurance.

## Dual Pathway of the Bannock County Crossover Youth Practice Model

The Bannock County Crossover Youth Practice Model includes protocols and practices for identifying and working with youth who have crossed over between systems (Crossover Youth), as well as identifying youth who are involved in one system with risk of formal involvement in the other (Crossover Prevention Youth).

Youth in the child protection system include youth and families currently under investigation, families participating in voluntary services, youth and families participating in protective supervision services, and youth who are in the legal custody of the Idaho Department of Health and Welfare.

Youth in the juvenile justice system include youth who are on diversion (law enforcement diversion, Court diversion, juvenile justice diversion, or prosecutorial diversion), youth on probation under an

informal adjustment, youth who are on formal probation, and youth who are in the custody of the Idaho Department of Juvenile Corrections.

### Definition of Crossover Youth

Crossover Youth are youth between the ages of 10-17 who experience maltreatment and engage in delinquent acts. These youth are simultaneously involved in the child welfare and juvenile justice systems. Youth enter the Bannock County Crossover Youth Practice Model through one of three pathways:

1. Youth who have an open case with the child protection system and are subsequently charged with a delinquent act.
2. Youth who have an open case with the juvenile justice system and have a current child protection investigation or the Court has ordered a Rule 16 Investigation.
3. Youth who have an open case with the juvenile justice system and subsequently receive services in the child protection system.

### Definition of Crossover Prevention Youth

Crossover Prevention Youth are individuals between the ages of 8-17 who enter the Crossover Prevention Youth Protocols through one of the following pathways:

1. Youth who have been referred to Attendance Court due to excessive absences, and the Juvenile Court orders a Rule 16 Screening or Investigation based on information provided at the Attendance Court hearing.
2. Youth who have an open case in the child protection system and are committing delinquent acts but have not yet been formally charged.
3. Youth who have an open case with juvenile justice with evidence of maltreatment, but do not have an open case with child protective services, and lack sufficient evidence to recommend a Rule 16 Investigation or Expansion.

## Crossover Youth Protocols

### Identifying Crossover Youth – Phase 1.1

Region VI Family and Children Services and Bannock County Juvenile Justice have identified liaisons that can be contacted to verify system involvement during the screening process to determine if a youth meets the criteria of being a Crossover Youth.

| | |
|---|---|
| Child Protection Liaison: | Racheal Peace |
| | Phone # 208-239-6200 (Office) |
| | Phone # 208-705-4902 (Cell Phone) |
| | Email racheal.peace@dhw.idaho.gov |

Bannock Co. Juvenile Justice Liaison: Matt Olsen
Phone # 208-235-2305
Email matto@bannockcounty.us

At the point either liaison confirms that a youth meets the criteria of being a Crossover Youth, an email will be sent within one business day by the confirming liaison notifying the following stakeholders of the youth's status as a Crossover Youth:

- The liaison of the partnering agency
- The child protection case worker
- The juvenile probation/diversion officer
- The prosecuting attorney
- The defense attorney (if applicable at the time)
- The CYPM Data Manager (currently Todd Mauger)

Absent a signed release of information, the details shared must be limited to generalized statements about the following:

- Length of time each system has been involved with the family
- The current case status
  - Child protection involved youth – 1) investigation, 2) voluntary, 3) protective supervision, or 4) legal custody.
  - Juvenile justice involved youth – 1) informal diversion, 2) formal diversion, 3) probation (informal adjustment and formal probation), 4) detention, or 5) Idaho Department of Juvenile Corrections Custody.
- What services are being provided and the goals of the services being utilized.

The child protection caseworker and juvenile probation/diversion officer will make contact with one another within five business days of receiving notification that a youth is a Crossover Youth to plan the implementation of the Crossover Youth Protocols. The worker from the agency that confirms crossover status will be responsible for initiating contact with the staff from the partnering agency and will be the lead agency throughout the Crossover Youth Protocols unless it is agreed upon by both agencies that it is in the best interest of the youth and family to do otherwise.

For example, if the child protection liaison confirms that a juvenile justice youth is involved in the child protection system, the assigned child protection caseworker will initiate contact with the assigned juvenile justice officer.

## Region VI Family and Children Services Screening Protocols

Child protection case workers assigned to investigate a child protection case involving a youth between the ages of 10-17 will utilize the following screening protocols to determine if a youth is a Crossover Youth:

- Check the Idaho Juvenile Offender System (IJOS) to determine if the youth currently has an open juvenile justice case or previously had an open juvenile justice case.
- Contact the Bannock County Juvenile Justice liaison within one business day of meeting with the identified child/family of concern to verify whether or not the youth is currently involved in the juvenile justice system.

Note: If the juvenile justice liaison confirms the youth is juvenile-justice-involved, the liaison will follow the notification protocols.

## Law Enforcement Screening Protocols

Law enforcement officers may screen youth at the time of arrest to determine if the youth meets the definition of Crossover Youth. The screening questions are included in the Juvenile Information section of the incident report and contain the following information:

1) Does the youth currently have an open case with child protective services? Has the youth previously had an open case with child protective services?
2) Conditions of maltreatment/abandonment/neglect or other risks to the safety of the youth being cited that were observed by the officer, but did not meet the level required to declare imminent danger.

## District 6 Juvenile Detention Screening Protocol – Pre-adjudicated Youth

The following screening protocol will be utilized to determine if a youth placed in detention on pre-adjudicated charges meets the criteria for being a Crossover Youth:

- The Bannock County Juvenile Justice staff member screening newly detained youth for a detention hearing will contact the child protection liaison within one business day of detention intake (excluding weekends and holidays) to verify whether or not the youth meets the criteria for being a Crossover Youth.

Note: If the child protection liaison confirms the youth is child-protection-system-involved, the liaison will follow the notification protocols.

## Bannock County Juvenile Justice Screening Protocols

Youth in Bannock County enter the Bannock County Juvenile Justice system through various pathways. The following screening protocols will be utilized by the point of contact of each pathway to determine if a youth meets the criteria of being a Crossover Youth:

### *Diversion Programs*

- The diversion officer will ask the family about child protection system involvement at the point of screening for eligibility for diversion services.
- The diversion officer may contact the child protection liaison for assistance in determining if the youth has a current child protection case.

### *Youth Referred to Court*

- File Review Process

- The juvenile justice staff member conducting the file review before Court will look for indicators of potential child protection involvement or youth maltreatment.
- The staff member may contact the child protection liaison to determine if the youth has an open child protection case.

- Meeting prior to Admit/Deny Hearing
  - Juvenile justice staff meeting with the family prior to the initial Court hearing will screen to determine if the youth has a current child protection case, prior system involvement, or has indicators of maltreatment and note it on the Admit/Deny Form.
- Probation Intake Meeting
  - The juvenile probation officer will contact the child protection liaison within one business day of the probation intake meeting to determine if a youth has a current child protection case if that determination has not been made prior to probation intake.
  - If a youth is determined to be a Crossover Youth prior to the probation intake meeting, the probation officer will obtain background information from the child protection case worker regarding the youth and family and invite the child protection case worker to the probation/diversion intake meeting.

At any point in the process, if a juvenile justice officer identifies signs of abuse, neglect, or other maltreatment that meets the criteria for mandated reporting, the officer will call child protection central intake (1-855-552-5437) to make a report.

## Notification to Youth and Guardian(s) of Crossover Status

Effective family engagement is a critical factor in achieving the positive outcomes stated in the Bannock County Crossover Youth Practice Model. Staff from both systems will work to ensure that youth and families are treated with dignity and respect, and that family involvement in decision-making occurs at all levels of the Crossover Youth protocols.

The child protection caseworker or juvenile justice probation/diversion officer initiating contact with the partner agency will be responsible to meet with the youth and family to discuss how the Crossover Youth Practice Model can aid the family in maintaining/achieving permanency and reduce risk for recidivism and further penetration into both systems. The youth and family will be provided a Family Guide (see Appendix A) that provides information regarding the Crossover Youth Practice Model.

The caseworker or juvenile justice officer meeting with the youth and family will request that the parent(s)/guardian(s) sign a release of information (see Appendix B) that will allow the sharing of pertinent information for the purposes of joint assessment and case management planning with the family and all stakeholders involved with the family.

## Decision-Making Regarding Charges – Phase 1.2

When a youth at any point of the juvenile justice continuum (pre-adjudicated, diversion, probation, detention, IDJC custody) receives a new charge and is determined to be a Crossover Youth, the following protocols may be implemented:

- The Court will be notified at the detention hearing or admit/deny hearing of the youth's status as a Crossover Youth, and an attorney will be appointed if the family is unable to afford one.
- The youth and family will be provided an opportunity to participate in a Crossover Youth Team Meeting prior to the pre-trial hearing to develop recommendations regarding charges and interventions, and if accepted, a pre-trial date will be scheduled for approximately one month after the initial hearing.
- The assigned worker from the lead agency will be assigned to schedule and facilitate the Crossover Youth Team Meeting prior to the pre-trial hearing and notify stakeholders of the date, time, and place of the meeting. Individuals that must attend the meeting include the following:
  - The youth and parent(s)/guardian(s)
  - The assigned juvenile justice officer and child protection caseworker.

  Other individuals that should be invited to the meeting include the following:
  - Any individuals identified by the family as support (e.g. extended family)
  - Prosecuting and defense attorneys
  - Current service providers
  - Education personnel (e.g. school counselor or administrator)
  - Detention staff (when applicable)
  - Children's Mental Health clinician
  - IDJC representative
- Agency representatives will bring assessment information and intervention history that may assist in the development of a consensus recommendation by the prosecuting attorney and defense attorney on decisions regarding the charge(s) and possible alternatives to formal adjudication.
- The representative from the lead agency will be responsible for completing and submitting the Crossover Youth Report to the prosecuting attorney and defense attorney (see Appendix E).

## Intake Protocols – Joint Assessment and Planning – Phase 2

All youth in the Bannock County Crossover Youth Practice Model will receive coordinated assessment and joint case management through a Crossover Youth Team Meeting. Agency representatives participating in the meeting will bring assessment information to be shared and discussed with members of the team for the purposes of developing a Family Case Management Plan (see Appendix C) that addresses the safety and well-being of the youth and also promotes positive outcomes that are associated with reduced risk for re-offending. Crossover Youth Team Meetings may occur prior to adjudication or post adjudication when a youth receives a new charge.

## Crossover Youth Team Meeting Participants

The following individuals *must* participate in the Crossover Youth Team Meeting:

- Parent(s)/guardian(s)
- The youth
- Child protection case worker
- Juvenile probation/diversion officer
- Court Appointed Special Advocate - if appointed

The following individuals *should* participate in a Crossover Youth Team Meeting when feasible and if appropriate:

- Support individuals identified by the family, such as relatives or other natural support people from their community
- School personnel
- Children's Mental Health clinician
- Service providers
- Attorney for the youth
- Attorney for the parent(s)
- Prosecuting attorney
- IDJC representative

The Coordinated assessment will include a review of the following topics:

- Behavior patterns of the youth and family over time
- Examination of the family strengths and protective factors
- Assessment of the overall needs of the youth and family that affect the safety, permanency, and well-being of the youth
- Assessment of criminogenic factors

Participants of the Crossover Youth Team Meeting will identify evidence-based services that are provided in the community that can be used as interventions to assist the family in accomplishing the goals and objectives identified in the Family Case Management Plan (See the Evidence-based Treatment Guide for District 6 Idaho at https://www.siphidaho.org/comhealth/behavioral-health.php).

Facilitators of the Crossover Youth Team Meeting are encouraged to use the Crossover Youth Team Meeting Facilitator Guide (see Appendix D) to promote effective family engagement and participation of all members of the team.

## Protocols for the Crossover Youth Team Meeting

The person/agency responsible for completing the various tasks of the Crossover Youth Team Meeting process is dependent on the pathway the youth entered the Crossover Youth Practice Model on.

*Pathway 1* - Youth who have an open case with the child protection system and are subsequently charged with a delinquent act.

- Child protection staff schedules and facilitates the meeting and writes the Family Case Management Plan.

*Pathway 2* - Youth who have an open case with the juvenile justice system and have a subsequent child protection investigation or open case.

- The juvenile justice staff member schedules and facilitates the meeting and writes the Family Case Management Plan. In the case of a Rule 16 Investigation, the child protection caseworker will follow agency protocols regarding the submission of an investigation report to the Court.

### Special Circumstances – Combined Rule 19 & Rule 16 Investigation/Screening

The youth has an open case with juvenile justice but does not currently have an open case with child protective services. Recommended when a juvenile is a candidate for placement with the Idaho Department of Juvenile Corrections, and there is evidence of a degree of neglect, abuse, abandonment, homelessness, or lack of stable home environment, but a factual basis does not currently exist to recommend a full investigation or expansion.

- Bannock County Juvenile Justice staff schedules and facilitates the meeting.
- The probation/diversion officer submits a Rule 19 Screening Report and comprehensive plan.
- Region VI Family and Children Services does not need to complete a full formal investigation prior to the screening team meeting, unless a Rule 16 Investigation is ordered.
- Region VI Family and Children Services as a result of the information provide at the screening team may determine that a child protection investigation is warranted and submit to the Court an investigation report in conjunction with or separate from the Rule 19 Screening Report and plan.

## Coordinated Case Management and Ongoing Assessment – Phase 3.1

Youth and families in the Crossover Youth Protocol will receive ongoing coordinated case management and assessment through a combination of regularly scheduled Crossover Youth Team Meetings and ongoing information sharing among participants throughout the period of Crossover Youth status. The child protection caseworker and juvenile justice officer should conduct at least one joint home visit within 30 days of the implementation of the Crossover Youth Protocols. Additional joint home visits may be conducted as needed to promote successful implementation of the Family Case Management Plan.

### Frequency of Crossover Youth Team Meetings

Crossover Youth Team meetings should occur at least quarterly, and more often if members of the team determine it would be beneficial to the safety and well-being of the youth. Issues that may require that the team reconvene prior to a scheduled date include the following:

- Change in placement status (see above)
- New offense
- New allegations of abuse or neglect
- Disciplinary issues at school
- When a family member requests a meeting

### Ongoing Information Sharing

Agency participants in the Crossover Youth Team Meeting will engage in ongoing sharing of information while a youth and family are in the Crossover Youth Practice Model. The juvenile justice staff member and child protection case worker should share information regarding case progress on a monthly basis. Information that is important to the achievement of the goals identified in the Family Case Management Plan may be shared as often as needed. This information may include the following:

- New or updated assessments
- Service provider reports/updates
- School record information related the goals of the Family Case Management Plan
- Case plan progress
- Change in status (e.g. being placed in detention or a change in home visitation schedule)
- Violations of probation
- When a family member requests a meeting.

## Planning for Youth Permanency, Transition, and Case Closure – Phase 3.2

The definition of permanency for Crossover Youth is youth and caregivers achieving a level of self-sufficiency which allows the youth to begin to be successful in the community with decreasing levels of support. The goal is youth success without interventions. Permanency for a youth can take place in the home of the biological family, guardianship family, or adoptive family.

### Concurrent Planning for Crossover Youth in Foster Care

- Family meetings are scheduled prior to the case planning hearing. The outcome of this meeting is the Child Welfare case plan, which outlines conditions necessary for reunification.
- Concurrent planning and preliminary identification of a permanency placement other than reunification is also discussed during the family meeting.
- The child protection caseworker will invite the juvenile probation/diversion officer to attend as one of the youth/family support participants.
- If the child protection caseworker is anticipating any changes in the concurrent plan goal, this will be discussed at the Crossover Youth Team meeting.

- The juvenile probation/diversion officer will be informed of Child Protective Service Court hearings where permanency plan recommendations are updated or modified.

## Transition Planning for Crossover Youth in Foster Care Stepping Down to Extended Home Visit or Protective Supervision

- Prior to stepping a child down from foster care to extended home visit or protective supervision, the child protection caseworker will inform the Crossover Youth Team participants of the upcoming change.
- Participants will discuss any plan changes which will need to take place to ensure necessary services are not disrupted.

## Transition Planning for Crossover Youth Exiting Residential Treatment and Returning to the Community

- Approximately 30 days prior to a Crossover Youth exiting residential treatment, a Crossover Youth Team Meeting will take place to develop a plan for the youth's successful transition back to the community and to a lesser restrictive living situation.

## Transition Planning for Youth Exiting Custody of the Department of Juvenile Corrections

- Approximately 30 days prior to a Crossover Youth being released from any Idaho Department of Juvenile Corrections (IDJC) facility, a Crossover Youth Team Meeting will take place to develop a plan for the youth's successful transition back to the community.
- The youth, the youth's IDJC group leader, IDJC juvenile service coordinator, and the juvenile probation/diversion officer will be invited to participate.

## Independent Living Services for Crossover Youth Who are in Foster Care.

- Crossover Youth who are in foster care for 90 consecutive days after their 14th birthday will have an Independent Living plan.
- If Independent Living needs for a Crossover Youth are identified during a Crossover Youth Team Meeting which are not already identified through the Independent Living plan, they will be added to the Independent Living plan.

## Independent Living Services for Crossover Youth Exiting Foster Care at Age 18

- Region VI Family and Children Services will begin scheduling transition meetings for Crossover Youth sometime after the youth turns 17.
- Juvenile Probation and other relevant agencies identified during the Crossover Youth Team Meeting will be invited to attend the transition meeting.
- Permanency Pacts for adults who have indicated a willingness to provide support to the youth will be written. The Crossover Youth will be provided a Health and Education Passport when he/she exit foster care.

### Case Closure

- Prior to case closure, the agency recommending the case closure will inform the Crossover Youth Team participants of the anticipated case closure.
- Team participants will discuss any plan changes which will need to take place to ensure necessary services are not disrupted.

# Crossover Youth Prevention

## Crossover Prevention Youth Protocols

The Bannock County Crossover Youth Practice Model seeks to prevent youth who are involved in one system from crossing over to the other system. The following pathways describe how youth in one system are at risk of becoming involved in the other.

### Attendance Court Pathway

The youth is referred to Attendance Court due to excessive absences, and the Court orders a Rule 16 Screening or Rule 16 Investigation to prevent further penetration into the child protection and juvenile justice systems.

This screening is ordered by the Court to develop a plan that will promote consistent school attendance and academic success. The purpose of this screening and investigative report is primarily preventative to address risk factors and needs that, if left unaddressed, increase the likelihood of further involvement in the child protection and juvenile justice systems.

- The child protection caseworker schedules and facilitates the Crossover Prevention Team meeting.
- Bannock County Juvenile Justice staff participates in the screening and plan development.
- All other protocol Crossover Youth Protocols may apply.
- The child protection case worker will submit the written Family Case Management Plan and Rule 16 Screening or Investigation Report to the Court.

### Child Protection Pathway

The youth has an open case with child protective services and is committing delinquent acts but has not been formally charged. The child protective services caseworker will contact the Juvenile Justice Liaison and determine if juvenile justice participation will reduce the likelihood of further penetration into the juvenile justice system.

- The child protection caseworker schedules and facilitates the meeting.
- Bannock County Juvenile Justice staff participates in the screening and plan development and coordination if requested by child protective services.

### Rule 16 Screening Pathway

The youth has an open case with juvenile justice but does not currently have an open case with child protective services. A Rule 16 Screening may be recommended at a juvenile court proceeding when there is evidence the youth has safety risk factors and needs associated with child protection issues, and there is a lack of sufficient evidence regarding the severity of the risk to recommend a Rule 16 Investigation or Rule 16 Expansion.

A Rule 16 Screening may be recommended when there is concern that circumstances have the potential to escalate to a more serious child protection issue if we do not successfully intervene to prevent abuse, neglect, child abandonment, or homelessness. For example: A recent case in detention reported a level of chaos and conflict in the home that did not reach the level of imminent danger but could escalate based on past history and the current level of conflict. The purpose of the screening team would be to identify services or an alternative short/long term placement to prevent the escalation of risk. **Child protection services does not need to complete a formal investigation prior to the screening team meeting, but may investigate to the level deemed appropriate, including a review of child protection records.**

- The Rule 16 Screening order is faxed by the Court clerks to the child protection liaison.
- The juvenile justice officer assigned to the case schedules the Rule 16 Screening Crossover Prevention Meeting.
- The child protection liaison assigns a caseworker to attend the meeting when notified by the juvenile justice officer of the date and time of the meeting.
- The juvenile justice staff facilitates the meeting and writes the Rule 16 Screening Report (see Appendix E) and the Crossover Youth Prevention Case Management Plan and submits the report and a copy of the plan to the Court.

## Data Collection and Analysis

Bannock County Juvenile Justice, the Idaho Department of Health and Welfare, and Family and Children's Services agree to collect data on Crossover Youth and Crossover Prevention Youth to ensure that we are achieving the program goals and objectives of the Bannock County Crossover Youth Practice Model.

The following data collection protocols apply to both Crossover Youth and Crossover Prevention Youth.

- At each point in the data collection process, the worker from the lead agency will forward the completed data sheet to the CYMP Data Manager
- The assigned child protection caseworker and juvenile justice officer will complete the respective information on the Crossover Youth or Crossover Youth Prevention Case Information: Initial Data sheet (see Appendix F) prior to the initial team meeting.

- The child protection caseworker and juvenile justice officer will complete the 9-Month Tracking Sheet: Follow-up Data portion of the data sheet after the 9-month follow-up meeting has occurred.
- The Data Manager will enter information from the data sheet completed by the child protection caseworker and juvenile justice officer into the Excel data sheet.
- The Data Manager will submit the Excel data sheet to the Idaho State Police on a quarterly basis.
- The Idaho State Police will run the data from the Excel sheet on a quarterly basis and provide the data analysis to all stakeholders.

Meetings with the stakeholders of the Bannock County Youth Practice Model will occur on a bi-annual basis to review the data and make decisions regarding any necessary program improvements.

# Appendix A

## Crossover Youth Family Guide

## Bannock County Juvenile Justice

### Mission Statement:

Our mission to the community of Bannock County is to protect its citizens from juvenile crime through the implementation of evidence based practices and programs, and to ensure that juveniles under our jurisdiction successfully repair the harm to victims and community caused by their offending behavior.

Bannock County Juvenile Court
137 South 5th Ave.
Pocatello, Idaho 83201
(208) 234-1087

## Important Contacts

**Case Worker:**

**Probation Officer:**

**Parent Attorney:**

**Child Attorney:**

**CASA Worker:**

# Bannock County Crossover Youth Practice Model

Working together to promote healthy children and families.

## What is a Crossover Youth?

A "crossover" youth is any youth who is involved in both the juvenile justice system and child welfare.

## What is the Crossover Youth Practice Model?

The Crossover Youth Practice Model (CYPM) describes the specific practices that need to be in place within a jurisdiction in order to reduce the number of youth who crossover between the child welfare system and juvenile systems.

According to research, children who face adverse experiences have a greater chance of involvement in the criminal justice system. Thus, the Crossover Youth Practice Model allows agencies and families to collaborate to produce the best outcomes for those youth and their families.

The Crossover Youth Practice Model values parental involvement and believes that youth and families have strengths that should beutilized in order to meet their needs. In doing so, we can provide long-term benefits for those youth and their families.

## Crossover Youth Practice Model Goals and Outcomes

- a reduction in the number of youth placed out of their home
- a reduction in the number of youth placed in residential or group facilities
- a reduction in the disproportionate representation of children of color
- a reduction in the number of children crossing over into the juvenile justice system
- a reduction in recidivism rates
- an increase in family and youth engagement
- an increase in collaboration among agencies and families
- an increase in communication among agencies
- an increase in the use of community-based programs
- an increase in the overall wellbeing of youth and their families

## Crossover Youth Practice Model Values

- We serve every child individually based on their history and experiences.
- We believe the most advantageous
- place for youth to grow up in in their own family.
- We believe that youth and families have strengths.
- We provide opportunities for professional development to ensure workforce efficacy.
- We work to maintain youth permanence.

## Parent's Role

This is a team effort! Parental involvement and support is crucial to the success of this program.

Together, we can develop an action plan that utilizes individual and family strengths and includes a role for everyone.

# Appendix B

## Bannock County Crossover Youth Practice Model Program

### Request and Authorization to Release Information/Records

# Bannock County Crossover Youth Practice Model Program

## Request and Authorization to Release Information/Records

Client Full Legal Name: Other Names Used:

Date of Birth: Case#:

I, _____ , authorize the following entities:

_____ Bannock County Juvenile Justice

_____ Idaho Dept. of Health & Welfare – FACS

_____Idaho Dept. of Health & Welfare – CMH

_____ Idaho Dept. of Health & Welfare - DD

_____ Idaho Department of Juvenile Corrections

_____Prosecuting Attorney/s

*(Name)*_____

_____Public Defender/other defense counsel

*(Name)*_____

_____Parents (if a juvenile)

*(Name)*_____

_____ Medicaid/Optum

_____School District 25

_____School District 21

_____Treatment Provider (specify):

_____

_____ Other (specify):

_____

to release, use, receive, mutually exchange, communicate with, and disclose to one another the following information:

- Attendance
- Diagnosis
- Urinalysis results
- Cooperation
- Prognosis
- Evaluation/Assessments
- Grades/Education
- Medications
- Mental Health Records
- Legal/criminal records
- Drug and alcohol treatment
- Psychosexual Evaluation
- Counseling Records
- Medical Records
- Treatment Records
- Social History
- Employment
- Other: _____

The purpose of the disclosure is to inform any person, entity, or agencies listed above of my attendance and progress in treatment and/or monitor my probation supervision.

I have read this authorization/had this authorization read/explained to me and I acknowledge an understanding of the purpose of the release of information. I am signing this authorization of my own free will. I understand that this authorization will allow my treatment team to plan and coordinate services I need, to impose appropriate sanctions or rewards based on my behavior, and to also allow any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I further understand that some or all of this information will be discussed in open court, a public forum, where any person in the courtroom may hear the information. I hereby request and give my permission for an open exchange of information to, by, among, or between any person, entity, or agency named in this authorization.

I understand that this information may include material like drug and alcohol treatment records, mental health records, and medical records, which are protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164. Although HIPPA requires that consents be revocable, 42 C.F.R. § 2.35 provides that if I am mandated into treatment through the criminal justice system or I am under legal/court supervision/probation, this authorization will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment. I also understand that if I do not comply with treatment, my non-compliance will be reported to the judge and the prosecuting attorney/deputy attorney. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

**COMPLIANCE AND QUALITY ASSURANCE QUESTIONNAIRE**

*Please read and discuss all items and have client initial as they have read and understood each statement.*

_____1. I have clear understanding of my rights as a client and have been given the opportunity to discuss any of my concerns.

_____2. I understand if I decide not to sign, which is my right, I can be removed from treatment and will be reported to probation/parole, the judge and the prosecuting/deputy attorney.

_____3. I was given this release of information prior to beginning of treatment services.

_____4. I have read the summary of the confidentiality laws above.

_____5. I understand that this authorization will expire one year from the signed date of release unless on probation.

_____6. I have read this authorization/had this authorization read/explained to me and I acknowledge an understanding of the purpose for the release of information.

_____7. I was provided a copy of the signed release of information.

_____ 8. The expiration date of this Release of Information is _____

| | | |
|---|---|---|
| Full Legal Signature of Client *or Authorized Personal Representative:* | Relationship to Client: | Date: |
| Full Legal Signature of Parent or Legal Guardian – *Required if Client is under 16 years of age, but only after signed by Client:* | Relationship to Client: | Date: |
| Name of Staff Person (print): | Initiating Agency Name/Location: | Date: |

**PROHIBITION ON REDISCLOSURE AND PROSECUTION:** I understand that my alcohol and substance abuse treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42, C.F.R. Part 2 and those recipients of this information may re-disclose it only in connection with their official duties. Federal rules limit any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

# Appendix C

## Family Case Management Plan

### District 6 Crossover Youth

# Family Case Management Plan
## District 6 Crossover Youth

| | |
|---|---|
| Date of Plan: | Date of Next Review: |
| Assigned CPS Supervision Level: | Assigned JJ Risk Level: |

| **Child's Information** | | | |
|---|---|---|---|
| Child's Name: | DOB: | Gender: | CP Case #<br>JJ Case # |
| Current Address: | Current Status: | | Telephone: |

| **Family Information** | | |
|---|---|---|
| Mother's Name: | Address: | Phone: |
| Father's Name: | Address: | Phone: |
| Guardian: | Address: | Phone: |
| Guardian: | Address: | Phone: |
| Family Member: | Address: | Phone: |
| Family Member: | Address: | Phone: |
| Family Member: | Address: | Phone: |
| Family Member: | Address: | Phone: |

| **Meeting Participants** | |
|---|---|
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |

| **Screening/Assessment Utilized** |
|---|
| ☐ Safety Assessment (CPS) |
| ☐ YLS/CMI (JJ) |
| ☐ Mental Health Evaluation |
| ☐ Adverse Childhood Experiences Questionnaire |
| ☐ Child and Adolescent Needs and Strengths |

- ☐ Substance Abuse Assessment (GAIN-I)
- ☐ Psychological/Neuropsychological
- ☐ MAYSI 2
- ☐ Suicide Risk Assessment
- ☐ Education Plan
- ☐ Other
  (explain):_____

| Identified Risk Factors and Needs | |
|---|---|
| **Safety Risk Factors & Needs – CPS** | **Criminogenic Risk Factors & Needs - JJ** |
| ☐ Abandonment | ☐ Offense History/Dispositions |
| ☐ Physical Abuse | ☐ Mental Health |
| ☐ Medical Neglect | ☐ Family Circumstances/Parenting |
| ☐ Education Neglect | ☐ Dev. Delay |
| ☐ Malnutrition | ☐ Education/Employment |
| ☐ Hazardous Home | ☐ Financial Problems |
| ☐ Sex Abuse | ☐ Peer Relations |
| ☐ Cruel Restraint | ☐ Parent Drug Abuse |
| ☐ Emotional Abuse | ☐ Substance Abuse |
| ☐ Inadequate Shelter | ☐ Parent Mental Health |
| ☐ Neglect | ☐ Leisure/Recreation |
| ☐ Chronic Lack of Supervision | ☐ Personality/Behavior |
| | ☐ Attitudes/Orientation |

**Safety Management Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

*Progress Update:*

**Joint Permanency Planning (If Applicable)**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

*Progress Update:*

**Family Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| | | | |

*Progress Update:*

**Education/Employment Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

*Progress Update:*

**Positive Peer Involvement Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

*Progress Update:*

**Substance Use Prevention Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

*Progress Update:*

**Mental Health Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

*Progress Update:*

**Accountability to Victims & Community Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

*Progress Update:*

**Additional Action Items**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

*Progress Update*

**Incidents/Issues That Will Trigger a Follow-up Meeting**

| | |
|---|---|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

**Upcoming Court Dates/ Other Scheduled Meetings**

| Date and Time of Hearing/Meeting | Meeting Purpose | Meeting Place |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

ACKNOWLEDGEMENT

By signing below, each party acknowledges that they understand the goals of this plan and agree to diligently work toward the achievement of these goals to enhance the safety of the child and the community.

| Participant Signature | Relationship to Child | Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

AGENCY REPRESENTATIVE CONTACT INFORMATION

| Agency | Agency Representative | Phone number | Email |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| | | | |

# Appendix D

## Bannock County Crossover Youth Practice Model

### Crossover Youth Team Meeting Facilitator Guide

# Bannock County Crossover Youth Practice Model
## Crossover Youth Team Meeting Facilitator Guide

**Purpose:** The purpose of a Crossover Youth Team Meeting is to develop an integrated case management plan that promotes the healthy development of youth, increases safe and responsive caregiving, and protects the community. Activities in the plan should reduce external sources of stress, develop responsive relationships with caregivers and other adults, and strengthen core life skills.

**I. Welcome and Introductions**

- Have each participant introduce themselves and which agency they represent.
- Have the family and their support members introduce themselves and their relationship to the juvenile.
- Set ground rules of respectful communication – no interrupting, accepting different opinions and ideas, no yelling, etc.

**II. Discuss the purpose and objectives of the Crossover Youth Team Meeting and provide a brief overview of the case history (e.g. current status with juvenile justice, such as a diversion or probation case, and current status with IDHW, such as protective supervision).**

**III. Discuss Confidentiality**

- Explain limits of confidentiality
- Identify the purpose of the meeting
- Identify who will receive copies of the report

**IV. Briefly Review Juvenile History**

- History of mental health issues or substance abuse treatment
- Family Structure and Dynamics
- Parental, guardian, or custodian engagement in counseling and treatment designed to develop positive parenting skills and understanding of the family's role in the juvenile's behavior.
- Academic Performance and School Behavior
- Prior intervention and treatment efforts by the family and/or the community
- Prior offenses
- Current and prior risk/need assessments

**V. Identify Current and Potential Risks Factors to the Safety and Health and Welfare of the Youth**

- Give each member of the Crossover Team an opportunity to state the potential risks to the safety and well-being of the youth. Encourage each participant to share objective indicators for their opinions It may be helpful to provide team members with a list of the Safety Risk Factors and Needs – CPS as identified on the Family Case Management Plan
  (IF A RULE 16 INVESTIGATION OR EXPANSION HAS BEEN ORDERED, THE CPS INVESTIGATOR WILL OUTLINE THE RISK FACTORS IDENTIFIED IN THE INVESTIGATION).

- List identified risk factors on a flip-chart or white-board. If multiple risk factors are identified, work with the group to develop a consensus in prioritizing the risk factors – *with priority given to risk factors that could cause death or significant injury/illness.*

## VI. Develop a Safety Management Action Plan

1. Develop measurable objectives that, when accomplished, will reduce the risk of endangering the safety and well-being of the youth
2. Service/Action Steps (Interventions) that will lead to the accomplishment of the identified objectives
3. Identification of who is responsible for initiating and following up on the action step
4. A timeline for when the service/action step will be implemented

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## VII. Develop a Family Action Plan

1. Work with team members to develop measurable objectives that, when accomplished, will promote increased safe and responsive caregiving by caregivers and other family members. The following are ideas of topics to consider in the Family Action Plan:
   Responsivity of Caregivers to Youth
   a. Increased parental/guardian emotional regulation and coping skills
   b. The development and implementation of parent-child interaction and parent management skills that promote healthy youth development
      1) Implementation of clear and consistent boundaries and expectations
      2) Non-coercive communication
      3) Frequent expressions of nurturance from caregiver to youth
      4) Effective monitoring and supervision
   c. Stable employment or income that adequately meets the basic needs
   d. Widen the circle of natural family supports by identifying other adults who can serve as mentors and positive support to youth (i.e. extended family, clergy, neighbors, coaches, etc.)

   Responsivity of Team Members to Caregivers and Youth – What do caregivers say they need?
   a. Provide access to services that do not conflict with other important caregiver roles, such as employment
   b. Support efforts to resolve conflicts in scheduling when they occur so that families can participate in services
   c. Coordinate schedules to reduce required separate meetings with multiple agencies
   d. Reduce duplication of services
   e. Access to caseworkers, probation officers, counselors, etc. during a crisis, including after hours and weekends
   f. Assistance with transportation
   g. Support access to participation of the youth in pro-social, extra-curricular activities
   h. Respite
   i. Provide information regarding access to food, utility, and housing assistance
   j. Recognition and affirmation of family strengths and progress
   k. Reductions or adjustments in financial requirements imposed by agencies
2. Identify services/action steps that will assist in achieving the objectives
3. Identify the person responsible for facilitating the access to services or the next action step

4. Develop a timeline for when the objective will be achieved

**VIII. Develop an Education/Employment Action Plan**

1. Work with the team to evaluate the academic performance, attendance history, behavior history, responsivity of school personnel to the needs of youth and parents, and testing and services to support educational achievement
2. Evaluate current caregiver efforts to support education achievement; identify activities that, if performed by the caregiver, would enhance educational achievement
3. Work with team members to develop measurable objectives that, when accomplished, will maintain or promote educational achievement
4. Identify services/action steps that will assist in achieving the objectives
5. Identify the person responsible for facilitating the access to services or the next action step
6. Develop a timeline for when the objective will be achieved

**IX. Positive Peer Involvement**

1. Work with the team to evaluate the impact of peer influence
   a. Some delinquent acquaintances
   b. Some delinquent friends
   c. No/few positive acquaintances
   d. No/few positive friends.
2. Work with the team to develop measurable objectives to maintain or increase the influence of positive peer association and neutralize the influences of negative peer association
3. Identify services/action steps that will assist in achieving the objectives
4. Identify the person responsible for facilitating the access to services or the next action step
5. Develop a timeline for when the objectives will be achieved

**X. Substance Abuse Prevention Action Plan**

1. Work with the team to evaluate current substance abuse risks and needs
   a. Occasional drug/alcohol use
   b. Chronic drug/alcohol use
   c. Substance abuse interferes with life
   d. Substance abuse is linked to offenses
2. Work with the team to develop measurable objectives to address risks and needs associated with substance use and abuse
3. Follow steps 3,4, & 5 in section IX

**XI. Mental Health Action Plan**

1. Work with the team to evaluate current mental health needs
2. Work with the team to develop measurable objectives to improving mental health of the youth/caregivers
3. Follow steps 3,4, & 5 in Section IX

**XII. Accountability to Victims and Community Plan**

1. Work with the team to evaluate who has been harmed by the behavior of the youth
2. Develop an accountability plan that will help the youth with the following:
   a. Understand the impact his/her behavior has had on others
   b. Plan steps that the youth can take to repair any harm done
      1) Restorative Conference

2) Letter of Apology
3) Restitution

3. Follow steps 3, 4, & 5 in section IX.

**XIII. Conclusion and Summary**

1. Provide a summary of the action plans in the identified areas
2. Determine the date and time for the next meeting – and the frequency of the meetings

**IV. Thank the group members for their participation and cooperation.**

# Appendix E

## Bannock County Crossover Youth Practice Model

### Rule 16 Screening Report/Crossover Youth Report

# Bannock County Crossover Youth Practice Model
## Rule 16 Screening Report/Crossover Youth Report

| Juvenile Information | | |
|---|---|---|
| Juvenile Name: | Case No: | Date of Birth: |
| Parent/Guardian: | Relationship: | Phone: |
| Parent/Guardian: | Relationship: | Phone: |
| Parent/Guardian: | Relationship: | Phone: |
| Parent/Guardian: | Relationship: | Phone: |

| Screening Team Information | |
|---|---|
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |

| Juvenile and Family Detailed History |
|---|
| History of Mental Health Issues/Substance Abuse Treatment: |
| Family Structure and Dynamics – Include any specific or potential threats of danger or safety: |
| Parental, Guardian, Custodian Engagement in Counseling and Treatment Designed to Develop Positive Parenting Skills and Understanding of the Family's Role in the Child's Behavior: |
| Academic Performance, School Behavior, Attendance & Education Needs (e.g. IEP): |

| |
|---|
| Prior Interventions and Treatment Efforts by the Family and/or Community: |
| Prior Offenses: |
| Current and Prior Risk/Needs Assessments: |

| **Community-based Monitoring and Supervision Needs to Adequately Address Youth Safety and Community Protection** | |
|---|---|
| **Home- and Community-Based Supervision Needs** | **Objective and Subjective Assessment of Family and System Strengths and Capacity to Meet the Need/Potential Barriers** |
| | |
| | |
| | |
| | |
| **Community-Based Competency Development Programs to Adequately Address Needs and Risks** | |
| **Evidence-based Community Intervention Program/Treatment/Counseling Services** | **Objective and Subjective Assessment of Family & System Strengths & Capacity to Engage & Implement the Intervention Program/Potential Barriers** |
| | |
| | |
| | |

| | |
|---|---|
| | |

| Screening Team Recommendations | | | |
|---|---|---|---|
| **Participant/Role** | **Recommendation** | **Participant/Role** | **Recommendation** |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Report Prepared by:

_____ _____

Signature Date

# Appendix F

## Cross Over Youth Data Project

# Cross Over Youth Data Project

## *Names and IDs*

If a youth has a current Health & Welfare or Juvenile Probation case, insert the respective agency number as identified below. If the youth is a Crossover Prevention client, please insert the first four letters of the first name and the year of birth in the identified field

| | |
|---|---|
| **Name:** | ***PREVENTION CASES ONLY*** **First four letters of first name, four-digit year of birth:** |
| **Child Welfare Agency Tracking #:** | **IJOS or other Diversion #:** |

## Prevention Youth

***Prevention Cases Only***

| | | |
|---|---|---|
| **Gender:**<br>1. Male<br>2. Female<br>3. Transgender (Female to Male)<br>4. Transgender (Male to Female)<br>5.Other | **Date of Birth:**_____ | **Pathway (Circle Current *Pathway to Dual Youth* Status):**<br>1. Youth who have been referred to Attendance Court due to excessive absences, and the Juvenile Court orders a Rule 16 Screening or Investigation based on information provided at the Attendance Court hearing.<br>2. Youth who have an open case in the child protection system and are committing delinquent acts but have not yet been formally charged.<br>3. Youth who have an open case with juvenile justice and there is evidence of maltreatment, but do not have an open case with child protective services and lack sufficient evidence to recommend a Rule 16 Investigation or Expansion. |

## Child Welfare Experience

***Prevention Cases Only***

| | | |
|---|---|---|
| **Identification Date:** | **In Care:**<br>1. No<br>2. Yes<br>3. Unknown<br>4. N/A | **Receiving Voluntary Services:**<br>1. No<br>2. Yes<br>3. Unknown<br>4. N/A |

## Arrest Referral Information

***Prevention Cases Only***

| | | | |
|---|---|---|---|
| **Was there contact with the Juvenile Justice System? (Yes/No)**<br>1. No<br>2.Yes<br>3.Unknown<br>4.N/A | **Was Youth Diverted? (N/A if no contact; Yes/No otherwise)**<br>1. No<br>2. Yes<br>3. Unknown<br>4. N/A | **Arrest & Release (N/A if no contact or Diverted; Yes/No otherwise)**<br>1. No<br>2. Yes<br>3. Unknown<br>4. N/A | **Detained (N/A if no contact, Diverted, or Arrested & Released; Yes/No otherwise)**<br>1. No<br>2. Yes<br>3. Unknown<br>4. N/A |

## Prosocial Programming

***Prevention Cases Only***

**Youth was involved with prosocial programming (Yes/No): (ex: after school program, mentoring program, church program, arts program, independent living program)**

1. No
2. Yes
3. Unknown
4. N/A

## Education

***Prevention Cases Only***

| **Attending School:** | **Youth has an Individualized Education Plan (IEP) or a 504 Plan:** |
|---|---|
| 1. No | 1. No |
| 2. Yes | 2. Yes |
| 3. Unknown | 3. Unknown |
| 4. N/A | 4. N/A |

## Mental Health

***Prevention Cases Only***

| **Youth has any identified mental health issues:** | **Youth has a pattern of substance use:** |
|---|---|
| 1. No | 1. No |
| 2. Yes | 2. Yes |
| 3. Unknown | 3. Unknown |
| 4. N/A | 4. N/A |

## Substance Use

***Prevention Cases Only***

**Youth has a pattern of substance use:**

1. No
2. Yes
3. Unknown
4. N/A

## *Crossover Youth Intake*

Date and Selection Decision

| **CPS/Supervisor Name:** | **Juvenile Probation/Diversion Officer/Court: Representative** | **Site Code (County):** | **What was the date on which this youth was identified as a dually-involved youth? (00/00/0000)** |
|---|---|---|---|
| 1. Lyndsey Walls<br>2. Amy Sweeten<br>3. Kallie Robinson<br>4. Ashley Vollmer<br>5. Krista Williams<br>6. Samantha Fuller<br>7. Savannah Matthews<br>8. Nichole Knowles<br>9. Penny Romane<br>10. Mel Tracy<br>11. Jerri Bergeman<br>12. Nicole Shackelford<br>13. Mark Peterson<br>14. Lisa Wilson<br>15. Bryson Vaughn | 1. Cody Brower<br>2. Anson Call<br>3. Jonathon Radford<br>4. Kristi Christopherson<br>5. Jill Davis<br>6. Connie Woodworth<br>7. Matt Olsen<br>8. Todd Mauger<br>9. Neomi Soto<br>10. Davey Burrell<br>11. Jesika Snyder<br>12. Dan Montgomery<br>13. Kora Jewell<br>14. Willie Walker<br>15. Tara Erickson<br>16. Kate Miller | 1. Bannock<br>2. Oneida<br>3. Power | _____ |

| | | | |
|---|---|---|---|
| | 17. Leslie Land<br>18. Robert Fernandez<br>19. Chuck Misner<br>20. Erin Flores | | |

| | |
|---|---|
| For Pre-Crossover Youth, enter referral/arrest date for all cases: _____ | **Youth is a Pre-Crossover Youth Practice Model Youth:**<br>1. No<br>2. Yes |

| | |
|---|---|
| **Through which pathway did this youth become identified as a dually-involved youth?**<br>1. Pathway 1: Open child welfare case (voluntary/preventative or formally adjudicated case) with subsequent delinquency charge.<br>2. Pathway 1A: Open child welfare case with subsequent charge in adult system.<br>3. Pathway 2: Delinquency charge with previous, but not current, child welfare case who was subsequently referred to child welfare.<br>4. Pathway 2A: Delinquency charge with previous, but not current, child welfare case who was NOT subsequently referred to child welfare.<br>5. Pathway 3: Delinquency charge with no previous child welfare case was subsequently referred for an abuse/neglect investigation | **At what processing stage was this youth identified as a dually-involved youth? (NOTE: may need adjusted)**<br>1. Not identified during processing (e.g. Pre-CYPM youth)<br>2. CW Shelter<br>3. Arrest/Referral<br>4. CW Intake<br>5. Juvenile Justice Intake<br>6. Pre-adjudication detention<br>7. Charging decision<br>8. Adjudication (i.e. by juvenile court or family/diversion court)<br>9. Time of case closure in delinquency<br>10. Transition from juvenile correctional institution to community.<br>11. Transition from adult correctional institution to community |

Demographics:

| | | | |
|---|---|---|---|
| **Date of Birth:** | **Youth's age (at the time they were identified as a dually-involved youth):**_____ | **Race:**<br>1. White/Caucasian<br>2. Black/African American<br>3. Asian-American<br>4. American Indian/Alaska Native<br>5. Latino<br>6. Mixed Race<br>7. Other | **Ethnicity:**<br>1. Hispanic/Latino<br>2. Non-Hispanic/Latino<br>3. Unknown |

| | |
|---|---|
| **Sex:**<br>1. Male<br>2. Female | **Gender Identity:**<br>1. Male<br>2. Female<br>3. Transgender (Female to Male)<br>4. Transgender (Male to Female)<br>5.Other |

| | |
|---|---|
| **Family Income (annual Household Income before taxes):** | **Number of people in household:** |

***Child Welfare Experience***

| | | |
|---|---|---|
| **At the time this youth was identified as a dually-involved youth, how many referrals to child welfare did this youth's family have?**_____ | **At the time this youth was identified as a dually-involved youth, how long (in months) has the current case been open in the child welfare system?**_____ | **Was Neglect a reason for their most recent entry into the child welfare system?**<br>1. No<br>2. Yes |

| | | |
|---|---|---|
| **Was Physical Abuse a reason for their most recent entry into the child welfare system?**<br>1. No<br>2. Yes | **Was Sexual Abuse a reason for their most recent entry into the child welfare system?**<br>1. No<br>2. Yes | **Was Sex Trafficking a reason for their most recent entry into the child welfare system?**<br>1. No<br>2. Yes |
| **Was a Felony Injury to Child/L&L a reason for their most recent entry into the child welfare system?**<br>1. No<br>2. Yes | **Another reason for their most recent entry into the child welfare system (specify):_____** | |
| **What type of <u>child welfare services</u> were they receiving during his/her most recent involvement in the child welfare system?**<br>1. NA – No current or prior involvement with child welfare system.<br>2. Voluntary/Preventative services<br>3. Court-imposed services | **At the time this youth was identified as a dually-involved youth, did they have <u>any placements</u> while in the care of child welfare?**<br>1. Yes<br>2. No current or prior involvement with CW<br>3. No placements during involvement with CW | **How many placements did they have while in the care of child welfare? (Count all placements experienced during entire involvement with the child welfare system) _____** |
| **Number of Relative Foster/Kinship placements?_____** | **Number of Non-Relative Foster Placements?_____** | **Number of Congregate Care placements?_____** |
| **Number of Residential Treatment Center placements?_____** | **Number of Hospitalization placements?_____** | **Number of Other placements?_____** | **Other placements (specify):_____** |

| ***Arrest-Referral Information*** | | |
|---|---|---|
| **Date of Contact: (NOTE: arrest, citation, referral)**<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____ | **What is the current arrest/referral for? (NOTE: If multiple charges in arrest, please indicate the most serious charge only.)**<br>1. Property Damage<br>2. Conflict<br>3. Drug Charge<br>4. Sex Offense<br>5. Weapons<br>6. Public Nuisance<br>7. Theft<br>8. Fraud<br>9. Trespassing<br>10. Alcohol<br>11. Tobacco<br>12. Runaway<br>13. Curfew<br>14. Beyond Parental Control<br>15. Truancy<br>16. None | **Was this offense related to a violation of probation?**<br>1.No<br>2.Yes |
| **What category of offense was this charge?**<br>1. Misdemeanor<br>2. Felony<br>3. Status Offense | **Was this youth placed in a pre-adjudication secure detention for 24 hours or longer at time of arrest/referral? (Including weekends and holidays)**<br>1. No<br>2. Yes | **If yes, for how many days? (Include weekends and holidays)_____** |

| | | |
|---|---|---|
| **If youth remained in detention, was their stay due to any of the following?**<br>1. NA – Youth was not detained after arrest/referral<br>2. No – Stay was not related these issues<br>3. Court Closure due to weekends and/or holiday<br>4. Inability to find a placement to release the youth to (i.e. youth could have been released if there had been a place for them to go) | **What was youth's living situation (of record if AWOL/runaway) at the time they were arrested/referred to the juvenile justice system?**<br>1. Home<br>2. Relative Foster/Kinship Placement<br>3. Non-Relative Foster Care<br>4. Adoptive Placement<br>5. Shelter<br>6. Congregate Care/Group Home<br>7. Residential Treatment Center<br>8. Hospital<br>9. Supervised Independent Living<br>10. Correctional Facility<br>11. Other | **Other Living Situation (specify):**_____<br>_____ |
| **Was this youth AWOL/Runaway at the same time they were arrested/referred to the juvenile justice system?**<br>1. No<br>2. Yes | **What was the youth's permanency goal at the time they were arrested to the juvenile justice system?**<br>1. Not Applicable-Not a pathway 1 youth<br>2. Remain at home<br>3. Reunification<br>4. Adoption<br>5. Guardianship<br>6. Permanent Planned Living Arrangements<br>7. Other | **Other permanency goal (specify):**_____<br>_____ |
| **Did this offense occur at the place the youth was living at the time? (e.g., home or placement)**<br>1. No<br>2. Yes<br>3. Unknown | **Did this offense occur at youth's school?**<br>1.No<br>2. Yes<br>3.Unkown | **At the time of this offense, did this youth have any prior arrests for criminal charges?**<br>1. No<br>2.Yes |
| **If yes, how many times was the youth arrested? (prior arrests)**_____ | **At the time of this offense, did this youth have any prior arrests/contacts for status offenses? (e.g. running away, beyond parental control, curfew, truancy, tobacco)**<br>1. Yes – status offense<br>2. No<br>3. Not Applicable (System doesn't capture) | |

***Relationship Contacts***

At the time the youth was identified as a dually-involved youth, did they have a consistent and stable contact (i.e. predictable and positive contact) with any of the following family members and/or other significant, positive adults below?

| | | | | |
|---|---|---|---|---|
| **Biological Mother:**<br>1. No<br>2. Yes | **Biological Father:**<br>1. No<br>2. Yes | **Other Legal Parent:**<br>1. No<br>2. Yes | **Adoptive Parent:**<br>1. No<br>2. Yes | **Legal Guardian:**<br>1. No<br>2. Yes |
| **Step-Parent:**<br>1. No<br>2. Yes | **Grandparent:**<br>1. No<br>2. Yes | **Aunt/ Uncle:**<br>1. No<br>2. Yes | **Siblings (at least one):**<br>1. No<br>2. Yes | **Foster Parent:**<br>1. No<br>2. Yes |
| **Friend of the family:**<br>1. No<br>2. Yes | **Mentor:**<br>1. No<br>2. Yes | **Teacher, School Counselor, or Coach:**<br>1. No | **Someone at church:**<br>1. No<br>2. Yes | **Unknown:**<br>1. No<br>2. Yes |

| | | | | |
|---|---|---|---|---|
| | | 2. Yes | | |

## *Prosocial Programing*

At the time the youth was identified as a dually-involved youth, were they involved in any of the prosocial programing listed below?

| | | | |
|---|---|---|---|
| **Afterschool program:**<br>1. No<br>2. Yes | **Mentoring program:**<br>1. No<br>2. Yes | **Church program:**<br>1. No<br>2. Yes | **Arts program (e.g., art, writing, theatre, dance, etc.):**<br>1. No<br>2. Yes |
| **Independent living program:**<br>1. No<br>2. Yes | **Other prosocial programming?**<br>1. No<br>2. Yes | **If other, enter activity name:**<br>1. No<br>2. Yes<br>3. Other: _____ | **It is unknown if they were involved in any pro-social activities:**<br>1. No<br>2. Yes |

## *Educational Status*

What was the youth's educational status at the time they were identified was a dually-involved youth OR, if not enrolled, at the time they stopped attending school?

| | | | |
|---|---|---|---|
| **Was youth enrolled in school or an educational program?**<br>1. No – not enrolled<br>2. No – graduated or completed GED<br>3. Yes – enrolled and attending<br>4. Yes – enrolled but not attending<br>5. Unknown | **Was youth experiencing academic or behavioral problems at school? (e.g. poor performance)**<br>1. No<br>2. Yes – academic (i.e., poor performance in the classroom leading up to the referral/arrest.)<br>3. Yes – behavioral (i.e., youth received disciplinary actions, suspensions, or expulsions within the past 6 months prior to being identified).<br>4. Yes – exhibited problems in both areas<br>5. Unknown | **Did youth have an Individual Education Plan?**<br>1.No<br>2. Yes | **If yes, what was the primary reason for Individual Education Plan?**<br>1. Autism spectrum disorder<br>2. Intellectual delay<br>3. Blindness or visual impairment<br>4. Deaf or hard of hearing<br>5. Developmental delay<br>6. Emotional behavioral disorder<br>7. Other health impairment<br>8. Specific learning disorder<br>9. Multiple disabilities<br>10. Orthopedic impairment<br>11. Speech or language impairment: Language<br>12. Speech or language impairment: Speech<br>13. Traumatic Brain Injury |

## *Mental Health – Substance Abuse*

At the time youth was identified as dually-involved youth, was there any indication that the youth suffered from mental health or substance abuse problems?

| | |
|---|---|
| **Mental health problems:**<br>1. No indication of mental health problems<br>2. Yes – some indication of symptoms<br>3. Yes – diagnosed with mental health disorders (i.e. received DSM-IVR diagnoses). | **Alcohol and/or drugs:**<br>1. No<br>2. Yes – use/misuse (indications of use but doesn't form a pattern, e.g. youth has tried marijuana once or twice).<br>3. Yes – pattern (use is regular and consistent, -e.g. youth uses marijuana every day before school).<br>4. Yes – abuse (youth has received a diagnosis of substance abuse).<br>5. Yes – dependency (youth has received a diagnosis of substance dependency). |

| If youth has evidence of a pattern of use, substance abuse, or substance dependency, which of the following is a problem for the youth? Answer questions below with yes/no answers; specify when requested. | | | |
|---|---|---|---|
| **Alcohol –** youth exhibits a pattern of use or has diagnosis for abuse or dependency:<br>1. No<br>2.Yes | **Marijuana –** youth exhibits a pattern of use or has diagnosis for abuse or dependency:<br>1. No<br>2.Yes | **Inhalants –** youth exhibits a pattern of use or has diagnosis for abuse or dependency:<br>1. No<br>2.Yes | **Other drugs such as cocaine/crack methamphetamine, heroin ecstasy, over the counter, etc. –** youth exhibits a pattern of use or has diagnosis for abuse or dependency:<br>1. No<br>2.Yes |

| ***9-Month and Promising Practices*** | | | | |
|---|---|---|---|---|
| 9-Month Tracking Sheet: Follow-Up Data April 1, 2018 – December 31, 2018 | | | | |
| **Was youth's CPS case closed within last 9 months?**<br>1. No<br>2.Yes | **If yes, what was the date of CPS case closure?**<br>_____<br>_____ | **Was youth's Juvenile Justice Case closed within the last 9 months? (Closed=diversion/ disposition successfully terminated from court supervision).**<br>1. No<br>2.Yes | **If yes, what was the date of Juvenile Justice case closure?**<br>_____<br>_____ | **Did youth's system involvement in both systems end before the 9-month mark (after initially identified) was reached?**<br>1. No<br>2.Yes |
| USE OF PROMISING PRACTICES: In the past 9 months, were any of the following promising practices used during the process of this youth? | | | | |
| **Was an interagency planning meeting (formal communication to facilitate the exchange of pertinent information) held and a joint assessment completed regarding this youth?**<br>1. No<br>2.Yes | **Was a Multidisciplinary Team (MDT) Meeting (involving CW, JJ, Behavioral Health, and Education, at a minimum) held and a joint assessment completed regarding this youth?**<br>1. No<br>2.Yes | **Was the youth present in at least one multi-disciplinary or interagency meeting regarding decision making?**<br>1. No<br>2.Yes | **Was the youth present at a least one multi-disciplinary or interagency meeting regarding case management?**<br>1. No<br>2.Yes | |
| **Was the youth's family/caregiver/committed adult present in at least one multi-disciplinary meeting regarding decision making?**<br>1. No<br>2.Yes | **Was the youth's family/caregiver/committed adult present in at least one multi-disciplinary meeting regarding case management?**<br>1. No<br>2.Yes | **Was the youth's case referred to a case management and/or supervision team designated for the supervision of dually-involved youth in the community?**<br>1. No<br>2.Yes | **Did Child Welfare and Juvenile Justice develop a unified case plan for this youth?**<br>1. No<br>2.Yes | |
| **Was permanency specifically discussed while creating and reviewing this youth's case plan?**<br>1. No<br>2.Yes | **Was this youth provided with wrap-around services specifically for dually-involved youths?**<br>1. No<br>2.Yes | **Other Special Handling?**<br>1. No<br>2.Yes | **Special Handling (specify):**_____<br>_____<br>_____<br>_____<br>_____ | **None of the above was applicable:**<br>1. No<br>2.Yes |
| ***Child Welfare Outcomes*** | | | | |
| CHILD WELFARE OUTCOMES: This is where we are at in the process | | | | |
| **What was the youth's living situation 9 months after they were identified as a dually-involved youth?**<br>1. Home<br>2. Relative Foster/Kinship Placement<br>3. Non-Relative Foster Care | **If other, please specify:**_____<br>_____<br>_____ | **What was youth's permanency goal 9 months after they were identified as a dually-involved youth?**<br>1. CW case closed; youth reunified<br>2. CW case closed; youth in independent living | | |

| | | |
|---|---|---|
| 4. Adoptive Placement<br>5. Shelter<br>6. Congregate Care/Group Home<br>7. Residential Treatment Center<br>8. Hospital<br>9. Supervised Independent Living<br>10. Correctional Facility or secure Detention<br>11. Other<br>_____<br>12. Not yet 9 months since identified as dually involved youth. | | 3. Remain at home<br>4. Reunification<br>5. Adoption<br>6. Guardianship<br>7. Permanent planned living arrangements<br>8. Other |

JUVENILE JUSTICE INFORMATION:

| | |
|---|---|
| **What outcome/disposition did this youth receive for this charge?**<br>**(NOTE: if this decision has not been made by the 9-month tracking date, you must update this information when it becomes available)**<br>1. Conditional dismissal (Prosecutor conditionally dismissed charge/petition with no court adjudication or disposition)<br>2. Non-Court diversion/dismissal (Charge/petition was referred to pre-court diversion program; charges/petition was not entered into the court system)<br>3. Court diversion/dismissal (Charge/petition was referred to court; adjudication and disposition will be dismissed upon successful completion of court order)<br>4. Informal Adjustment (charge/petition was referred to court; adjudication and disposition will be dismissed upon successful completion of court order)<br>5. Formal Probation<br>6. Formal Probation and commitment to Idaho Department of Juvenile Correction<br>7. Waived to Adult Court, sentenced as an adult | **What was the living situation at the 9-month tracking date?**<br>1. Home on probation – Juvenile<br>2. Home not on probation – Juvenile<br>3. Congregate care/group home<br>4. Residential treatment center/hospital<br>5. Juvenile Correctional Institution or Alternative – County<br>6. Juvenile Correctional Institution or Alternative – State<br>7. Home on Probation – Adult<br>8. Home not on Probation – Adult<br>9. Adult Correctional Institution/Alternative |

| | | |
|---|---|---|
| **If youth was adjudicated for this offense, what was the offense for which they were adjudicated?**<br>**(NOTE: if multiple charges in an arrest, please indicate the most serious charge only)**<br>1. Property Damage<br>2. Conflict<br>3. Drug Charge<br>4. Sex Offense<br>5. Weapons<br>6. Public Nuisance<br>7. Theft<br>8. Fraud<br>9. Trespassing<br>10. Alcohol<br>11. Tobacco<br>12. Runaway<br>13. Curfew<br>14. Beyond Parental Control<br>15. Truancy<br>16. None | **What type of charge was this?**<br>1. Misdemeanor<br>2. Felony<br>3. Status Offense | **Was youth charged as an adult or waived to adult court?**<br>1. No<br>2. Yes |

| ***Recidivism-CW and JJ*** | | | |
|---|---|---|---|
| **Recidivism-Child Welfare and Juvenile Justice- JJ Recidivism - Note: For situations in which the juvenile is arrested as a juvenile but subsequently is given a hearing to waive the case to adult court, please code in the following ways:** 1. If the decision to waive the case to adult court occurred within the 9-month period, count the youth in the new arrests as an adult. 2. If the decision to waive the adult court is not made within the 9-month period, count the youth in the new arrests as a juvenile. | | | |
| **If child welfare case was closed prior to 9-month tracking date, did youth or family have another referral to the child welfare system between the case closure and 9 months after the youth was identified as a dually-involved youth?**<br>1. No<br>2.Yes<br>3.N/A | **Did this youth have any new arrests/referrals (as a juvenile) within 9 months of being identified as a dually-involved youth? (NOTE: Must be at 9-month mark when case(s) is not closed)**<br>1. No<br>2. Yes – Juvenile Criminal Charges<br>3. Yes – Adult Criminal Charges<br>4. Yes – Status Offenses | **If youth had new arrests/referrals (as a juvenile) within 9 months of being identified as a dually-involved youth, how many did they have?_____** | **Did this youth have any new sustained petitions (i.e. found responsible/guilty for charges) in the juvenile justice system within 9 months of being identified as a dually-involved youth? (NOTE: Must be at 9-month mark when case(s) was not closed.)**<br>1. No<br>2. Yes – Juvenile Criminal Charges<br>3. Yes –Adult Criminal Charges<br>4. Yes – Status Offenses |
| If youth had new sustained petitions within 9 months, how many juvenile criminal charges were there?_____ | If this youth had any new sustained petitions (i.e. found responsible/guilty for charges) in the juvenile justice system within 9 months of being identified as a dually-involved youth, how many did they have?_____ | If youth had new sustained petitions within 9 months, how many adult criminal charges were there?_____ | If youth had new sustained petitions within 9 months, how many status offense charges were there?_____ |

| ***Joint Coordinated Assessment*** | |
|---|---|
| **In the past 9 months, did youth receive a joint/coordinated assessment/meeting after being identified as a dually-involved youth?**<br>1. No<br>2.Yes | **If youth received a joint/coordinated assessment/meeting, at what point in the process did this occur?**<br>1. Not applicable – did not receive joint assessment/meeting<br>2. Anytime between arrest/referral and giving the youth diversion or adjudicating them (i.e., pre-adjudication)<br>3. Post-adjudication/pre-disposition<br>4. Shortly after (within one month) after disposition<br>5. Toward the end of the youth's completion of disposition |

If youth received a joint/coordinated assessment/meeting, who was involved in the assessment? Answer all questions below with yes/no answers.

| **Not Applicable - did not receive a joint assessment/meeting:**<br>1. No<br>2.Yes | **Youth's CPS/Social Worker:**<br>1. No<br>2.Yes | **Youth's Probation Officer:**<br>1. No<br>2.Yes | **Education Representative:**<br>1. No<br>2.Yes | **Mental Health Representative:**<br>1. No<br>2.Yes |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **Substance Abuse Representative:**<br>1. No<br>2.Yes | **The Youth:**<br>1. No<br>2.Yes | **The Youth's parents/ guardians/ caregivers:**<br>1. No<br>2.Yes | **Other:**<br>1. No<br>2.Yes | **Other Specified:**<br>1. No<br>2.Yes |
| ***9 Months School Relations Etc.*** | | | | |
| 9 months after the youth was identified as a dually-involved youth, did they have consistent and stable contact (i.e. predictable and positive contact) with any of the following family members and/or other significant, positive adults? | | | | |
| **No contact with any family member or significant positive adult:**<br>1. No<br>2. Yes | **Biological Mother:**<br>1. No<br>2. Yes | **Biological Father:**<br>1. No<br>2. Yes | **Other Legal Parent:**<br>1. No<br>2. Yes | **Adoptive Parent:**<br>1. No<br>2. Yes |
| **Legal Guardian:**<br>1. No<br>2. Yes | **Step-Parent:**<br>1. No<br>2. Yes | **Grandparent:**<br>1. No<br>2. Yes | **Aunt/Uncle:**<br>1. No<br>2. Yes | **Siblings (at least one):**<br>1. No<br>2. Yes |
| **Foster Parent:**<br>1. No<br>2. Yes | **Friend of the family:**<br>1. No<br>2. Yes | **Mentor:**<br>1. No<br>2. Yes | **Teacher/School Counselor/ Coach:**<br>1. No<br>2. Yes | **Someone at church:**<br>1. No<br>2. Yes |
| **Other Positive Community Member:**<br>1. No<br>2. Yes | | **Other Positive Community Member Specified:**_____ | | |
| 9 months after the youth was identified as a dually-involved youth, were they involved in any prosocial programming? (e.g. afterschool program, mentoring, extracurricular activities, etc.) | | | | |
| **Is the youth involved in any pro-social programing?**<br>1.No<br>2.Yes<br>3.Unkown | **Is the youth involved in an afterschool program?**<br>1.No<br>2.Yes<br>3.Unkown | **Is the youth involved in a mentoring program?**<br>1.No<br>2.Yes<br>3.Unkown | **Is the youth involved in a church program?**<br>1.No<br>2.Yes<br>3.Unkown | |
| **Is the youth involved in an Arts program? (e.g. art, writing, theatre, dance, etc.)**<br>1.No<br>2.Yes<br>3.Unkown | **Is the youth involved in an independent living program?**<br>1.No<br>2.Yes<br>3.Unkown | **Other pro-social programming?**<br>1.No<br>2.Yes<br>3.Unkown | **If other, please specify.**<br>1.No<br>2.Yes<br>3.Unkown | |
| 9 months after they were identified as a dually-involved youth: | | | | |
| **Is the youth enrolled in school or educational program?**<br>1. No – not enrolled<br>2. No – graduated or completed GED<br>3. Yes – enrolled and attending<br>4. Yes – enrolled but not attending | **Was there any indication that there had been improvement in the youth's academic performance (or if currently not enrolled, at the time they stopped attending school)?**<br>1. No<br>2.Yes | **Was there any indication that there had been improvement in the youth's behavior at school (or if currently not enrolled, at the time they stopped attending school)?**<br>1. No<br>2.Yes | **Was there any indication that the youth's mental health had changed?**<br>1. Not applicable – No evidence of mental health problems when identified as a dually-involved youth or now<br>2. No – condition has remained the same<br>3. Yes – condition worsened | |

| | | | |
|---|---|---|---|
| | | | 4. Yes – condition improved |
| ***Assessment and Services*** | | | |
| What types of assessments/services did the youth receive after they were identified as a dually-involved youth? | | | |
| **Further Mental Health Assessment:**<br>1. No<br>2.Yes | **Further Educational Assessment:**<br>1. No<br>2.Yes | **Juvenile Justice Assessment (Risk/Needs):**<br>1. No<br>2.Yes | **CW Comprehensive Assessment:**<br>1. No<br>2.Yes |
| **Medication Assessment/Maintenance:**<br>1. No<br>2.Yes | **Mental Health Treatment:**<br>1. No<br>2.Yes | **Sex Offender Treatment:**<br>1. No<br>2.Yes | **Substance Abuse Treatment:**<br>1. No<br>2.Yes |
| **Behavioral/Social Interventions:**<br>1. No<br>2.Yes | **Educational Services:**<br>1. No<br>2.Yes | **Other Assessment/Services:**<br>1. No<br>2.Yes | **Other Assessment Specified:**_____ |
| Did this youth receive any services specifically related to the development of independent living skills since they were identified as a dually-involved youth? | | | |
| **Vocational assessment and employment:**<br>1. No<br>2.Yes | **Household maintenance, budgeting, shopping:**<br>1. No<br>2.Yes | **College and higher education planning:**<br>1. No<br>2.Yes | |
| **Understanding how to navigate the healthcare system/health life choices:**<br>1. No<br>2.Yes | **Other services specifically related to independent living skills:**<br>1. No<br>2.Yes | **Other Specified:**_____ | |

**Bannock County Juvenile Justice**

**Rule 16 (Crossover Youth) Facilitator's Guide**

**Purpose: The purpose of a Rule 16 staffing is to develop an integrated case management plan that promotes the healthy development of youth, increases safe and responsive caregiving, and protects the community. Activities in the plan should reduce external sources of stress, develop responsive relationships with caregivers and other adults, and strengthen core life skills.**

**I Welcome and Introductions**

- Have each participant introduce themselves and which agency they represent.
- Have the family and their support members introduce themselves and their relationship to the juvenile.
- Set ground rules of respectful communication – no interrupting, accepting different opinions and ideas, no yelling etc.

**II Discuss the purpose and objectives of the Screening Team, and provide a brief overview of the case history (e.g. current status with juvenile justice such as a diversion or probation case and current status with IDHW such as protective supervision).**

**III. Discuss confidentiality**

- Explain limits of confidentiality
- Identify the purpose of the meeting
- Identify who will receive copies of the report

**IV Briefly Review Juvenile History**

- History of mental health issues or substance abuse treatment
- Family Structure & Dynamics
- Parental, guardian or custodian engagement in counseling and treatment designed to develop positive parenting skills and understanding of the family's role in the juvenile's behavior.
- Academic Performance and School Behavior
- Prior intervention and treatment efforts by the family and/or the community
- Prior offenses
- Current and prior risk/need assessments

**V Identify current and potential risks factors to the safety and health and welfare of the youth**

- Give each member of the screening team an opportunity to state the potential risks to the safety and well-being of the youth. Encourage each participant to share objective indicators for their opinions It may be helpful to provide screening team members

with a list of the Safety Risk Factors and Needs – CPS as identified on the Family Case Management Plan
(IF A RULE 16 INVESTIGATION OR EXPANSION HAS BEEN ORDERED, THE CPS INVESTIGATOR WILL OUTLINE THE RISK FACTORS IDENTIFIED IN THE INVESTIGATION).

- List identified risk factors on a flip-chart or white-board. If multiple risk factors are identified, work with the group to develop a consensus in prioritizing the risk factors – with priority given to risk factors that could cause death or significant injury/illness.

## VI Develop a Safety Management Action Plan

1. Develop measurable objectives that when accomplished will reduce the risk of endangering the safety and well-being of the youth.
2. Service/Action Steps (Interventions) that will lead to the accomplishment of the identified objectives.
3. Identification of who is responsible for initiating and following up on the action step.
4. A timeline for when the service/action step will be implemented

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## VII Develop a Family Action Plan

1. Work with team members to develop measurable objectives that when accomplished will promote increased safe and responsive caregiving by caregivers and other family members. The following are ideas of topics to consider in the Family Action Plan:
   Responsivity of Caregivers to Youth
   a. Increased parental/guardian emotional regulation and coping skills
   b. The development and implementation of parent child interaction and parent management skills that promote healthy youth development.
      1) Implementation of clear and consistent boundaries and expectations
      2) Non-coercive communication
      3) Frequent expressions of nurturance from caregiver to youth
      4) Effective monitoring and supervision.
   c. Stable employment or income that adequately meets the basic needs.
   d. Widen the circle of natural family supports by identifying other adults that can serve as mentors and positive support to youth (extended family, clergy, neighbors, coaches, etc.)

   Responsivity of Team Members to Caregivers and Youth – What do caregivers say they need?
   a. Provide access to services that do not conflict with other important caregiver roles such as employment.
   b. Support efforts to resolve conflicts in scheduling when they occur so that families can participate in services.

c. Coordinate schedules to reduce required separate meetings with multiple agencies.
d. Reduce duplication of services
e. Access to caseworkers, probation officers, counselors etc. during a crisis, including after hours and weekends.
f. Assistance with transportation.
g. Support access to participation of the youth in pro-social extra-curricular activities.
h. Respite
i. Provide information regarding access to food, utility, and housing assistance.
j. Recognition and affirmation of family strengths and progress.
k. Reductions or adjustments in financial requirements imposed by agencies.

2. Identify services/action steps that will assist in achieving the objectives.
3. Identify the person responsible for facilitating the access to services or the next action step.
4. Develop a timeline for when the objective will be achieved.

**VIII Develop an Education/Employment Action Plan**

1. Work with the team to evaluate the academic performance, attendance history, behavior history, responsivity of school personnel to the needs of youth and parents, and testing and services to support educational achievement.
2. Evaluate current caregiver efforts to support education achievement. Identify activities that if performed by the caregiver would enhance educational achievement.
3. Work with team members to develop measurable objectives that when accomplished will maintain or promote educational achievement.
4. Identify services/action steps that will assist in achieving the objectives.
5. Identify the person responsible for facilitating the access to services or the next action step.
6. Develop a timeline for when the objective will be achieved.

**IX Positive Peer Involvement**

1. Work with the team to evaluate the impact of peer influence
   a. Some delinquent acquaintances
   b. Some delinquent friends
   c. No/few positive acquaintances
   d. No/few positive friends.
2. Work with the team to develop measurable objectives to maintain or increase the influence of positive peer association, and neutralize the influences of negative peer association.
3. Identify services/action steps that will assist in achieving the objectives
4. Identify the person responsible for facilitating the access to services or the next action step.
5. Develop a timeline for when the objectives will be achieved

**X Substance Abuse Prevention Action Plan**

1. Work with the team to evaluate current substance abuse risks and needs.

a. Occasional drug/alcohol use
b. Chronic drug/alcohol use
c. Substance abuse interferes with life
d. Substance abuse is linked to offenses

2. Work with the team to develop measurable objectives to address risks and needs associated with substance use and abuse.
3. Follow steps 3,4, & 5 in section IX

**XI Mental Health Action Plan**

1. Work with the team to evaluate current mental health needs
2. Work with the team to develop measurable objectives to improving mental health of the youth/caregivers
3. Follow steps 3,4, & 5 in Section IX

**XII Accountability to Victims and Community Plan**

1. Work with the team to evaluate who has been harmed by the behavior of the youth.
2. Develop an accountability plan that will help the youth with the following:
   a. Understand the impact his/her behavior as had on others
   b. Steps that the youth can take to repair the harm
      1) Restorative Conference
      2) Letter of Apology
      3) Restitution
3. Follow steps 3, 4, & 5 in section IX.

**XIII Conclusion and Summary**

1. Provide a summary of the action plans in the identified areas
2. Determine the date and time for the next meeting – and the frequency

**For a combined Rule 16 & Rule 19 evaluate the following criteria**

- Categorize the potential risks on a flip chart on the following categories:
  a. Risk for Physical Violence or Crimes That Could Result in Serious Bodily Injury or Death to Others (Settings)

  b. Risk for Offenses of a Sexual Nature (Settings)

  c. Risk for the Property Rights of Others

  d. Demonstrating a pattern of misdemeanor or felony criminal behavior, escalating in its impact on public safety or the juvenile's safety or well-being over time.

FLIP CHART EXAMPLE

| | |
|---|---|
| Identified Risk for Physical Violent/Serious Bodily Injury | Settings<br>• Occurs at Home |

| | |
|---|---|
| • Verbal Threats to kill parents<br>• Physically assaulted parents with a stick<br>• Held a knife to step-mom's throat | • No history of violence or behavior problems in the school or in the community |
| Identified Risks for Offenses of a Sexual Nature<br><br>No Risk Identified | Settings<br><br>NA |
| <u>Sale, Manufacture, Delivery of Controlled Substance</u><br><br>• Current history of drug use. Rumors of dealing, but no charges | <u>Settings</u><br><br>Community |
| <u>Risk for Property Rights of Others</u><br><br>• Takes parents car without permission. Sneaks out | <u>Settings</u><br><br>Home |
| | |

- Ask each member to identify the most serious threat to the community. Develop a consensus regarding the top 3 risks to the community.

- Have a discussion with the screening team about what conditions or safeguards could possibly be developed to reduce and effectively manage the identified risks. Start with the highest identified risk. List the ideas on the flipchart. Give everyone an opportunity to respond. This is brainstorming. Everyone should be invited to share an idea. We are not evaluating the ideas at this point. This is a discussion about what needs to change. List the ideas on the flipchart.

- From the list generated, work with the group to develop a consensus regarding the most important and necessary safeguards and conditions that would need to exist in order to effectively reduce and manage the risk. Place this on the flipchart under the identified risk.

- Identify any barriers that may exist with respect to the family or system engagement in implementing the recommended monitoring/supervision conditions.

- Identify the family and system strengths that can be called upon to help ensure the success of the implementation of a safety plan that could effectively reduce and manage the risk. (This can include extended family member support and other close family supports that have agreed to participate in the safety plan) parents engagement and commitment to follow through with the safety plan, etc.

  From a system standpoint, strengths may include the ability to make frequent home visits, to use an on-call probation officer to consult with the parents after hours, frequent drug testing, etc.

**If the risk the juvenile poses to the community is high and in a high threat category (violence, sexual nature etc) and the group cannot develop conditions and safeguard that could adequately reduce and manage the risk to the community – OR if the conditions and safeguards are identified, but the family and system strengths are not able to meet the needs of those conditions – then there is no need to move on to the next step. Community safety requires the long-term placement of the juvenile in a secure setting.**

**In the event that conditions and safeguards are developed that could adequately reduce and manage the risk AND the family and system has identified strengths that will ensure the likelihood of successful implementation – GO TO THE NEXT STEP.**

**I. Identify the Competency and Skill Development needs of the juvenile and parents**

- Review the competency and skill development Action Plans in sections VII - XII

- Develop a Consensus with the group on the top 3 Competency or skill development needs at this time.

- Priority should be given to criminogenic risk factors in the YLSI domains of Attitudes and Orientation, Personality and Behavior, and Family Circumstances.

**II Identify community based interventions that utilize evidence based practices to effectively address the identified treatment needs.** Identify any barriers that may exist in implementing the evidence based intervention and work to resolve the barriers focusing on family and system strengths.

*** If the risk the juvenile poses to the community is high and in a high threat category (violence, sexual nature etc) and the group cannot identify or access community based interventions that use evidence based practices to effectively address the treatment needs OR either the family or the system do not have the capacity to resolve the barriers to effective implementation of community based counseling/treatment programs, the safety of the community requires a long-term placement of the juvenile in secure setting where the needed treatment can be obtained.**

**III** **Review with the participants the outcome of the decision and the identified plan. Ask each person whether or not they support the decision that the group has determined to be the appropriate actions.**

**IV** **Thank the group members for their participation and cooperation.**

# Bannock County Juvenile Justice
## Rule 16 Screening Report

| Juvenile Information | | |
|---|---|---|
| Juvenile Name: | Case No: | Date of Birth: |
| Parent/Guardian: | Relationship: | Phone: |
| Parent/Guardian: | Relationship: | Phone: |
| Parent/Guardian: | Relationship: | Phone: |
| Parent/Guardian: | Relationship: | Phone: |

| Screening Team Information | |
|---|---|
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |

| Juvenile and Family Detailed History |
|---|
| History of Mental Health issues/Substance Abuse Treatment: |
| Family Structure and Dynamics – Include any specific or potential threats of danger or safety: |
| Parental, Guardian, Custodian Engagement in Counseling and Treatment Designed to Develop Positive Parenting Skills and Understanding of the Family's Role in the Child's Behavior: |
| Academic Performance, School Behavior, Attendance & Education Needs (e.g IEP): |
| Prior Interventions and Treatment Efforts by the Family and/or Community: |

| |
|---|
| |
| Prior Offenses: |
| Current and Prior Risk/Needs Assessments: |

| **Community-based Monitoring and Supervision Needs to Adequately Address Youth Safety and Community Protection** | |
|---|---|
| **Home and Community Based Supervision Needs** | **Objective and Subjective Assessment of Family and System Strengths and Capacity to Meet the Need/Potential Barriers** |
| | |
| | |
| | |
| | |
| **Community-Based Competency Development Programs to Adequately Address Needs and Risks** | |
| **Evidence-based Community Intervention Program/Treatment/Counseling Services** | **Objective/Subjective Assessment of Family & System Strengths & Capacity to Engage & Implement the Intervention Program/Potential Barriers** |
| | |
| | |
| | |
| | |

| **Screening Team Recommendations** | | | |
|---|---|---|---|
| **Participant/Role** | **Recommendation** | **Participant/Role** | **Recommendation** |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| | | | |

Report Prepared by:

_____ _____

Signature Date

# Family Case Management Plan

District 6 Crossover Youth Bannock County

| | |
|---|---|
| Date of Plan: | Date of Next Review: |
| Assigned CPS Supervision Level:Voluntary | Assigned JJ Risk Level:Low |

| **Child's Information** | | | |
|---|---|---|---|
| Child's Name: | DOB: | Gender: | CP Case #<br>JJ Case # |
| Current Address: | Current Status: Home on Diversion | | Telephone: |

| **Family Information** | | |
|---|---|---|
| Mother's Name: | Address: | Phone: |
| Father's Name: | Address: | Phone: |
| Guardian: | Address: | Phone: |
| Guardian: | Address: | Phone: |
| Family Member: | Address: | Phone: |
| Family Member: | Address: | Phone: |
| Family Member: | Address: | Phone: |
| Family Member: | Address: | Phone: |

| **Meeting Participants** | |
|---|---|
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |

**Screening/Assessment Utilized**

☐ Safety Assessment (CPS) ☐ Child and Adolescent Needs and Strengths ☐ MAYSI 2
☐ YLS/CMI (JJ) ☐ Substance Abuse Assessment (GAIN-I) ☐ Suicide Risk Assessment
☐ Mental Health Evaluation ☐ Psychological/Neuropsychological ☐ Individual Education Plan
☐ Adverse Childhood Experiences Questionnaire
☐ Other (explain)_____

**Identified Risk Factors and Needs**

| **Safety Risk Factors & Needs – CPS** | | **Criminogenic Risk Factors & Needs - JJ** | |
|---|---|---|---|
| ☐ Abandonment | ☐ Physical Abuse | ☐ Offense History/Dispositions | ☐ Mental Health |
| ☐ Medical Neglect | ☐ Education Neglect | ☐ Family Circumstances/Parenting | ☐ Dev. Delay |
| ☐ Malnutrition | ☐ Hazardous Home | ☐ Education/Employment | ☐ Financial Problems |
| ☐ Sex Abuse | ☐ Cruel Restraint | ☐ Peer Relations | ☐ Parent Drug Abuse |
| ☐ Emotional Abuse | ☐ Inadequate Shelter | ☐ Substance Abuse | ☐ Parent Mental Health |
| ☐ Neglect | | ☐ Leisure/Recreation | |
| ☐ Chronic Lack of Supervision | | ☐ Personality/Behavior | |
| | | ☐ Attitudes/Orientation | |

**Safety Management Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Progress Update:**

**Joint Permanency Planning (If Applicable)**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Progress Update:**

**Family Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Progress Update:**

---

**Education/Employment Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Progress Update:**

**Positive Peer Involvement Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Progress Update:**

**Substance Use Prevention Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Progress Update:**

**Mental Health Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Progress Update:**

**Accountability to Victims & Community Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Progress Update:**

**Additional Action Items**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Progress Update:**

**Incidents/Issues That Will Trigger a Follow-up Meeting**

| | |
|---|---|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

**Upcoming Court Dates/ Other Scheduled Meetings**

| Date and Time of Hearing/Meeting | Meeting Purpose | Meeting Place |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

ACKNOWLEDGEMENT

By signing below, each party acknowledges that he/she understands the goals of this plan and agrees to diligently work toward the achievement of these goals to enhance the safety of the child and the community.

| Participant Signature | Relationship to Child | Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| | | |
|---|---|---|
| | | |
| | | |

AGENCY REPRESENTATIVE CONTACT INFORMATION

| Agency Representative | Agency | Phone number | Email |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

# Family Case Management Plan

District 6 Crossover Youth Bannock County

| | |
|---|---|
| Date of Plan: 11/6/19 | Date of Next Review:2/4/20 |
| Assigned CPS Supervision Level:Prevention | Assigned JJ Risk Level:Medium |

| **Child's Information** | | | |
|---|---|---|---|
| Child's Name: Jon Doe | DOB: 06/xx/2006 | Gender: Male | CP Case #<br>JJ Case #JV-19-XXXX |
| Current Address: XX N 45th st #13 | Current Status: Home on Diversion | | Telephone: 208-xxx-xxxx |

| **Family Information** | | |
|---|---|---|
| Mother's Name: Mom Doe | Address: XX N 45th st #131 | Phone: 208-xxx-xxxx |
| Father's Name: Dad Doe | Address: XX N 45th st #131 | Phone: 208-xxx-xxxx |
| Guardian: | Address: | Phone: |
| Guardian: | Address: | Phone: |
| Family Member: Jon Doe | Address: XX N 45th st #131 | Phone: |
| Family Member: Jill Doe | Address: XX N 45th st #131 | Phone: |
| Family Member: Jimmy Doe | Address: XX N 45th st #131 | Phone: |
| Family Member: Jackie Doe | Address: XX N 45th st #131 | Phone: |

| **Meeting Participants** | |
|---|---|
| Member (Role):BCCJ PO (Bannock County) | Member (Role): CPS Supervisor (CPS) |
| Member (Role): School Counselor (Irving Middle Schoo) | Member (Role): Vice Principal, Irving |
| Member (Role): Clinician #1 (CMH) | Member (Role): Dad Doe (clients father) |
| Member (Role): Mom Doe (clients mother) | Member (Role): Jon Doe (client) |
| Member (Role): | Member (Role): |
| Member (Role): | Member (Role): |

**Screening/Assessment Utilized**

- ☐ Safety Assessment (CPS)
- ☐ Child and Adolescent Needs and Strengths
- ☐ MAYSI 2
- ☒ YLS/CMI (JJ)
- ☐ Substance Abuse Assessment (GAIN-I)
- ☐ Suicide Risk Assessment
- ☐ Mental Health Evaluation
- ☒ Psychological/Neuropsychological
- ☐ Individual Education Plan
- ☐ Adverse Childhood Experiences Questionnaire
- ☒ Other (explain) Psychological Evaluation is currently in process, current 504 plan from Irving Middle School.

**Identified Risk Factors and Needs**

| **Safety Risk Factors & Needs – CPS** | | **Criminogenic Risk Factors & Needs - JJ** | |
|---|---|---|---|
| ☐ Abandonment | ☐ Physical Abuse | ☐ Offense History/Dispositions | ☐ Mental Health |
| ☐ Medical Neglect | ☐ Education Neglect | ☒ Family Circumstances/Parenting | ☐ Dev. Delay |
| ☐ Malnutrition | ☐ Hazardous Home | ☒ Education/Employment | ☐ Financial Problems |
| ☐ Sex Abuse | ☐ Cruel Restraint | ☐ Peer Relations | ☐ Parent Drug Abuse |
| ☐ Emotional Abuse | ☐ Inadequate Shelter | ☐ Substance Abuse | ☐ Parent Mental Health |
| ☐ Neglect | | ☐ Leisure/Recreation | |
| ☐ Chronic Lack of Supervision | | ☒ Personality/Behavior | |
| | | ☐ Attitudes/Orientation | |

**Safety Management Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Not Applicable | | | |
| | | | |
| | | | |

**Progress Update:**

**Joint Permanency Planning (If Applicable)**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| Not Applicable | | | |
| | | | |
| | | | |

**Progress Update:**

**Family Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| Reduce family crisis situations | Parenting With Love and Limits through Bannock Youth Foundation | Mom and Dad-Parents Jon, Jill, Jimmy, Jackie-Siblings | January 7, 2019 |
| Improve family sleeping arrangements | Contact Sleep in Heavenly Peace. Request bed online at https://www.shpbeds.org/ | Mom and Dad will submit a online request for beds. | 12-1-19 |
| Improve family housing situation | Contact Naviagtion to sign up for housing. | Mom and Dad will contact Navigation | 12-1-19 |
| Improve family financial situation | Contact SEICCA at 208-232-1114 ext 111 and particpate in free financial education program. | Mom and Dad will contact SEICCA, sign up and complete Financial Education Class. | 12-1-19 |

**Progress Update:**

---

**Education/Employment Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| Reduce unacceptable behaviors in educational setting. | Comply with 504 plan developed by Irving Middle School | Jon Doe | 11-12-19 |
| Reduce unacceptable behaviors in education setting | Morning phusical education to help with medication. | Jon Doe, Irving Middle School Staff | 11-12-19 |
| Reduce unacceptable behaviors in educational setting | Irving will provide medication for Jon in the morning. Parents will ensure that Irving has medication for Jon. | Jon Doe, Irving Middle School Staff, Mom and Dad Burke | 11-12-19 |
| Reduce unacceptable behaviors in educational setting | Jon will have supervision and Irving Middle School staff will monitor appropriate bathroom use. | Irving Middle School Staff. | 11-12-19 |
| Reduce unacceptable behaviors in educational setting | Irving Middle School staff will allow Jon to have appropriate wiggle time (inside classroom) if teachers see fit. | Irving Middle School Staff | 11-12-19 |

**Progress Update:**

**Positive Peer Involvement Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| Jon will continue to participate in Wrestling at Irving Middle School | Jon will earn grades that will allow him to particpate in wrestling. | Jon | 11-12-19 |
| Jon will continue to particpate in Wrestling at Irving Middle School | Jon will follow rules at home and school that will allow him to continue to be part of the wrestling team. | Jon | 11-12-19 |

| | | | |
|---|---|---|---|
| River Buddies/Pocatello Baptist Church | 1. Jon will particpate in River Buddies if he meets all his requirments.<br>2. Jon will participate in Pocatello Babtist Church. | 1. JPO/Jon<br>2. Mom, Dad, Jon | 1. 8/20<br>2. 11/12/19 |

**Progress Update:**

**Substance Use Prevention Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| Not Applicable | | | |
| | | | |
| | | | |

**Progress Update:**

**Mental Health Action Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| Jon will reduce impulsive unacceptable behaviors. | Jon will complete Psych-evaluation that has began at Mental Health Specialists. Once completed family and Jon will comply with recommendations | Mom and Dad | 11-12-19 |
| Jon will reduce impulsive unacceptable behaviors | Jon will work with Health West Counselor at Irving Middle School. The focus will be on CBT. Parents will meet with Amanda with Health West Counselor, and get counseling started. | Mom and Dad | 11-12-19 |
| Jon will reduce impuslive unacceptable behaviors | Jon will take medications as directed. Mom and Dad will ensure that school has medications for Jon so that meds can be distributed at school as needed. | Mom, Dad, Jon, Irving Middle School Staff. | 11-12-19 |
| Jon will reduce impulsive unacceptable behaviors | Jon will have his medications reviewed. This can be done through Mental Health Specialists. Mom and Dad will request the review. | Mom, Dad, Jon | 11-12-19 |

**Progress Update:**

**Accountability to Victims & Community Plan**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| Accountability Restore Harm | 20 hours of Community Service, Community Service can be completed with the wrestling team, or at Irving Middle School. | Jon | 1/24/19 |
| | | | |
| | | | |

**Progress Update:**

**Additional Action Items**

| Objective | Services/Action Steps | Person Responsible | Timeline |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Progress Update:**

**Incidents/Issues That Will Trigger a Follow-up Meeting**

| | |
|---|---|
| 1. Violation of school rules | 4. Failure of parents to follow through with requirements of case management plan |
| 2. Violation of home rules | 5. Failure to comply with court order |
| 3. Failure to compy with Family Case Management Plan | 6. |

**Upcoming Court Dates/ Other Scheduled Meetings**

| Date and Time of Hearing/Meeting | Meeting Purpose | Meeting Place |
|---|---|---|
| Not Applicable at this time | | |
| | | |
| | | |
| | | |

ACKNOWLEDGEMENT

By signing below, each party acknowledges that he/she understands the goals of this plan and agrees to diligently work toward the achievement of these goals to enhance the safety of the child and the community.

| Participant Signature | Relationship to Child | Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

AGENCY REPRESENTATIVE CONTACT INFORMATION

| Agency Representative | Agency | Phone number | Email |
|---|---|---|---|
| JPO | Bannock County Juvenile Justice | 208-235-XXXX | XXXXXX.com |
| CPS Supervisor | Department of Health and Welfare | 208-239-XXXX | XXXXXX.com |
| School Counselor | Irving Middle School | 208-232-XXXX | XXXXXX.com |
| Vice Principal | Irving Middle School | 208-232-XXXX | XXXXXX.com |
| Clinician | Children's Mental Health | 208-234-XXX | |

# Bannock County Juvenile Justice
# Rule 16 Screening Report

| Juvenile Information | | |
|---|---|---|
| Juvenile Name: Jane Doe | Case No: JV03-19-0803 | Date of Birth:12/4/19 |
| Parent/Guardian: | Relationship: Father | Phone: |
| Parent/Guardian: | Relationship: Mother | Phone: |
| Parent/Guardian: | Relationship: Step Mother | Phone: |
| Parent/Guardian: | Relationship: Mother's Boy Friend | Phone: |

| Screening Team Information | |
|---|---|
| Member (Role):Todd Mauger (Juvenile Justice) | Member (Role):Kimberly Andrews (Juvenile Justice) |
| Member (Role): Racheal Peace (Child Protection Services) | Member (Role): Teresa Wilson (Child Protective Services) |
| Member (Role):Karen Gonzalez (Children's Mental Health) | Member (Role): Stace Gearhart (IDJC) |
| Member (Role): Jane (client) | Member (Role): (Brother) |
| Member (Role): (sister in-law) | Member (Role):Katie Leavitt (CMH) |
| Member (Role): (mother) | Member (Role): (father) |
| Member (Role): (step-mother) | Member (Role): Amy Prescott (SD #25) |

## Juvenile and Family Detailed History

**History of Mental Health issues/Substance Abuse Treatment:**

Clinical Formulation: Jane is a 15-year-old female who was referred for a mental health assessment via a 20-511A court order. Some of the present concerning behaviors include behavioral and interaction problems at home, physical violence towards mother, oppositional and defiant behavior towards parents and authority figures, manipulation and triangulation, and not taking accountability for her actions. The following is relevant when evaluating Jane's Mental health issues:

- Jane has a Disorderly Conduct charge pending adjudication, which she received after getting into a physical altercation at High School.
- Jane has admitted to experimenting with alcohol and marijuana.
- Jane has a history of threatening suicide or self-harm when she is upset. Historically, there is one suicide attempt by overdosing which occurred over a year ago.
- Jane denied any current suicidal thoughts or thoughts of harm to self. She also denied thoughts of harm to others; however, her emotional reactivity has led her to act aggressively towards her mother and others.
- Jane was admitted to the Behavioral Health Center for threatening suicide December 2019.
- She has multiple visits to the emergency room for threatening suicide.
- Jane has previously attended individual counseling at (service provider) around four years ago. She has however refused to participate.
- Jane began receiving medication management at New Horizons Mental Wellness Clinic December 2017. She has not been consistent in taking the medications.

Jane current diagnosis's are as follows:

- Disruptive Mood Dysregulation Disorder (DMDD). However, Jane does not currently meet the diagnostic criteria for DMDD.
- Oppositional Defiant Disorder (ODD).
- Anxiety Disorder, Unspecified.

- Jane also has exhibited some personality traits that are consistent with Narcissistic Personality Disorder.

Jane has the following deficits in her functional areas:

- Vocational/Educational: Jane has been suspended from school due to aggression towards another student. Jane has also struggled with following school rules and requests; Social Relationships: Jane struggles to make and maintain positive friendships as she often wants "all or nothing" from those around her.
- Legal: Jane is involved in the juvenile justice system; Home: Jane struggles with listening and following instructions from her parents, struggles with being respectful towards others, has gotten verbally and physically aggressive, and manipulates others for her own personal gain.
- Medical Necessity: Jane would benefit from mental health treatment at this time to manage her mental health symptoms, to communicate better with others, and decrease aggressive outbursts and manipulative behaviors. It is hopeful that with intervention at this time, Jane will learn skills to help her and to decrease the need for more intensive services in the future.
- Readiness and Motivation: Engage in Treatment: Historically, Jane has refused to participate in mental health treatment. When asked if she would be willing to do counseling, Jane said that she does not want to, but she would attend counseling.
- Develop a Treatment Plan: Jane can participate in the development of a treatment plan, but it will be challenging due to her not taking accountability for her actions and minimizing her needs. Adhere to

Treatment Recommendations:

- Continued medication management services with a child psychiatrist or a P.A. whose work is overseen by a child psychiatrist, to determine ongoing needs.
- Individual counseling to assist the development of insight, judgement, decision making, address impulse control, and emotional regulation.
- Parenting with Love and Limits (PLL)
- Establish and utilize planned or emergency respite services through the BPA Voucher Respite Program to assist in establishing a positive, structured, and supervised environment while giving parents a planned and short-term rest from caregiving.
- Case Management: Case management will include Intensive Care Coordination (ICC; Wraparound).
- Pro-social Activity- Jane would benefit from positive involvement in the community to regulate mood, improve social skills, and provide opportunities for positive peer involvement.
- It is also recommended that Jane's substance use continues to be monitored with random drug testing.
- Psychological and/or Psychiatric Evaluation

**Family Structure and Dynamics – Include any specific or potential threats of danger or safety:**

Jane's family structure and current dynamics does impact her current legal situation and does offer the potential for threats of danger or safety to her mother. The following are the contributing factors:

- Parents are divorced and currently have 50/50 custody that rotates weekly.
- Mom recently moved to American Falls. Jane attends an Alternative School. Mom is employed in Rigby. This distance creates difficult for Jane and mom as Jane is dropped of early and picked up late when mom works during the weeks Jane is with her.
- Dad has supported mom in the past, but is currently having a difficult time with the inconsistency of not knowing when he and his family will be called on for assistance.
- Jane currently triangulates mom and dad to get what she wants, and turns them against each other.
- Jane has become violent while in mom's home and under her supervision. Jane recently injured and bruised mom during an argument that got physical.
- Both Dad and his family, and mom and her supports become exhausted with Jane's behaviors and at times are unable to continue with her in their home.

During the rule 16 screening it should be noted that the family does possess many strengths that include:

- Dad and mom are both supportive of getting outside help for Jane.
- Jane reports good positive relationships with both parents.

- David and Lisa, Jane's brother and sister in-law are willing to help supervise and provide respite for Jane. It should be noted that they both work, and are willing to help if it is scheduled and planned out in advance.
- Sheila, dad's wife, is engaged and supportive of treatment and caring for Jane during Dad's scheduled custody weeks.
- Mom's lives alone, but has a brother who lives next door who is willing to help out in the evenings and on weekends.

The following recommendations were recommended by the screening team when evaluating the family situation:

- Parenting with Love and Limits
- Respite Care
- Family Group Decision Making (to create a consistent plan of supervision and support among family members).
- Family Group Meetings
- Family Counseling
- Individual Counseling (Mom felt she would benefit from individual counseling)
- Support from Juvenile Justice in the form of probation and case management.

**Parental, Guardian, Custodian Engagement in Counseling and Treatment Designed to Develop Positive Parenting Skills and Understanding of the Family's Role in the Child's Behavior:**

The screening team identified that there had not been any parental resources put in place or attempted. The family is open to the idea of participating in parenting classes, family counseling, and individual counseling. The family identified that they would engage and are motivated to participate in any treatment that was recommended by the treatment team.

**Academic Performance and School Behavior:**

Jane's school behavior is very similar to what her parents have expressed they have experienced since she was very young. Her behavior report indicates that she began having behavioral issues at school while attending Te Elementary in 2012 through 2019 when she placed at an Alternative High School for a fight and social media threats while attending High School. The following are her behavioral reports:

- 11/22/19- Insubordination, Outcome: Referred to Law Enforcement
- 11/8/19- Fight, Outcome Transfer to New Horizons
- 11/07/19- Truancy 2, Outcome: Community Service
- 10/31/19- Truancy 1, Outcome: Parent Notified
- 04/15/19- Aggression, Outcome: No Contact Contract
- 03/08/19- Verbal Aggression, Outcome: In school suspension
- 04/12/19- Aggression, Outcome: In school suspension
- 03/08/19- Verbal Aggression, Outcome: Restorative Conference
- 02/20/19- Truancy 1, Outcome: In school suspension
- 02/14/19- Truancy, Outcome: Community Service
- 05/10/18- Truancy 2, Outcome: Friday Night School
- 04/26/18- Electronic Device Violation #2, Outcome: Parent Notified
- 04/25/18- Disrespect, Outcome: Student Conference
- 04/18/18- Middle School: Sexual Offense, Outcome: In School Suspension
- 04/02/18- Middle School: Dress Code Violation, Outcome: Parent notified, clothes changed
- 11/27/17- Middle School: Truancy #1, Outcome: In School Suspension
- 11/15/17- Middle School: Electronic Device, Outcome: Pick up phone after school
- 11/29/16- Middle School: Cell Phone Violation 2, Outcome: Mom picked up phone
- 10/25/16- Middle School: Cell Phone Violation 1, Outcome: Parent Notified

- 04/19/16- Middle School: Insubordination, Outcome: Community Service
- 04/07/16- Middle School: Insubordination, Outcome: Stay in office for day
- 03/09/16- Middle School: Disrespect, Outcome: Pass for one day
- 03/17/15- Elementary School: Disrespect, Outcome: Verbal Warning
- 05/12/14- Elementary School: Truancy, Outcome: Both parents notified in writing
- 02/22/12- Elementary School: Truancy, Outcome: Parent Notified

Jane has done well since transferring to High School. The Principal reports that Jane is doing well at school behaviorally and educationally. She has earned 18 credits and needs 44 to graduate if she was to remain at her current school. The principal indicated that if she remains and earns all credits possible she could graduate at the end of her Junior year.

Jane has plans for the future that might include going dental assisting school. Mom and dad report that her plans change day to day as to what she wants to do in the future.

**Prior Interventions and Treatment Efforts by the Family and/or Community:**

Prior interventions include the following:

- Medication Management by Medical Doctor (current, but sporadic)
- Individual Counseling (refused to participate)

Jane indicated that if she was ordered by the court to participate in services, and it was part of her probation that she would probably participate because she would have to.

**Prior Offenses:**

Jane has had no prior offenses.

Current Offense- JV----, Disorderly Conduct. The charge alleges that on (date) Jane fought with another student, posted the fight on social media, and threatened to fight again upon returning to school.

Jane has recently had the police contacted while she was living with her mother in American Falls. Jane reports that there was a report filed for battery on her. The charge is currently pending, and it is known if it will be filed.

**Current and Prior Risk/Needs Assessments:**

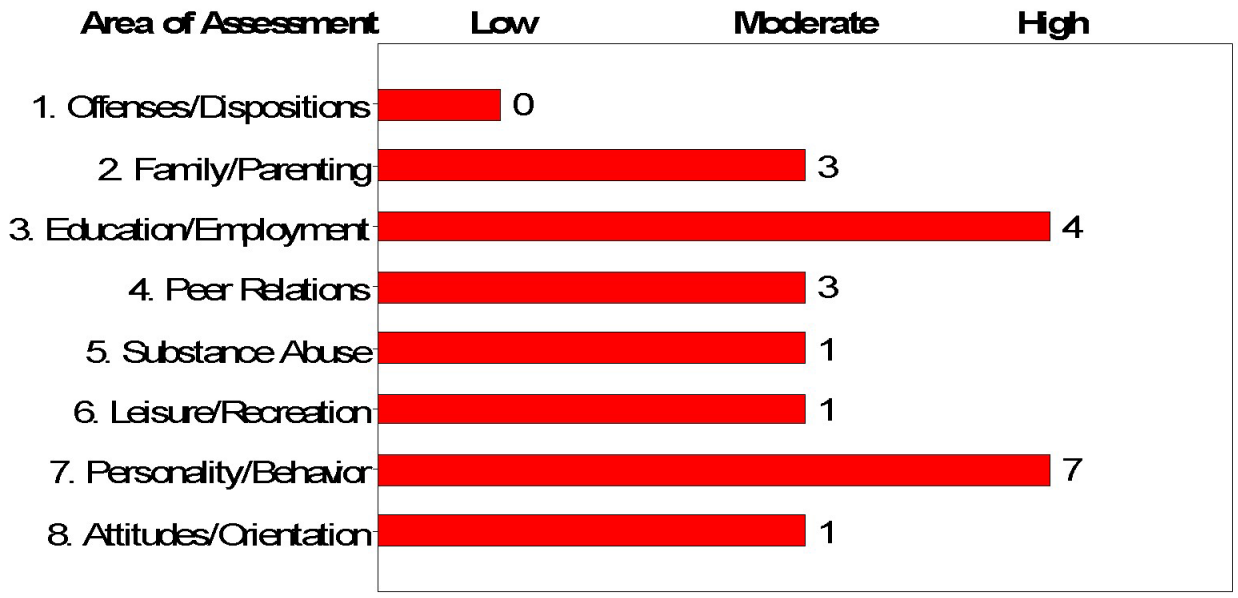
A Youth Level of Service Inventory was completed. Jane's Total Risk/Need Level is High, with a score of 20. The following table shows the cut-off scores used to determine Total Risk/Need Level.

Standard Cut-offs

| Range | Risk Level |
|---|---|
| 0 - 8 | Low |
| 9 - 19 | Moderate |
| 20 - 28 | High |
| 29 - 42 | Very High |

The score is as high or higher than 89.5% of a US normative group* of adjudicated female young offenders serving sentences in the community (e.g., parole, probation).

Talesa Sampson's YLS/CMI 2.0 Total Score is 20, which categorizes her as High risk relative to other US Community females. High risk/need factors include Education/Employment and Personality/Behavior. Moderate risk/need factors include Family Circumstances/Parenting, Peer Relations, Substance Abuse, Leisure/Recreation and Attitudes/Orientation. Low risk/need factors include Prior and Current Offenses/Dispositions. Recommended supervision level is Medium Supervision.




| Identified Risks Areas and Interventions | |
|---|---|
| Risk Category | Protection Factors/Evidenced-based Intervention Programs/Treatment Counseling Services to address Risk |
| Personality and Behavior- Screening team targeted Manipulation, Anger Outbursts, Oppositional Defiant, Anxiety, Physical Violence, Social Boundaries, Drastic Mood Swings, and Manic Episodes that would need to be addressed to address Personality and Behavior risks. | • Medication Management<br>• Individual Counseling<br>• Respite<br>• Parenting with Love and Limits<br>• ART<br>• Neurofeedback Therapy<br>• DBT/CBT<br>• Full Psychological Assessment<br>• Wrap Around Services |
| Education/Employment-Screening team identified Truancy, Violence at School, and Academic Underachievement would need to be addressed to reduce educational and employment risks. | • New Horizon's High School<br>• Youth Development Center |
| Family/Parenting-Screening team identified that improving consistency in parenting and supervision, communication, co-parenting and a putting a crisis plan together | • Parenting with Love and Limits<br>• Respite care<br>• FGDM<br>• FGM<br>• Family Counseling |
| Peer Relations-Screening Team targeted several peer relationships that raise Jane's risk in the peer category. | • Approved friends list<br>• Become involved in pro-social activity<br>• Cross Country (Jane indicates this isn't an |

| | |
|---|---|
| | option if she has to run track at her previous school)<br>• Weight Lifting<br>• Voices girls program |
| Substance Abuse- The screening team indicated that supervision and drug testing would indicate if further action was needed in the substance abuse category. | • Gain SS and Comply<br>• Random UA's |

**Screening Team Recommendations to the Court**

Each team member responded with recommendations at the end of the screening team meeting. It should be noted that all screening team members, other than Jane felt that informal probation would be appropriate and needed for the family to make the changes needed to be successful in helping Jane reduce her risks.
Jane however would prefer a diversion, and did not feel probation was needed. The following are the recommendations to the court:

- Informal Probation- Jane has exhibited behaviors in the past that she will not comply with counseling or treatment. Probation will be able to provide, case management, supervision, drug testing, and make sure all parties follow through with court ordered and recommended services.
- Comply with mental health evaluation and recommendations including med management, individual counseling, Family Counseling, neurofeedback therapy, respite, and psychological evaluation
- Family Group Decision Making- It will be imperative for the family to use the FGDM process to come up with a consistent plan of supervision and support.
- Parenting with Love and Limits- Mom and Dad committed to attending the 6 week program together in District VI.
- Pro-Social Activity- Jane should be involved in a pro-social activity, this could include the Voices program, wrap around services, or another pro-social activity is his interested in.
- 20 hours community service.

Report Prepared by:

_____ _____

Signature Date

# Bannock County Juvenile Justice
# Rule 16 Screening Report

| Juvenile Information | | |
|---|---|---|
| Juvenile Name: Jane Doe | Case No: XXXXXXX | Date of Birth: X/X/XX |
| Parent/Guardian: Mom of Jane Doe | Relationship: Mother | Phone: XXX-XXX-XXXX |
| Parent/Guardian: | Relationship: | Phone: |
| Parent/Guardian: | Relationship: | Phone: |
| Parent/Guardian: | Relationship: | Phone: |

| Screening Team Information | |
|---|---|
| Member (Role): JPO (Juvenile Justice) | Member (Role):CPS worker #1 (CPS) |
| Member (Role): Clinician(Children's Mental Health) | Member (Role):CPS worker #2(CPS) |
| Member (Role): Principal(School District #25) | Member (Role): BFY Staff (Bannock House) |
| Member (Role): (Mother) | Member (Role):CPS Supervisor(CPS) |
| Member (Role): (Youth) | Member (Role): D6 Liaison(IDJC) |
| Member (Role): | Member (Role): |
| Member (Role): | |

## Juvenile and Family History

**Family Structure and Dynamics and current living situation:**

Jane reports that she has been residing at Bannock House; she was placed there in March, 2018. She is currently in the custody of the Idaho Department of Health and Welfare Services. A psychological evaluation was completed by Psychological Assessment Specialists on 3/3/19. It reports Jane and her CPS worker reported a lifelong history of family instability related to her mother's drug use as well as extensive CPS involvement due to reports of physical abused perpetrated by her mother. Jane also reported a history of drug and alcohol abuse which ended after being taken in by the Bannock Youth Foundation. The following information relates to her current family and living situation.

- Placed in the DHW family protection services.
- Resides at Bannock House
- Mom resides in Pocatello with her mom, and other family members, she was released from Idaho Department of Corrections in October, 2019
- Jane reports that her biological father signed away his rights.
- Grandmother is a family support, and Jane currently does visits at her home. Jane reports she is able to see her mom while on these visits. Jane was placed with Grandmother but the placement ended when Grandmother received a DUI.
- Jane has an Aunt and Uncle in Blackfoot and Marsh Valley; they are not current options for placement.
- The aunt of Jane family in Marsh Valley may be a non-relative placement option; however when the family was looked into their foster care license has expired.
- Jane is currently enrolled in the Independent Living Program.
- Reunification is the current goal of Health and Welfare. A case management plan was not provided by Health and Welfare.
- The CPS caseworker reports reunification with Jane's mother has begun, currently over nights, and extended visitations are in place. CPS caseworker was not willing to provide an idea of when reunification may happen. She stated she was hoping for it to occur before Jane turns 18.
- Jane expressed to the Screening Team that she is not confident at all that reunification will happen; she hates to get her hopes up.

**History of Mental Health issues/Substance Abuse Treatment:**

A Psychological Evaluation dated 3/19 from Psychological Assessment Specialists indicates the following regarding Jane's mental health.

- Low average to average cognitive function with relative weaknesses in working memory and fluid reasoning abilities.
- Performance during evaluation was inconsistent across tasks and is not fully consistent with formal diagnosis of attention–deficit/hyperactivity disorder.
- Academic performance was largely commensurate with her overall cognitive abilities and does not indicate the presence of specific learning disability.
- Behaviorally- Jane has a history of difficulty managing anger which has resulted in conflict with others.
- Emotionally-Jane reports a history of depressive symptomatology and currently has a high level of somatic complaints that she discussed during feedback, this was also observed by the psychometrician during testing.

It should be noted that the report indicated that Jane's behavioral and emotional difficulties are likely exacerbated by historical family instability as well as her current living situation.

The Psychological Evaluation provides the following recommendations:

- Regular individual outpatient psychotherapy to provide Jane with coping strategies to continue addressing ongoing symptoms of depression and emotional dysregulation in general. The use of cognitive behavioral strategies for symptoms of depression as well as overly negative interpretations of physical sensation will likely be helpful in reduction of her overall emotional stress.
- Due to Jane's mild variability on attention measures, she may receive some benefit from basic ADHD accommodations in the classroom. Accommodations of benefit may include preferential placement in the classroom, a distraction free environment for completing tests and assignments as needed, as well as additional time on academic assignments.
- Jane continues to consult with her physician in regards to medication management of depression. The Psychologist is not recommending medication management of mild attention deficits at this time given her inconsistency in performance across these measures as well as her historical tendency to engage in substance abuse.

The ICD-10 Diagnoses include:

- F33.0 Major Depressive Disorder, recurrent, mild severity.
- F43.25 Adjustment Disorder with mixed disturbance of emotions and conduct.
- F90.8 Other Specified Attention-Deficit/Hyperactivity Disorder with insufficient attention/impulsive symptoms.

In reviewing Jane's substance abuse situation it should be noted that she has had two charges in regards to possession of a controlled substance.

- 10/31/19 JV03-2019-XX Possession of a Controlled Substance, Marijuana- Currently Pending Bannock County
- 3/12/19 JV 18-XX Possession of a Controlled Substance, Dismissed, Bingham County

It should be noted that the Psychological Evaluation reported that Jane reported a significant history of substance abuse, including prior daily alcohol use, weekly marijuana use, and occasional opiate, cocaine, and Coricidin abuse. She reports that her substance abuse ended when she was placed at Bannock House. Juvenile Probation completed a Youth Level of Service Inventory when ordered by the court to complete a Rule 16. Jane indicated that her substance use was very minimal. She reported occasional marijuana use, and no alcohol or other substance use.

Jane is currently participating in the following services related to Mental Health and Substance Abuse Treatment:

- Individual Counseling with Deanna at Center Counseling.
- Participating in Medication Management, reports taking Wellbutrin for depression.

**Parental, Guardian, Custodian Engagement in Counseling and Treatment Designed to Develop Positive Parenting Skills and Understanding of the Family's Role in the Child's Behavior:**
Upon meeting for the initial rule 16 screening team meeting CPS Caseworker and Jane's mom did not attend. A second meeting occurred and both individuals attended and reported the following:

- Reunification is the current goal for Health and Welfare, Jane, and Jane's mother.
- CPS worker reports Jane's mom is not pro-active, and is currently working to get her situation stabilized after being reintegrated back into the community from prison. She is not currently involved in any parental education programs.
- Jane's mom is employed at McDonalds.
- Mom and Jane both stated that parenting classes are not needed. They report they have been through many. Jane's mom did report she thought some family counseling would be good, and that Jane needs to continue with her individual counseling that is in place.
- Both Jane and her mom think it would be helpful to get a passes to Planet Fitness. They report they could work out, tan, and recreate together.
- Jane's mom reports a desire to purchase ground in the McCammon area and placing a camper on it for her and Jane.

**Academic Performance and School Behavior:** Jane attended elementary school in the Pocatello/Chubbuck School District #25. She attended 3 different elementary schools which included, Lewis and Clark, Jefferson Elementary, and Ellis Elementary. She attended Alameda Middle School during the 2015-16 school year. She then left the Pocatello school district and returned to New Horizon's High School the 2017-18 school and has attended New Horizon's ever since. Jane did attend and complete 3 credits during summer school 2018. She is currently a Junior. Her educational strengths include:

- Jane has earned 29 credits of the 46 needed to graduate.
- Jane needs only 17 credits to graduate one year early.
- She has gained employment which would allow her to earn 6 credits of work study.
- There are 4 blocks of school left in which she could earn a total of 6 credits.
- Jane currently has a 2.42 GPA and is ranked 22$^{nd}$ out of 73 students in her graduating class.

Some risks to Jane's education include her defiant behavior and violations of school rules. The following are behavior write ups that have occurred since starting New Horizon's in 2015-16:

- 11/22/19- Tobacco Use- Resolution: Referred to Law Enforcement-PENDING
- 10/30/19- Drug Para, Use- Resolution: Referred to Law Enforcement, Detention Center-PENDING
- 10/07/19- Profanity- Resolution: Parent Notified by Phone
- 10/02/19- Tardies- Resolution: Parent Notified by Phone
- 09/25/19- Insubordination- Resolution: In-School Suspension
- 09/20/19- Computer Violation- Resolution: Parent Notified, no computer use until behavior is appropriate. The inappropriate use was regarding drug related searches.
- 11/16/18-Had Phone during Class- Resolution: Pick up phone after school.

Jane's attendance records indicate that she does get to school regularly but has been late for classes consistently. She has missed school due to suspension and legal issues.

Jane's employment history is as follows:

- Recently obtained employment at Taco Bell, and is working approximately 25 hours per week.
- Worked in the past at Dominos, and Fuji.

Jane reports her plans for the future include graduating from High School and attend trade school. She indicates that she would like to go into welding.

**Prior Interventions and Treatment Efforts by the Family and/or Community:**
Jane reports that she is currently participating in counseling and medication management. She indicates that she enjoys counseling and feels that it is worth her time. Jane feels that she has a good relationship with her counselor. The screening team added the following intervention efforts and information.

- Jane has not been on medications long enough to know if it is an effective intervention.
- Jane is participating in the Independent Living Program through Bannock Youth Foundation.

Services in Twin Falls include

- D7- substance abuse treatment groups
- In home family work, Craig Herzog
- Love and Logic
- Individual and Family Counseling
- Group sessions at CMH
- Smoking Cessation

Family Suggests-

- Mom feels she needs to do a lot of trust building with Jane.
- Mom is attending aftercare classes two times a week for Parole.
- Mom and Jane would like to work out together and do some family enrichment activities.
- CPS Caseworker has concerns with Jane overstepping boundaries. Especially getting mom to do things she wants. Caseworker recommends that Jane and mom participate in Individual and Family Counseling at Bannock House.

**Prior Offenses:** Jane's prior offense history is difficult to follow, as she has relocated to several different counties during the court processes. There are several counties involved that include her home county Twin Falls, and the county's she has relocated to Ada County, Bingham County, and Bannock County. In reviewing I-Courts the following charges were reviewed, and it appears that some of the cases on ICourts are actually the same charges being transferred from County to County.

Twin Falls County-

- JV42-xx-xxxx 1/20/16 Petit Theft – Informal, Credit for 7 days in detention
- JV42-xx-xxxx 10/31/19 Petit Theft- Informal, Credit for 7 days 3 days suspended
- JV42-xx-xxxx 6/19/17 Runaway- Transfer of supervision 10B, Informal probation, 12 months probation, Community Service

Bingham County-

- JV-16-xxx x2/17/16Willful Concealment- Transfer to Ada County
- JV-16-xxxx 10/26/17 1. Willful Concealment 2. Runaway (dismissed)- Transfer for disposition
- JV 18-xxxx1/19/18 Runaway- Rule 16 expansion CPA, Rule 19 Screening Team (Hearing Vacated)
- JV 18-xxxx 3/12/19 Possession of Controlled Substance (Dismissed)

Ada County-

- JV 16-xxxx 3/23/16 Petit Theft-Transfer from Bingham County, FTA Guilty Transfer to Twin for Sentencing.

Bannock County-

- JV 2013-xxxx 4/30/14 Truancy (attendance court)
- JV 2015-xxxx 10/13/15 Petit Theft (Dismissed by Prosecutor)
- JV 2016-xxxx 09/06/16 Petit Theft (Dismissed by Prosecutor)
- JV 2019-xxxx 10/31/19 Possession of a Controlled Substance (Pending)

Jane was placed on probation in Twin Falls, and it was transferred Blackfoot, Charges included Petit Theft, Driving w/o Privileges, Failed UA served some time for it and went to Bannock House. She has been placed in detention on several occasions. This includes a Bench Warrant for failure to appear.

Jane has had no new charges since she was released from probation in March 2018.

Current and Prior Risk/Needs Assessments:

Jane Doe's YLS/CMI 2.0 Total Score is 21, which categorizes him as Moderate risk relative to Other US Community females. High risk/need factors include Prior and Current Offenses/Dispositions, Leisure/Recreation and Attitudes/Orientation. Moderate risk/need factors include Family Circumstances/Parenting, Education/Employment, Substance Abuse and Personality/Behavior. Low Risk/need factors include Peer Relations. Recommended supervision level is Other (Specify). The score is as high or higher than 87.9% of a US normative group* of adjudicated female young Offenders serving sentences in the community (e.g., parole, probation).


| **Identified Risk Areas** | |
|---|---|
| Risk Factors | Protection Factors/Evidenced-based Intervention Programs/Treatment Counseling Services to address Risk |
| Family/Parenting | • FIA<br>• PLL<br>• Ind. Counseling=Deanna Smith<br>• Family Counseling<br>• Family Enrichment activities-Gym |
| Education/Employment | • Continue working at Taco Bell<br>• Graduate from High School in May 2020.<br>• Peer List as Peers at school are a risk<br>• Probation, could provide support at school<br>• IL services for tuition, housing, employment options and vocational training in welding. |
| Attitudes/Orientation | • Voices girls program<br>• Seeking Safety<br>• Aggression Replacement Training<br>• Individual Counseling (currently attending) |

| | |
|---|---|
| | • Independent Living Program (currently attending) |
| Leisure/Recreation | • Want to try guitar-Poky's Band? Mikes Music? Main Street Music<br>• Continue employment at Taco Bell |
| Substance Abuse | • Gain SS and Comply<br>• Probation-Drug Testing?<br>• Diversion/Probation-Drug Testing?<br>• Families in Action<br>• Strengthening Families<br>• Online Marijuana 101 Class, 3rd Millennial Classroom. |

| **Screening Team Recommendations** | |
|---|---|
| Jane Doe's Mom- No Juvenile Justice System, She can do it on her own. | • Relationship is on me as mom. I need to focus on not choosing a man, drugs and prison over Jane. |
| Jane- Diversion | • It will be important for me to learn to play the guitar.<br>• Doesn't feel that she has any substance abuse issues.<br>• Feels continuing counseling is very important<br>• Is willing to comply with family counseling. |
| CPS Worker #1- Informal Probation (INFORMAL PROBATION) | • Informal Probation will be most beneficial for Kymberlee, something that will not stick with her and she can have charges dismissed. |
| CPS Worker #2-Child Protection Services Case Manager | • Informal Probation needs the supervision and support. |
| CMH Worker- Children's Mental Health | • No Probation<br>• Individual and Family counseling<br>• Wrap Around Services if family would like them. |
| Bannock House Staff-Bannock House | • Diversion<br>• Gain SS and comply with services<br>• Some aspect to hold her accountable, such as community service.<br>• She has more supervision that most kids. |
| IDJC Worker- Idaho Department of Juvenile Corrections | • Diversion<br>• Online Substance Abuse Education |
| CPS Supervisor-Idaho Department of Health and Welfare, Child Protection Services | • Diversion<br>• Wrap Around<br>• Cross Over Youth Dual Services Case Management Plan |
| BCJJ Staff- Juvenile Justice | • Diversion<br>• Gain SS and Comply<br>• Individual and Family Counseling<br>• Random drug testing to be requested by Bannock House or Parent/Guardian |

| Recommendations to Court |
| --- |
| Upon completing the Rule 16 screening team and report probation is providing the following recommendations to the court.<br>• Diversion<br>• No new law violations for 6 months<br>• Follow all rules at home and school<br>• 20 hours of community service<br>• Gain SS and comply with recommendations, if no GAIN I is recommended then Kymberlee should complete a substance abuse education program.<br>• Random UA's to be requested by Bannock House Staff or Parent and Guardian if necessary<br>• Individual Counseling-Continue with services currently in place<br>• Family Counseling as directed by Family and Children Services<br>• Wrap around services through Children's Mental Health if family and Jane is interested and willing to comply.<br>These recommendations are based on the fact that Jane is currently residing at Bannock House, and in the custody of the Idaho Department of Health and Welfare Family Services. At this time Jane experiences more supervision than most kids who are on probation. Currently she is engaged in counseling and participating in case management with Health and Welfare and has access to all services that are needed. Jane has not reoffended in several years, and was released from probation in Bingham Co in March 2019. She is currently on track to graduate in May from New Horizon's High School, and will turn 18 in September 2020. The ability to have Juvenile Justice assist with drug testing if asked or requested by Bannock House Staff would be beneficial in making sure that Kymberlee is not using substances. Jane reported that a diversion would keep her on track long enough to graduate from high school, and turn 18 and become an adult. |

Report Prepared by:
Wylie C. Oyete -JPO Bannock Co. 12/16/19

_____ _____

Signature Date

# YLS/CMI 2.0™

## Youth Level of Service / Case Management Inventory 2.0

*By R. D. Hoge, Ph.D. & D. A. Andrews, Ph.D.*

## Profile Report

| | |
|---|---|
| **Name:** | JANE Doe |
| ID Number: | 139483 |
| Age: | 17 |
| Gender: | ~~F~~ Male |
| Race/Ethnicity: | White |
| Current Location: | Idaho; IDJC; Bannock |
| Date: | November 25, 2019 (Online) |
| Assessor's Name: | William C. Oyler |
| Normative Option: | US Community |
| Offender Type: | Drug/alcohol offender |


P.O. Box 950, North Tonawanda, NY 14120-0950
3770 Victoria Park Ave., Toronto, ON M2H 3M6

# Introduction

The Youth Level of Service/Case Management Inventory 2.0 (YLS/CMI 2.0) is a risk and needs assessment tool. This report summarizes the results of the YLS/CMI 2.0 assessment, and provides information pertinent to the assessment of the individual. The results of this inventory can be helpful in formulating a case management plan for the juvenile. See the YLS/CMI 2.0 User's Manual published by MHS for more information about this instrument and its results.

This computerized report is an interpretive aid and should not be given to clients or used as the sole basis for diagnostic decisions and case management plans. This report is most effective when combined with other sources of relevant information.

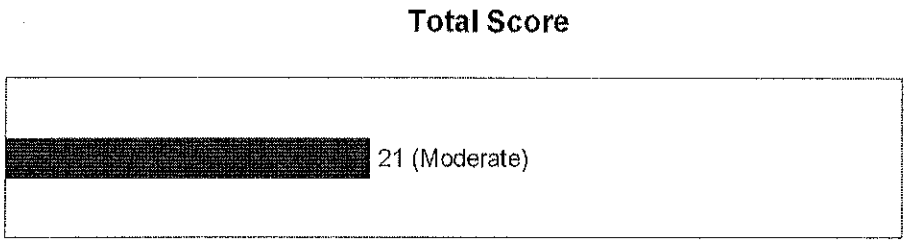
Scores represent the number of items overall or within an assessment area that apply to the youth being assessed.

# Narrative Report

JANE DOE YLS/CMI 2.0 Total Score is 21, which categorizes him as Moderate risk relative to other US Community males. High risk/need factors include Prior and Current Offenses/Dispositions, Leisure/Recreation and Attitudes/Orientation. Moderate risk/need factors include Family Circumstances/Parenting, Education/Employment, Substance Abuse and Personality/Behavior. Low risk/need factors include Peer Relations. Recommended supervision level is Other (Specify).

# Overall Assessment Based on YLS/CMI 2.0 Total Risk/Need Level

The graph below displays the YLS/CMI 2.0 Total Score and indicates the classification level associated with that score.




The Total Risk/Need Level is **Moderate**, with a score of 21. The following table shows the cut-off scores used to determine Total Risk/Need Level.

**Standard Cut-offs**

| Range | Risk Level |
|---|---|
| 0 - 9 | Low |
| 10 - 21 | Moderate |
| 22 - 31 | High |
| 32 - 42 | Very High |



MHS

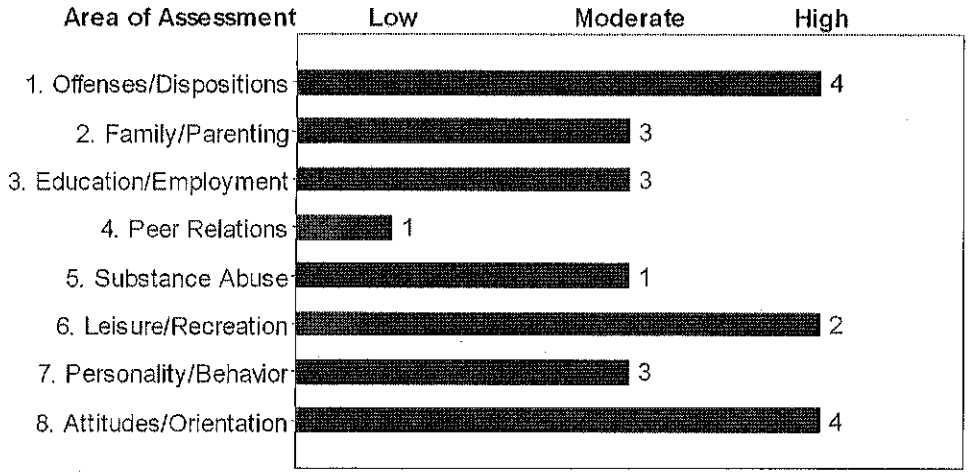
## Comparison to Young Offenders

The score is as high or higher than 87.9% of a US normative group* of adjudicated male young offenders serving sentences in the community (e.g., parole, probation).

*Note: For details on the normative group, please see Page 33-38 of the YLS/CMI 2.0 User's Manual.

## Assessment of Risks and Needs

The graph below displays the risk level for each area of assessment.




The following table shows the standard cut-off scores used to determine risk level for each area of assessment.

| Area of Assessment | Low | Moderate | High |
|---|---|---|---|
| 1. Offenses/Dispositions | 0 | 1-2 | 3-5 |
| 2. Family/Parenting | 0-2 | 3-4 | 5-6 |
| 3. Education/Employment | 0 | 1-3 | 4-7 |
| 4. Peer Relations | 0-1 | 2-3 | 4 |
| 5. Substance Abuse | 0 | 1-2 | 3-5 |
| 6. Leisure/Recreation | 0 | 1 | 2-3 |
| 7. Personality/Behavior | 0 | 1-4 | 5-7 |
| 8. Attitudes/Orientation | 0 | 1-3 | 4-5 |

# Profile Summary

One area was assessed as low risk:
4. Peer Relations

Four areas were assessed as moderate risk:
2. Family/Parenting
3. Education/Employment
5. Substance Abuse
7. Personality/Behavior

Three areas were assessed as high risk:
1. Offenses/Dispositions
6. Leisure/Recreation
8. Attitudes/Orientation

No areas were assessed as strength areas.

# Details Regarding Assessment of Risks and Needs

The following table contains detailed information regarding each area of assessment, including the specific items that apply tc JANE'S case, sources of information, and comments, and indicates which areas are considered to be ones of strength for Kymberlee Phillips.

| Area of Assessment | Items Selected | Strength | Items Not Selected | Comments | Sources |
|---|---|---|---|---|---|
| 1. Offenses/ Dispositions | -Three or more prior convictions<br>-Two or more failures to comply<br>-Prior probation<br>-Prior custody | — | -Three or more current convictions | No current convictions- 1 pending charge<br>Jane has been placed in detention on 8 times, including current pending charge<br>Jane reported she had not had a charge in 5 years, and was released from probation in April 2018. Upon looking her up in Icourts, and IJos it was determined that she was not honest or forgot.<br>Jane has had numerous charges, in several different county's including numerous failures to comply. | Kymberlee<br>IJOS<br>ICourts |

| Area of Assessment | Items Selected | Strength | Items Not Selected | Comments | Sources |
|---|---|---|---|---|---|
| 2. Family/Parenting | -Inconsistent parenting<br>-Poor relations (father - youth)<br>-Poor relations (mother - youth) | | -Inadequate supervision<br>-Difficulty in controlling behavior<br>-Inappropriate discipline | Currently living in Bannock House. Has done so since March 2018, Does not know Biological father, Jane reports that he signed away his rights. Mom lives in Pocatello, was released from Prison in October 2019. Mom has been in and out of jail. Bannock House currently provides adequate supervision, doesn't have issues controlling Jane behavior, and disciplines appropriately. | Jane |

| Area of Assessment | Items Selected | Strength | Items Not Selected | Comments | Sources |
|---|---|---|---|---|---|
| 3. Education/ Employment | -Disruptive classroom behavior<br>-Disruptive behavior on school property<br>-Truancy | | -Low achievement<br>-Problems with peers<br>-Problems with teachers<br>-Unemployed/not seeking employment | Jane passed 2 of 3 classes last semester. She has had some difficulty with following rules at school. Since first of school year she has had the following write ups at New Horizons<br>9/20/19-Searching Drug Related Topics on Internet at school<br>9/25/19-Insubordination<br>10/2/19-Tardies<br>10/7/19-Profanity/Disruption<br>10/30/19- Poss. of Marijuana (Current Pending Charge)<br>11/22/19-Tobacco/Vaping<br>Jane just started a new job at Taco Bell. | Infinite Campus<br>Jane |
| 4. Peer Relations | -Some delinquent acquaintances | | -Some delinquent friends<br>-No/few positive acquaintances<br>-No/few positive friends | Jane reported that she has a few friends she talks to at school, and reports they are all on probation. However, reports in reality she has no friends. States she doesn't have anyone she enjoys associating with that is a positive influence. | Jane |

| Area of Assessment | Items Selected | Strength | Items Not Selected | Comments | Sources |
|---|---|---|---|---|---|
| 5. Substance Abuse | -Occasional drug use | | -Chronic drug use<br>-Chronic alcohol use<br>-Substance abuse interferes with life<br>-Substance use linked to offense(s) | Jane reports that she uses marijuana seldomly. Not on a consistent basis.<br>Reports no alcohol use.<br>Substance use did interfere with school, she was removed placed in detention and then in school suspension when she returned. | Jane<br>Courts |
| 6. Leisure/ Recreation | -Limited organized activities<br>-Could make better use of time | | -No personal interests | Jane reports she is interested in Boxing, working out, would like to learn how to play the guitar.<br><br>Reports she is not involved in any prosocial activity.<br>Is just starting a job next week. | Jane |

| Area of Assessment | Items Selected | Strength | Items Not Selected | Comments | Sources |
|---|---|---|---|---|---|
| 7. Personality/ Behavior | -Short attention span<br>-Poor frustration tolerance<br>-Verbally aggressive, Impudent | | -Inflated self-esteem<br>-Physically aggressive<br>-Tantrums<br>-Inadequate guilt feelings | Jane is depressed, doesn't think highly of herself. She has not had any offenses or behaviors related to being physical aggressive and reports she hates fighting. Reports that she does struggle to focus, this includes having ADHD in school and outside of school. As interview continued she struggled to discuss things and got fidgety. She does get angry and can become verbally aggressive, and told the interviewer stories about when she has. Reports she does feel bad about the trouble she has created for others. | Interview with Jane |

| Area of Assessment | Items Selected | Strength | Items Not Selected | Comments | Sources |
|---|---|---|---|---|---|
| 8. Attitudes/ Orientation | -Antisocial/procriminal attitudes<br>-Not seeking help<br>-Actively rejecting help<br>-Callous, little concern for others | | -Defies authority | Reports that she wants help, but when asked more specifically reports she didn't. has been going to counseling and enjoys it, feels she gets something out of it. During interview a lot of things were not true that Jane reported. Down played a lot of things. Later found out that she had received a new behavior incident for vaping. | |

# Assessment of Other Needs and Special Considerations

The following factors should be considered when developing a case management plan:

## Family/Parents

Chronic history of offenses
Emotional distress/psychiatric
Drug/alcohol abuse
Financial/accomodation problems
Uncooperative parents
Significant family trauma: Mother has served a lot of time in prison, foster care for Kymberlee
Comments: No information provided

## Youth

Anxious
Communication problems
Depressed
Engages in denial
History of running away
Low self-esteem
Manipulative
Protection issues
Underachievement
Victim of physical/sexual abuse
Comments: No information provided

## Professional Override

The rater's estimate of risk level does not differ from that of the inventory.

Comments: No information provided

## Contact Level

Level of supervision selected for this youth: Other (Specify)

Comments: No information provided

## Case Review

Changes in circumstances, including new charges, court appearances, or contacts since last review:
Current Charge is possession of marijuana
Non-compliance with court orders (action taken, comments): n/a;n/a;YLSI being conducted to assess for an ordered rule 16 screening team.

Date Printed: Tuesday, November 26, 2019
**End of Report (Assessment # 816302)**

# IJR 16 RESOURCES FOR JUVENILE JUDGES

*Bench Card*

**GOALS**

Idaho Juvenile Rule 16 authorizes the juvenile court to order an investigation, a screening team or expand the juvenile case to a Child Protective Act (CPA) case. Advantages to a graduated approach include avoiding possible delay caused by ordering investigation or expansion, engaging the family in a less confrontational manner, and creating a problem-solving forum with all stakeholders at the table. In appropriate cases, the screening team approach can avoid the need to order an investigation or expand the juvenile case to a child protection case**.**

**WHEN**

At any stage of a Juvenile Corrections Act (JCA) proceeding, when the court has reasonable cause to believe that a juvenile living or found within the state is neglected, abused, abandoned, homeless, or whose parents or legal custodian fails or is unable to provide a stable home environment.[1]

**RESOURCES**

1. Investigation – Direct Idaho Department of Health and Welfare (IDHW) to investigate the facts and circumstances of the juvenile and the juvenile's family and report to the court. (See JV Order for Investigative Report to the Court under IJR 16)
2. Screening Team – Order a screening team to convene and report to the court. (See JV Order for Screening under IJR 16)
3. Expansion – Expand the JCA proceeding into a Child Protection Act proceeding.[2] (See JV Order Expanding Juvenile JCA Proceeding to CPA Proceeding)

**PURPOSE**

1. IDHW Investigation:
   An order for investigation is best used when there exist child protection issues but many facts are unknown and should be gathered for the decision makers before determining whether to use a screening team approach or expansion.
2. Screening Team:
   The purpose of the screening team is to develop a coordinated plan to safely meet the needs of the juvenile and the juvenile's family, based on all resources available to the juvenile and the juvenile's family.
   a. The focus of the screening team is to assess the safety of the juvenile in the juvenile's home and determine whether the juvenile's needs, including services and treatment, can be addressed safely and appropriately (preferably in the juvenile's home using community-based services).
   b. The screening team prepares a written report to the court summarizing the findings and recommendations of the screening team.
   c. The court may order both an investigation and screening team.
3. Expansion to a Child Protection Case:
   An expansion is best used when a crisis exists and/or imminent safety concerns for the child exist.

a. If the proceeding is expanded to a CPA case, the JCA court may, in its discretion, order the juvenile placed in shelter care. The CPA court must hold a shelter care hearing within 48 hours of the child being placed in shelter care, excluding Saturdays, Sundays and holidays.[3]
b. If the child is not removed, the CPA court must hold an adjudicatory hearing within 30 days of the JCA court's determination to expand the proceedings.[4]

**REQUIRED FINDINGS (if expanded)**

1. There is reasonable cause to believe the juvenile is living or found within the state and is neglected, abused, abandoned, homeless, or the juvenile's parents or other legal custodian(s) have failed or are unable to provide a stable environment.[5]
2. If the court orders an expansion of a JCA proceeding and removal of the juvenile from the home or present surroundings, the court must make written, case-specific findings that:[6]
   a. the juvenile was placed in shelter care because continuation in the child's home or present condition or surroundings would be contrary to the welfare of the juvenile; and,
   b. vesting legal custody of the juvenile with IDHW is in the juvenile's best interest.

**ORDER**

1. The order expanding the JCA proceeding to a CPA proceeding must be in writing and contain the factual basis supporting the order.[7]
2. The order expanding the Juvenile Corrections Act proceedings to Child Protective Act proceedings, serves the function of the CP Petition.[8]

**ENDNOTES**

[1] I.J.R. 16(a).
[2] I.J.R. 16(a)(1)-(3).
[3] I.J.R. 16(b).
[4] I.J.R. 16(d).
[5] I.J.R. 16(f).
[6] 45 C.F.R. § 1356.21(c); I.C. § 16-1615(5); I.J.R. 16(a) and (f).
[7] I.J.R. 16(a).
[8] I.J.R. 16(h)