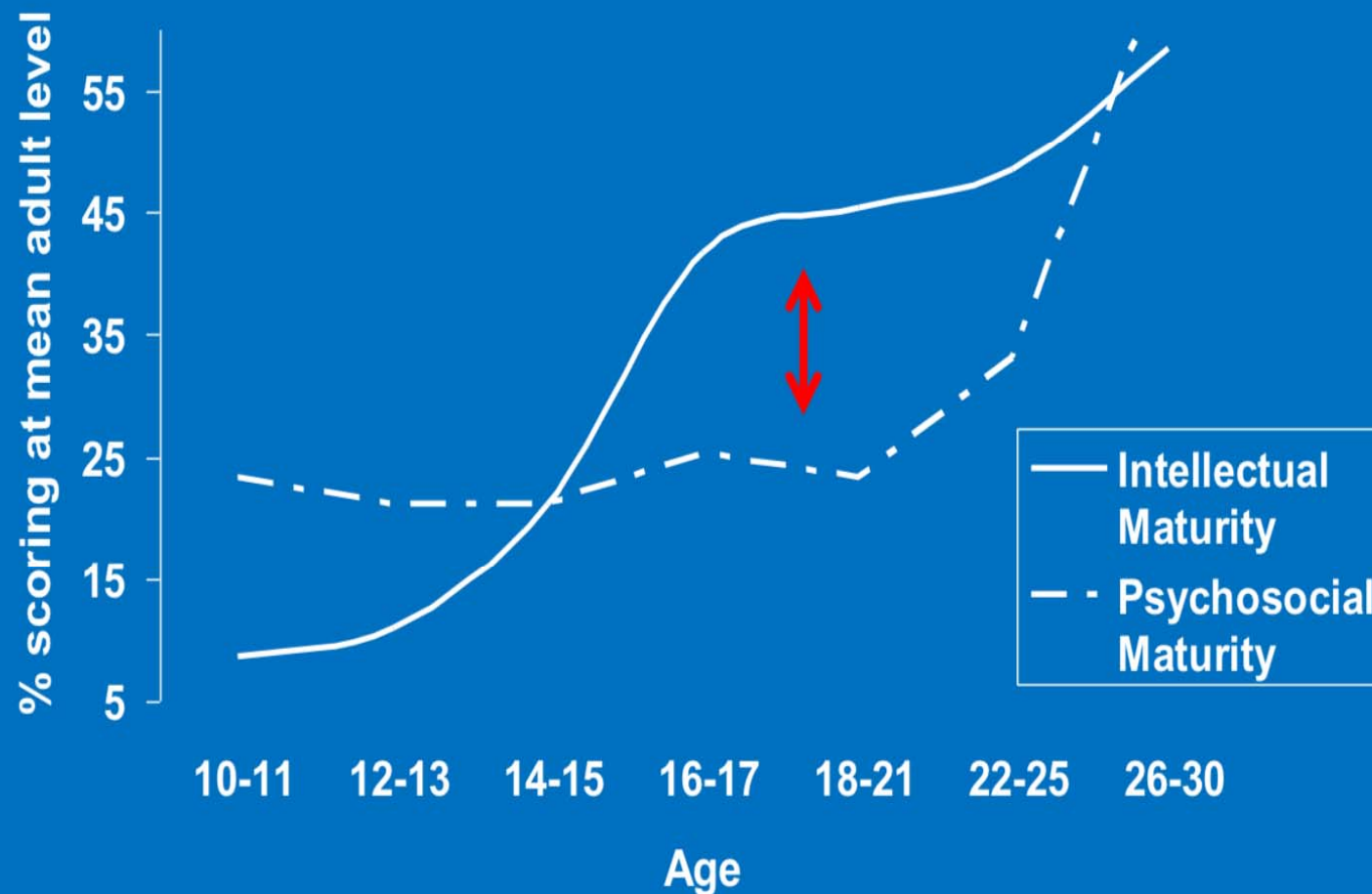


Treatment and Programming Needs of Transition Age Youth



Individuals Mature Intellectually Before They Mature Socially and Emotionally



Steinberg et al., 2009



North Carolina Department of Public Safety

Components of Psychosocial Maturity

- ▶ Delaying gratification in the service of longer term goals
- ▶ Considering the implications of one's actions on others
- ▶ Resisting the influence of peers
- ▶ Controlling one's impulses, especially when in the presence of peers and when emotional (regulating emotions as well as the propensity for risky activities)



Adolescents vs. Emerging Adults vs. Adults

How Young Adults Are Distinct From Youth	How Young Adults Are Distinct from Adults
<ul style="list-style-type: none">More cognitively developedMore vulnerable to peer pressure and other external influencesMore likely to engage in risky behaviorsSeeking autonomy from families/caregivers	<ul style="list-style-type: none">More impulsiveLess able to control emotionsLess likely to consider future consequences of their actions



The Council of State Governments Justice Center, *Reducing Recidivism and Improving Other Outcomes for Young Adults in the Juvenile and Adult Criminal Justice Systems* (New York: The Council of State Governments Justice Center, 2015).

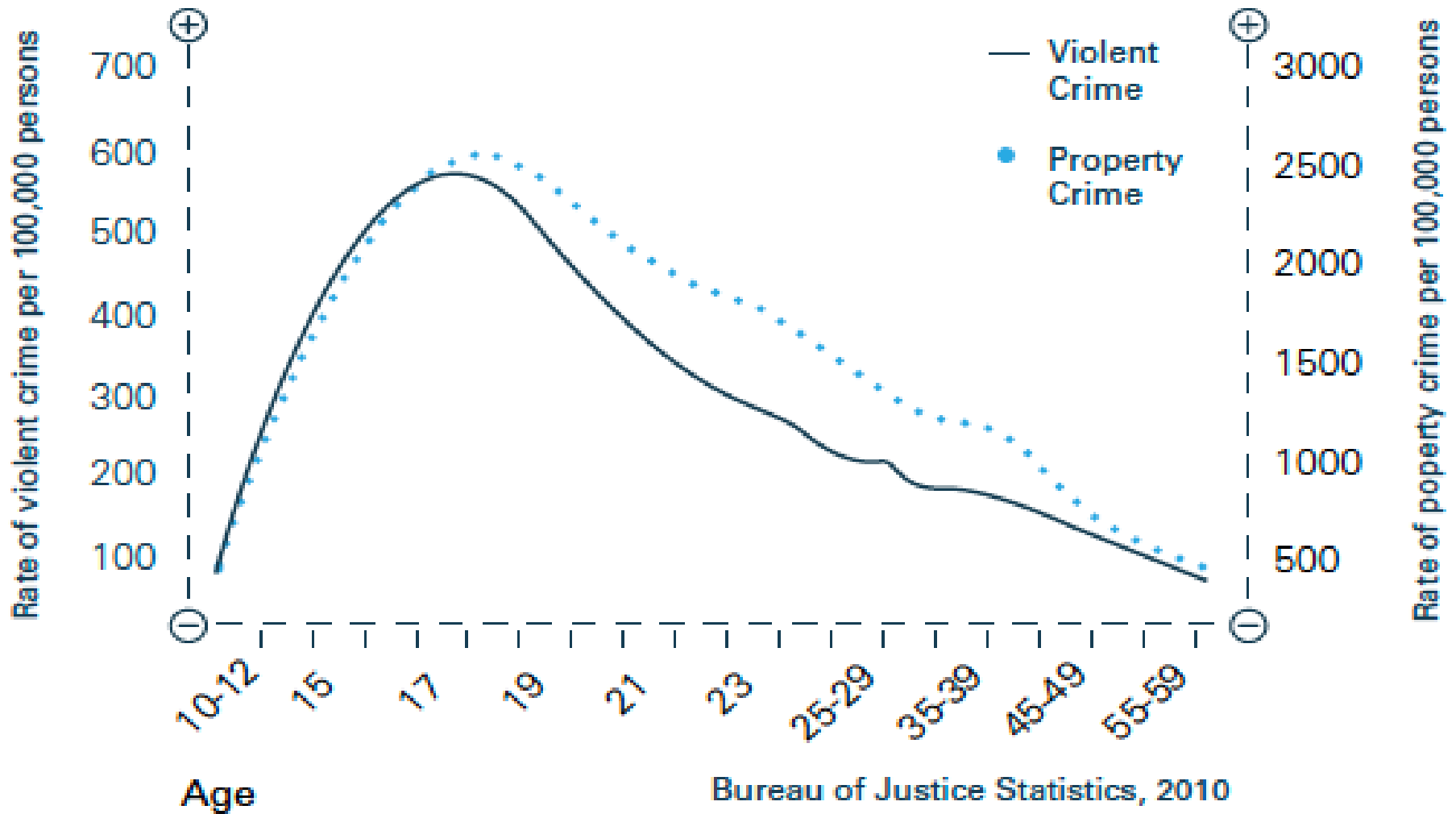


Treatment and Programming Needs

»» Pathways to Desistance



Age-Crime Curve

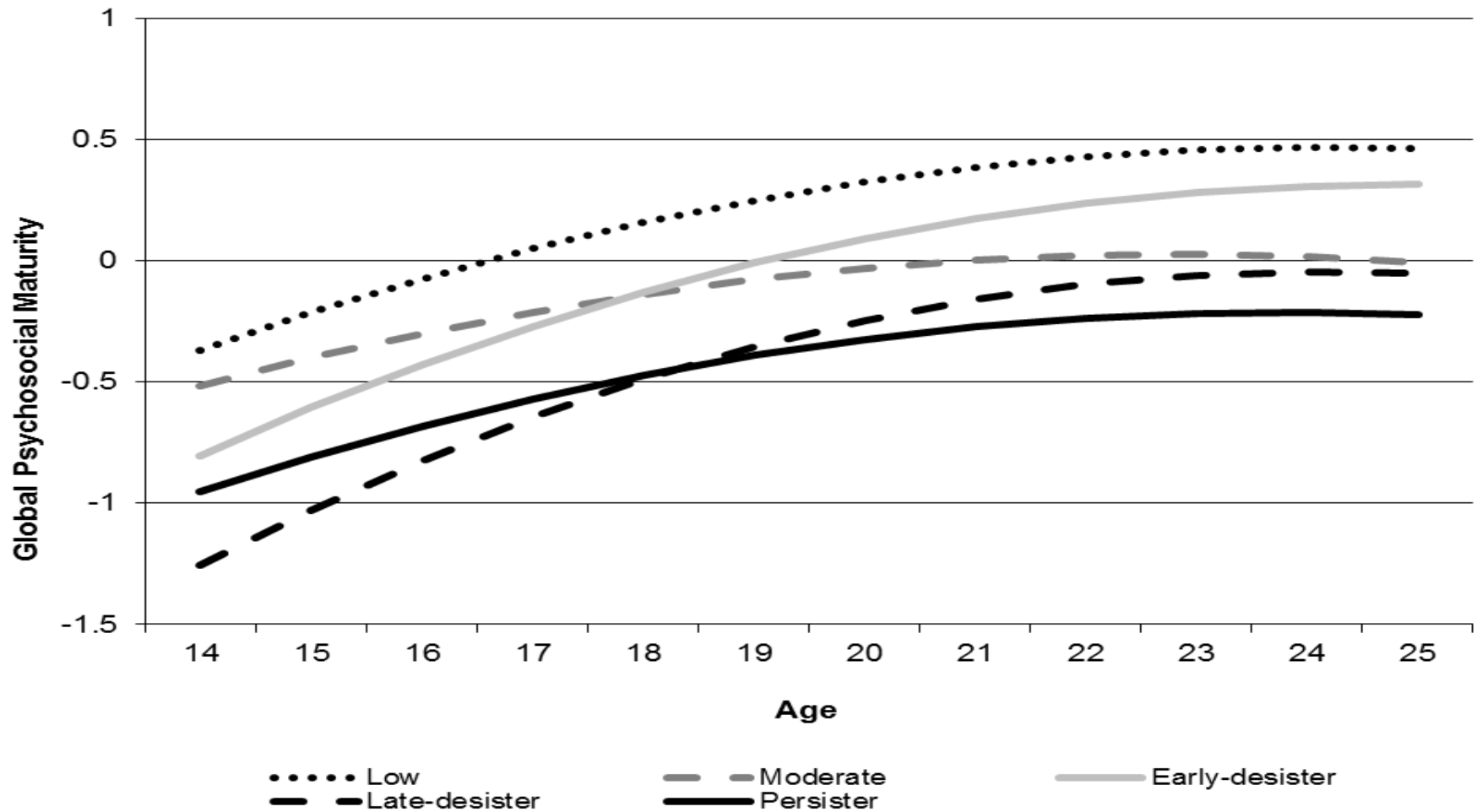


The *Pathways to Desistance* Studies

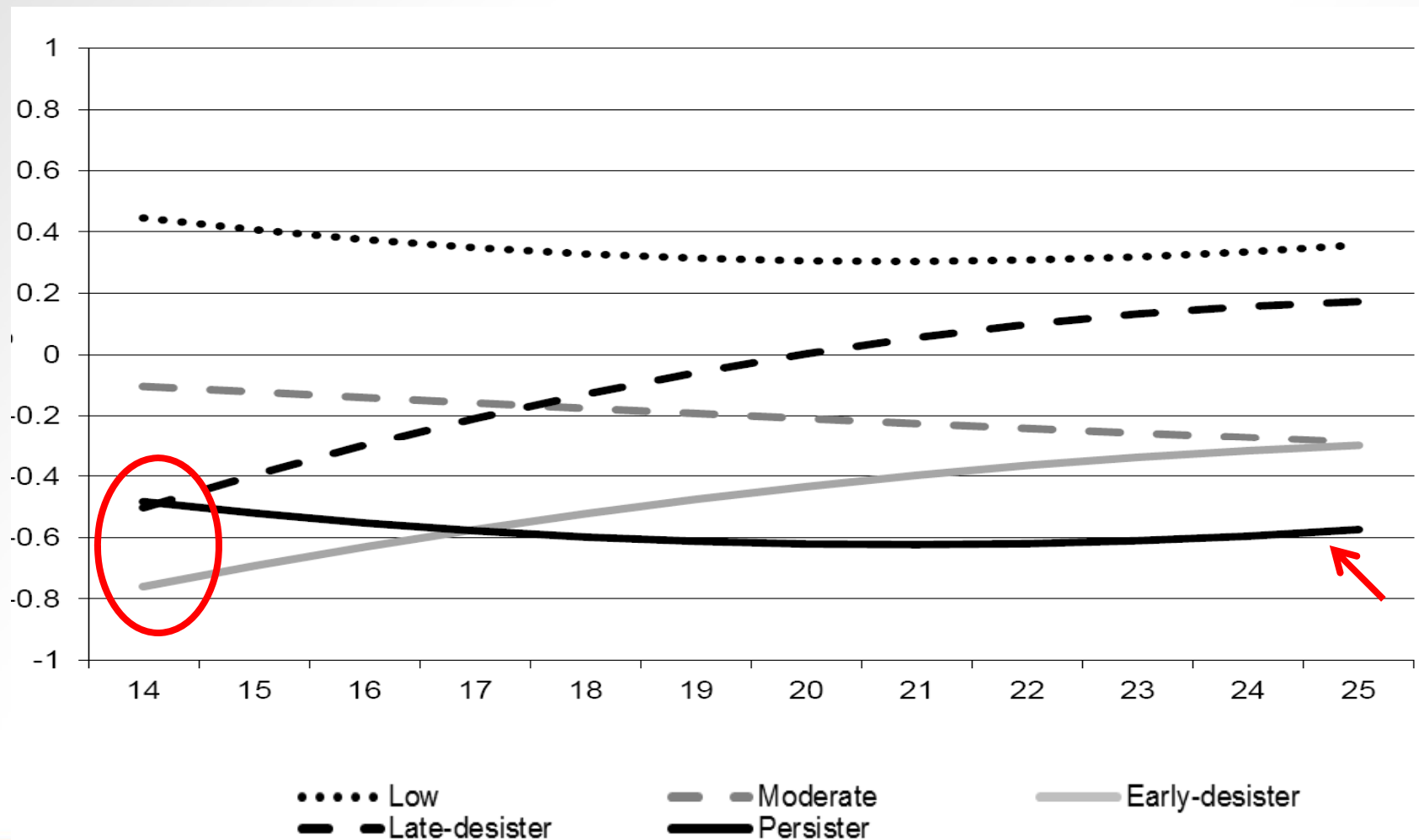
- ▶ Two-site study (Pennsylvania and Arizona)
- ▶ Followed 1,354 juvenile justice-involved adolescents with serious complaints as they make the transition from adolescence into early adulthood over a 7 year span
- ▶ Used regular interviews, measures, and official records over a seven year period
- ▶ Key question: since the natural course for juvenile offenders is toward less crime, what distinguishes those who desist from crime from those who persist?



Psychosocial Maturity and Desistance from Crime



Persistent Offenders Show Especially Stunted Development of Temperance



Main Finding

- ▶ Psychosocial maturity is related to criminal offending patterns and desistance from crime.
- ▶ Psychosocial maturity (Steinberg):
 - Temperance – the ability to control impulses, including aggressive impulses (especially for high risker risk youth with serious offenses)
 - Responsibility - the ability to take personal responsibility for one's behavior and resist the influences of others
 - Perspective – thinking about oneself, others, and consequences of one's actions



Programming Suggestions for this Period of Heightened Brain Plasticity

To target impulsivity and self-regulation, consider:

- Programs that target problem-solving and decision-making skills, e.g.:
 - SODAS (Situation-Options-Disadvantages-Advantages-Solution; cf. <http://sodasgosukai.blogspot.com/2017/02/sodas-problem-solving.html>)
 - Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- Cognitive-Behavioral Programs that target self-regulation (frustration tolerance, impulse control, anger management) such as:
 - Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
 - Dialectical Behavior Therapy – Emotion Regulation, Mindfulness, and Distress Tolerance modules
 - Aggression Replacement Training - Social Skills, Anger Management, and Moral Reasoning
 - Stop Now and Plan (SNAP)



Treatment and Programming Needs

»» Risks-Needs-Responsivity



What Works in Reducing Recidivism

- ▶ **RISK PRINCIPLE:** Match the intensity of intervention with an individual to their risk of reoffending
- ▶ **NEED PRINCIPLE:** Target criminogenic needs
- ▶ **RESPONSIVITY PRINCIPLE:** Tailor the intervention to the learning style, motivation, culture, demographics, and abilities of the offender. Address the issues that affect responsivity (e.g., mental health, trauma, substance use).



Applying the Risk Principle

- ▶ High risk juveniles should receive more intensive services for a longer period of time
 - Intensity = more groups, services, supervision more often
- ▶ Low risk juveniles have fewer problems and more pro-social supports.
 - They usually do not require intensive interventions/supervision.



What Makes a Youth High Risk?

- ▶ They have many risk factors.
 - Static criminogenic risks
 - Criminogenic needs
 - Dynamic (changeable) factors related to recidivism

- ▶ To reduce risk we must address the criminogenic needs.

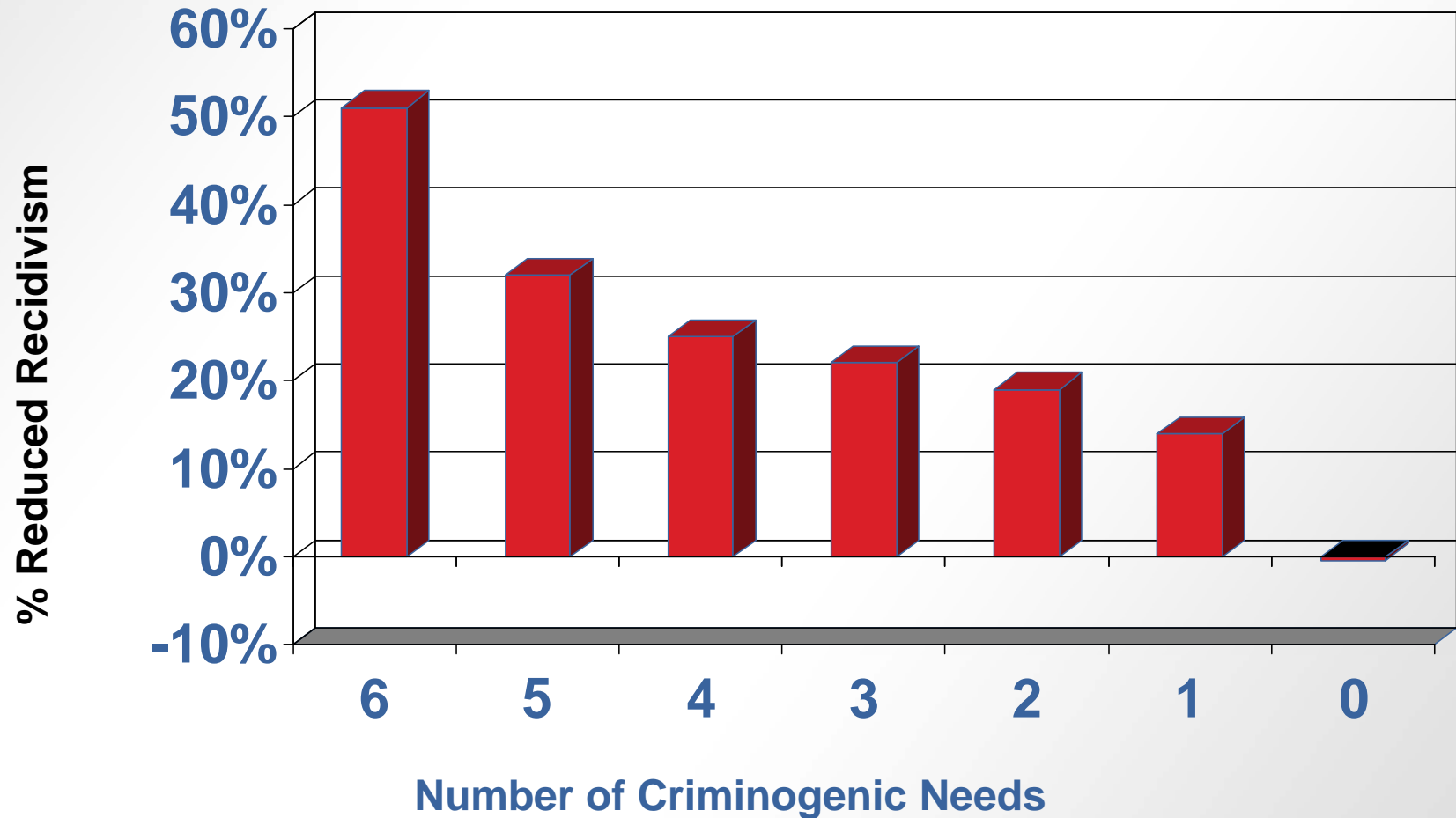


The Need Principle

- ▣ Assess and target the needs/problems *related to criminal behavior* that can change.
- ▣ Criminogenic needs = dynamic risk factors
 - Criminal thinking, attitudes, values, and beliefs; attitudes, impulsivity and poor decision-making; delinquent or pro-criminal peers; family issues; substance use/misuse; low educational and/or vocational achievement; and unstructured leisure time
- ▣ Non-criminogenic needs = problems not directly related to criminal behavior.
 - Medical issues, low self-esteem or mental health issues, artistic or musical ability and/or skills, physical ability, etc.



Targeting Multiple Criminogenic Needs



Responsivity Principle:

- ▶ Refers to the learning/interaction styles of the juveniles which can affect their engagement/success in response to programming
- ▶ Identify responsivity characteristics and then match the juvenile to various staff and groups to assist in removing the barriers



Responsivity Factors

- ▶ Specific/internal – youth learn differently and have certain obstacles (mental health problems; trauma-related problems) that interfere with their ability to benefit from services. These specific factors may need to be addressed before or during programming.
- ▶ General/external – programs that are based on cognitive-behavior and social learning theories are generally responsive to juveniles and emerging adults.



Criminogenic Needs to Target in Emerging Adults

▶ Criminal Thinking

- Cognitive behavioral programs
- Mentoring programs
- Aggression Replacement Training

▶ Education services targeting the following issues:

- Lower educational levels
- Problems with literacy and core math skills
- Over-age relative to grade level
- Deficit in credits
- Failure to value education and understand role in success in work



Criminogenic Needs (cont'd)

▶ **Employment**

- Job readiness
- Employment experience
- Vocational training

▶ **Peer Influence**

- Mentoring
- Exposure to pro-social peers/natural supports
- Relationship skills

▶ **Family Issues**

- Transition to independence; reduced family influence and changing social networks are the norm.
- Life skills
- Independent living skills



Cognitive Behavioral Programs

- ▶ Address thinking
 - Cognitive restructuring – changing “what” a person thinks (distortions, cognitive errors, maladaptive thoughts)
 - Cognitive skills – changing how a person thinks; processes like paying and sustaining attention, reasoning, problem-solving, and decision-making

- ▶ Address behaviors
 - Modeling – staff teaching by example
 - **Practicing – youth role-playing**
 - Feedback
 - Reinforcement



Meta-Analysis of CBT Programs for Juvenile and Adult Offenders

- ▶ Reviewed 58 studies:
 - 19 random samples
 - 23 matched samples
 - 16 convenience samples
- ▶ On average, CBT reduced recidivism by 25% (from recidivism rates of 40% to 50%), but the most effective configurations found more than 50% reductions

Landenberger, N, and M. Lipsey (2005). The Positive Effects of Cognitive Behavioral Programs for Offenders: A Meta Analysis of Factors Associated with Effective Treatment. *Journal of Experimental Criminology*.



What Made a Difference:

- ▶ Risk level of participants
 - Higher risk offenders benefited more
- ▶ How well treatment was implemented
 - Higher impact on recidivism if CBT was combined with other services.
 - Staff training and fidelity monitoring matters.
- ▶ Sessions per week (2 or more)
- ▶ Higher proportion of treatment completers
- ▶ Brand name was no better than home-grown CBT programs.



Key Treatment Elements:

- ▣ Individual attention in addition to group sessions
- ▣ Anger control
more powerful
- ▣ Cognitive restructuring (more powerful than cognitive skills training)
- ▣ Interpersonal problem-solving
- ▣ Victim impact and behavior modification components were associated with smaller effect sizes!

Landenberger, N, and M. Lispey (2005). The Positive Effects of Cognitive Behavioral Programs for Offenders: A Meta Analysis of Factors Associated with Effective Treatment. *Journal of Experimental Criminology*.



Treatment and Programming Needs

- »» Mental Health and Substance Use Disorders

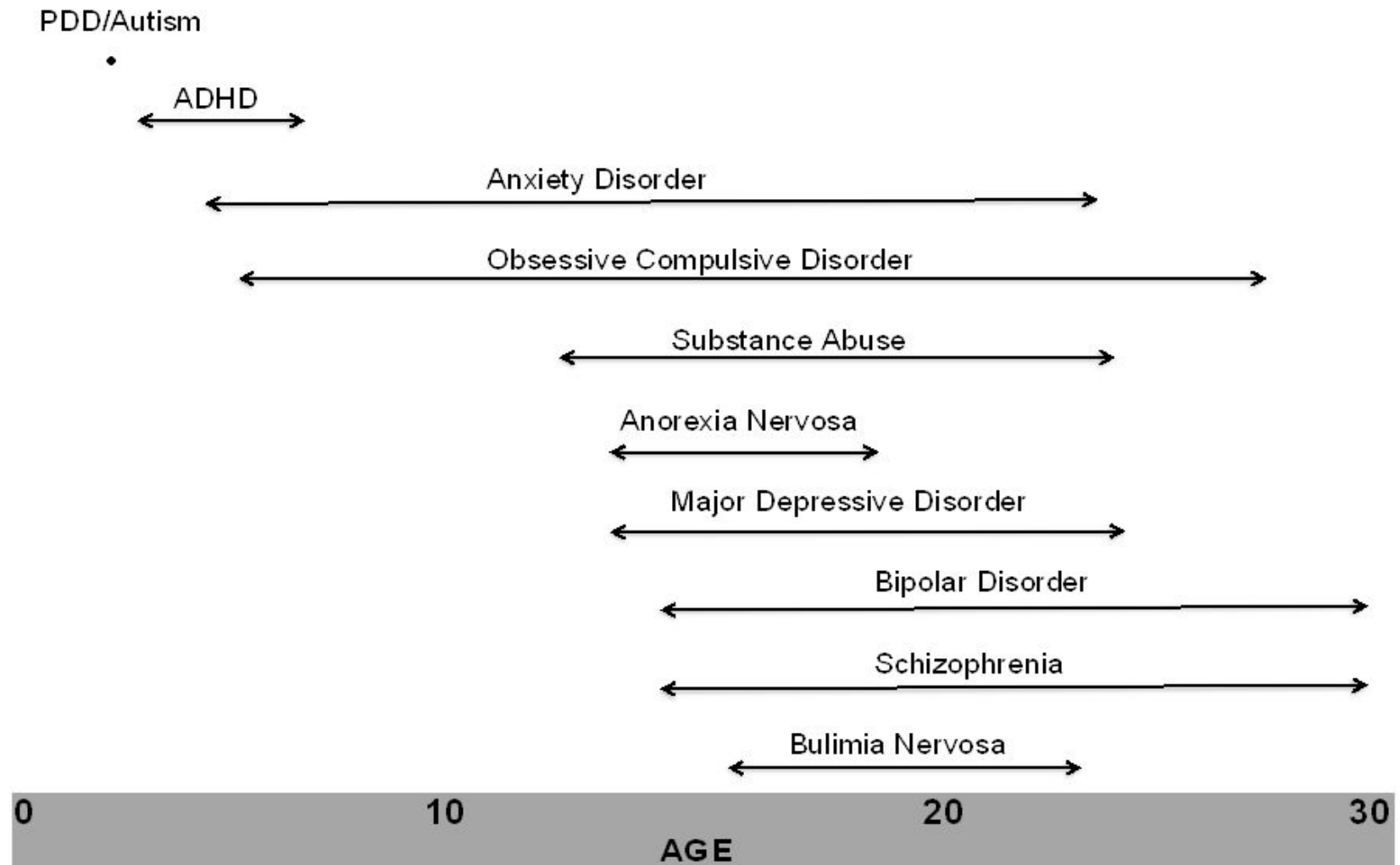


Mental Health Issues among Transition Age Youth

- ▶ 50 to 70% of all youth coming into contact with the juvenile justice system have at least one diagnosable mental health problem.
- ▶ Transition age youth are especially vulnerable; SAMHSA reports that this group has the *highest* rates of mental health diagnoses.
- ▶ Further, utilization of MH services declines sharply during this developmental period.

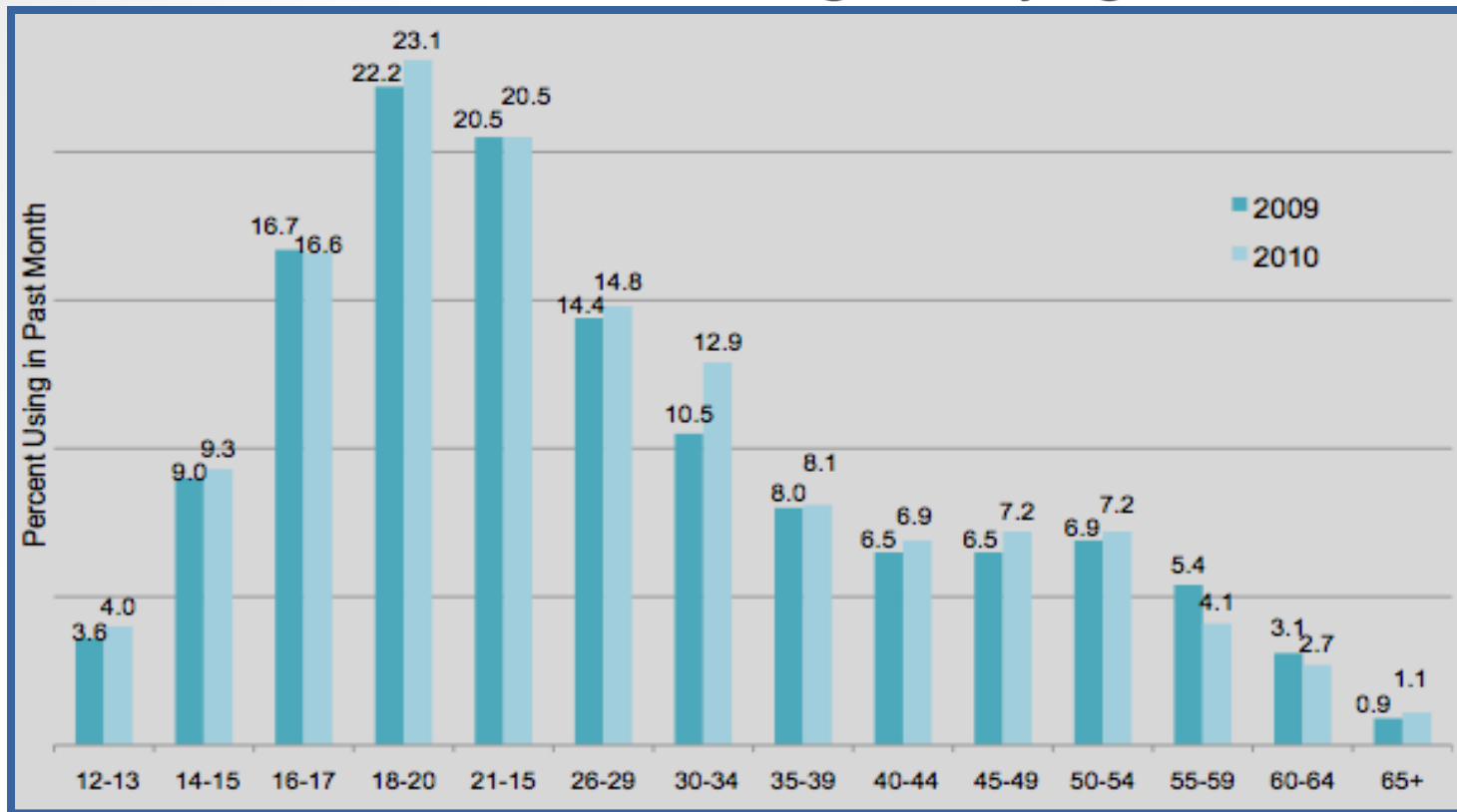


Age of Onset of Mental Disorders



The transition age also has the highest rates of onset of problematic substance use and substance use disorders (i.e., abuse, dependence).

Past Month Illicit Drug Use by Age



<http://www.recoveryanswers.org/recovery/epidemiology/epidemiology-of-substance-use-disorders/>

Pregnancy and Parenting

2015 Teen Pregnancies in North Carolina

*Rates based on small numbers (<20 pregnancies) are unstable and not provided. All rates are per 1,000.

Number of pregnancies among 15-19-year-old girls: 9,802

Teen pregnancy rate per 1,000 15-19-year-old girls: 30.2

Teen pregnancy rates by race/ethnicity

African American: 41.1

Hispanic: 49.1

White: 21.3

Teen pregnancy rates by age

15-17-year-olds: 14.3

18-19-year-olds: 53.6

Number of pregnancies among 15-17-year-old girls: 2,759

Number of pregnancies among 18-19-year-old girls: 7,043

Percent of Repeat Pregnancies: 22.7%

Teen birth rate per 1,000 15-19-year-old girls: 23.5

Latest National Ranking (out of 50 states): 22

Change since 2010**: -39.2%

<http://www.shiftnc.org/data/map/northcarolina>



To Date:

- ▶ Six presentations to program and service providers who belong to the NC Association of Community Alternatives for Youth discussing gaps in services and program needs for this population.
- ▶ Meeting with local LME/MCO regarding service definitions needed. Transitional Living service definition (ages 17 – 21) has been submitted to the federal Center for Medicare and Medicaid Services (CMS) as part of state-wide Medicaid b plan proposal; approval expected in October.
- ▶ Contact initiated with Benchmarks (a non-profit association of treatment provider agencies) regarding development of a service array; meeting schedule in June.



Challenges and Opportunities

- ▶ *Transitioning to adult health care systems.* In NC, Medicaid will cover MH treatment for youth up to age 21, so lapses in coverage will not be an issue.
- ▶ What **IS** an issue is that the state's mental health system has not incorporated what we have learned about brain science into their array of services.
 - Residential placements (PRTFs, group homes) licensed by the state's Division of Health Service Regulation (within DHHS) end at age 18 in the child mental health system, then start at 18 for adults.
 - There is no licensing available for residential treatment homes and facilities specifically for transition age youth/emerging adults (17 – 25).
- ▶ Perhaps invite Stephanie Gilliam from DHSR to speak to CAY?





Juveniles With Problematic Sexual Behavior

How do we identify these youth?

▶ Statistically normal

Developmentally normal

- Typical and accepted
- Unfamiliar
- Uncomfortable

Unhealthy

Abusive

Illegal



What do we call these youth?

- ▶ Sexually Reactive Youth
- ▶ Sexually Aggressive Youth
- ▶ Youth With Sexual Behavior Problems or Problem Sexual Behavior (PSB) Youth
- ▶ Youth Who Sexually Harm
- ▶ Juvenile Sex Offenders



What they are not

- ▶ Predator
- ▶ Psychopath
- ▶ Pedophile
- ▶ Child Molester
- ▶ Sexual Deviant
- ▶ Serial Rapist



What do we know about these youth?

- ▶ Juveniles perpetrate about 40% of all child sexual abuse in the United States
- ▶ They are a heterogeneous population with no typologies (i.e., predator, pedophile, psychopath, etc.)
- ▶ Numerous factors motivate youth to sexually harm (sexual, criminal, poor social skills, emotional/social deprivation, power/control, etc.)



Facts Regarding Sexual Re-offending

Most studies show that juvenile sexual recidivism rates vary from 4-14%

	<u>Follow-up</u>	<u>Sex Offense Study Recidivism Rate</u>
Caldwell (2007)	5 years	6.8%
Worling (2000)	2-10 years	5.17%
Letourneau (2009)	9 years	2.5 – 7.5%
Rasmussen (1999)	5 years	14.1%
Vandiver (2006)	3-6 years	4.3%
Hendriks (2008)	9 years	11%
Kahn (1991)	20 months	7.5%
Sample & Bray (2003)	5 years	6.5%
Parks & Bard (2006)	≤ 134 months	6.4%



Caldwell, 2016

- ▶ 106 studies involving 33,783 adolescents adjudicated of a sexual offense between 1938 and 2014
- ▶ Mean follow-up time of nearly 5 years (59.98 months)
- ▶ 33 studies between 2000 and 2015 and reported a weighted mean sexual recidivism rate of **2.75%** -- which is **73%** lower than the rate of 10.30% reported by studies conducted between 1980 and 1995



NC Department of Public Safety (Juvenile Justice)

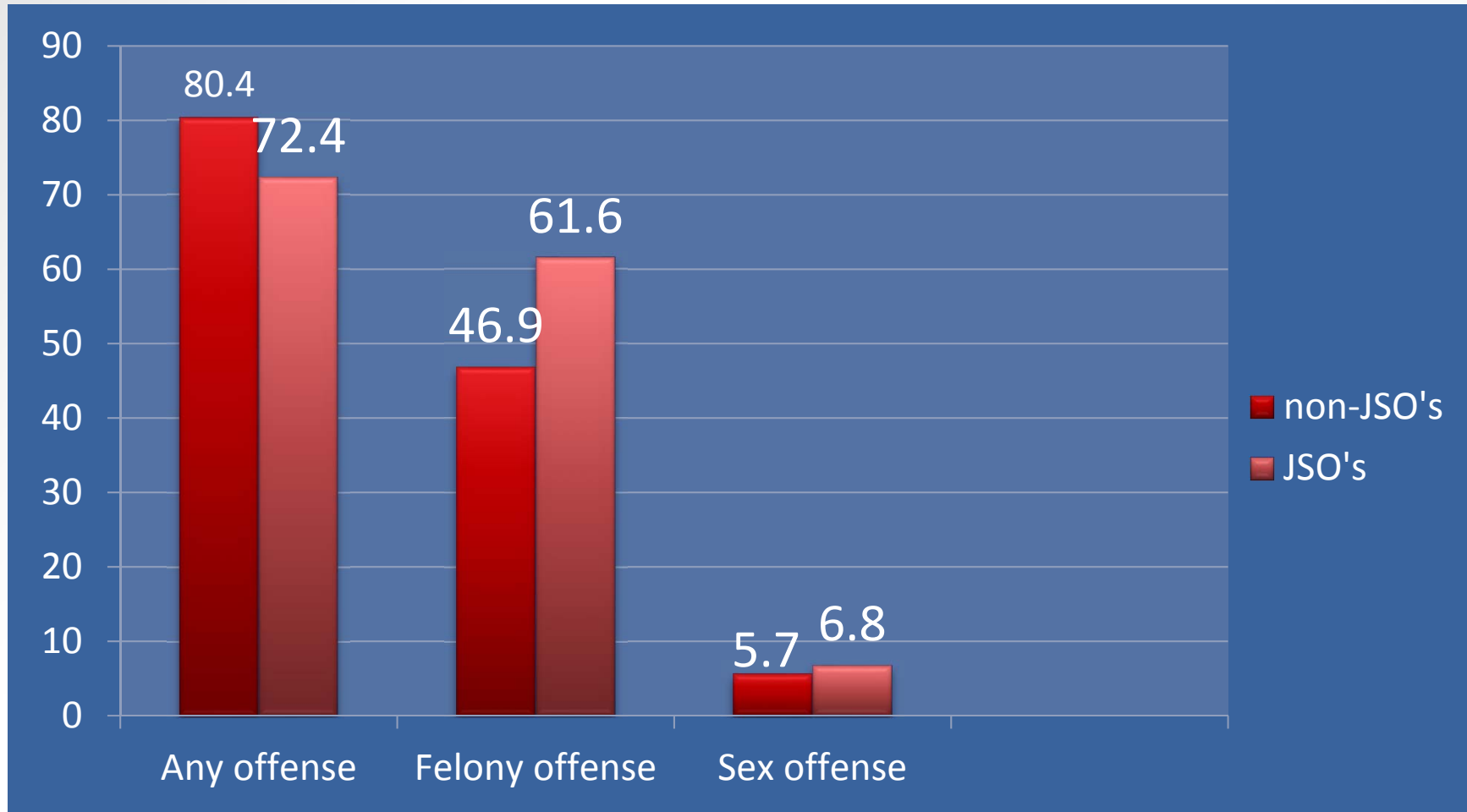
youth adjudicated for sexual offenses (Jan 1, 2007 – Dec 31, 2016)

Gender of Adjudicated SO Complaints	Complaints	% of Total
Female	183	4%
Male	4,388	96%
Total	4,571	100%

Age at Offense : Adjudicated SO Complaints	Complaints	% of Total
6	5	0.11%
7	14	0.31%
8	25	0.55%
9	65	1.42%
10	144	3.15%
11	339	7.42%
12	829	18.14%
13	1,165	25.49%
14	1,084	23.71%
15	899	19.67%
16	2	0.04%
Total	4,571	100.00%



Recidivism: JSO's vs. Non-JSO's



These Youth Do Not Only Commit Sexual Offenses.

- ▶ 55% had a prior non-sex offense
- ▶ 61% were convicted of non-sex offenses as adults
- ▶ 5% were convicted of sex offenses as adults
 - Of sexual recidivists, 72% were also convicted of non-sex offenses as adults.



Trauma- Informed Approach to Working With These Youth



The Story of the ACE (Adverse Childhood Experiences) Study

- ▶ Very large sample
 - 17,000 Patients at Kaiser Permanente HMO
 - Average age 57
- ▶ High Functioning
 - All insured
 - Middle Class
 - 74% attended college



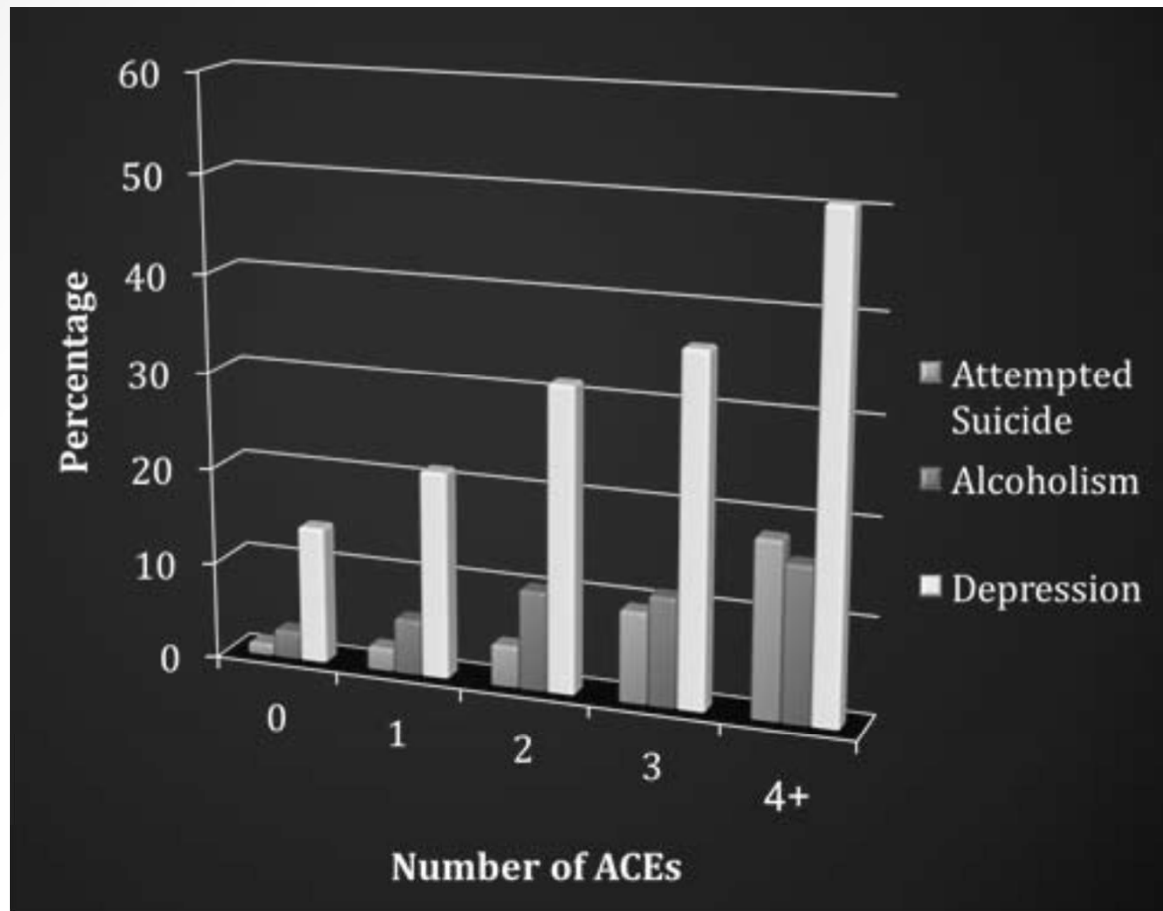
ACE Categories

- ▶ **ABUSE AND NEGLECT**
 - ▶ •Emotional abuse
 - ▶ •Physical abuse
 - ▶ •Sexual abuse
 - ▶ •Emotional neglect
 - ▶ •Physical neglect

- ▶ **HOUSEHOLD DYSFUNCTION**
 - ▶ •Mother Treated Violently
 - ▶ •Household Substance Abuse
 - ▶ •Household Mental Illness
 - ▶ •Parental Separation or Divorce
 - ▶ •Incarcerated Household Member



FINDINGS: HIGH ASSOCIATION TO NEGATIVE HEALTH OUTCOMES



Trauma (Ford et al., 2012)

- ▶ Approximately 90% of youth in juvenile detention facilities reported a history of exposure to at least one potentially traumatic event in two independent surveys of representative samples

e.g., being threatened with a weapon (58%), traumatic loss (48%), and physical assault (35%)



Trauma (Ford et al., 2012)

- ▶ Two complex trauma sub-groups:
 - 20% of them reported some combination of sexual or physical abuse or family violence
 - 15% emotional abuse and family violence but not physical or sexual abuse

The resultant combined prevalence estimate of 35% for complex trauma history is about three times higher than the 10-13% estimates of poly-victimization from epidemiological study of children and adolescents.



Trauma (Ford et al., 2012)

- ▶ Sexual offending in adolescence has been linked with complex trauma exposure in several studies. Interviews with the clinicians treating 40 JSOs found that 95% of these youths had a documented history of at least one past traumatic event, and 65% were determined to have met diagnostic criteria for PTSD.
- ▶ Notably, clinicians viewed the trigger(s) for sex offending as related to a prior trauma in 85% of the youth, including intense trauma-associated fear for 37.5% of the youth, helplessness for 55%, and posttraumatic horror for 20%.
- ▶ 1 in 7 JSOs were found to meet criteria for a dissociative disorder, with physical abuse associated with elevated levels of dissociative symptoms.



How does early adversity translate into sexual assault? (Understanding sexual assault through a lens of trauma)

Emotional congruence with children
(less threatening)

General Self-regulation

Early conditioning experiences for
maladaptive coping

Sexual Self-regulation

Role modeling of poor boundaries

Emotional Self-regulation

Learned behavior about misusing power
differential to get what you want

*Using sexual assault to
meet emotional and social
needs

Sexualized coping



ORIGINS OF SEXUAL BEHAVIOR PROBLEMS

Child Vulnerabilities

Development or language delays
Impulse control problems

Modeling of Sexuality

sexual abuse, nudity,
exposure to pornography,
exposure to adult sexual
behavior

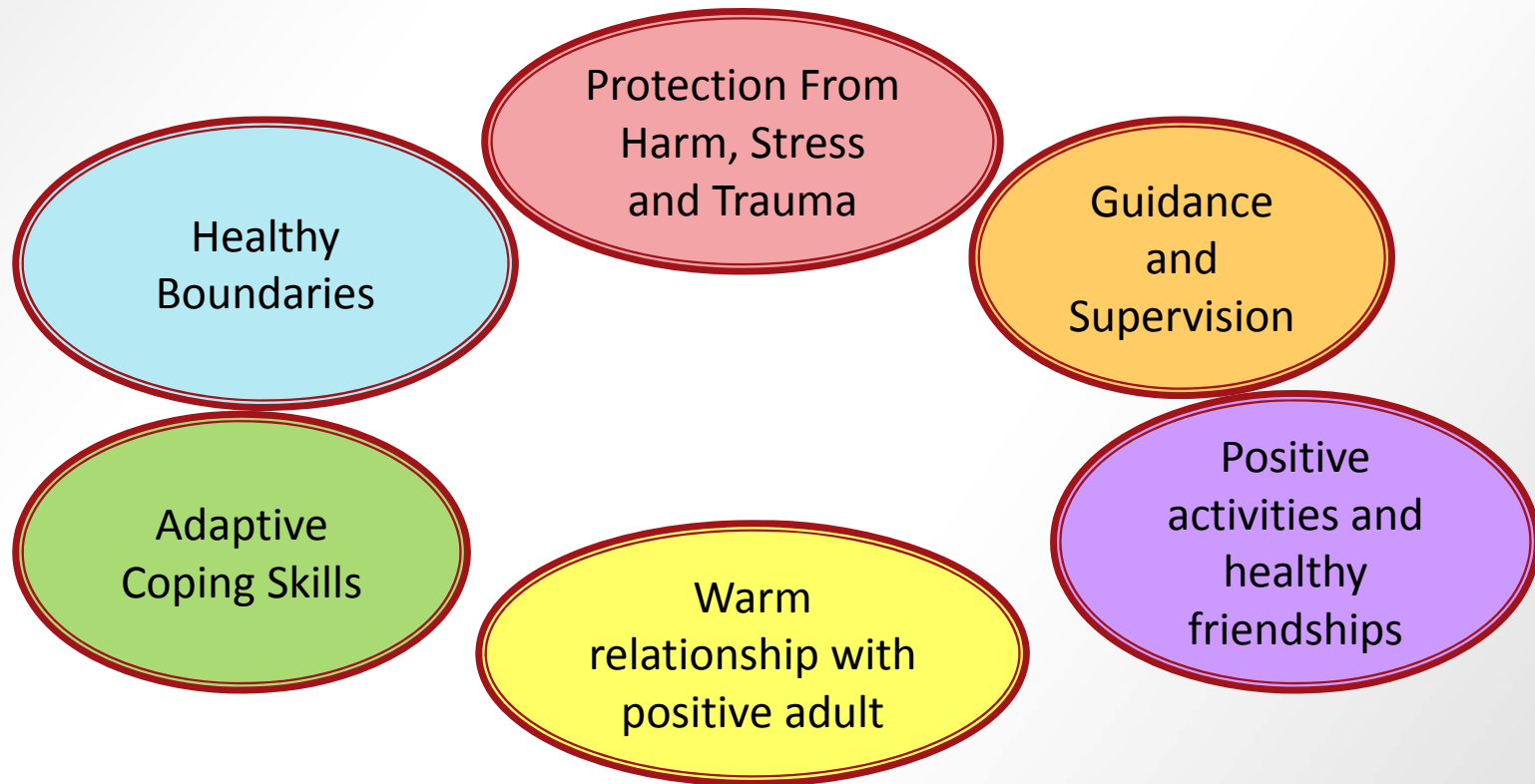
Family Adversity

lack of supervision,
stress and trauma,
substance abuse,
parental mental health

Modeling of Coercion

physical abuse, domestic
violence, peer violence
community violence

SUPPORTIVE AND PROTECTIVE FACTORS



Overlap of Public Policy and Treatment

Public pressure for criminal justice response even though “research findings have repeatedly demonstrated that some sex offender management policies such as registration and public notification-especially when applied to youth are ineffective at reducing already low recidivism rates”

“Such policies have harmful collateral effects for youth’s prosocial developments”:

- Disrupting positive peer relationships and activities
- Interfering with school and work opportunities
- Harassment, rejection, social alienation and lifelong stigmatization and instability



What can we expect with
raising the juvenile age?



Current Most Common Offenses

A-G Felonies

- ▶ First Degree Rape
- ▶ Second Degree Rape
- ▶ First Degree Sexual Offense
- ▶ Second Degree Sex Offense
- ▶ Statutory Rape of Sexual Offense
- ▶ First Degree Sexual Exploitation of a Minor

H or I Felonies, Misdemeanors

- ▶ Crime Against Nature
- ▶ Sexual Battery



Raise the Age Gaps

Placements for Youth Who Cannot Return to Their Families

Options to Increase Supportive and Protective Factors

