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ABSTRACT

This monograph, one of a series on youth with disabilities and the juvenile justice system, focuses on best practices for reducing delinquency and preventing recidivism. This essay notes that, because of the connection between disability and delinquency, it is likely that a significant portion of court-involved, disabled youth can be expected to manifest social skill deficits and thus be difficult to manage. However, interventions that are skill based, use positive discipline, teach self-control, social cognitive skills, and problem solving, and which involve the youth's family are shown to reduce recidivism as well as to increase a youth's prosocial behavior, commitment to school, and trust in working with systems. The monograph identifies eight types of research-based effective practices for working with court involved youth. These practices include: (1) individual juvenile planning; (2) skill-based interventions (including counseling, social skills training, academic and vocational interventions, and life skills/multimodal approaches); (3) medical interventions (including

medication and substance abuse treatment); (4) behavioral systems; (5) family involvement; (6) the use of individualized transition planning (such as wrap-around planning and supports); (7) effective staffing; and (8) the ongoing assessment of program effectiveness. Five model programs are described. Appended is a sample Individualized Justice Plan for youth with disabilities. (Contains 59 references.) (DB)

BEST PRACTICES FOR SERVING COURT INVOLVED YOUTH WITH LEARNING, ATTENTION AND BEHAVIORAL DISABILITIES

By

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Promising and Preferred Practices for Serving Court Involved Youth with Learning, Attention and Behavioral Disabilities

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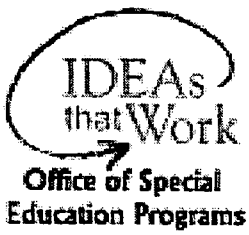

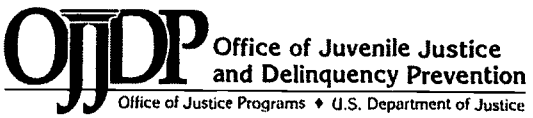

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BEST PRACTICES for Serving Court Involved Youth with Learning, Attention and Behavioral Disabilities

Introduction

The purpose of this monograph is to identify best practices for reducing delinquency and/or preventing recidivism in court involved youth with learning, attention and behavioral disabilities. A second purpose of this monograph is to identify and describe evaluated model programs currently existing which are directed towards court involved juveniles with disabilities.

Youth with emotional and behavioral disorders, and learning disabilities are represented in the juvenile justice system in numbers disproportionate to their incidence in the general population. It may be that as much as 90 percent of youth in the justice system meet the diagnostic criteria for one or more mental health disorders (Otto, 1992). A comprehensive national longitudinal study showed that 32% of all youth with learning disabilities and 57% of all youth with serious emotional disturbance are arrested at least once (Wagner, D'Amico, Marder, Newman, & Blackorby, 1992). A 1995 survey of adolescents in corrections settings and adolescents in public schools indicates that more than twice as many of the adolescents in corrections had been placed in special education classes for learning problems (Harrison, Fulkerson & Beebe, 1996). In fact, another study determined that over 98 percent of juvenile offenders entering adult correctional facilities are high school drop-outs (Ingersoll & LeBoef, 1997) and, therefore, likely to have a high incidence of disabilities.

Conduct disorder is the most commonly diagnosed behavioral disorder among delinquent youth. At least half of the youth in correctional institutions are believed to have conduct disorder (Nelson, 1996; Otto, 1992). Although conduct disorder is not specially addressed in the Individuals with Disabilities Education Act (IDEA), a number of studies have shown that between one third and one half of all youth diagnosed with conduct disorder also have co-existing diagnoses of attention deficit hyperactivity disorder and/or learning disabilities (Barkley, 1997; Shamsie et al., 1996). Consequently, they may qualify for special education services because these disorders interfere with their learning and their behavior.

Learning, attention, and behavioral disorders, particularly when a youth has a combination of disabilities (a common occurrence), can be extremely challenging for even those who specialize in treating youth with these disabilities because social skill deficits make youth with disabilities more difficult to manage. A recent analysis (Kavale & Forness, 1996) of 152 studies comparing learning disabled youth to nondisabled peers found that 75% of youth with learning disabilities manifest social skill deficits. Because of the connection between disability and delinquency, it is likely that a significant proportion of court-involved disabled youth can be expected to manifest social skill deficits and as a consequence be difficult to manage.

However, a case-managed multifaceted intervention that is skill based, that uses positive discipline and teaches self-control and social cognitive skills and problem solving and which involves the youth's family is shown to reduce recidivism as well as increase a youth's prosocial behavior, commitment to school and trust in working with systems (Gendreau, 1996; Heggenler, 1997; Palmer, 1996; Walker, 1991) Approaches that address the needs of a youth in all of his or her environments have a greater chance for success than those directed exclusively at a youth's behaviors (Heggenler et al., 1995).

Literature Search of Best Practices

To identify best practices, a wide range of research was reviewed using the Psychologist Information Data Base, the ERIC Data Base, and Psychological Abstracts. Sadly, we could find almost no research evaluations of interventions with court involved youth with learning, attention, and behavioral disabilities. We did, however, find a number of studies testing interventions for delinquent youth in general, and from these culled those that could accommodate youth with disabilities. Additionally, Gendreau (1996) and Palmer (1996) recently completed comprehensive reviews of effective offender rehabilitation programs, including juvenile rehabilitation programs which have been empirically evaluated during the past *three decades*. Thus, research on delinquency, coupled with research studies from the field of special education and the Gendreau and Palmer reviews provided the basis for what we have identified as best practices for serving court involved youth with learning, attention, and behavioral disabilities.

The Search for Model Programs

The second purpose of this monograph is to identify model programs so that practitioners can get a feel for how best practices are applied. Our initial criteria for selecting a program as a model was that the program had to have some *empirical* evaluation showing its effectiveness with court involved youth with disabilities. This threshold proved to be too restrictive as we found almost no programs with outside empirical evaluation. Consequently, we broadened our criteria to include programs that consisted of best practices components and which had some evaluation data even if only from "in house" and with less than perfect controls. We had limited success identifying model programs through a literature search, thus, we began interviewing professionals in the field–State Directors of Youth Services, University Professors, Program Directors in corrections, and private consultants known in the field of disabilities education. This was a much more meaningful method of finding effective programs.

We did not intend to interview or identify every program that effectively serves court involved youth with disabilities. We simply tried to identify programs having at least some basic evaluation data that also provided some, if not all, of the best practices components identified as being important for serving court involved juveniles with disabilities. The programs and services highlighted in this monograph are representative of effective programs and most have been rigorously evaluated.

Best Practices for Effective Programming

Based on the interviews and the literature review, eight Best Practices for effective programming were identified. The Best Practices are:

Individual Juvenile Planning

Skill Based Interventions

- Counseling
- Social Skills
- Vocational
- Academic
- Life Skills/Multimodal

Medical Interventions
- Medication
- Substance Abuse Treatment

Behavior Systems

Family Involvement

Transitioning
- Transition Plan
- System of Care/WrapAround

Staffing

Assessment of Program Effectiveness

The following sections describe best practices that are supported by research. Every attempt has been made to provide enough details so the reader can apply some, if not all of the information in each section immediately. In those cases where sufficient details are not provided, the reader can use the information as a guide for further inquiry.

THE WHAT'S AND HOW'S OF BEST PRACTICES

Individual Juvenile Planning

Active and comprehensive planning of goals and intervention strategies for each youth with disabilities involved in a prevention or intervention program has been found to be essential. Of course, by law, youth with disabilities require Individual Education Programs and many qualify for protection under Section 504 of the Rehabilitation Act of 1973 in the form of an Accommodation Plan. However, the quality and detail of these plans vary with each program. Obviously, these plans need to dovetail into the youth's Probation Agreement, Individualized Justice Plan, Correction Plan, or whatever your state moniker is for the juvenile justice plan. Listed below are basic essentials that should be included in the planning phase of programming. The Appendix has a sample Individual Justice Plan for youth with disabilities.

- **Every juvenile should be assessed to determine specific skill needs in the social, family communication, psychological, academic, and vocational areas**. Assessment must take into consideration cultural factors as well as accommodations for the youth's disability. Social needs should be assessed in multiple contexts and in interaction with peers and adults and, if possible, with family members.
- **A plan including social behavioral goals as well as family, psychological, academic, and vocational goals and strategies for achieving the goals should be formulated for each juvenile**. Juveniles should participate in the formulation of goals and should know clearly what their goals are and how they will be evaluated. It should be specified how the youth will attain goals and how each caretaker and service provider will help the youth to that end. Everyone involved should know the specific part they play in the plan. Goal attainment should be tied to progressing through the program and to the

reinforcement system. The goals should specify how the juvenile is expected to demonstrate that a goal has been reached.

- **The plan should include how the youth's progress will be monitored and a caremonitor or casemanager for daily or weekly oversight of plan implementation should be assigned.** Successful goal attainment requires careful and on-going monitoring of the youth's progress. Goal attainment is more likely to be accomplished when the youth is assigned a specific caremonitor or caseworker who can carefully monitor youth progress and coordinate services provided. One primary reason for failure of youth to progress through set goals is that the youth is "allowed" to fail for too long. Service providers or staff become responders not preventers. This is almost always because the service providers are not "on top" of how the youth is doing and by the time the youth's failure is addressed it has become an entrenched pattern, a situation of crisis or so severe that relapse is unavoidable. Youth with learning, attention, and behavioral disabilities need frequent on-going monitoring to "nip in the bud" any off-track behaviors. For day treatment or community programs, frequent monitoring means daily monitoring with a phase in of weekly monitoring and then monthly and so forth. In residential programs, it can mean hourly monitoring with a phase in of daily monitoring and so forth. Of course, the whole point of monitoring is that adjustments are made to remediate the youth's off-track behavior. This may entail simple "booster" sessions with the youth or it may mean calling a formal meeting of service providers or staff to modify the plan and strategies for implementation.
- **Goals should be changed as the youth progresses or fails to progress through the program and all service providers, staff, and family should know what the new goals are.** This will require clear procedures for communicating among various caretakers.

In summary, each court involved youth with learning, attention and behavioral disabilities needs to be assessed academically, vocationally, socially, psychologically, and in terms of family needs. A specific plan that includes the role of service providers or individual staff, the youth, and the family should be developed and criteria for success or failure of goal attainment should be clear. The plan needs to be youth centered and dynamic so that careful monitoring of the youth can suggest if and how the plan might be adjusted.

Skill Based Interventions

Research clearly shows that preventing recidivism and reducing delinquency is best attained by providing youth with coping skills. Thus, interventions that actively teach a skill, whether through counseling, classroom instruction, or other training modes, are the most effective for court involved youth with disabilities. Obviously, some skills are more essential than others. Direct instruction of academic, vocational, and social skills appears absolutely necessary for preventing recidivism and reducing delinquency. However, rehabilitation is not so simple as providing direct skill instruction in these areas. First, many court involved youth with disabilities have co-occurring disabilities that must be addressed, especially if medical intervention is indicated. Additionally, problematic social skills and poor self-control often prevent direct instruction from taking place because of interfering behavior. Thus, implementation of a behavioral system to bring order to a youth's behavior is critical and research shows that such a system is associated with reduced recidivism. To complicate matters even more, there is a good chance that court involved youth with disabilities are substance abusers and will need access to a treatment program. And finally, direct instruction will not be successful if it takes place in a vacuum. Thus, a transition plan that

involves the family adds to the complexity of the intervention but is essential for successful rehabilitation.

In the following sections we review the efficacy of various single interventions that show promise. However, the reader should keep in mind that providing a *combination* of the following interventions is necessary. Thus, multifaceted programming, often identified as Life Skill Training, is the most promising approach. The following review will help the reader make informed decisions about what combination of interventions to choose when creating a comprehensive program. Additionally, the following sections provide the reader with some essential "how tos" of single interventions.

Counseling

According to the extensive review by Palmer (1996) evaluations of the effectiveness of group counseling for reducing recidivism are mixed but tend to show a lack of effectiveness. There are some exceptions however. Group counseling that is focused and problem-solution oriented, as opposed to open ended, shows promise and counseling that took place *outside* of juvenile justice contexts was twice as likely to reduce recidivism—it is not clear if this is due to better training and skills of outside therapists or differences in the characteristics of youth.

The effectiveness of individual counseling or therapy is not clear but overall nondirective or psychodynamic counseling did not reduce recidivism. Specifically, therapy that emphasized a good relationship with the therapist as the primary goal—unraveling the unconscious and gaining insight; fostering positive-regard; self-actualizing through self-discovery; externalizing blame to parents and society; or ventilating anger—were found to be ineffective (Gendreau, 1996). Individual counseling that taught problem solving or social skills showed promise.

Cognitive therapy or social cognitive training that intends to change the youth's cognitions, attitudes, values, and expectations has been shown to be very effective (Larson, 1998; Palmer, 1996). In fact, social cognitive training is the single approach that is most likely to reduce recidivism in youth with learning, behavioral, attention, and emotional disabilities (Abramowitz & O'Leary; Sadowski & Kelley, 1993). It has been found that teaching social problem solving and self-control skills (both of which are social cognitive skills) are essential for reducing recidivism regardless of what other interventions are provided. However, cognitive training is even more powerful when provided in conjunction with academic and vocational interventions (Gendreau, 1996; Larson 1985, 1998)

In summary, evaluation of individual and group counseling interventions shows mixed results with open-ended approaches showing little influence on recidivism and problem- or youth-focused approaches that teach skills showing favorable influence on recidivism.

Social Skills Training

Deficits in social skills are one of the defining characteristics of youth with behavioral and emotional disabilities (Frederick & Olmi, 1994). These deficits result in a failure to establish positive social relationships with family members, teachers, peers, and community members. In addition, youth with behavioral disabilities often exhibit various inappropriate social behaviors such as aggression, poor anger control, and hostility. Likewise, a large body of research has shown that youth with learning disabilities (LD youth) generally have social difficulties.

Research has shown that an effective comprehensive social skills training program arguably has the *greatest* positive single influence for reducing recidivism or preventing

antisocial behavior in youth with disabilities (Gendreau, 1996; Palmer, 1996; Ross & Fabiano, 1985; Walker & Bullis, 1996). Because of the importance of teaching social skills, the following section is quite extensive and will introduce important issues to consider when developing a social skills program and will identify which social skills to teach and the components of an effective social skills training program.

Quite a bit has been written in education and psychology about social skills (Quinn, Mathur & Rutherford, 1996). However, there is much confusion about what is meant by the term *social skills*; it seems to mean different things to the different people.

Social skills may be defined differently because of the influence of culture but generally social skills are categorized into three types. These are *overt interaction skills, social-cognitive skills*, and *self-control skills*. Overt interaction skills are discrete observable social behaviors. Examples of these types of social skills are sharing, self-disclosure, complementing others, negotiating, accepting criticism, disagreeing, introducing people, and resisting peer pressure. Cognitive social skills are not overt behaviors themselves but rather are thinking skills that are applicable to a variety of social situations and that lead to or influence overt social behavior. Cognitive social skills include defining a problem clearly, goal setting, alternative solution thinking, step-by-step planning, perspective taking or empathy, identifying social pitfalls, and consequential thinking. Social self-control skills are a combination of overt social skills and cognitive skills that help prevent an individual from displaying aversive or antisocial behavior. So, for example, the social skill of impulse control in a potentially hostile situation would include both the cognitive skill of positive self-talk *and* the strategy of walking away from the situation. Self-control skills include: delay of gratification, anger, impulse and aggression control, emotional self-awareness, self-talk, and self-monitoring.

Assessment of Social Skills

Assessment of social skills becomes critical when one has the responsibility for helping a youth who is deemed to lack social competence. Assessing social skills may mean assessing the use of a particular behavior or skill such as turn taking, disagreeing with authority or controlling one's temper, or it may mean assessing a constellation of behaviors such as sustaining friends or behaving cooperatively.

When assessing a youth for social skill competence, one needs to first determine which social skills are important for a youth to acquire. (The following sections give suggestions in this regard). Then it needs to be determined how each youth's social competence to produce each of the targeted skills will be assessed. There are a variety of assessment methods but perhaps the most straightforward is to use a checklist of targeted skills that can be rated by a professional who is or has been in a position to observe the youth interact in a *variety* of social situations with *both* peers and adults.

Goals of a Social Skills Program

There are three goals in teaching social skills to court involved and at-risk youth. The first is to enhance a youth's likelihood of making prosocial choices in solving social problems or in fulfilling psychosocial needs (e.g., need for recognition or need for affiliation) so that antisocial and criminal behavior and recidivism are reduced. Cognitive social skills and self-control skills are targeted to accomplish this goal. The second goal is to enhance a youth's social interaction skills so that the youth can establish satisfying social relationships and prosocially negotiate social encounters. Overt social interactive skills and self-control skills are targeted to accomplish this goal. The third goal is to reduce social conflict in the youth's life by eliminating or substituting negative or antisocial behavior. Self-control skills and cognitive skills are targeted to accomplish this goal.

Overt Social Skills

Acting positively and prosocially has been linked to reductions in recidivism (Gendreau, 1996). Relevant to court involved youth, examples of overt social skills that are positive and prosocial include initiating greetings, apologizing, listening well, resisting peer pressure, showing empathetic concern, negotiating, sharing, behaving cooperatively, complimenting others, effectively disagreeing, handling conflict, providing emotional support, helping, expressing one's feelings and ideas, and interacting with the opposite sex.

In order to teach a specific social skill, its subskills must be identified and operationalized. Specific steps in performing each subskill must be clarified so that a youth can be instructed in exactly how to perform the skill. So, for example, effective negotiating would include eye contact, a positive tone of voice, respectful expression of feelings or desires, taking the perspective of the other, suggesting a compromise and the benefits thereof, expressing willingness to compromise, and expressing gratitude if the negotiation is successful or compliance if appropriate.

One important area of overt social skill training that enhances social interaction is teaching a youth how to be assertive. Fodor, (1992) defines assertiveness as ownership of one's experience and a willingness to express it to another in a mutually beneficial way. When a youth behaves assertively he or she does not blame others, act aggressively, be accusatory, act passively-aggressively or avoid solving conflicts. A central feature of teaching assertiveness is clarifying the distinction between assertiveness and aggressiveness. Teaching a youth assertive skills can help him or her avoid social conflicts as well as more effectively and independently resolve conflicts once they arise.

Some typical problematic situations for at-risk adolescents lend themselves well to assertiveness training. These appear to be socially valid skills to teach and when a youth is able to spontaneously perform these skills they will be well on their way to interacting prosocially. See the Appendix for related resources and programs that train overt social skills. Overt social assertiveness skills that are relevant to youth with disabilities include:

- **Dealing with positive and negative feedback**.
- **Initiating interactions.**
- **Dealing with dating situations and sexuality.**
- **Disagreeing**.
- **Learning how to say no**.
- **Asking for help**.
- **Negotiating**.

Cognitive Social Skills

During the last two decades there has been a great deal of research substantiating the relationship between lack of cognitive social skills and criminality and delinquency (Larson 1994; Palmer, 1996; Ross & Fabiano, 1985). Additionally, youth with learning disabilities, conduct disorders, attention-deficit disorders, depression, psychiatric problems, and substance abuse problems also have been shown to be deficient in cognitive social skills (Fodor, 1992; Kendall & Panichelli-Mindel, 1995; Lochman & Wells, 1996).

A variety of studies done in the mid 1970s found at-risk youth, when compared to peers, were less able to: define problems clearly, obtain relevant information about a problem situation, perceive situations from another's perspective, plan ahead for pitfalls, generate alternative options, spontaneously explore pros and cons prior to making decisions, and conceptualize a step by step process to a goal.

All of the above skill deficits can be defined as cognitive social problem-solving deficits. Males with problem-solving deficits have been found to have more anti-social ideas

than males with high problem-solving skills (Lochman & Wells, 1996). Individuals with poor problem-solving skills tend to be aggressive and impulsive (Fodor, 1992; Kendall & Panichelli, 1995). Deficiencies in social problem solving are associated with poor adjustment in a correctional facility (Larson & Gerber, 1987; Ross & Fabiano, 1985).

The cognitive social skills that are shown to enhance social competence, reduce aggressiveness and recidivism, and can be taught directly are social interpersonal problem-solving skills. See the Appendix for related resources or programs for training social problem solving. Important social problem-solving skills include:

- **Defining and recognizing a problem.**
- **Understanding other's point of view and feelings.**
- **Clarifying the problem.**
- **Identifying relevant variables of the situation.**
- **Setting clear and realistic goals.**
- **Estimating one's own ability to solve the problem adequately.**
- **Connecting cause and effect.**
- **Predicting and evaluating consequences.**
- **Anticipating pitfalls in carrying out a solution.**
- **Developing an internal locus of control orientation.**

Self-Control Skills

Several self-control skill deficits have been identified in delinquent, and conduct disordered youth and youth with learning disabilities. Lack of self-control creates a host of negative social consequences for a youth. It tends to increase the likelihood the youth will be involved in social conflict as well as hampers a youth from resolving a social conflict prosocially. Moreover, lack of self-control serves to isolate a youth and increase peer rejection (Interbitzen-Pisaruk & Foster, 1990). Teaching these skills has been shown to reduce recidivism, enhance positive social interactions and social relationships, and increase prosocial behaviors. See the Appendix for related resources and programs that train self-control skills. Self-control skills that can be taught include:

- **Impulse control.**
- **Regulation of anger and aggression.**
- **Social self-monitoring.**
- **Emotional self-awareness.**

Components of an Effective Social Skills Program

Although this monograph cannot adequately explain the methods for teaching cognitive social skills, overt interaction skills, and self-control skills, there are some basic techniques that can be described in order to give the reader a sense of how social skills are enhanced. A description of basic social instructional components follows.

Presentation of the idea. The first instructional step in social skill training is a concerted attempt to "sell" the benefits of using the skill. It is at this time that trainees begin to identify situations where they have failed to use the skill and also situations where they might use the skill. With adolescents, it is helpful to present the idea in a group format where youth can develop insight, share experiences, and provide each other with support.

Modeling. With the help of a role-play partner, the trainer demonstrates use of the skill while verbalizing what is being done and all of the substeps that make up the skill. The trainer also models nonexamples or ineffective examples of using the skill and explains how they are inadequate.

Role-play/Guided practice. In this phase of the training, the trainee practices implementing the skill in role-play situations. It is often beneficial to have the youth also role-play an ineffective implementation of the skill in order to highlight the features of how the skill should and should not be produced.

Corrective feedback. It is here that the trainer and peers help the trainee identify what they did well in the role-plays and what aspects of their skill production need changing or improvement.

Generalization training. At this stage of learning the trainer helps the trainee identify different types of situations where the skill might be used. The trainee is also encouraged to relate the skill to specific experiences in his/her own life outside the program.

Coaching and reinforcement. The youth should be expected to produce the skills in daily living. Coaching and reminding a youth to use the instructed skill is imperative during the first stages of learning. An incentive system and praise should be tied to the youth's production of the skill.

Recycle learning. As necessary, the trainer will again model the skill and have the trainee role-play the skill with corrective feedback. This procedure is repeated as necessary.

Review. As with any other type of learning, instruction should be reviewed in follow-up sessions and trainees should be helped to identify and share where they are having success or difficulty using the skill.

Pitfalls in Training Social Skills

There have been over 1000 studies and over 150 commercial packages directed at social skills training (see Quinn et al., 1996); yet, the effectiveness of social skills training efforts are often questionable (Rutherford, 1997).

The most common reasons (Landrum & Lloyd, 1992; Walker & Bullis, 1996) why social skills training programs fail to get a youth to apply the trained skills in real life situations are: 1) the training program is not effectively designed and formally implemented but rather done off the cuff or hit and miss, and 2) the training program does not train the youth to generalize the skill to a variety of settings and does not include coaching and reinforcing the youth to apply the trained social skills in real life or daily living contexts. In other words, social skills training programs will not change real life behavior if training is haphazard or stopped immediately after the youth learns to produce the skill in role play, counseling, or classroom settings. Even if the youth learns to produce the skill very well in these settings, real life behavior will be impacted only in a limited way if coaching and reinforcement does not occur in real life settings. Daily living and interpersonal contacts within a locked facility constitute a "real life" setting but social skills training needs to include discussions about using newly learned skills in "outside" situations. Work furlough, attending a community vocational school, and visitations by family members, social service workers or probation officers offer incarcerated youth a chance to practice prosocial skills with members outside the facility.

Social Skill Maintenance

Staff need to model, coach, and reinforce youths to produce the desired cognitive, interpersonal, and self-control skills that they are being taught. Staff should model, coach and reinforce production of desired skills during daily contact. Modeling is done when staff themselves exhibit targeted cognitive and behavioral skills and when staff verbalize to the youth their own thinking process when arriving at a decision on how to behave. Coaching is done by staff to encourage and remind a youth to use a specific skill in a specific situation the youth is facing. When a staff member coaches a youth on how to handle a specific

encounter, that staff should follow up with the youth to see how things went. This then becomes a time for reteaching or positive reinforcement. Coaching can be done formally through group or individual counseling sessions as well as informally as staff relate to the youth during the day. Reinforcement may be either social through praise and encouragement or concrete through providing incentives.

Youths must be given the opportunity to choose and practice trained skills and desired behavior. This cannot be accomplished if social behavior is suppressed to the point of taking away all volition or opportunity for the youth to decide if, when and how to behave. Youths must have opportunities to practice desirable cognitions and behaviors. To teach and change independent prosocial behavior, as much control of behavior as possible must be given back to the youth while still maintaining an orderly environment. The youth should be rewarded for *deciding* to behave prosocially.

Generalization of Behavior (transfer training)

In residential programs, when deemed ready and if it is possible, opportunities should be provided for youth to "practice" new social skills at the same or nearly the same level of restriction as in the community. Otherwise the youth needs to be coached to practice skills in as many "inside" contexts as possible and with as many different people as possible. In day treatment, youth should be given the opportunity in the community for "guided practice" of skills taught in counseling or education.

Both education, on-line, and other treatment staff, and if possible, security staff should participate in coaching and reinforcing targeted social skills. This sets the expectation and opportunity that the youth will generalize the learned social skills to various contexts and with various people.

Education and on-line staff should devise a system to communicate regularly on the social behavior progress of the youth. Team case-management meetings are beneficial; however, because of limited resources communication among various staff will often have to take place either informally or via paperwork. Therefore, the format and content of record forms is critical and records should be kept up to date.

Youths should be specifically transitioned back into the community. See the Section on Transition.

Integrating Education and Treatment or Living Unit Staff to Create a Comprehensive Social Skills Program

Teachers can participate in a social skills program in a number of ways. First, they can design the skills instruction program and decide which social skills will be targeted. Teachers can also participate in choosing or designing a social skills assessment instrument, as well as observe the youth to determine social skill goals. Because of their training and experience, many teachers are also well equipped to teach social skills in a direct instruction program. Teachers should collaborate with line-staff if a consistent and comprehensive social skills treatment program is to be implemented.

Line-staff and treatment personnel are key to successful social skills programs. First, they can play a role in helping to design the skills instruction program and can help decide which social skills will be targeted. Line-staff and treatment personnel can also participate in choosing or designing the social skills assessment instrument as well as help observe the youth in various activities to determine social skills goals. Treatment personnel can integrate the social skills curriculum into their therapy or counseling sessions. Line-staff and treatment personnel can incorporate social skills reinforcement lessons into small group sessions focused on issues such as substance abuse, family life, teen pregnancy, employment, and self-esteem. Both line-staff and treatment personnel will also need to actively participate in

modeling, coaching, and reinforcing targeted social skills in all activities. Social skills training needs to become a part of the day and evening treatment goals. In this regard, line staff and treatment personnel help youth learn to generalize targeted social skills to different contexts and with different people. Line-staff and treatment personnel will need to collaborate with educators in order to implement an effective social skills program.

In summary, an effective social skills program would identify which social skills to teach, specifically targeting social cognitive problem-solving skills, assertiveness skills, and impulse and anger control skills. An observation checklist to assess individual youth as they enter the program would be developed to fit the facilities characteristics. Upon intake, social skills assessment would be done by at least two professionals who can observe the youth functioning in different contexts. Family members as well as teachers at the youth's previous school can provide useful input in this process. Goals would be determined in the areas of cognitive social problem-solving skills, assertiveness and self-control skills. The youth would participate in making the behavioral plan and would clearly know what was expected and how expectations were tied into the incentive system. The youth would be scheduled to receive direct social skill instruction and follow-up instruction at least three days per week.

Modeling, coaching, and reinforcing by staff would take place continuously throughout the youth's day, both on the living unit and in the school program. Psychiatrists, psychologists and counselors would reinforce targeted skills and incorporate the instruction into their counseling contacts. The incentive system would be tied to meeting behavioral goals. Youth would be coached to generalize the targeted social skills to all settings within the facility, as well as with parents and other visitors, or in programs attended outside the facility.

To insure generalization of social skills, all caretakers outside the facility (such as public schools, counselors, employers, etc.) would be informed of the youth's behavioral goals and, if necessary, the youth would circulate a "feedback" report card from the outside contacts. As the youth progresses through the social skills program he or she would be given more and more opportunities to independently use the targeted social skills. When the youth is stabilized and finishes the program, a plan would be devised to transition the youth back into the community. Formulation of the plan would include discussing the youth's social skills goals and program with parents or guardians to help family members respond effectively to the youth. Follow-up or after care would be provided.

In summary, social skills training for court involved and at-risk youth has many potential rewards both for the youth and for society in general. However, implementing an effective social skills program is a complex endeavor requiring staff training and collaboration among all adults who interact with a youth.

Academic Intervention

Low literacy is consistently related to delinquent and criminal behavior. A large variety of research has shown that increasing a youth's academic skills will have a positive effect on recidivism. For detailed information about education interventions within the juvenile justice system the reader is referred to Howell and Wolford (this series). This monograph highlights some accommodations that should be made to academic learning contexts for youth with learning, attention and behavioral disabilities.

Three Principals of Instruction (Jones, 1994)

- **Brevity.** Attention and concentration are greatest in short activities. Frequent brief drills or lessons covering small chunks of information will result in greater learning.
- **Variety**. Children with learning or attention difficulties tend to perform more poorly on the second presentation of a task because they are hindered by what one researcher calls

"flagging attention" (Douglas, 1983) . A child with attention problems who perceives an activity as repetitive or "boring" will have difficulty staying on task. By presenting the same material in slightly different ways or with different applications, you can maximize students' attention.

- **Structure/Routine**. A consistent routine, enhanced by a highly organized format to activities, will provide a focused environment for easily distracted youth. Specific daily schedules that include well-planned experiences with smooth, well-defined transitions from one task to another are optimal for disorganized youth. Rules, expectations, and consequences should be clearly stated and specific (Jones, 1994).

Academic Accommodations for Youth with Learning, Attention, and Behavioral Disabilities

- Obtain the youth's full attention and eye contact before giving instructions. Provide clear and short instructions both orally and in writing. Repeat instructions. Ask the youth to reiterate instructions.
- Provide "hands-on" and "discovery" learning. Relate lessons to the here and now and help the youth identify how the concept under consideration relates to his or her own life experience.
- Use cooperative learning with heterogeneous grouping with each student assigned to a specific group role. Obtain individual as well as group evaluation of student work. Evaluate both the product of the group as well as how the group and individuals functioned during the task.
- For lessons from a text or lecture, rather than have the youth take notes, provide the youth with written notes that identify main concepts and important details and, if possible, refer the youth to specific pages in the text or provide notes in which the youth must fill in the blank as the lesson progresses.
- Before each lesson or assignment, provide the youth with an "advance organizer" that states what is going to be learned, why it will be learned, how it will be learned, how it relates to previous concepts, lessons or experiences, and how learning will be evaluated.
- Have the student use an organizer - show him or her how to use it.
- After each lesson or assignment, summarize what has been learned and identify the main concepts orally and in writing.
- When teaching a concept, provide a variety of items or conditions that *are* examples of the concept and provide a variety of items or conditions that *are not* examples of the concept.
- Provide more time or shorten the amount of work required to complete an assignment.
- Provide the youth with access to word processing and spell check.
- Permit the youth to take written tests orally and to turn in oral tapes or illustrations and graphs instead of written reports. Don't time tests.
- Stress accuracy of work over quantity of work.
- Before evaluation of an assignment or test, decide whether neatness and correct spelling are primary considerations; if not, correct errors but do not take points off.
- Monitor stress and fatigue: adjust activities or change instructional pace.
- Establish a cue between the teacher and student for unacceptable behavior.
- Provide a checklist for student, parents, and/or teacher to record assignments or completed tasks.
- Give the student the opportunity to stand while working.

In summary, academic intervention is related to lower recidivism. Youth with learning, attention, and behavioral disabilities need academic remediation and can be successful in mainstream classrooms if a variety of accommodations are provided. These accommodations focus on clarity of instructions, organization of work habits, work quality, flexibility of testing and evaluation, modification of time or amount of work, group work, focusing and maintaining attention.

Vocational Intervention

The difficulty with determining the effectiveness of vocational training in reducing recidivism is that few programs offer it as the sole intervention. Nevertheless, data indicate that vocational interventions have a very positive impact on recidivism. In programs primarily vocational in nature, analysts consistently found lower recidivism in one of every three programs. When vocational training was paired with academic intervention, lower recidivism was found in half the programs (Palmer. 1996).

Vocational programs vary along a number of dimensions ranging from simple career awareness to certified training and job placement. There is one program that has consistent positive results over a long period of time. This is JAGS (Jobs for America's Graduates) established in 1979 and currently the largest national model of an in-school youth employment program for at-risk and disadvantaged youth. JAGS helps states implement a statewide vocational program for high-risk youth. In 1996, JAGS served 40,000 in-school and out-of-school youth in 600 high schools and vocational centers in 26 states. Over a long period of time JAGS has developed a basic model of vocational intervention with impressive results. After 17 years of serving 200,000 people, JAGS achieved an 89% overall graduation/GED rate with 79% of the participants placed full-time on a job, in the military, or enrolled in postsecondary education or training. JAGS has found that full-time employed graduates more than repay the cost of their being in the program within 14 months in total taxes paid. Currently JAGS operates a five-year dropout prevention program in 100 high schools (4 years during 9th-12th grades and 1 year post-graduation). JAGS also implements an 18-36 month school dropout recovery program in which participants earn a diploma or GED, learn a marketable skill, and obtain a quality job. See the Appendix for JAGS address.

When developing a vocational program, JAGS has found that for high-risk youth to obtain a quality job the vocational program must be very intensive with frequent youth contacts on a year round basis over at least 18 months. Specific principles of an effective vocational program include:

- mission driven with well-trained staff
- a highly motivational, student-led peer support organization
- core competencies in the areas of career development, job attainment, job survival, communication, leadership and teamwork, personal self-development, and problem solving
- 9-12 months of support and training after the participant obtains a job and additional help for the participant to achieve a raise or promotion
- strict personal accountability of success rates of individual staff with caseloads of 30-50 youth
- an Individualized Development Plan for each youth to guide them through high school graduation and into a career
- intensive direct instruction time of 720 hours plus summer school over five years
- year round contact with the youth while in the program
- work-based experiences

- training in a marketable skill for a quality job using school or community vocational programs
- on-going accountability records of each youth with monthly reporting of youth's status and vocational competency attainment and quarterly reporting of youth's school achievement and behavior (attendance, suspensions, grades, credits, etc.)

In summary, effective vocational programs for high-risk youth are intensive over at least 18 months and actively work to have the youth obtain a diploma or GED. During the time the youth is in the program, his or her vocational and educational progress needs to be closely monitored. Youth need to be taught not only how to do a job but also how to get a job, keep a job, and achieve promotion through leadership and teamwork skills.

Life Skills and the Multimodal Approach

A Life Skills program is a mixture of various approaches, such as academic, vocational, and social skills training, along with mental health treatment as necessary. However, a review of these programs revealed that the components of Life Skills programs vary from program to program. Consequently, in determining the effectiveness of the Life Skills approach it has not been possible to evaluate a specific combination of components. Life Skills programs do have similarities, however, in that they are "skill oriented" generally including academic, vocational, and social skills components with perhaps a substance abuse or outdoor experience component.

Within the juvenile justice system, Palmer (1996) reports that the Life Skills training is a promising approach, reducing recidivism on average by 20 percent. *Outside* the justice system, Life Skills training also has been shown to be an effective approach, reducing recidivism on average by 32 percent. In interpreting these results it should be kept in mind that the Life Skills programs evaluated were not identical; thus, the most appropriate conclusion is that a *multicomponent program* that is *skill based* including at minimum academic, vocational, and social skills training is likely the most successful approach for reducing recidivism in youth with disabilities. The conclusion that a multicomponent approach is substantially more effective is supported by results of an evaluation of so called "multimodal" programs which are broad based and comprehensive and provide youth an extensive intervention. Evaluations showed the relatively new multimodal approach to be very promising for reducing recidivism (Palmer, 1996).

In summary, interventions that are multifaceted and skill based are referred to as Life Skills or Multimodal. Such an approach, at minimum, provides academic, vocational, and social skills training, and substance abuse treatment. Life Skills Training is associated with reduced recidivism.

Medical Interventions

Medication

There is no empirical evidence that medication is associated with reduced recidivism. However, adolescents with anxiety disorders, conduct disorders, obsessive compulsions, depression, bi-polar disease, eating disorders, hyperactivity, and attention deficits may be candidates for medication intervention. Many experts have noted that the criteria of a successful treatment program for court involved youth with disabilities includes both the fostering of normal development and the elimination of symptoms of abnormal behavior. Thus, studies on the efficacy of medication on youth with disabilities show that although appropriate doses of medication may help reduce hyperactivity and increase attention, normalize mood, and stabilize mental disorientation, these youth still exhibit social skill and problem-solving deficits that have to be remediated through direct instruction. Thus, a

regime of medication and social skills training may be a more effective long-term approach (Idaho State Department of Education, 1996).

Substance Abuse Programs

Clearly, youth with disabilities are at increased risk for substance abuse. Studies have established that adolescent substance abuse is associated with poor social skills, aggression, noncompliant behavior, and psychological problems (Galanter & Kleber 1994; Hover & Gaffney, 1991). In fact, Keller, Lavori & Beardslee (1992) found that 89 percent of non-treatment seeking adolescent substance abusers also had an additional diagnosis of some mental health disorder. Conduct disorder and major depression are most commonly seen in substance abusing adolescents. Youth with conduct disorder have an odds ratio greater than 2:1 to be diagnosed with substance abuse (Kaminer, 1994). Individuals with ADHD have been reported to be up to seven times more likely to develop drug problems (Manluzza, Gittelman-Klein, & Horowitz-Konig, 1989). Likewise, there is a strong correlation between delinquency and substance abuse. Consequently, providing delinquent youth with disabilities access to an effective drug treatment program appears necessary for preventing recidivism or reducing delinquency. However, there are no specific studies indicating that this is so.

Substance abuse is one of the most urgent and serious problems facing society and increasing resources should be devoted to treatment. However, there is a consistent consensus in the field that we do not yet know what treatment approaches are most effective or how to match patients to specific approaches. This is particularly true with adolescents (Hird, Khuri, Dusenbury, & Millman, 1996). The substance abuse field has recognized, however, that programs must help clients achieve "more than abstinence" to effect optimal life functioning. Three goals have been identified for effective treatment (Schuckit, 1994): 1) maximizing motivation for abstinence and developing strategies for abstinence, 2) learning skills necessary to achieve economic, educational, employment and social adequacy, and 3) learning skills necessary for relapse prevention.

The reality is that there is a likelihood that effective programs designed to treat substance abuse in offender populations are not widespread. Although there is no recent data, a survey (Gendreau, Goggin, & Annis, 1990) of 112 offender substance abuse programs in 1990 found that only 10 percent of the programs had elements that would indicate effective service, based on the criteria of the Correctional Program Assessment Inventory (Gandreau & Andrews, 1994). Another study of juvenile offender programs found similar results (Hoge, Leschied, & Andrews, 1993). Thus, even if there was a 500 percent improvement of treatment efficacy since this survey, that still leaves about half the programs likely to be ineffective.

Nevertheless, reviews of available longitudinal data of substance abuse treatment effectiveness permit several conclusions (Hird et al., 1996). First, that any amount of treatment is better than no treatment. Second, the best predictor of recovery is amount of time spent in treatment with a minimum of one year being the best predictor of success. Third, family involvement improves likelihood of recovery. Fourth, programs that train youth life skills as well as abstinence are most effective. And fifth, aftercare, including self-help and support groups, has a positive influence on recovery.

Although few drug treatment programs are designed to specifically serve adolescents, some studies have investigated which adolescent characteristics are most associated with successful treatment. Court involved youth with disabilities seem to be at the greatest risk for treatment failure - that is, poorer outcomes are associated with youth who have exhibited criminal behavior, who are from low-income and minority backgrounds (two-thirds of youth with disabilities are poor minority children), who are not attending school or some

educational program (youth with learning and behavioral disabilities have the greatest rate of school dropout), and who have psychological or learning problems (Hird et al., 1996). Thus, one can infer that court involved youth with disabilities have the greatest need for access to sustained substance abuse treatment.

Although programs vary, the basic components of a drug-free adolescent program include individual counseling, individual therapy, self-help groups for the patients and caretakers, substance abuse education, breathalizer testing, family therapy and/or involvement, relapse prevention techniques, refusal techniques, educational, vocational and social skill training, legal assistance, contingency contracting, medications, and written assignments related to the recovery process (Kaminer, 1994).

In summary, while addiction is the same for youth and adult populations, youth have some unique treatment needs especially in terms of the role of peers, family, and coping skills, and in terms of the likelihood of co-occurring psychological disorders. Youth may need clarification of concepts and more time to accept the idea that they have a problem and need to participate in treatment. Additionally, youth need structured treatment strategies that provide outpatient services in the social, educational and vocational domains (Hird et al., 1996). Finally, court involved substance abusing youth with learning, attention and behavioral disabilities frequently have co-occurring disabilities and need to be assessed for co-occurrence.

Behavioral Systems

Implementing a behavioral system to structure treatment and create an orderly learning environment is critically necessary for youth with behavioral and emotional disabilities (Walker & Bullis, 1996). Virtually all behavioral systems are based on the notion that reinforcement of a behavior will increase the likelihood of that behavior in the future. A behavioral system that *includes* a cognitive social skills program and generalization training has been recognized as being among the best and strongest approaches to reducing recidivism and preventing antisocial behavior (Walker & Bullis, 1996; Gendreau, 1996). Additionally, a behavioral incentive system may enhance other intervention components by creating a consistent and positive atmosphere and by moderating youth behavior such that other learning can take place (Palmer, 1996). There are several critical tenants to effective behavioral systems for youth with disabilities. These are as follows:

- **The behavioral system should accentuate the positive.** Research clearly shows that punishment in and of itself will not lead to reductions in antisocial behavior or recidivism; therefore, it should be used only when absolutely necessary to maintain security (Gendreau, 1996). Positive discipline has the most probability of *changing* a youth's behavior in desirable ways (Hyman, Weiler, Shanock, & Britton, 1995). Positive discipline emphasizes providing natural consequences to the youth's behavior - cleaning up after a mess is made, less freedom of choice if independent decision making is chronically not prosocial, writing or saying an apology for disrespecting others, paying for something broken (or working off the debt), and so forth.
- **The behavioral system should be tied directly to achieving specified cognitive skills, overt behaviors, and self-control skills**. The purpose of an incentive system is to encourage desired behavior so that the youth "practices" producing prosocial skills until they occur naturally.
- **The behavioral system must reflect a meaningful reduction in restraint or restriction.** As a youth acquires more social skills, restrictions should be noticeably reduced so that on the highest level there is minimal restriction necessary to maintain an orderly environment.

- **The behavioral system should include incentives that youth actually want and can actually have**. For example, visiting privileges is not an effective incentive if a youth never has visitors. A useful way to determine what privileges are reinforcing is to ask youth to rank order or rate potential incentives.
- **A variety and continuum of incentives should be created**. Some incentives can be provided occasionally and gradually increased as behavior improves. For example, radio time could be increased from one day a week to every day contingent upon increased social skills; or in a day treatment program the youth can earn "vacation" days or opportunities for less direct supervision.
- **Incentives or positive reinforcement should exceed punishment by at least a 4:1 ratio**. The program should be creative in devising concrete incentives. Positive reinforcement is often the hardest for staff to be consistent with over time.
- **Youth should be able to earn "special" incentives**. This will maintain motivation over time and encourage the youth to "practice" desired behavior. For example, every two weeks, if the youth has maintained targeted behavior, he or she should earn something extra, such as a radio or magazine day even if radio use may not be regularly permitted at the level they are on. In a day treatment program, a field trip might be a special incentive. If a point system is used, then bonus points for maintaining behavior over a period of time are effective for maintaining momentum.

In summary, treatment interventions of court involved youth with disabilities will require the implementation of a behavioral system. A behavioral system has two purposes: 1) to teach prosocial behavior and 2) to create an orderly environment so that other learning or interventions can successfully take place. Implementation of a behavioral system is associated with reduced recidivism especially in conjunction with a cognitive social skills program.

Family Involvement

Ultimately, juvenile justice must be concerned primarily with relapse prevention. Youth with behavioral and learning disabilities are at increased risk for relapse into delinquent behavior. Because family members will most likely play a significant role in the youth's life after treatment, family participation with the youth's intervention is critical for relapse prevention. Furthermore, several studies have found that family structure and interaction style is related to antisocial behavior and aggression and that social skill attainment of delinquent youth is related to family structure (Matlack, McGreevy, & Rouse, 1994). It should be noted, however, that despite these findings, several researchers have cautioned that statistical correlations between family variables and delinquency should not necessarily be interpreted to mean that family factors caused delinquency but rather in combination with other factors, family factors prove to be important.

Most studies confirm that maintaining family ties while youth are incarcerated or in treatment and establishing or preserving positive family relationships correlate with a successful transition back into the community, and ultimately, with reduced recidivism (Dague & Tolin, 1996; Palmer, 1996). Yet, according to one report (Residential Facilities for Juvenile Offenders, 1995), most surveys of correctional staff indicate that not enough is done to involve families. Justice professionals need to create ways to make meaningful contacts with the youth's family so that family members feel included in a team approach to the youth. Family involvement is essential regardless of the limited opportunities available for families and professionals to effectively share valuable information about the youth.

Families often have a wealth of information about the youth that is important to professionals as they work with the youth throughout the justice process. This information,

particularly as it relates to a youth's strengths and needs, can be valuable when justice and corrections personnel are making assessment decisions, programming and placement determinations, and aftercare and transition plans. Also, the family is likely to be at a part of the youth's life long after the role of justice professionals has ceased and can have an impact on the youth's future success. If a youth's family is unwilling or unable to participate in the youth's life, it is imperative to appoint surrogate parents or at minimum a volunteer role model.

Families with a child with learning, behavioral, or mental health disabilities need support because these disabilities often run in families. Moreover, a longitudinal study found that youth with disabilities are more than twice as likely to have parents without high school diplomas as are nondisabled youth (Wagner et al., 1992). So, both the child and the parent might need counseling to understand the dynamics of their situation, as well as strategies to help cope with day to day living. In order to participate meaningfully in the juvenile justice process, families of youth with disabilities need information about the juvenile justice system and how it works, and the youth's rights to special education services and disability specific accommodations.

When coupled with other interventions, family counseling has been shown to reduce antisocial behavior and recidivism; however, only a few family counseling approaches show positive effects (Palmer, 1996). Counseling that is carefully structured, that teaches skills, and focuses on family problems or youth needs is shown to reduce recidivism. Open and nonfocused family counseling is *not* associated with reduced recidivism. A combination of cognitive problem-solving training and parent training has been found to be the most effective approach for reducing antisocial behavior in youth and in reducing stress and depression in parents (Kazdin, Siegel, & Bass, 1992).

To effectively integrate family participation in treatment, programs must have a clear strategy for establishing family rapport and must be able to communicate to the family that they are valued members of a team. To prevent relapse, family members should be helped to accept the positive changes their youth has made in treatment, know how to help the youth implement the relapse prevention plan, know how to monitor adherence to the youth's relapse plan, and know how to seek assistance if the youth becomes high risk for relapse (Christensen, 1998).

Effective programs help the family help the *youth* accomplish four goals: 1) recognize their problem pattern, 2) understand details of their problem pattern including early warning signals and high risk situations, 3) learn and practice new behaviors in place of the problem pattern, and 4) learn how to prevent oneself from falling back into the old pattern (Christensen, 1998).

In summary, family involvement is essential in reducing recidivism or relapse in court involved youth with disabilities. Families have important and pertinent information about the youth. Families are most motivated to be involved in the youth's treatment and transition if they are treated as valuable members of a care provider team. Families should be taught how to help the youth maintain prosocial behavior, implement his or her transition plan, and avoid relapse risk. Problem oriented skill-based family counseling is associated with reduced recidivism.

Transitioning

The broadest form of transitioning is to provide a continuum of integrated services often referred to as a System of Care or WrapAround. The idea is to "wrap" the youth and family with services that are needs-driven, coordinated and that offer one point of contact for the family. This concept of service has been found to be very effective for youth with

emotional and behavioral disabilities who usually require a complex range of interventions offered by a variety of agencies in both the public and private sector. WrapAround is highly effective for court involved youth with disabilities exiting a correctional facility or in a day treatment program. WrapAround and the transition plan are key elements to preventing relapse and are described in more detail below.

The Transition Plan

Historically, treatment has involved providing the youth with "a program" that had a specific timeframe. The context of treatment was limited in scope to a classroom setting, counseling session, or residential placement. Youth traditionally moved from the intervention context to independent "real life" or another less restrictive intervention context without any attention paid to phasing them into the new situation. It was assumed that newly acquired behaviors or skills would automatically transfer to the next context. Such assumptions lead to high rates of failure, recidivism, and relapse for youth with disabilities.

We now know that people do not automatically generalize or use new skills in settings other than the treatment setting. People, including court involved youth, need to be helped to apply a new skill in many different contexts until it becomes generalized across a variety of settings. This help can be structured in the form of a transition plan where specific strategies are identified to help the youth apply or maintain new skills over time and in many settings. There are two transition zones–transitioning from one program phase to another with more privileges or freedom and transitioning out of an intervention program altogether. A well thought out, individualized plan is useful for both types of transitions.

There are several tenants of an effective transition plan for maintaining and generalizing behavior.

- **Plan and practice new behaviors in increasingly difficult and realistic situations prior to the transition.** If the youth is already in the community such as in day treatment programs, then "fading" techniques can be used prior to exiting the program. Fading consists of providing as much staff support as necessary for the youth to succeed in community contexts and then gradually withdrawing support until the youth is functioning independently. For example, staff may monitor the youth on a daily basis regarding employment or vocational school and then gradually withdraw monitoring as the youth becomes successful.
- **Prior to transitioning, develop a multidisciplinary integrated transition plan with the youth, family, and relevant service providers of the new "environment."** This plan should specify immediate and intermediate goals for the youth and it should specify what factors constitute success and what constitute failure. Hazards for relapse should be specified in the transition plan and strategies to overcome obstacles should be developed. In addition, the specific roles and actions family members and service providers will play should be specified in writing. Specifically planning what the youth will do every day for the first two weeks following release from a facility is very effective.
- **Monitor and anticipate problem situations that could exist after the youth is released.** Prior to release help the youth, family and relevant service providers plan effective responses to the anticipated problem situations.
- **Train significant others, such as family, friends, and the probation officer to be aware of relapse risks and risk situations and train them how to provide reinforcement for prosocial behavior.**
- **Provide booster sessions.** If possible, adults who worked with the youth in the treatment program should provide booster sessions after the first week of transition and then phase out booster sessions as appropriate.

In summary, transition programming is critical if the juvenile is to adapt successfully in the community. In order to transition a juvenile out of a facility and into the community, opportunities need to be provided for them to "practice" new social skills at the same or nearly the same level of restriction as in the community. Transition also requires aftercare or follow-up contacts by individuals who know what the youth's social strengths and weakness are. Transition includes working with the family prior to release in order to help family members or guardians know what the youth's goals are and how the youth can effectively fit into the family structure.

System of Care/WrapAround

System of Care/WrapAround, although slightly different concepts, have been defined as a comprehensive spectrum of mental health and other necessary services that are organized into a coordinated network to meet the multiple and changing needs of severely emotionally disturbed children and adolescents (Flam, 1998). The goals of System of Care/WrapAround are better outcomes for youth and families and cost-effectiveness. As a youth transitions out of a program, developing a WrapAround plan is extremely helpful so that as many services as needed are provided in a coordinated way. Such a system requires a case manager or care coordinator.

There are eight components that have been articulated to define WrapAround for SED youth (Flam, 1998). First, family participation through respect for families, recognition of family strengths, involvement of families in setting priorities and through centering service delivery on the needs of families. Second, integration and coordination of services including mental health services, social services, educational services, health services, vocational services, recreational services, and operational services to minimize the fragmentation of service delivery. Third, a continuum of community-based services including intensive residential and nonresidential placements with an emphasis on serving youth through the least restrictive environment. Fourth, strength-based, individualized services that are tailored to meet the unique needs of each youth and family with an emphasis of "wrapping" services around the youth and family. Fifth, the WrapAround system must be culturally competent. Sixth, there must be parental involvement at all levels of the process. Seventh, participating agencies should be flexible and have noncategorized funding. Eighth, services should be unconditional and have a no reject no eject policy.

Staffing

An issue that is often overlooked when discussing intervention programs is staffing—their skills and their personalities. Research shows that both these factors lend considerable weight to the effectiveness of a treatment. This section introduces some key research findings regarding staff interactions with youth under care. The most important finding is that positive rapport between staff and youth is substantially influential for achieving positive outcomes.

- **Care providers need training in how to work with youth with learning, behavioral, and attention disabilities (Thornton, 1995).** Staff need training in issues of co-occurrence of disabilities and in how to apply behavioral principals and how to teach, coach and reinforce a social skills program (Gendreau, 1996). On-going staff training is critical for maintaining a quality program that is current with best practices in the field.
- **Care providers should relate to youth in interpersonally sensitive and constructive ways and should be trained and supervised appropriately (Gendreau, 1996).** Most exemplary programs that report reductions in recidivism also mention the importance of staff skills, whereas ineffective programs rarely pay attention to this factor (Gendreau, 1996).

Care providers should be selected on the basis of interpersonal skills. These include clarity of communication, warmth, humor, openness, and ability to relate affect to behavior and set appropriate limits. Staff need to be comfortable relating to youth with learning and behavioral disabilities - including youth with serious acting-out behavior. While staff characteristics were less essential in supervising low risk youth (Andrews & Kiessling, 1980), probation officers, volunteers, and other professionals who were rated interpersonally sensitive were the most effective in supervising high risk youth. In fact, client positive regard for staff was found to increase specific intervention effects (Palmer, 1996). In one program, recidivism rates were 10% when the juvenile and caseworker had mutual high regard and were 40% when the juvenile and caseworker had mutual dislike (Palmer, 1996).

- **In relating to a youth and in teaching, coaching, and reinforcing skills, particularly social skills, staff should be matched to a youth's characteristics or adapt their behavior and interaction style to individual characteristics of youth.** Youth vary by temperament, personality traits, attitudes and beliefs; thus each service provider's specific style of relating will not "fit" all youth. Research has shown that recidivism is significantly increased when youth's "responsivity" is taken into account and matched to the caregiver (Palmer, 1996). Some youth with disabilities need to be given constant encouragement or instructions and explanations using clear and simple language. Highly anxious youth need quieter more sensitive care providers, while impulsive juveniles need care providers who give clear instructions and more structure. In one study, care providers who were characterized by a surveillance and control orientation had their greatest difficulties with youth who were impulsive or verbally hostile-defensive but these same staff had success with those who were dependent and anxious (Palmer, 1996). If a youth cannot be matched to care providers, then care providers need to be prepared to use different styles and demeanors with individual youth.
- **Cultural awareness and sensitivity should permeate all staff interactions**. The early notion of America as a melting pot has been replaced with the more accurate recognition that American social structure is a mosaic of various cultures. Youth with disabilities are a culturally diverse group. So too, juvenile justice prevention and habilitation programs are living laboratories for issues related to the culture diversity of our society. Cultural differences affect youth behavior. For example, cultural differences have been found to appreciably affect social patterns in instructional settings (Cartledge & Milburn, 1995). Staff need specific training in cultural awareness and sensitivity so that they are knowledgeable and responsive to the cultural influences and social needs of each youth.

Assessment of Program Effectiveness

Professionals need to know if what they are doing is working and when to fix it if necessary. To gain this information professionals need to assess their program both in an on-going way as it is being implemented (formative evaluation) and at some fixed point in time (summative evaluation) as participants exit the program or at longer term follow-up.

To conduct a meaningful assessment, a program should:

- **Have a definition of success that can be measured**. There may be several indicators of success such as school attendance days, arrests, behavior reports, employment, and reading scores. Both short and long term measures need to be determined. The focus of assessment should be juvenile centered with assessment determining how the program is affecting youth participants.
- **Determine how a target behavior *during* or *after* treatment can be compared to behavior *before* treatment**. This is usually accomplished either by comparing youth in

treatment to similar youth who did not receive the treatment, by comparing the youth's own pre- and post-behavior to itself, or by comparing program "stats" such as recidivism, fights, number of GEDs earned and so forth before the program was implemented to program "stats" after the program was implemented.

- Defining comparable groups is much more difficult than it sounds. In fact, this is the most crucial step in assessment. Yet, most programs fail to select *comparable* comparison groups and as a result, draw faulty conclusions about how their program is working. If one group of youth (treatment) is to be compared to another (nontreatment), it is essential that the two groups are similarly affected by "outside" factors that could influence results and that they were equally likely to engage in the target behavior prior to the treatment intervention. If one time period (pre-treatment) is to be compared to another time period (post-treatment), it is essential that the same length of time be measured and that both time periods are equally affected by "outside" factors that could influence results.
- **Determine how the data will be collected and by whom.** Protecting confidentiality of individual youth and families is imperative. Data must be accurate and reliable, if not, don't use it.
- **Determine how the data will be analyzed and by whom.** Rather than lumping the target behavior together to make some large score (such as counting the number of disciplinary reports all the youth together have or the number of employment days all the youth together have) it is better to determine each youth's "score" and then find the average score of all the youth. Determining percent of "successful" youth is another way to analyze data effectively. In this way, one youth with very high scores does not mask the poor showing of several other youth or vice versa.
- **Determine how the results will be communicated to staff, participant agencies, families and the community.**
- **Determine how and when the data will be used to make necessary changes in the program.** There must be agreement in advance by all parties involved in implementation of the program that particular services or methods may be cut, added, or modified depending upon assessment data.

In summary, to maintain quality, programs need on-going formative assessment that guides staff to make programmatic changes as needed to be most responsive to youth's needs. Additionally, the end results or outcomes need to be assessed using summative evaluations in order for staff to determine if the program achieves positive and meaningful impacts for youth.

DESCRIPTIONS OF MODEL PROGRAMS

In the following sections we describe a sample of model programs for court involved youth with disabilities. All of the programs have been evaluated, some more rigorously than others, and all show promise for increasing prosocial behavior and for reducing recidivism and delinquency in youth with disabilities. Although none of the programs include *all* best practices, each illustrates how many of the best practices can be effectively implemented. Additionally, all of the programs have limitations or considerations which we highlight at the end of each description. A contact person who has consented to serve as a resource has been provided with each description in case the reader wishes to acquire more details about a specific program.

A Correctional-Community Program

Oregon Transition Support Initiative: The Farrell School

Sponsored and funded by Collaboration Through Leadership, Oregon Department of Education and Juvenile Corrections Education Program.

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Target Population

The youth in the program range from age 12 to 20, with the majority in their mid-teens, and a 70% male predominance. The program supports a widely divergent population with the following ethnicity makeup: Caucasian, African American, Hispanic, Asian, and Native American backgrounds. Youths are incarcerated for violence, chronic law breaking, many with extensive gang involvement and most with serious substance abuse issues. Seventy percent of the students have been eligible for services covered under IDEA. Each teaching team develops an appropriate service plan for the student; this usually includes an IEP.

Evaluation

The Northwest Accreditation Association has accredited the Farrell School. This was done in keeping with Oregon's comprehensive 21st Century School Reform legislation.

Portland State University evaluated the school's curriculum and the University of Oregon is completing the evaluation data on recidivism. Initial results are very promising with a 400% increase in high school diplomas and an increase in GED completion. Also, the staff report a significant reduction in assaults and discipline referrals.

An article entitled "Initiative Forges Partnership to Reintegrate Youth" published in School Safety, (Winter, 1997) by Gilham, Montesano, McArthur, Kruse, Woodruff, & Lehman describes the early development of this effort.

Overview

Oregon's Transition Support Initiative is facilitated by the Juvenile Corrections Education Program (JCE), which is part of the Oregon Department of Education. JCE has developed a collaborative relationship between local school districts and state corrections personnel. The main purpose of this collaboration is to successfully reintegrate adjudicated youth into the community, particularly the school community. The key players in the transition effort are: corrections education, juvenile court/probation, and the local school

district. Special features of the program include student orientation, academic restructuring, and a problem-solving center.

Student orientation. Students complete 40 hours of career exploration, developing social problem-solving skills, accessing community services, and making decisions on where they need to go in life and how to get there. Students also begin to develop communication and school success skills that help them learn to advocate for themselves. School success skills include: attendance, skill mastery, focusing, following directions, tolerance for diversity, communication skills, flexibility, conflict resolution, and classroom protocol. This implicit curriculum is supported by staff and student handbooks, staff training, and Oregon Youth Authority staff. Students must also review the choices they made that led them to incarceration. A transitional assessment is completed to identify peer relations problems, family concerns, educational issues and long term employment goals. As students develop life goals, their actions are held accountable relative to how their current behavior is helping or hindering the accomplishment of these life goals.

Upon completing orientation, each student must share his or her plan with the teaching team and develop a teaching schedule/plan. Teaching team members also work toward the students transition back into the mainstream by working with student's corrections and probation staff as well as the student's parents.

Academic restructuring. The Farrell School utilizes an A or B day so students can get both individualized academic and vocational instruction. On "A" day, half the students attend vocational/technical classes while the remaining half attend academic classes. On "B" day, the configuration is reversed. Students attend two 2.25 hour length classes each day, one in the morning and one in the afternoon. Each student has four teachers, most teachers save approximately 20 students per day. The teaching team is usually comprised of 5 teachers and 40-45 students. A desired teaching-team consists of two academic teachers, two vocational teachers and one special education teacher, who also functions as the team's case manager. The team meets for at least one hour every day to discuss individual student progress and program concerns. The teaching team also is responsible for developing and implementing a student's Individualized Education Programs (IEP) if appropriate.

Finally, this team plays a key role in developing the student's exit/transition summary which is geared toward academic success as well as social and employment information, and includes the student's current level of performance, strengths and weaknesses.

Problem-solving center (PSC). If a student does not make positive behavioral choices, he or she must attend the PSC. If, however, the problem behavior is illegal, it is immediately referred to the corrections staff. A referral to the PSC does not constitute a discipline referral, but is indicative of a structured/caring opportunity. Most students respond favorably to this type of problem-solving approach. While the student is in the PSC, the whole emphasis is placed on refocusing the problem behavior so that a more appropriate means of handling the problem can be practiced the next time a similar situation arises.

Curriculum

The curriculum utilized for students at the Farrell School is designed to teach basic academic skills as well as social skills and work-place relevant skills. There is curriculum support in the areas of focusing/goal setting, conflict resolution, classroom rules/protocol, appropriate communication, tolerance for diversity, and basic attendance.

Instructional Support/Professional Development

Summer institute. Community Teams from all over the state participate in a summer training session designed to build collaborative working teams within a specific community. This student-centered planning effort provides more efficient and effective educational and

social services programming for not only the returning youth but the family as well. Participating school district and probation staffs have the opportunity to acquire the knowledge and skills necessary to develop appropriate curriculum which includes planning course statements, course goals and objectives, and formulating a team strategy for teaching and evaluating a student's/program's success in the local community.

Again, an essential component of the Summer Institute is to build a student-centered collaborative effort within the local community and the correctional facility returning the youth. The curriculum/program materials and student orientation materials are free.

The Role of Paraprofessionals

Cross-professional collaboration also is practiced at the Farrell School. Non-certified staff are used in the Problem Solving Center after training. Instruction via a specialized license to teach vocational education, special education, and regular education are offered through the Oregon Office of Education. The Office of Corrections Education has a team-building summit annually. The emphasis is on communication.

Considerations

This model started in the Farrell School and has been expanding throughout Oregon. If this model is replicated in other states, the implementing state would need initial collaboration at the State Office of Education level; particularly, within the Corrections Education Department. Analyzing which partners should participate in the initial planning would be essential to any implementation effort.

A Correctional Program

Ferris School for Boys

Located in Wilmington, Delaware. The sponsor/funding agent is the State of Delaware.

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Target Population

The Ferris Facility is a secure juvenile corrections facility that targets adjudicated males between the ages of 14-18 who have a history of violence, chronic delinquency, gang involvement and substance abuse. These youth come from different racial backgrounds, and usually are incarcerated for 6-9 months.

Evaluation

Program effectiveness data was being collected at the time of writing. Because the program is so new (about 16 months), recidivism data is not yet available. Observation of the student population have given everyone reason for optimism. Students are moving through the program and completing treatment plans and educational plans. They are successfully transitioning back into the community. The vast majority of the students successfully complete their levels at an acceptable pace and competency rate. Please note academic evaluation data under Program Description. Students completing a six-month review have an average increase of two grade levels in reading, spelling and math.

Overview

The Ferris program is described as a therapeutic community and total learning environment. Students participate in a typical high school academic day from 7:50 A.M.-1:50 P.M. The staff at the Ferris Facility consists of certified teaching staff and direct care treatment staff, who serve as surrogate parents that aide and support the delivery of academic material. The treatment staff provides one-on-one and small group tutoring. Educational programs are designed and delivered via the youth's treatment plan.

Treatment plans are developed by the clinical psychologist, the treatment specialists (direct care staff), and education personnel. The plan is directly correlated to the youth's actions which led to incarceration. The components include drug and alcohol therapy, aggression replacement therapy, parenting classes, grief and loss counseling, sex education, and guided group interaction. Treatment plans are reviewed every 30 days to determine progress and make modifications as needed. Teachers are an integral part of this treatment team. Teachers provide data to the team. The majority of Ferris students have been deprived of what would be considered a normal educational experience. They have not had the parent

relationships that would have allowed for a 'law and order' existence. The treatment specialists act as surrogate parents, disciplinarians, and mentors. They provide the students with the safe and secure existence that is necessary to learn. Ferris students are coming to school, for the first time, free from the outside distractions that contributed to their problems. They are well-rested, well-fed, drug free, safe, accountable for their actions, expected to succeed, and under constant adult supervision. Students are required to attend school everyday. All students are expected to participate in every class - no exceptions. Homework is given in all subjects, 100% completion is mandatory. Each student receives personal support and guidance.

The education program is based on providing individualized service to students, i.e., transition plans which are written for each student during the intake process. Destinational curriculum allows the student, treatment specialist, education staff, and parent to decide the most appropriate course of academic action. Students are prepared to return to high school, test for the GED, obtain training through the Department of Labor, and/or become gainfully employed.

The academic program is self-correcting. Every student is evaluated every three weeks and interim reports are issued by teachers in three and six weeks intervals. Report cards are issued every nine weeks. The three and six week evaluations are qualitative satisfactory or unsatisfactory reports. Unsatisfactory performance demands action on the part of the teacher, student, and/or treatment specialist. Students are not permitted to fail. Of the over 400 grades issued to students in August 1998, one student failed 2 courses; all other students passed their courses. Approximately 50% of the students achieved an average of 87% or above. The teaching staff at Ferris has begun to regard their assessments as 'bits of curriculum'. In this review, an assessment is integrated naturally into the curriculum. The assessment model is part of good instruction. Performance assessment is the culminating activity of a unit and provides opportunities for students to synthesize their learning and develop a broader understanding of major concepts.

The Ferris education program is evaluated through the use of authentic assessment measures. Student scores on standardized tests and in the classroom measure a student's success as they move through their program toward transition. Students' programs are destinational in nature. The program takes the student from a point of actual educational experience (past history) to desired outcomes in the six to nine months. Students are prepared for the work world through OJT or Department of Labor training programs.

Curriculum

The concepts of a carousel curriculum were developed to meet real situations. Ferris students are adjudicated to Ferris by Family Court. Placements occur every month of the year. Students begin their Ferris experience upon arrival. In the past, teachers and administration looked at the program in a longitudinal sense from September to June with a separate summer school program. Students who arrived in April were started in academic classes that had been running for a semester. Students were often confused and teachers were pressured to bring the students through a partial credit experience.

The carousel approach to instruction recognizes all students as a new student regardless of when they enter the program. All students receive individualized instruction for a nine-month period. Upon course completion, the student receives credit.

Transition educational plans are developed around the student's past experience. Students who arrive at Ferris at the age of 17 with no high school experience or credits cannot expect to make-up lost time and credits in a realistic timeframe. Their transition plan

would reflect the need to catch them up with their contemporaries through the GED and then move them into post high school opportunities.

Students who arrive at grade level and have some desire to return to school can accumulate up to six high school credits. Ferris academic program has been accredited by the Middle States Association. The Ferris curriculum is comprehensive. Students are exposed to a full range of academic programming.

Instructional Support/Professional Development

Staff development has been a massive undertaking. Staff development is mandatory and on-going. All staff members are required to receive the training as dictated by the American Corrections Association. There is written policy, procedure and practice that requires the facility's staff development program be planned, coordinated and supervised by a qualified supervisor. The primary training areas include:

- supervision/behavior management skills development
- suicide prevention
- appropriate use of restraint techniques
- safety procedures
- interpersonal relationship skill development
- communication skill development
- counseling techniques
- drug and alcohol counseling
- family counseling
- group interactions
- social/cultural lifestyles of the juvenile population

The Role of Paraprofessionals

Paraprofessionals are an intricate part of the Ferris School Program. They perform many small group or one-on-one services. These services include academic support, surrogate parents, behavior/discipline support, and mentor/friends. Paraprofessional services are critical to program/juvenile success.

Considerations

Until the Ferris School made the effort to have an integrated service delivery model, the youth in their custody did not make the progress they needed to successfully re-enter society. This program will not work without the commitment of all personnel working within the youth corrections facility. Training, funding, and planning are essential ingredients to the overall success of any effort to create a program like the one at the Ferris Facility.

A School Dropout Program for SED and LD Low-Income Youth

ALAS (Achievement and Learning for All Students)

A pilot dropout and high-risk behavior prevention program in Los Angeles Unified School District. Funded by the U.S. Department of Education, Office of Special Education Research. One of three national prevention programs targeting LD and SED youth.

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The social skills curriculum *Social Thinking Skills* of ALAS is currently used at numerous juvenile correctional facilities. An example of using *Social Thinking Skills* with youth with disabilities at a long-term youth facility for males and females is Ventura School of the California Youth Authority, 3100 Wright Road, Camarillo, CA 93010. Contact Gary Delanoye, Academic Assistant Principal for special education and college, (805) 986-0358. An example of using *Social Thinking Skills* with emotionally disturbed and conduct disordered inmates is at Oregon State Penitentiary, 2605 State St NE, Salem, OR 97310. Contact Donald Dutch, Education Coordinator in the Inmate Management Unit, (503) 373-1904.

Target Population

ALAS was initially designed for and evaluated with 7th, 8th, and 9th graders. However, the program directors believe it would be effective for both middle and senior high school youth. Youth in the ALAS pilot program were from very low-income neighborhoods and were diagnosed as learning disabled, seriously emotionally disturbed, or manifesting severe behavioral or academic problems and at greatest risk for school dropout.

Two-thirds of the students in the project were male. 90 percent of the students were Latino and 10 percent were African American. About 70 percent of the students were not native English speakers. The average silent reading score of participants was below the 25th percentile on national norms. Seventy-five percent of the participants' parents were *not* high school graduates. The community where the program took place had half the per capita income of other areas in Los Angeles, was one of 10 Los Angeles Police "hot spots" and had a high rate of school dropout, AIDS, gang activity, neighborhood blight, and drug use.

Evaluation

Approximately 50 highest-risk youth (not formally identified as LD or SED) were compared to 50 highest-risk control youth who did not participate in ALAS. At the end of 9th grade when the intervention terminated, compared to the control group, ALAS students were 15% less likely to have dropped out of school; half as likely to have failed a class; four times less likely to have excessive absences; and almost twice as likely to have fully accrued one year of credits toward 12th grade graduation. Long term delinquency follow-up three years after the youth exited the program showed that compared to the control group, highest-risk ALAS participants were half as likely to have been incarcerated. In a separate study for a special education population, approximately 75 identified LD or SED youth who participated in ALAS were compared to 55 identified LD/SED control youth who did not participate in ALAS. By the end of 9th grade when the intervention terminated, 85 percent of the ALAS participants were still enrolled in school compared to 69 percent of the control group. Twice as many participants (70 percent) had earned a full year of graduation credits compared to the

control group (30 percent) and participants received about 65 percent fewer failed classes than the control group. School attendance was also greatly improved. There was no data available on the delinquency record of special education students.

Overview

The ALAS program is multifaceted, comprehensive and directed at three contexts of influence: the school, the family, and the community. ALAS staff are based at the school site every day and access the community and home contexts as needed. The ***first component*** of the ALAS intervention is to positively enhance students' social and task-related behavior as well as self-esteem. This is done using a social cognitive problem-solving training approach combined with teaching empowerment and racial and ethnic pride. The ***second component*** of the ALAS intervention is school monitoring of period-by-period attendance. Parents are contacted daily about student truancy or extended absence. When necessary parent conferences are held to address the school attendance problem and to help solve difficulties at home that lead to absenteeism. The ***third component*** of the ALAS intervention addresses the need to feel affiliated with the school. The ALAS office becomes a place where many ALAS students want to be and where ALAS students feel they are a member of something in the school. The ***fourth component*** of the ALAS intervention program provides teacher feedback to parents and students on a regular and frequent basis. The project sends weekly, in some cases daily, notes to parents regarding their child's school performance. Parent conferences develop specific suggestions for parents to decide actions (consequences or rewards) to take with their adolescent. The ***fifth component*** provides direct instruction and modeling to parents in how to reduce their child's inappropriate or undesirable behavior and how to increase desirable behavior at home, in school and in the community. Additionally, parents receive instruction and support in how and when to participate in school activities and how and when to contact teachers and administrators. The ***sixth component*** to increase collaboration between school, family, and community is accomplished through case management consultation. The ***seventh component*** of the intervention is student advocacy. Advocacy emanates from the need to reduce high-risk student's alienation from school and to validate cultural/racial perspectives of students and parents.

A targeted student is assigned an ALAS counselor/advocate caseworker. The student is enrolled in the *Social Thinking Skills* program which is best provided as an elective class (with nonALAS participants) or as part of another regular class (with non-ALAS participants). The typical ALAS student circulates a daily or weekly teacher feedback report which is turned into the ALAS counselor/advocate caseworker. Based on teacher feedback, the counselor/advocate caseworker "pulls" the student out of some classes and problem solves with the student regarding teacher feedback. The counselor works closely with the parents and student (often daily) to develop a home-school plan to monitor the student's behavior and school work. The counselor helps the parents and student develop a reinforcement system to bring about desired behavior at school and home. As needed, the counselor helps the parents and student solve family problems that are impacting the student. The counselor also implements an incentive program with the student (e.g., outings, pizza, lunch party) and keeps students after school to complete missing assignments. As needed, the counselor works directly with community agencies (e.g., probation, gang intervention programs, parks and recreation, Boys Club, mental health, etc.) to advocate for service or to offer suggestions on how to best serve a particular youth. The counselor works directly with teachers to plan strategies for student intervention and the counselor also attempts to get administrators and teachers to implement less punitive, individualized effective discipline with targeted students. The ALAS staff work continuously to instill in the students a sense of hope, vision and pride in their culture and race.

Curriculum Materials

A 50-lesson program titled *Social Thinking Skills* published by Clear Pointe Press is available for training social problem-solving skills to students. This program includes a

teacher's manual, student evaluation guidelines, scripted lessons, student worksheets and journal activities and student posters. In three empirical studies conducted through the University of California, this program was found to be significantly effective for enhancing school achievement and social behavior and for reducing delinquency and drug use. This program costs $1700 for the complete program materials: teacher's manual with scripted lessons, student worksheets and lesson notes for duplication, and one set of 30 individual student workbooks. Additional teacher manuals cost $99 - $150 and student workbooks cost $9.95 each.

A 45 page manual titled *PACT Manual: Parent and Community Teams for School Success* published by the Institute on Community Integration at the University of Minnesota is available. This manual describes in detail how to create and implement parent support and training groups for high-risk youth. This is available at cost plus a small handling fee.

Instructional Support/Professional Development

The ALAS Director as well as counselors of the ALAS program are available for technical assistance and training of staff. Intensity and type of staff training varies depending upon how comprehensively the ALAS program is implemented within a school site and community. Training requires 3-5 days. Training is $1500 per day plus travel expenses and can accommodate a large group of people per training session. (It is possible for multiple school sites to send staff and share training costs). Specific training for special education staff is also available. Technical assistance is available directly or through telephone and email communication. Some technical assistance will be at no charge and some is at a negotiated cost.

Technical assistance is available to advise school reforms including implementation of a 1) school wide discipline/social responsibility program; 2) parent involvement program; 3) school dropout program; and 4) at-risk youth case management program; as well as assistance in designing school wide programming for at-risk youth.

The Role of Paraprofessionals

Paraprofessionals can be used to staff the ALAS office, contact parents, monitor student progress, translate non-English languages as needed, write parent notes home, and assist counselor/caseworker advocates. It is also possible, depending upon experience, for paraprofessionals to be used to teach students the *Social Thinking Skills* program and serve as counselor/advocate caseworkers.

Considerations

A major assumption of this program is that ALAS staff, especially the counselors, are highly dedicated and caring individuals who feel a strong commitment to at-risk youth and families and who are willing to "do whatever it takes." ALAS counselors must be willing to hold themselves accountable for failures or regressions believing that they must figure out how to make it possible for the student and parent to succeed. The presence of such ALAS staff makes it easier for the program to occur in schools where few or no teachers buy into the ALAS concept. ALAS staff help students to work effectively with difficult teachers, even if these teachers won't work with them.

Although the results at the end of 9th grade can be phenomenal for highest-risk junior high students compared to students simply given a traditional comprehensive high school experience during grades 10th through 12th, it is unlikely that the gains achieved will be maintained unless the program is continued into senior high school. Students who are so comprehensively at-risk (educationally, socially, emotionally) require ALAS type programs throughout their secondary careers, although possibly with less intensity in the later grades.

A Home-Based Chronic Offender Program

Multisystemic Therapy (MST)

Piloted in Columbia, Missouri and Simpsonville, South Carolina. The sponsor/funding agent is OJJDP and public and private funds.

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Target Population

Columbia, Missouri. The target population is made up of the two hundred youths and their families who are referred from local DJJ offices. Of these, ninety-two youths and their families received MST services and 84 youths and their families received individual counseling. The youth all had extensive criminal histories, with previous arrests averaging at 4.2. Sixty three percent (63%) of the juveniles had previously been incarcerated.

Simpsonville, South Carolina. The study included eighty-four chronic offenders. Fifty four percent had committed a violent crime.

Evaluation

Columbia, Missouri. At post-treatment, families receiving MST reported and evidenced more positive changes in their family interactions than did individual therapy (IT) families. For example, MST families reported increased cohesion and adaptability and showed increased supportiveness and deceased conflict-hostility during family discussions as compared with IT families. Of note, parents in the MST group showed greater reductions in psychiatric symptomatology than did parents in the IT condition. Most importantly results from a 4-year follow-up of recidivism showed that youth who received MST were significantly less likely to be re-arrested than youth who received individual therapy. Specifically, MST completers (n=77) had lower recidivism rates (22.1) than MST dropouts (46.6%, n=15), IT completers 71.4%: n= 63), IT dropouts (71.4%; n=21), and treatment refusers (87.5%; n=24). Moreover, MST dropouts were at lower risk of re-arrest than IT completers, IT dropouts, and refusers.

Simpsonville, South Carolina. Results showed that MST was effective at reducing rates of criminal activity and institutionalization. At the 59-week post-referral follow-up, youth receiving MST had significantly fewer re-arrests (Ms=.87 vs. 1.52) and weeks incarcerated (Ms=5.8 vs. 16.2) than did youth receiving usual services. Families receiving MST reported more cohesion, whereas reported family cohesion decreased in the usual

services condition. In addition, families receiving MST reported decreased adolescent aggression with peers, while such aggression remained the same for youth receiving usual services. Moreover, a 2.4 year follow-up by Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993, in the Journal of Child and Family Studies (2, 283-293), showed that MST doubled the percentage of youths who did not recidivate, in comparison with usual services. Thus, this study demonstrated that an intensive home- and family-based service could reduce the criminal activity of violent/chronic juvenile offenders while maintaining these youths in the community.

In all of the randomized trials of MST, treatment was provided via a home-based model of service delivery. While the particular treatment modalities used in home-based programs can vary, critical service delivery characteristics are shared (Nelson & Landsman 1992) and include: (a) low caseloads (5 families per clinician) that allow intensive services to be provided to each family (2-15 hours/week), (b) delivery of services in community settings (e.g., home, school, neighborhood center), (c) time-limited duration of treatment (4-6 months), (d) 24 hour/day and 7 day/week availability of therapists, and (e) provision of comprehensive services.

Overview

Multisystemic therapy (MST) is a family and community based treatment that strives to change how youth function in their natural settings in ways that promote positive social behavior while decreasing antisocial behavior. MST typically uses the family preservation model of service delivery, where therapists have small caseloads, are available 24 hours a day, 7 days a week, and provide services in the family's home at times convenient to them. The average length of treatment is about 60 hours of therapy provided during a 4-month period. MST therapists focus on empowering parents by using identified strengths to develop natural support systems and remove barriers. MST has successfully served as a clinically and cost-effective alternative to out-of-home placements (e.g., incarceration, psychiatric hospitalization) for youth presenting serious clinical problems.

An earlier clinically oriented volume described MST in detail (Henggeler & Borduin, 1990), and specific guidelines for implementing MST for serious problems in youth are presented in a recent volume published in David Barlow's treatment manual series with Guilford Press (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). A central feature of the MST treatment model is its integration of empirically-based treatment approaches, which have historically focused on a limited aspect of the youth's social ecology (e.g., the individual youth, the family), into a broad-based ecological framework that addresses a range of pertinent factors across family, peer, school, and community contexts. The choice of modality used to address a particular problem is based largely on the empirical support. These include strategic family therapy (Haley, 1976), structural family therapy (Minuchin, 1974), behavioral parent training (Munger, 1993), and cognitive behavior therapies (Kendall & Braswell, 1993).

MST interventions are directed toward individuals, family relations, peer relations, school performance, and other social systems that are involved in the identified problems. The design and implementation of MST interventions are based on nine core principles of MST. These principles serve to operationalize MST, and evaluations of treatment fidelity are based on participants' (i.e., parent, youth, therapist) ratings of therapists' adherence to the MST principles predict favorable long-term outcomes for violent and chronic juvenile offenders, whereas poor adherence predicts high rates or re-arrest and incarceration (Heggeler, Melton, Brondino, Scherer, & Hanley, 1997). In light of these findings and years of anecdotal evidence suggesting that high adherence is linked with favorable outcomes and

low adherence with poor outcomes, considerable training, supervisory, and consultative resources are devoted to maximizing therapist adherence to the MST treatment principles, as described subsequently.

Basic Strategies of MST

- Improve care taker discipline skills
- Enhance family relationships
- Increase youth association with prosocial peers
- Decrease youth association with deviant peers
- Engage youth in prosocial recreation activities
- Improve school/vocational skills
- Develop an indigenous support system
- Aftercare long-term and on-going

Curriculum

Because the MST model is basically a treatment service, there is no "curriculum" for the client(s) per se. Families do receive a great deal of consultation and service which may include materials that are utilized to strengthen family skills; particularly the parents.

Instructional Support/Professional Development

Training in MST is provided on-site by Multisystemic Therapy Services, Inc. using essentially the same protocol that has been used in successful clinical trials of MST with violent and chronic juvenile offenders. Therapists and supervisors receive training in MST in three ways. First, 5 days of intensive training are provided. Second, 1.5 day "booster" sessions occur on a quarterly basis. Third, treatment teams and their supervisors receive weekly telephone consultation from MST experts.

The objectives of the initial 5-day training program are to (a) familiarize participants with the scope correlates and causes of the serious behavior problems addressed by MST; (b) describe the theoretical and empirical underpinnings of MST; (c) describe the family, peer, school, and individual intervention strategies used in MST; (d) train participants to conceptualize cases and interventions in terms of the principles of MST; and (e) provide participants with practice in delivering MST interventions. Training procedures include slide presentations, structured discussion, role-play, and interactive formats. The training is attended by all agency staff who will have clinical or supervisory responsibility in the MST program. In addition, administrators and stakeholders from collaborating agencies often attend the first day of training to become oriented to program rationale goals, procedures, and so forth.

Quarterly booster training is provided on-site by an MST consultant. These sessions are designed to provide the therapists and supervisors training in special topics (e.g., parental substance abuse) and to address issues that may arise for individuals and agencies using MST (e.g., agency accountability for outcome, interagency collaboration). The booster sessions are also designed to allow for discussion of particularly difficult cases. In general, the issues addressed in the booster sessions are based on the individualized needs of the training site--that is, the agendas of the booster sessions are primarily site-driven.

Weekly phone consultation is provided for each treatment team (therapists and supervisor) by the MST consultant. Consultation is provided for each treatment team (therapists and supervisor) by the MST consultant. Consultation sessions focus on promoting adherence to MST treatment principles, developing solutions to difficult clinical problems, and designing plans to overcome any barriers to obtaining strong treatment adherence and favorable outcomes for youths and families. As noted earlier, high treatment adherence is

critical to obtaining favorable long-term outcomes for serious juvenile offenders, and, as such, the central goal of the training and consultation process is to maximize adherence to the MST principles.

In addition to these elements of clinical training, the package of services provided by MST Services includes a pre-training site assessment, assistance with program specification and design, and ongoing assistance with overcoming barriers to achieving successful clinical outcomes. Examples of the assistance provided with regard to program specification and design include the review of RFP documents and/or responses, review of MST related job descriptions, review of hiring advertisements, recommendations regarding clinical record keeping practices, specification of program discharge criteria, and evaluations of outcome measurement concepts. Ongoing assistance overcoming barriers to achieving successful clinical outcomes may include tracking treatment fidelity and adherence, promotion of MST program within the broader service community, and developing program-level interventions designed to increase referrals, reduce staff attrition, or restructure program funding mechanisms.

Further information regarding training, including cost estimates, can be obtained from MST Services. Further information regarding the research base of MST, including the publication list for the citations in this overview, can be obtained from the Family Services Research Center, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina (see contact information).

The Role of Paraprofessionals

Paraprofessionals are not typically used due to the nature of MST services.

Considerations

The MST model is not yet widely disseminated. Since funding for members of this initial research for MST come from the Office of Juvenile Justice and Delinquency Prevention, extra time has been taken to replicate results. Replication findings are still pending. If replication results are positive, opportunities will need to be expanded to meet the nationwide need.

A Peer Mediated Program

The EQUIP Program

The program is currently implemented in multiple sites. Example of EQUIP in a long-term facility: Lubbock County Youth Detention Center, 2025 N. Akron Ave., Lubbock, TX 79415 (806) 775-1800. Contact Joel Travino. Example of EQUIP in a long-term residential facility for females: New Mexico Girls School, Albuquerque, NM. Contact Sandy Porter, Deputy Superintendent, (505) 841-2427.

Contact

John Gibbs, Ph.D., professor of developmental psychology at The Ohio State University and lead author of the EQUIP book. Dr. Gibbs has extensive research and field experience in youth corrections including serving as a former member of the Ohio Governor's Council on Juvenile Justice and working as a faculty associate of The Ohio State University Criminal Justice Research Center. He has written extensively on social and moral development. In partnership with Bud Potter (below), he provides training on the EQUIP program.

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Bud Potter, M.Ed., co-author of the EQUIP book, consultant and former Regional Director for the Ohio Department of Youth Services has over 30 years experience in the field or corrections and parole. He is president of the Ohio Correctional and Court Services Association. In partnership with John Gibbs (above), he provides training on the EQUIP program.

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Target Population

EQUIP is a treatment program for young people with anti-social behavior. The authors of the program believe that youth acting-out delinquent behavior is a result of social skill deficiencies (including anger management); social developmental delays; and social cognitive distortions. Youth in the program evaluated were not specifically diagnosed learning disabled or seriously emotionally disturbed but manifested behaviors consistent with these labels.

The authors of the EQUIP program have helped implement the program in a variety of environments that serve youth who have serious social, behavioral, or emotional problems. These environments include schools, short-term residential settings, and day treatment facilities. The book referenced below briefly discusses how the program might be implemented in these various settings.

Evaluation

The EQUIP program has been evaluated in a controlled study. The study was conducted at a medium-security correctional facility maintained by the juvenile corrections department of a midwestern state. Participants were 57 male incarcerated juvenile offenders, aged 15 through 18. Subjects were randomly assigned to the EQUIP group, a motivational message group or a passage of time group (just incarceration). Both institutional and post-release outcomes were evaluated. While incarcerated, the EQUIP group had significantly fewer staff-filed incident reports, significantly less self-reported misconduct, and significantly better school attendance. Staff reported that the EQUIP unit was dramatically easier to manage than the other units which did not have the EQUIP program in place. At 6 months and 12 months the recidivism rate for the EQUIP group was 15 % whereas the recidivism rate for the control group was 30% and 41% at 6 and 12 months respectively.

Overview

The EQUIP curriculum typically lasts 10 weeks and is administered as part of an on-going help group program. The program and has two basic components: 1) developing a positive caring youth culture in which youth help one another change; and 2) teaching helping skills, that is, remediating social skills deficits, socio-moral developmental delays, and cognitive distortions. The underlying assumption is that antisocial youth can effectively help one another succeed if they are given the skills necessary to provide a constructive caring culture. The philosophy is that by helping others, youth will help themselves. The EQUIP program can be flexibly adapted for a period longer than 10 weeks; below describes a recommended 10 week program.

First, targeted youth are brought together to form a support group of approximately seven youth. This group meets three times a week, with each session lasting from 1 to 1 1/2 hours. Trained staff, using group development techniques, set out to establish a "positive youth culture" through the mutual support group. Youth are specifically taught techniques which facilitate trust, cohesiveness, and helping others to improve their behavior. Youth are taught to: 1) help others accept responsibility for their behavior and not place blame elsewhere, 2) help others through caring confrontation to become aware of the effects of their actions on others, 3) remind other group members to regain self-control and 4) help others re-label rejected or mislabeled values (e.g., "helping others" becomes relabeled as a sign of strength not weakness or "admitting and recognizing social misbehavior" is relabeled as a sign of intelligence and high moral development not foolishness). Throughout the support group meetings, youth identify their own and others' reported behaviors with one of 12 labels. These are: low self-image, inconsiderate of self, inconsiderate of others, authority problem, easily angered, aggravates others, misleads others, easily misled, alcohol or drug problem, stealing, lying, and masking true feelings.

Second, youth are given direct instruction in social skills, moral development and recognizing and correcting cognitive distortions. This instructional group meets twice weekly. As many as fifty social skills are taught, some of these are: saying thank you, giving a compliment, apologizing, expressing care constructively, asking permission, negotiating, using self-control, giving a complaint, dealing with accusation and dealing with group pressure. Youth are taught to recognize and remediate cognitive distortions of egocentric bias or self-centeredness, minimizing, assuming the worst and blaming others. Through discussion, to help youth move past their immature moral development, youth are given opportunities to examine social scenarios and take the perspective of others. Youth also advance their moral development by being given opportunities to provide community service through group projects.

Curriculum Materials

The authors of the EQUIP program have written a 360 page book which describes in detail the rationale and implementation of the program. This book is titled

The EQUIP Program
by John C. Gibbs, Granville Bud Potter and Arnold P. Goldstein.
Published 1995 by Research Press (1-800-519-2707), Champaign, Illinois
ISBN # 0-87822-356-8

Instructional Support/Professional Development

Using the book The EQUIP Program as a reference, if (and that is a BIG if) staff are experienced and skilled at facilitating youth groups, it appears possible to implement the program successfully without further training. However, the authors of the program

recommend staff training for a minimum of 2 days if participants have good group leadership skills otherwise 4 days of training is recommended.

John Gibbs and Bud Potter provide the training (see above). Cost of training staff is $1200 to $1500 per day plus expenses.

The Role of Paraprofessionals

All staff directly involved with the youth can help facilitate a support group, teach the skills and model, reinforce and maintain the skills the youth are learning. To be successful, the authors recommend that staff work specifically to develop a positive staff culture with empowerment through participatory management of the treatment program and a shared mission.

Cost of Implementation

Implementation costs are for personnel. Existing staff could be used but would possibly have to be redistributed in order to run the EQUIP groups and handle an EQUIP caseload group of 7-9 youth. The cost of training should be added to implementation costs.

Considerations/Limitations

The skills of the group facilitator are critical to the success of the program. Without training and experience facilitating youth support groups, positive outcomes are questionable. There is no specific aftercare component when the youth has exited the EQUIP program. However, the authors recommend that aftercare service providers and parents receive training in order to reinforce and cue skills learned in EQUIP. Other research clearly shows the need for aftercare, thus a transition program would have to be added to the EQUIP model. Additionally, EQUIP itself is not a complete program inasmuch as academic, vocational and substance abuse intervention are not a part of the formal model. However, these and other components could easily be added to compliment the EQUIP groups.

Appendix

A Sample Plan for Youth with Disabilities

The Individualized Justice Plan

In Nebraska, the IJP is used in cases where people with developmental disabilities have entered the justice system. Original materials are from the Special Offender Training Manual, written by Jean Morton and published by Crime and Community, Inc. in 1983.

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The IJP is an attempt to integrate issues (and possible services) from the area of education, developmental disabilities, community services, and the legal system. It is intended to assist in the formulation of a plan of response which will:

1. Optimally utilize available community resources
2. Effectively integrate with the justice system
3. Utilize the least restrictive appropriate alternative
4. Hold the individual accountable
5. Address adaptive deficits
6. Assure the individual's civil and legal rights (Morton, 1983)

The literature on offenders with developmental disabilities and learning disabilities show that many such individuals are treated unfairly in the criminal justice system. Major inequities include: receiving longer sentences, being more vulnerable and more at risk for victimization, receiving less habilitation, receiving fewer probation determinations, and having longer periods of incarceration. They also tend to be subject to abuse.

A major problem is the lack of identification of offenders who have disabilities and the lack of interagency coordination and planning in meeting their needs.

Objectives for the IJP. These objectives include:

1. To assist the person to obtain services so that he/she can remain in the community.

2. To obtain a continuum of services that will meet the individual's needs.

3. To promote the development of the person's skills through the use of resources and settings available to all citizens.

4. To increase the skills of the individual so that she/he may participate in and contribute to the community.

5. To support and assist the person's family in meeting his/her needs.

6. To increase the public's understanding of the abilities and needs of the individual.

7. To advocate for the person's rights and responsibilities as a citizen and to assist in the understanding and utilization of both.

8. To provide support necessary to fulfilling the responsibilities of professionals involved with the person.

9. To provide a structure to deal with developmentally disabled offenders in a manner consistent with the philosophy of normalization, least restrictive alternative, and non-use of incarceration.

10. To develop more cost-effective responses to offending behavior.

11. To assist in the development of an increasingly sage community.

12. To hold individuals accountable for their behavior. (Morton, 1983)

Thus the IJP attempts to integrate the special skills and talents of all involved for a common purpose; that is to deal with the behaviors that have brought the client into conflict with the law.

How to Write an IJP.

I. **PROBLEM IDENTIFICATION**

Those behaviors that have brought the client into conflict with the law should be specifically defined, including their topography, rate, severity, and likelihood that they will reoccur. The social implications of the behaviors should also be assessed in terms of the extent to which the behaviors jeopardize the client's placement, interfere with educational objectives, or stigmatize the client by way of his or her integration into a community. It is also helpful to review past offenses, if applicable, and accurately identify the current offense.

II. **ASSESSMENT**

It should be attempted to determine the cause (antecedent) and result (consequence) of the presenting problem. Various aspects of the client' life should be examined to determine:

A) Whether this component is contributing to the presenting problem (e.g. skill deficit, environmental structure, medical problem).

B) Whether changes in an area may lessen or eliminate the problem.

C) Whether this aspect constitutes an area of strength for the client, which may be built upon to assist in eliminating the problem.

Areas that are recommended to be addressed by the IJP include:

A. Residential

Does the current residential environment have an impact on/or help the problem?
Does the current setting meet the client's need in terms of the presenting problem?
Would a change in living environment be recommended?

B. Vocational

Does the client's current job situation contribute to the problem?
Does it provide a source of stability and structure for the client?
Can the problem be controlled in this setting?

C. Educational

Does this client have specific learning disabilities identified by the school?
If yes, does the client have an IEP? What services are to be provided?
Are they in fact, being provided? Should the client be receiving classroom accommodations as set out in Section 504 of the American Rehabilitation Act of 1973?
Does the client have skills deficits (e.g., social skills, communication) which result in the presenting problem?
What further training might eliminate the problem?
What kind of organizational skills does the client exhibit?

D. Social/Recreational

Does excessive free time and/or lack of ability to organize leisure time contribute to the problem?
Does the client have friends who may encourage the problem behavior?

E. Family

Does the client have an active and supportive family?
Do family influences contribute to the problem?
Can the family assist in appropriate behavior development?

F. Medical

Do medical impairments or physical handicaps contribute to the problem?
Are there certain problems in this area which are untreated presently and which could contribute to the problem?
Are proper medications being used?
Are medications being taken? At proper dosage?
Are generic medications being used?

G. Psychological/Psychiatric

Does this client suffer from a mental illness which contributes to the problem?

Does the client have learning deficits or coping deficits that cause concern?

H. Transportation

How mobile is the client?

Do transportation issues contribute to the problem at hand?

I. Advocacy

Is the client able to insure his/her rights are upheld?

Can the clients be taught how to advocate for themselves?

Is an outside advocate needed?

Can the guardian insure his/her ward's rights are upheld?

Does the client desire an advocate?

J. Money Management

Is the problem related to lack of funds or to mismanagement of money?

K. Assessment Inventory

What assessments have been made?

Are further assessments needed?

L. Other

Is there any other relevant information that would assist in determining antecedent and maintaining variables for the presenting problem?

III. TEAM RECOMMENDATIONS

Resources available to the client, whether through the current judicial system, social services, existing community agencies, public education, medical services, or juvenile services should be evaluated. Possible treatment options in terms of special services (e.g. counseling, psychiatric care, use of probation, jail, state hospital) should all be considered if relevant. The team should decide which options represent the least intrusive but potentially most effective means of treating the problem behaviors.

The plan should specify in descriptive terms what the outcome(s) of the current situation should be. This may be evident by a specific IJP goal/objective. Additionally, the plan should take into account the possible reoccurrence of the target behaviors and should include a written description of what will take place should the behaviors occur again.

IV. IJP CONCEPTS

When designing an IJP, several concepts or themes must be kept in mind:

A. Accountability

The IJP must be planned such that the client is accountable for his/her behavior, just as a nondisabled person would be.

B. Competency

The client is to be presumed competent, unless otherwise established.

C. Control vs. Incarceration

There may be other, less restrictive and more appropriate methods to assure control rather than incarceration. Incarceration is not only the most restrictive alternative, but a highly costly one, as well.

D. Due Process

The IJP should ensure that due process is followed, and that the case can be handled in a timely and meaningful manner.
Does the client have access to an attorney?
Has the client been informed of his/her rights?
Does he or she understand them?
Has the client given informed consent of the IJP?

E. Least Restrictive Alternative

The IJP recommendations should be based on a stepped care approach, which means they present the least restrictive by effective alternative for that client?

F. Normalization

In an effort to provide a normalized lifestyle for the client, natural consequences should occur as much as is appropriately possible (Morton, 1983).

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J. Marlene Snyder, Ph.D. provides consultation and facilitation services to a wide spectrum of organizations nationwide concerning Attention Deficit Disorders and other disabilities. These organizations include various state agencies, nonprofit organizations, public K-12 schools, colleges/universities and juvenile justice/court systems.

Immediately prior to moving to Whitefish, Montana, Dr. Snyder was the curriculum and human resources director at the Center on Children, Families and the Law at the University of Nebraska-Lincoln. As part of her responsibilities, she developed teacher training entitled "Accommodating the Child with Attention Deficit Disorders in the Regular Classroom." Each training session is customized to meet the needs of audiences teaching in pre-school through post secondary school systems. Dr. Snyder also conducts training for child welfare workers and juvenile justice professionals about attention deficit disorders in youth and families with whom they work. The training provides many practical insights and tips for accommodations that can be immediately transferred into the workplace. Dr. Snyder involves the audience in her training workshops and has become a popular speaker and presenter for professional organizations who are concerned about the welfare of children.

Marlene's most recent experiences include consultation with the University of South Carolina in Columbia. This chapter in her professional life involves designing and delivery of training for judges, educators, juvenile justice professionals and state legislators on research findings of promising practices for youth with disabilities in the juvenile justice system. Dr. Snyder is also authoring curriculum for the Child Welfare League of America who plans to introduce a national training curriculum for foster/adoptive parents about youth with attention deficit disorders in the fall of 1999.

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Dr. Clare B. Jones operates a multi-disciplinary center designed to meet the varying academic and developmental needs of children and young adults. Recognizing that each individual's growth pattern is unique and complex, the team of professionals at the center are able to provide a range of services. Services include: individual educational and psychological assessments, academic therapy, consultations with school districts, support

groups for children with special needs, speech therapy in English and Spanish, parent counseling and educational workshops for teachers, therapists, physicians and parents.

Dr. Jones is a nationally recognized speaker who presents workshops training teachers and other professionals in working with children with learning disabilities and attention disorders. She serves as an educational consultant to school districts throughout the United States. The focus of many of her workshops for schools is reaching the hard to teach and how to work with the challenging student. She has published numerous articles and is the author of three books on attention disorder with a fourth book due out in 1999. She has a video for training teachers and is a contributing editor to two text books.

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Dr. Larson is a research scholar at the University of California, Santa Barbara. She received her doctorate in special education with a speciality in adjudicated youth with disabilities. She has over 25 years experience designing numerous Federally sponsored programs for high-risk low-income adolescents to succeed in school and for incarcerated or court-involved youth with disabilities to prevent relapse or recidivism. Dr. Larson has numerous articles about how to teach social skills to high-risk youth and is the author of *Social Thinking Skills* a problem-solving social skill program used in over 200 correctional facilities.

She has designed, implemented and evaluated several programs for chronic and gang involved youthful offenders in Los Angeles. In these projects recidivism rates were reduced by nearly 70% and school/employment days were increased by 200%, costs over 15 months were cut by 2/3rds. She recently designed a school dropout project for LD and SED Latino youth which significantly cut dropout, and doubled passed classes and attendance.

Dr. Larson is a recommended trainer of the International Correctional Education Association and trains corrections personnel across the United States. She offers workshops and consults regularly with school districts regarding high-risk youth and youth at risk for expulsion.

Resources

Addresses

JAGS:
Jobs for America's Graduates
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Alexandria, VA 22314-2720

Books

Choosing Correctional Options that Work by Alan T. Harland. (1996). Published by Sage Publications, Thousand Oaks, California. This book provides an up-to-date review of what interventions have been shown to reduce recidivism.

Aggression Replacement Training by Arnold Goldstein and Barry Glick. (1987). Published by Research Press, Champaign, Illinois. This book provides a review of research in aggression and methods for teaching aggression control.

Preventing Childhood Disorders, Substance Abuse and Delinquency by Ray Peters and Robert McMahon (Eds.). (1996). Published by Sage, Thousand Oaks, California. A variety of articles that describe programs for at-risk youth.

Adolescent Assertiveness and Social Skills Training: A Clinical Handbook by Iris Fodor (Ed.). (1992). Published by Springer Publishing Company, New York, New York. A how to book on assertiveness training.

Time to Think: A Cognitive Model of Delinquency Prevention and Offender Rehabilitation by Robert Ross and Elizabeth Fabiano. (1985). Published by the Institute of Social Sciences and Arts, Inc., Johnson City, Tennessee. ISBN 0-915165-06-6. An extensive review of research showing the connection between criminality and deficits in cognitive social skills.

Psychosocial Development During Adolescence by Gerald Adams, Raymond Montemayor and Thomas Gullotta. (1996). Published by Sage, Thousand Oaks, California. Describes the various issues involved in adolescent development.

Reason to Hope: A Psychosocial Perspective on Violence and Youth by Leonard Eron, Jacquelyn Gentry and Peggy Schlegel. (1994). Published by the American Psychological Association, Washington, D.C. Describes research on violence in a variety of youthful populations, describes interventions and makes policy recommendations.

Behavioral Approaches for Children and Adolescents by Henck van Bilsen, Philip Kendall and Jan Slavenburg. (1995). Published by Plenum Press, New York, New York. Describes intervention methods using behavior modification approaches.

Improving the Social Skills of Children and Youth with Emotional/Behavioral Disorders by Bullock, L., Gable, R. and Rutherford, R. (Eds.). Published by Council for Children with Behavioral Disorders, Reston, VA.

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Cultural Diversity and Social Skills Instruction: Understanding Ethnic and Gender Differences by Cartledge, G. and Milburn, J. (Eds.). (1996). Published by Research Press, Champaign, IL.

Curriculum

Social Thinking Skills: A Program to Teach Social Cognitive Skills, Problem Solving, Impulse Control and Assertiveness Skills (to juvenile offenders) by K. Larson. (1996). Published by Clear Pointe Press, Ventura, California.

Adolescent Assertiveness and Social Skills Training by I. Fodor. (1992). Published by Springer, New York.

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