

The Pro Kids and Families Program

An Effective Diversion Strategy

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History of Pro Kids and Families

- ▶ 1993 Cuyahoga County Juvenile Court established a goal to divert status offenders from official court involvement.
 - ▶ In response to an RFP, OhioGuidestone created the Pro Kids and Families Program.
 - ▶ Pro Kids and Families provides diversion services to those youth who have been charged with a status offense
 - ▶ Upon successful completion of the program no official record is kept in the Juvenile Court System.
 - ▶ Pro Kids provides a highly effective, cost-conscious solution for those youths who have an unruly filing
 - ▶ The program is in line with the central tenets of the Juvenile Justice Delinquency Prevention Act
 - ▶ Has measurable outcomes
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What is a Status Offense?

- ▶ An offense that would not be a crime if committed by an adult
 - AWOL
 - Unruly, incorrigible
 - Truancy
 - Curfew Violation
 - Possession of Tobacco
 - Non-Criminal Traffic Offenses.



The Early Years of Pro Kids

- ▶ Focused on improving social skills and reducing recidivism
- ▶ Pro Kids Services included, but were not limited to:
 - Car washes
 - Trips to Grafton Correctional Institute
 - Classes on sexual education and disease prevention
 - Anger Replacement Training (ART) groups

10 years Later ...

- ▶ Pro Kids began providing college tours instead of prison tours
- ▶ Provided a more in-depth assessment to provide a complete biopsychosocial view of the individuals needs.
- ▶ Provided Trauma-Informed care
- ▶ Provided access to Medicaid for client's with significant needs. These services included:
 - Individual Counseling
 - Psychological Assessment
 - Psychiatry
 - Pharmacy Access

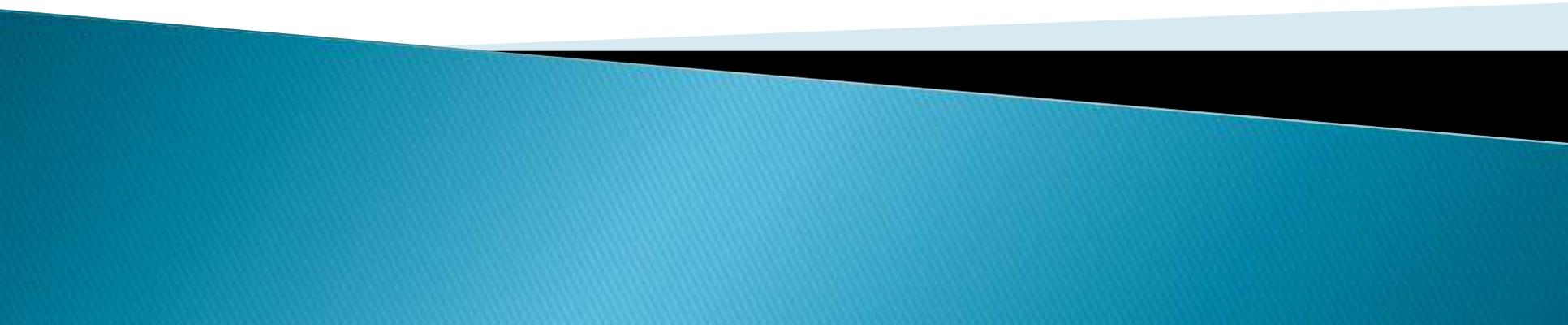
10 Years Later Continued...

- ▶ Higher standards for clients outcomes and greater documentation
 - ▶ Client progress on goals became as important as recidivism
 - ▶ Data analysis became more sophisticated
 - ▶ A logic model was created
 - ▶ Fidelity Measures were developed and implemented
 - ▶ The Family Workbook was created
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23 Years Later....

- ▶ Pro Kids and Families has successfully helped more than 20,000 youths across Cuyahoga County.
 - ▶ Historical success rates indicate that between 79% and 85% of clients who complete our core program avoid further court involvement for at least 12 months
 - ▶ 91% Parent Satisfaction ratings
 - ▶ Expansion into Lorain and Erie Counties.
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Our Philosophy



Our Philosophy?

Look Beyond the Behavior

- ▶ National research confirms our experience that a youth's initial presentation of unruly behavior is most often just the external symptom of underlying personal, familial, community, or systemic issues.
- ▶ Risk factors increase a juvenile's likelihood of becoming a delinquent
 - Research has shown that a 10 year old exposed to 5 or more risk factors is at least 10 times as likely to commit a violent act by the age of 18 as compared to a 10 year old exposed to 2 or fewer risk factors.

Risk Factors Include

- ▶ Alcohol or drug use
- ▶ Mental health concerns
- ▶ Poor school performance
- ▶ History of trauma
- ▶ Exposure to violence
- ▶ History of child maltreatment
- ▶ Negative peers
- ▶ Socioeconomic issues
- ▶ Neighborhood factors



Protective Factors

- ▶ Factors that mediate or moderate the effect of exposure to risk factors
 - ▶ Based on the best-practice guidelines from the OJJDP, an effective diversion program should address risk factors while strengthening a youth's protective factors.
 - ▶ This philosophy is at the foundation of the Pro Kids and Families Program
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Protective Factors Include

- ▶ Warm, supportive relationships with parents
- ▶ Supportive adults
- ▶ Parental Monitoring
- ▶ Parents' positive evaluation of peers
- ▶ Commitment to school
- ▶ Pro Social Activities
- ▶ Positive peer relationships



The Important Role of the Parent

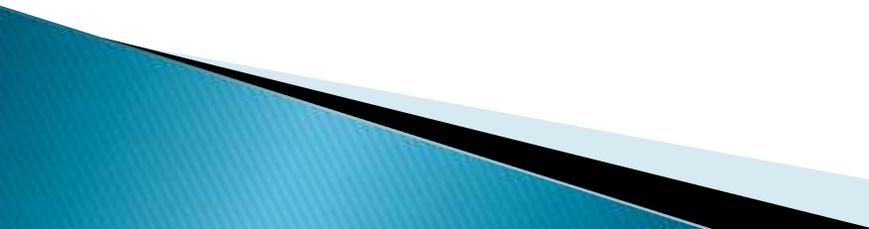
- ▶ Research has shown that many unruly youths have recurring parental and family struggles
 - ▶ Inappropriate parenting practices are one of the leading risk factors in the development of adolescent–conduct problems
 - ▶ Negative parenting behaviors include
 - Low parental involvement
 - Poor supervision
 - Harsh, inconsistent discipline
 - Lack of parental responsiveness and warmth
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The Parents Risk Factors

- ▶ Elevated feelings of hopelessness
- ▶ Feelings of inadequacy as a parent
- ▶ Fear of physical harm by the child
- ▶ Difficulty monitoring the child
- ▶ Exasperation with the child
- ▶ Mistrust of the justice system
- ▶ Shame over parenting self-efficacy

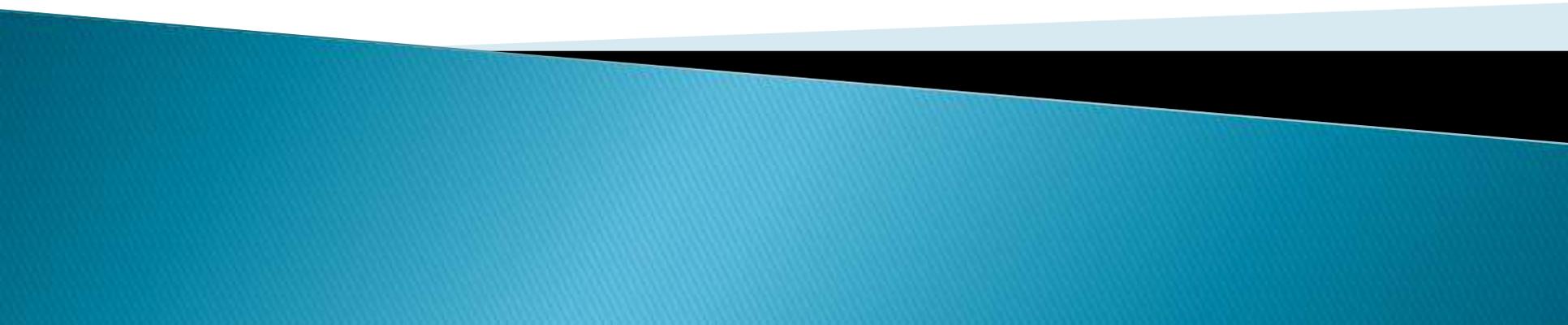


In Summary

- ▶ It is imperative that we address not only the youth risk factors that contribute to the presentation of the unruly symptoms but also the parental and familial risk factors.
 - ▶ By addressing the larger problems, we can successfully ameliorate a youth's primary presentation of unruly behavior.
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Why Diversion?

Because Adolescents Are Not Adults



Developmental Theory

- ▶ Adolescents are independence-seeking
 - ▶ Peer relationships take precedence
 - ▶ Increased moodiness
 - ▶ Rule Testing
 - ▶ Need for privacy
 - ▶ Less communicative with parents
 - ▶ Can be secretive and/or argumentative
 - ▶ Previously successful discipline strategies no longer work
 - ▶ A push-pull begins. The child pushes for autonomy and independence, the parent pushes back for authority and control
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Brain Development

- ▶ Brain undergoes a major reorganization during the 12th through the 25th year of life
- ▶ Imaging work completed in the 90's shows that these physical changes move in a slow wave from the brain's rear to its front
- ▶ Different parts of the cortex mature at different rates
- ▶ Basic functions mature first
- ▶ The parts of the brain responsible for
 - Controlling impulses
 - Planning ahead
 - Assessing riskMature last
- ▶ The corpus callosum continues to thicken
- ▶ Stronger links develop between the hippocampus and the areas of the brain that set goals and weigh deferent agendas and/or potential risks.
- ▶ When brain development proceeds normally, a youth is able to integrate memory and experience into their decision making, they are able to balance impulses, desire, goals, self-interest, rules, ethics and even altruism.

Adolescent VS. Adult Brain

Adolescents are:

- ▶ Less able to regulate their own behavior in emotionally charged contexts
- ▶ More sensitive to external influences such as peer pressure and immediate rewards
- ▶ Less ability to make judgements and decisions that require future orientation



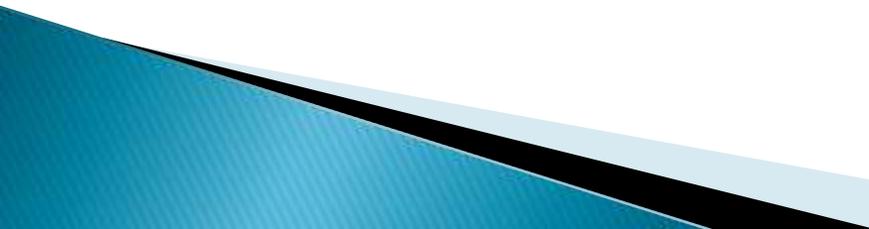
Legal Support for Diversion

- ▶ 1974 Federal Juvenile Justice Delinquency Prevention Act (JJDPDA)
- ▶ Core Mandates of the Act
 - Deinstitutionalization of status offenders
 - Separation of juvenile and adult offenders
 - Removal of juveniles from adult jails
 - Reduction of disproportionate minority contact

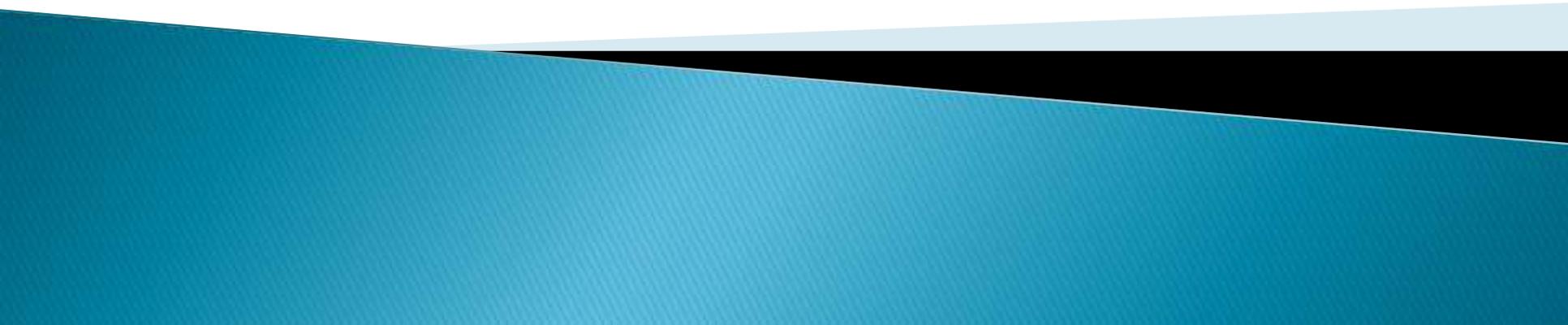
Legal Support Cont...

- ▶ When status offenders are detained
 - Recidivism rates increase
 - School engagement and success decrease
 - Emotional, social, familial, and other problems are exacerbated
 - Youth are exposed to other antisocial individuals and peer groups

Truant Youth Do Not Need Detention

- ▶ Typical adolescent behaviors have become criminalized
 - Zero Tolerance policies
 - ▶ In 2011, truancy accounted for 40% of all formally petitioned status offenses nationwide
 - ▶ Youth's detained for truancy were found to be 14.5 times less likely to graduate than similar youths without detainment (Colorado Study)
 - ▶ Florida study revealed that out-of-school suspensions led to low academic performance and continued behavioral issues.
 - ▶ Removal of a youth from school leads to lower earning power, few job opportunities, unemployment, poverty, and criminal behavior.
 - ▶ A youth's barriers to school attendance are only removed successfully by addressing the underlying drivers.
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Pro Kids and Families Program Overview



Program Overview

- ▶ After the referral is received from Juvenile Court, we contact the family within 24 hours of referral
- ▶ Mental health screening is provided
- ▶ Based on needs, a mental health assessment is completed
- ▶ Offer a 360 approach
- ▶ Weekly face-to-face services
- ▶ Collaborative
- ▶ Services are provided in the home, schools, and community settings at varying intensity and include the referred youth, parents, school officials, and other natural or community supports.
- ▶ Targeted and solution-focused
- ▶ Family-based
- ▶ Multiple modes of intervention
 - CPST and case management
 - Individual and family therapy
 - Aod individual counseling and Aod case management
 - Linkage with supportive services such as psychiatry and psychological testing

Program Overview

- ▶ Empowers families with protective factors, community resources, and effective parenting training.
 - ▶ Examines the child through the lens of risk and protective factors.
 - ▶ Engages the whole family unit
 - ▶ Pro –social skill building
 - ▶ Skill development
 - ▶ Education regarding mental health symptoms
 - ▶ Exploration of thinking errors using CBT
 - ▶ Promotion of healthy bonds between youth and family
 - ▶ Utilizes a Nurturing Parenting approach
 - ▶ Accountability
 - ▶ Mediation when necessary
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Mental Health Vs. Non-Mental Health Services

Mental Health

- ▶ Comprehensive mental health assessment
- ▶ Drug screening
- ▶ Aod addendum (if applicable)
- ▶ Individual Service Plan is developed
- ▶ Child Behavior Checklist
- ▶ Case management services begin within 7 days
- ▶ Weekly CPST, counseling services, or both
- ▶ Services continue until no longer medically necessary
- ▶ Billed to Medicaid

Non-Mental Health

- ▶ Psychosocial assessment
- ▶ Youth Level of Service Case Management Inventory (YLS/CMI)
- ▶ Case management services begin within 7 days
- ▶ Two contacts per month for duration of 120 days
- ▶ Unlimited 15 minute phone calls

Program Characteristics

- ▶ Services and interventions designed to target criminogenic challenges while simultaneously treating mental health symptoms.
 - ▶ Based upon a cognitive behavioral psychoeducational philosophy.
 - ▶ Parents must be a part the treatment process
 - ▶ Nurturing Parenting – Dr. Stephen Bavolek – is utilized in work with parents.
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Youth Interventions

Drug Treatment

- ▶ If a youth is identified as having a drug problem, we integrate Aod services into the ISP.
 - ▶ Our approach utilizes the National Institute of Drug Abuse's (NIDA) philosophy of risk factors and protective factors.
 - ▶ Utilizes Motivational Interviewing and the Stages of Change
 - ▶ Provide individual and family counseling using cognitive behavioral therapy and contingency management
 - ▶ Strong emphasis placed on building assets and resiliency as well as a sober support system.
 - ▶ Family recovery
 - ▶ Referral to a higher level of care if needed
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Trauma, Abuse, and Neglect

- ▶ Youth involved in juvenile court statistically have a higher than average incidence of trauma, abuse and neglect.
 - ▶ All case managers are trained in trauma-informed care.
 - ▶ Implementation of the 9 essential elements of trauma informed care.
 - ▶ Education provided regarding trauma and how it affects the brain
 - ▶ Trauma loss histogram.
 - ▶ Trauma narrative
 - ▶ Social skills, trust, communication, conflict resolution, and healthy relationship development
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Prosocial Involvement and Social Skill Training

- ▶ Pro social activities lead to better habits, positive connections with friends, learning responsibility, an experience of pride, and future-oriented thinking.
 - ▶ Case managers assist in linking youth with activities such as jobs, hobbies, organized sports, and extracurricular activities or clubs.
 - ▶ Social skill training is provided including
 - Communication skill development
 - Conflict resolution
 - Problem Solving and decision making –
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Goal Setting and Resiliency Building

- ▶ Case managers work with youth to develop both short and long-term goals for the future
 - ▶ Identify inconsistency between goals and current choices/behavior
 - ▶ Identify resiliency-producing factors in child's life to increase prosocial bonding and opportunities for meaningful participation.
 - ▶ Strengths identification to increase confidence and parlay that into goal orientation
 - ▶ Encourage client's to take on tasks to help others, and in turn, boost their own feelings of self-efficacy
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Emotional Regulation

- ▶ **1. Being able to identify their own emotions and understand their own personal emotional process. –**
 - feeling identification
 - Identify overactive vs. underactive emotional process
- ▶ **2. Being able to identify the emotions of others. –**
 - emphasis on empathy building
- ▶ **3. Being able to soothe self when confronted with negative emotions–**
 - Positive Coping Skills
 - Counting, time to cool off
 - Breathing– calming breaths
 - Thinking – using water thoughts to “extinguish” the fiery negative thoughts.
 - Cognitive reframing – Utilizing CBT and challenging distorted beliefs
 - Keeping things in perspective – teach the “three by three by three” rule
 - Letting Go – letting go of things we cannot control

Support–System Identification

- ▶ Cultivate a positive support system
 - ▶ A positive support system can be found
 - Within the family
 - Extended family members
 - Church affiliates
 - Coaches
 - Teachers
 - Parents of friends
 - Formal mentoring programs
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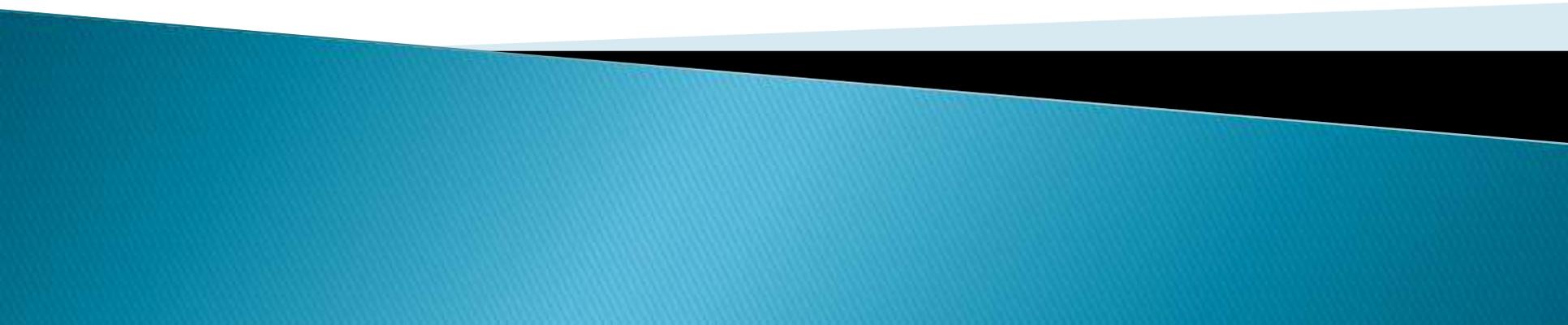
Positive Peer Association

- ▶ Studies have confirmed that negative or delinquent peer associations precede the onset of one's delinquent behavior.
- ▶ Why?
 - peer approval of delinquent behavior
 - attachment or allegiance to peer group,
 - time spent with peers
 - peer pressure to commit devious acts
- ▶ Finding positive replacements is the case managers primary goal.
- ▶ Why?
 - Studies have confirmed that when a youth spends time with peers who disapprove of delinquency, their involvement in delinquent acts decline.

Community Restitution

- ▶ Case managers facilitate or participate with the youth in the following activities
 - Feeding the homeless
 - Going to the Animal Protective League to clean cages or walk the dogs
 - Cleaning religious centers
 - Doing small odd jobs for the elderly
 - Cleaning police vehicles
 - Volunteering at local community gardens

Family Interventions



Parent Classification

- ▶ Diana Baumrind created three classifications of dimensions of warmth and control to identify
 - **Authoritative – moderate warmth and moderate control.** Characterized by warm, child-centered approach that includes high expectations and clear standards for children. These parents monitor limits, expect mature, independent, and age appropriate behavior. Punishment is consistent, not arbitrary or violent.
 - **Authoritarian – low warmth and high control.** Restrictive, punishment-heavy parenting style in which parents make their children follow directions with little to no explanation. Punishment is plentiful and includes corporal punishment and yelling.
 - **Permissive – high warmth and low control.** Highly nurturing and accepting style that is responsive to the child's needs and wishes. These parents do not require their children to regulate themselves or behave appropriately and punishment is sparse.
 - **Neglectful parenting style** was added in 1983 by Maccoby and Martin to expand upon Baumrind's three original parenting styles. Maccoby and Martin defined neglectful parenting as having low warmth, low control, low demand, and low responsiveness, and is associated with negative outcomes across all domains.

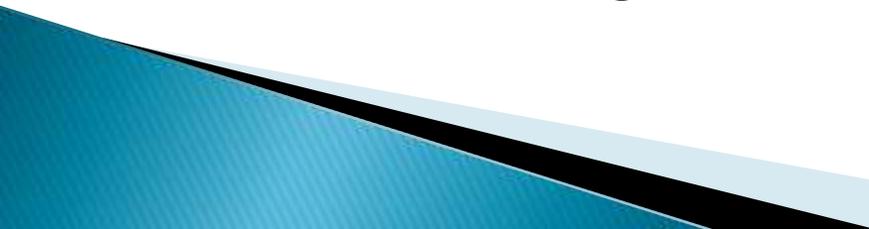
Supervision

- ▶ A 2003 study found that as parental knowledge gained through monitoring decreased, delinquency rates increased
- ▶ Parental monitoring/supervision is a set of behaviors that involve attention to and the tracking of the child's whereabouts and activities
- ▶ Structure the child's after school and weekend hours with positive activities
- ▶ Monitor the child's space – bedroom, basement, rec room – Be aware of hiding spots
- ▶ Have 5 basic pieces of information for supervision
 - Who are they with?
 - What are they doing?
 - Why are they doing it?
 - When will they be home?
 - Where will they be?

Family Rules

- ▶ It is important for a parent to have clear and consistent expectations of their child
- ▶ Creating a list of “family rules” can help a parent accomplish this.
- ▶ Appropriate discipline and Parental Reinforcement is explored and taught
- ▶ The parent should ask themselves
 - Do I have clear expectations of my child?
 - Does my child know what those expectations are?
 - Are they written down and posted in my house?
 - Am I consistent with my expectations?

Parental expectation, roles, and communication

- ▶ Parental Expectation/psychoeducation – Case managers review the appropriate developmental expectations for their child based on age and ability as well as normalize mental health challenges
 - ▶ Parent–Child Roles – In some cases we have to confront a parent–child role reversal.
 - ▶ Warmth and Parental Involvement – We focus on the parent–child relationship and reinstating warmth that may have been lost. Model Nurturing Parenting
 - ▶ Remembering that communication is key
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Addressing Feelings of Hopelessness, Inadequacy, and Anger within the Parent

- ▶ Normalize
 - ▶ Acknowledge
 - ▶ Reframe
 - ▶ Help the parent pursue forgiveness of the child
 - ▶ Referral for a parent to receive his or her own services if needed.
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School Interventions

Communication with Schools

- ▶ Open up communicating with school administrators, teachers, support staff, security guards.
 - ▶ Assess school's perception of the child
 - ▶ Gather information regarding attendance and behavior
 - ▶ Develop a plan of correction
 - ▶ Begin to transfer these responsibilities to the parent
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Organization and Preparedness

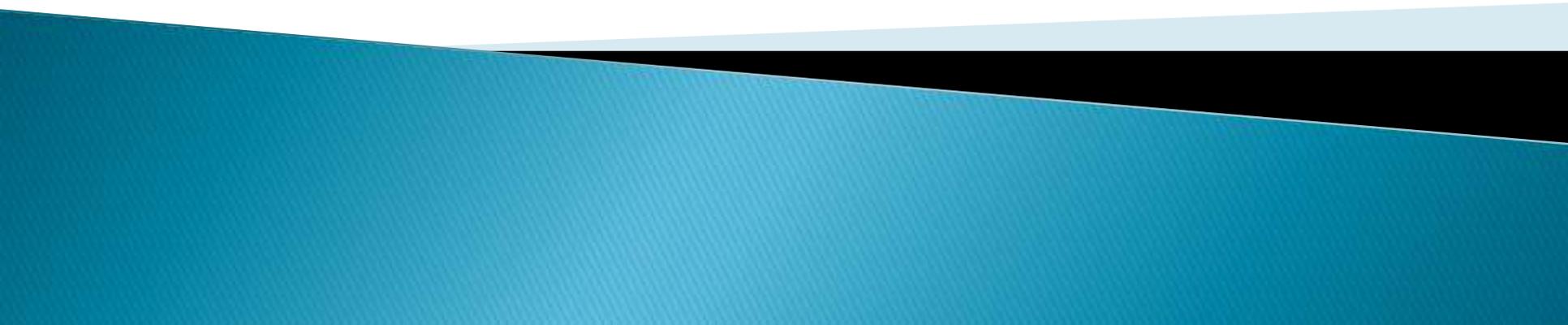
- ▶ Help establish a routine for school
 - ▶ Identify issues related to completing homework, getting bags packed, getting ample sleep, and getting up on time.
 - ▶ Implementation of incentive plans and behavior modification
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Advocacy and Education of School Personnel

- ▶ Actively advocate
- ▶ Testing
- ▶ Appropriate interventions
- ▶ Correct educational setting/placement
- ▶ Education of mental health symptoms



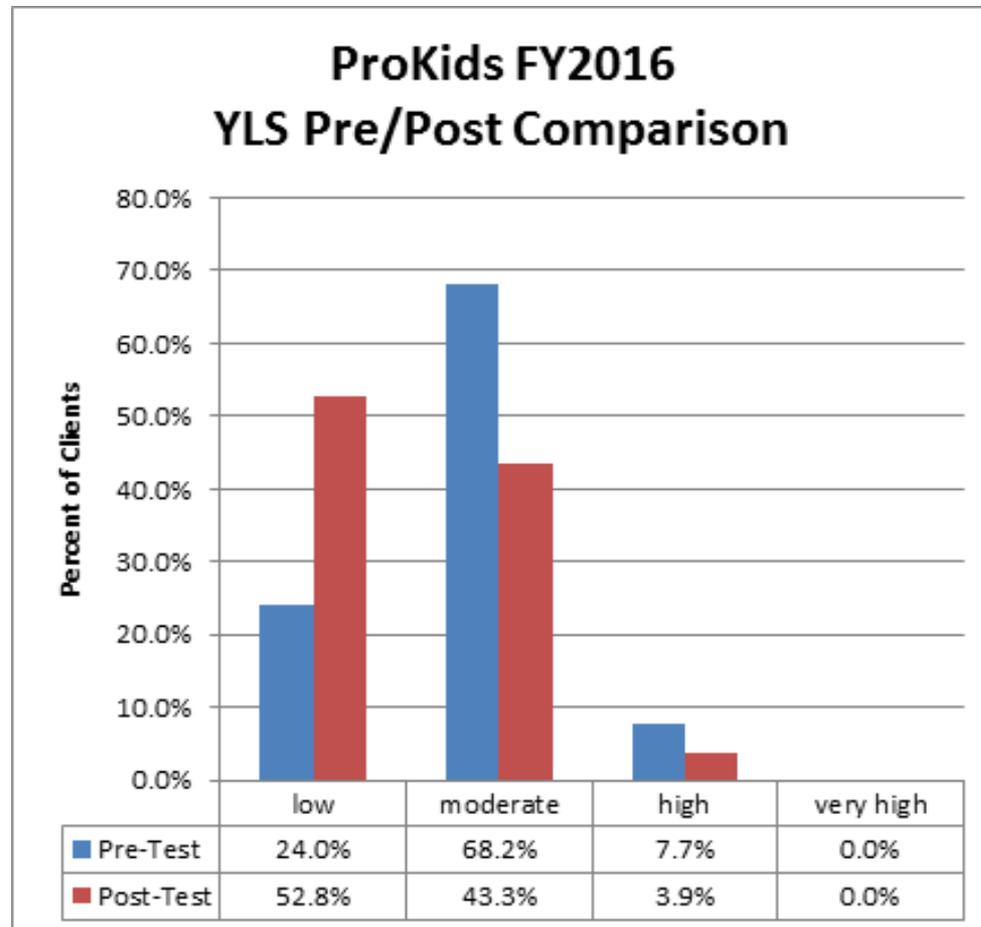
Data Analysis



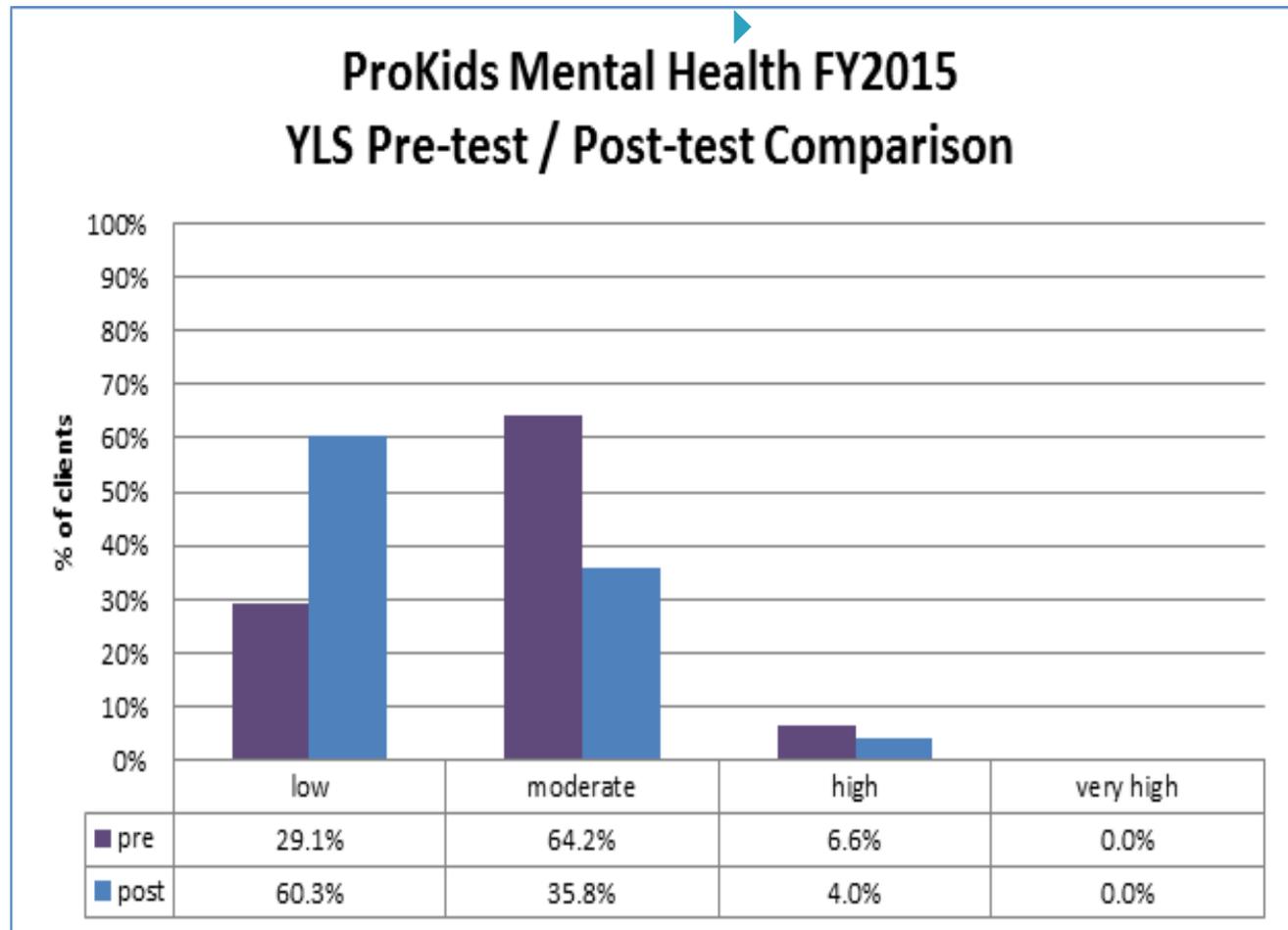
Individual Risk Factors

- ▶ We track level of risk using the Youth Level of Service Case Management Inventory (YLS/CMI). The YLS/CMI (Hoge and Andrews 2002) is designed to assess the established predictors of criminal conduct. We give this inventory at the beginning of treatment and again at closing.

Youth Level of Service Case Management Inventory – 2016



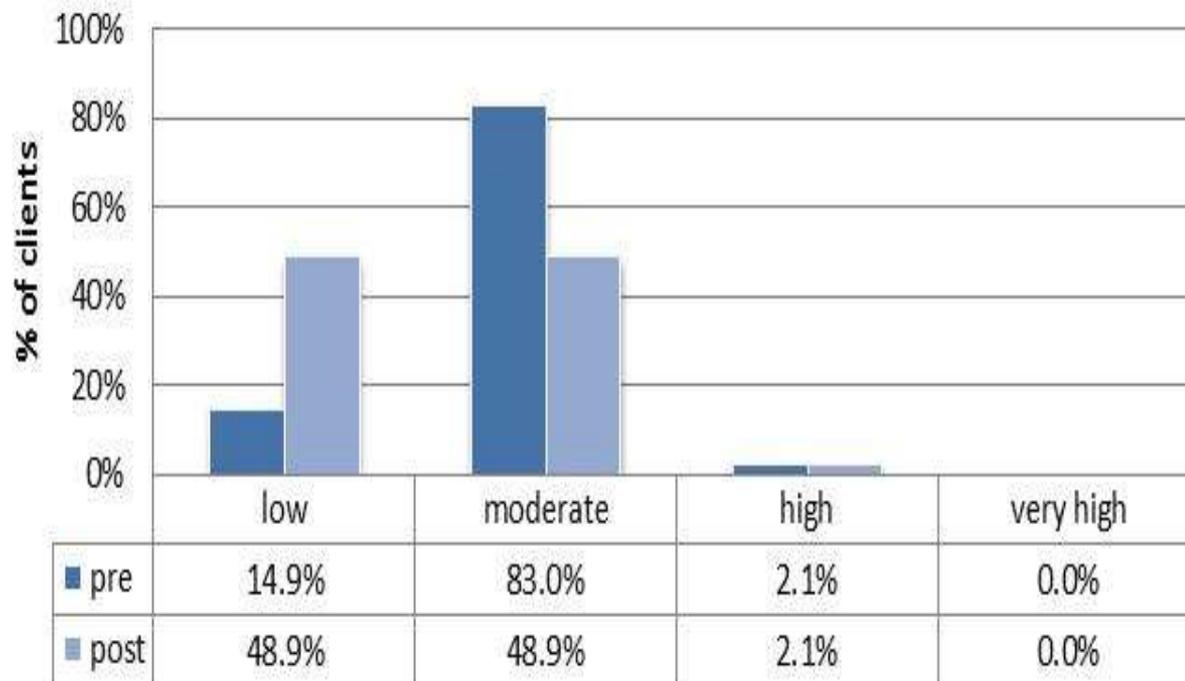
Youth Level of Service Case Management Inventory – 2015



Youth Level of Service Case Management Inventory – 2014

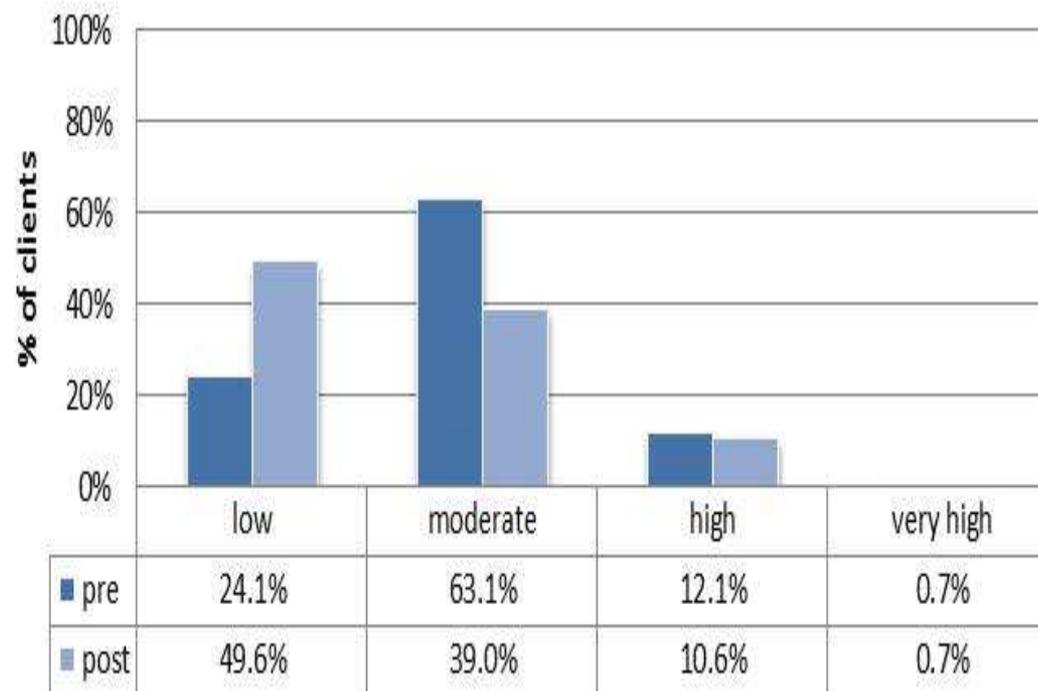
ProKids FY2014

YLS Pre-test / Post-test Comparison



Youth Level of Service Case Management Inventory – 2014

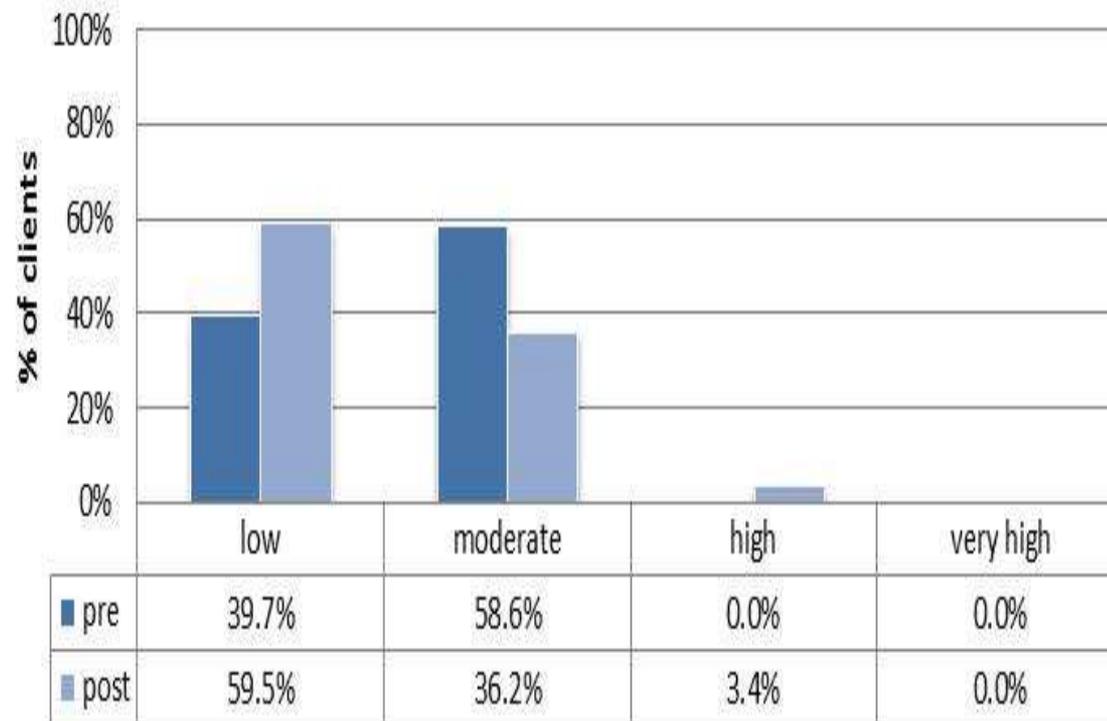
ProKids Mental Health FY2014 YLS Pre-test / Post-test Comparison



Youth Level of Service Case Management Inventory – 2013

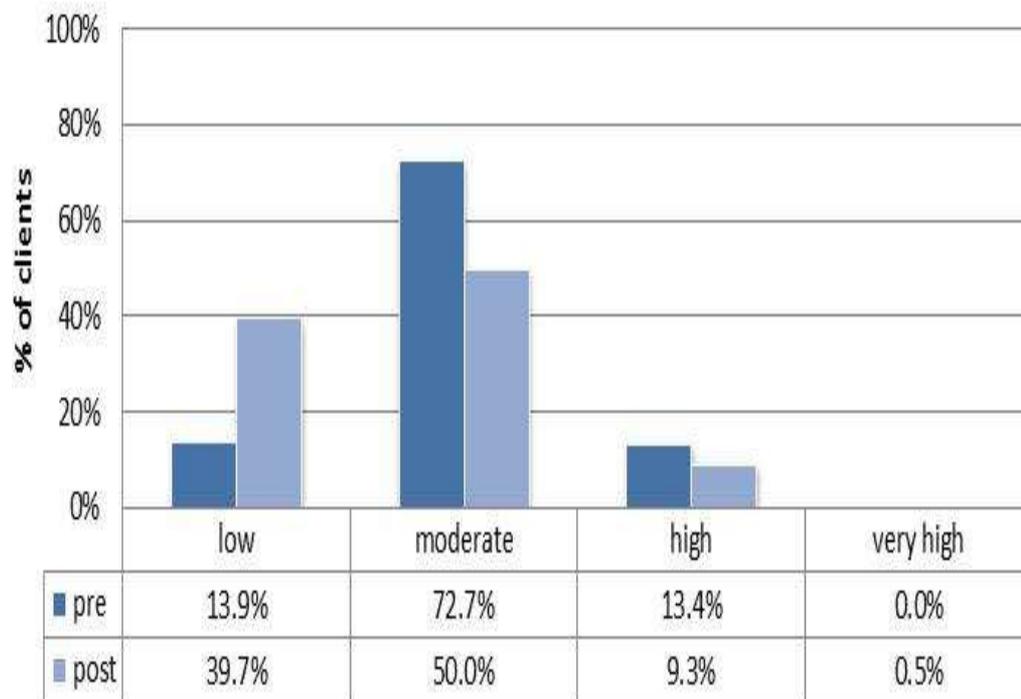
ProKids FY2013

YLS Pre-test / Post-test Comparison

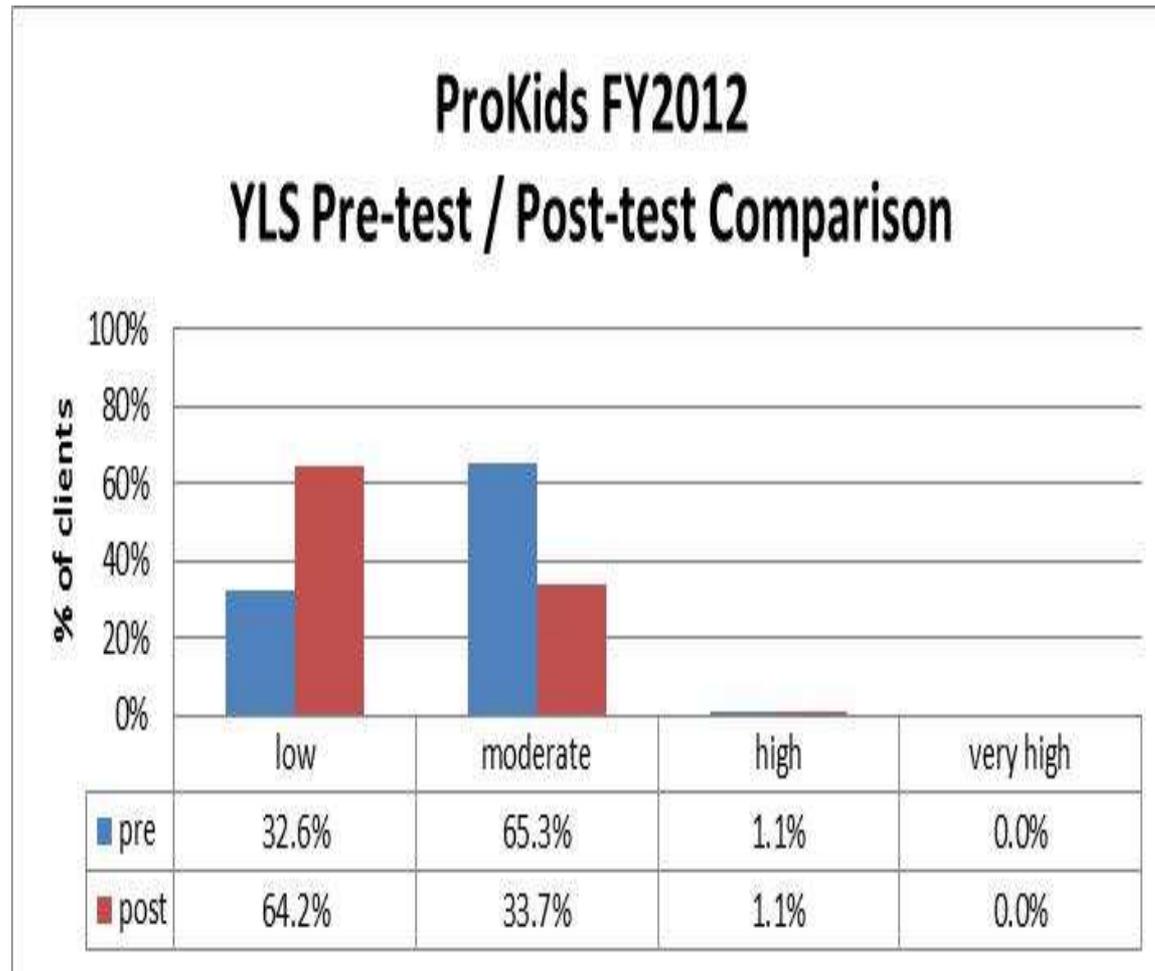


Youth Level of Service Case Management Inventory – 2013

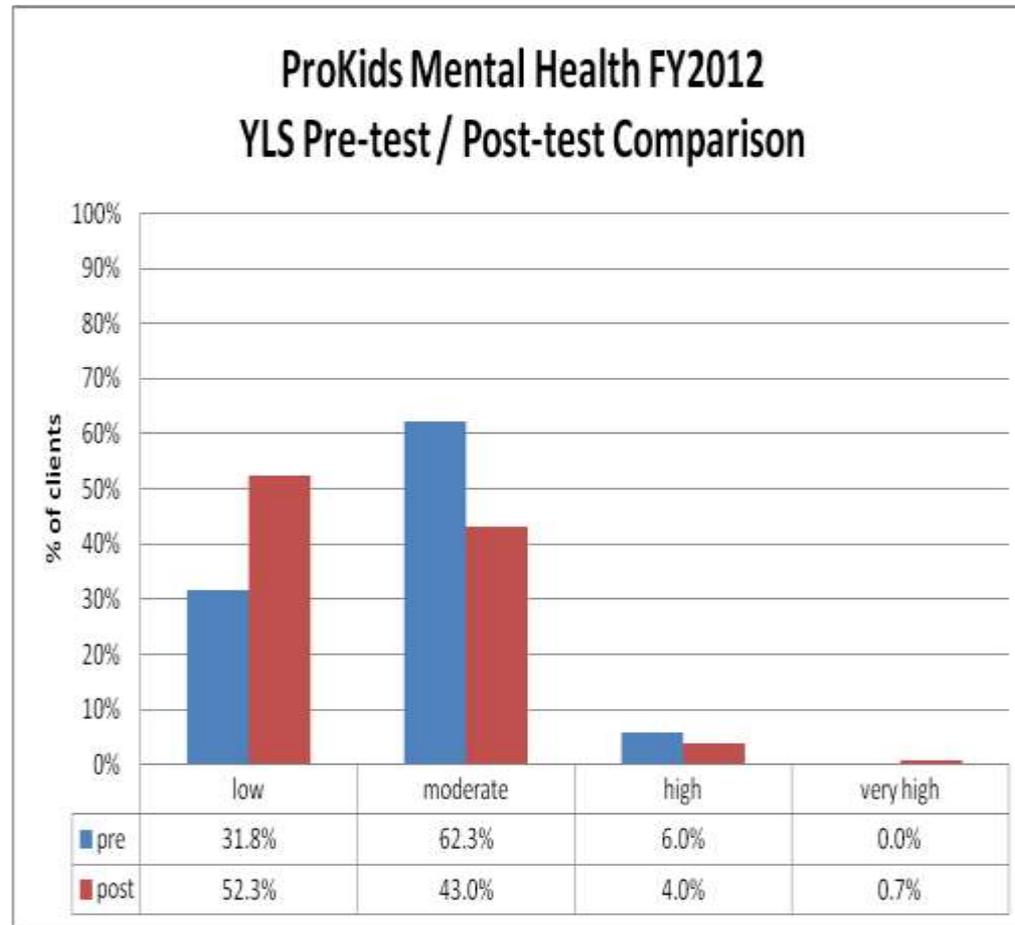
ProKids Mental Health FY2013 YLS Pre-test / Post-test Comparison



Youth Level of Service Case Management Inventory – 2012



Youth Level of Service Case Management Inventory – 2012



Clinical Symptoms

- ▶ Clients are given the Child Behavior Checklist (CBCL) at the beginning of treatment, every six months while in treatment, and again at case closure. The CBCL is a checklist parents complete to detect emotional and behavioral problems in children and adolescents.

CBCL – 2016

Scale Name	Initial Mean	Clinical Range	Final Mean	Clinical Range	Mean Change	TSD
Internalizing	58.28	Normal	53.37	Normal	4.9*	12.57
Externalizing	66.72	Clinical	61.22	Borderline Clinical	5.51*	13.00
Total Problems	63.25	Clinical	58.08	Normal	5.17*	12.67

CBCL – 2015

Scale Name	Initial Mean	Clinical Range	Final Mean	Clinical Range	Mean Change	TSD
Internalizing	60.10	Borderline Clinical	54.25	Normal	5.85*	11.50
Externalizing	66.95	Clinical	60.59	Borderline Clinical	6.35*	9.65
Total Problems	64.38	Clinical	58.10	Normal	6.28*	9.64

*indicates statistically significant change

CBCL- 2014

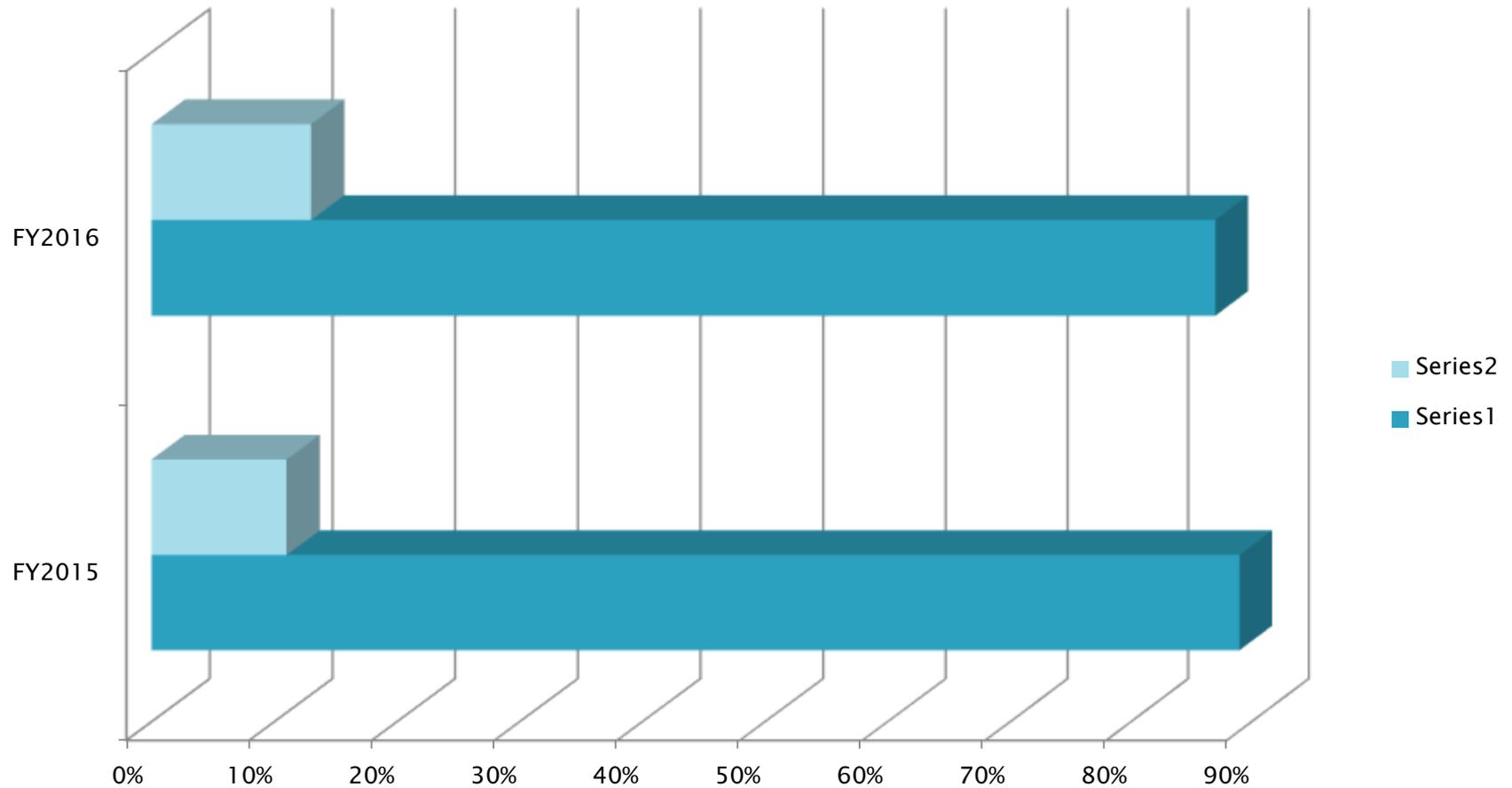
<i>PKMH (n=138)</i>	Initial		Close		Mean Change	
	<i>mean</i>	<i>range</i>	<i>mean</i>	<i>range</i>	<i>mean</i>	<i>TSD</i>
<i>Syndrome Scale</i>						
Anxiety	60.1	Borderline Clinical	56.0	Normal	4.1	8.56
Withdrawn	64.4	Clinical	59.6	Normal	4.7	10.05
Somatic	57.3	Normal	55.6	Normal	1.7	7.32
Social	60.5	Borderline Clinical	57.7	Normal	2.8	8.66
Thought	60.5	Borderline Clinical	58.8	Normal	1.7	8.97
Attention	64.9	Clinical	61.6	Borderline Clinical	3.2	10.07
Rule-Breaking	68.4	Clinical	64.7	Clinical	3.7	9.17
Aggressive	68.7	Clinical	61.9	Borderline Clinical	6.8	10.23

CBCL – 2013

<i>PKMH (n=83)</i>	Initial		Close		Mean Change	
	<i>mean</i>	<i>range</i>	<i>mean</i>	<i>range</i>	<i>mean</i>	<i>TSD</i>
<i>Syndrome Scale</i>						
Anxiety	59.5	Normal	55.3	Normal	4.2	8.910
Withdrawn	62.4	Borderline Clinical	58.0	Normal	4.4	9.984
Somatic	57.6	Normal	54.7	Normal	2.9	7.630
Social	61.7	Borderline Clinical	58.0	Normal	3.8	9.600
Thought	61.2	Borderline Clinical	56.8	Normal	4.3	10.169
Attention	65.4	Clinical	60.3	Borderline Clinical	5.1	10.668
Rule-Breaking	68.2	Clinical	62.2	Borderline Clinical	6.0	8.719
Aggressive	67.3	Clinical	59.8	Normal	7.5	10.324

Recidivism at Close

Program Closing Codes



Recidivism at Close

Program Closing Status

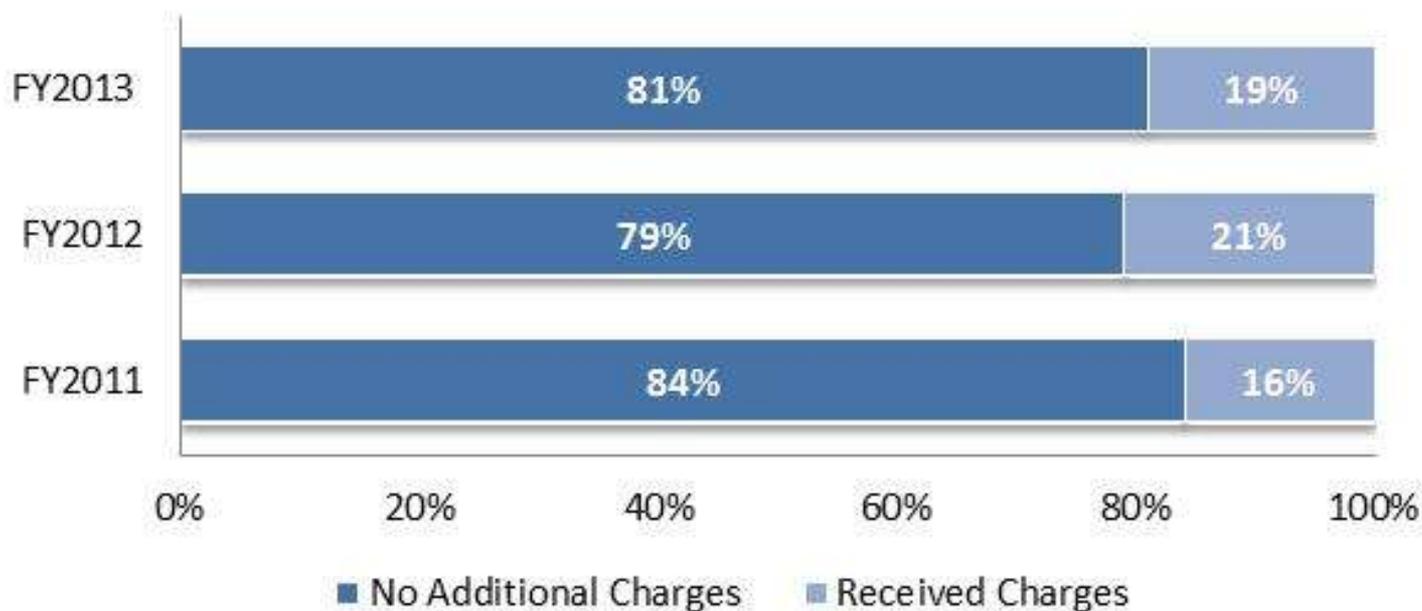


Recidivism at Twelve Months Following Closure

- ▶ Recidivism following treatment is calculated based on the number of youths picking up additional charges within one year of successful completion of treatment.

Recidivism at Twelve Months Following Closure

Recidivism Status 12 Months Post Discharge



In Summary

- ▶ After the successful completion of our program, historic success rates indicate that between 78 and 84 percent of our clients remain court free for at least 12 months following our program.
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“I think it's important for us as a society to remember that the youth within juvenile justice systems are, most of the time, youths who simply haven't had the right mentors and supporters around them – because of circumstances beyond their control.”

–Q'orianka Kilcher



Questions? Comments?

