Resource Guide for Mental Health Professionals Working with Youth Involved in the Juvenile Justice System

MODULE 5

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Module 5 MENTAL HEALTH INTERVENTIONS IN THE JUVENILE JUSTICE SYSTEM

This module and its contents are intended for educational purposes.

> "[My therapist] helped me when I got that news from court because, you know, court sucks. So after bad Harvey, hearing bad news really sucks. And it feels like that you can't. It just feels horrible. And she got me through that, and she was able to help me with what it called learned in your anger management. Basically, like, it's okay to get angry, but you can't."
>
> -Youth in Detention

The goal of this module is to describe the most commonly used evidence-based interventions for youth involved in, or at risk of involvement in, the juvenile justice system. Some of these interventions may differ from those provided in non-juvenile justice settings.

Note: Mental health interventions that are typically used in non-juvenile justice settings are not included here, as they are likely to be more familiar to mental health professionals.

Commonly Used Juvenile Justice Interventions

Evidence-based treatments (EBTs) are interventions that have achieved successful outcomes after undergoing scientific testing, typically in the form of research studies. Below are some examples of EBTs that are commonly used with youth in the juvenile justice system. For additional information about research-practice partnerships related to the implementation of interventions in the juvenile justice system, please see this APA Monitor article[1].

Missouri Youth Services Institute (MYSI)[2]

According to the Missouri Youth Services Institute, "[t]he Missouri approach to juvenile justice emphasizes moving beyond symptoms to the root causes of juvenile delinquency so that changes made by young people are long-lasting, preparing them to return and contribute positively to their school, home, and community. Our broad-based approach works with the entire family and engages the community through active community liaison councils and partners."[3]

Model Resources	
Introduction to Model	• This video provides an introduction to MYSI[4] • This MYSI Overview provides a comprehensive look at the MYSI model and it's underlying principles.
Components	MYSI is a therapeutic group treatment model for residential settings. The following are fundamental components of the model: 1. Youth reside in small, non-institutional facilities, ideally near their communities, and they remain in the same groups of 10-12 throughout their stay; 2. Youth engage in structured and predictable programming throughout the day, with an emphasis on developing skills, insight, and self-awareness; 3. Every youth has an individualized treatment team; 4. All staff are trained in the model, engage in respectful interactions with youth, and supervise youth 24/7; 5. All youth attend educational classes and teachers are part of the treatment teams; 6. Family engagement and collaboration is emphasized; 7. Each youth is assigned a case manager at intake to support them through discharge[5]
Settings	MYSI is used in detention and correctional settings.

Multisystemic Therapy (MST)[6]

MST "is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The primary goals of MST are to decrease youth criminal behavior and out-of-home placements. Critical features of **MST** include: (a) integration of empirically based treatment approaches to address a comprehensive range of risk factors across family, peer, school, and community contexts; (b) promotion of behavior change in the youth's natural environment, with the overriding goal of empowering caregivers; and (c) rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change."[7]

Model Resources	
Introduction to Model	This Introduction to Multisystemic Therapy (MST) video provides a brief overview of the model[8]
Components	In MST, a team of Master's-level therapists work intensively with youth and their families 3-5 months. At least one therapist on every team is available to the family 24 hours a day, 7 days a week. The main components of MST include: • Setting concrete rules and specific consequences for specific behaviors • Engaging parents in rule-setting, enforcing, and posting rules • Supporting and reinforcing parents for following through with consequences • Helping to reframe parent frustrations when a youth breaks a rule • Helping the family to build support systems outside of the home to increase the chances of rule-following behavior.
Settings	MST is primarily delivered in the community. Therapists work with youth and their families in the home, school and other community-based settings.
Other Resources	• MST Services: Youth & Family Intervention Resources & Training • Find a Licensed MST provider: MST Services: Our Juvenile Justice Services Community

Functional Family Therapy (FFT)[9]

According to FFT LLC, FFT "is an effective, short-term evidence-based family counseling service designed for 11-to-18-year-old youth who are at risk or have been referred for behavioral or emotional problems. FFT works with a young person's entire family and extrafamilial influences to facilitate positive growth and development. Our effectiveness stems from the idea that families are not identical—they all have a unique set of circumstances, so our treatment plans are individualized to fit the specific needs of youth and their families."[10]

Model Resources	
Introduction to Model	• The FFT LLC website provides a comprehensive overview of the FFT model, including goals, components and underlying principles. • In this video, Diane Gehart, Ph.D provides an overview of the FFT Model[11]. • This video discusses the reality of implementing an FFT program in Ireland[12].
Components	FFT includes 8-12 one-hour sessions, with up to 30 sessions for families in need of more intensive services. Treatment is typically delivered over the course of 3 months and is divided into phases. The phases include[13]: 1. Engagement 2. Motivation 3. Relational assessment 4. Behavior change 5. Generalization
Settings	FFT is delivered in outpatient settings and is also used as a home-based model.
Other Resources	Authorized FFT Sites

Multidimensional Family Therapy (MDFT)[14]

MDFT is a manualized family-based treatment and substance abuse prevention program that targets adolescent drug and behavior problems, as well as delinquency. It can be delivered in both inpatient and outpatient settings[15].

Model Resources	
Introduction to Model	• MDFT A Research-Proven, Innovative Treatment for Adolescent Substance Abuse[16]

Components	MDFT treatment is framed by 10 principles[17]: 1. Adolescent drug abuse is a multidimensional phenomenon. 2. Problem situations provide information and opportunities. 3. Change is multidetermined and multifaceted. 4. Motivation is malleable. 5. Working relationships are critical. 6. Interventions are individualized 7. Planning and flexibility are two sides of the same therapeutic coin. 8. Treatment and its multiple components are phasic. 9. Therapist responsibility is emphasized. 10. Therapist attitude and behavior are fundamental for success.
Settings	Delivered in both community and residential settings

Multidimensional Treatment Foster Care (MTFC)[18]

MTFC provides an alternative to residential placement for youth with chronic offending and other challenging behaviors. In MTFC, youth reside with a trained foster parent for a specified period of time. The intervention is delivered to youth, the foster parent and the biological parent or other discharge resource[19].

Model Resources	

Introduction to Model	• This video, Multidimensional Treatment Foster Care, provides an overview of the MTFC model[20]
	• There are three versions of MTFC:
	  ○ MTFC–P (for preschool children, ages 3 to 6)
	  ○ MTFC–C (for middle childhood, ages 7 to 11)
	  ○ MTFC–A (for adolescents, ages 12 to 17)

Components	MTFC intervention activities include: 1. Behavioral parent training and support for MTFC foster parents 2. Family therapy for biological parents (or other aftercare resources) 3. Skills training for youth 4. Supportive therapy for youth 5. School-based behavioral interventions and academic support 6. Psychiatric consultation and medication management, when needed
Settings	MTFC is multifaceted and can be delivered in multiple settings.

Mode Deactiviation Therapy (MDT)[21]

"Mode deactivation therapy provides an empirically based treatment for adolescents with behavioral problems such as anger, oppositional defiant and sexual and physical aggression (Apsche & DiMeo, 2010). It offers therapists a more efficient and timely intervention that positively affects recidivism rates; MDT is derived from Cognitive Behavior Therapy, Acceptance and Commitment Therapy, Dialectical Behavior Therapy, Functional Analytic Psychotherapy and Mindfulness and Meditation from ancient Buddhist practices."[22]

Model Resources	
Introduction to Model	This meta-analysis provides an overview of the MDT model[23]. Mode Deactivation Therapy (MDT) a case Conceptualization[24]
Components	MDT "systematically assesses and expands underlying compound core beliefs that are a product of [the] unconscious experience merging with their cognitive processing, acceptance, balance, and validation"[25]. MDT incorporates meditation, imagery, and other relaxation techniques to increase emotion regulation and facilitate cognitive processing.
Settings	Can be used in a variety of settings, including residential.

Adolescent Community Reinforcement Approach (A-CRA)[26]

"The Adolescent Community Reinforcement Approach (A-CRA) is a developmentally-appropriate behavioral treatment for youth and young adults ages 12 to 24 years old with substance use disorders. A-CRA seeks to increase the family, social, and educational/vocational reinforces to support recovery. A-CRA includes guidelines for three types of sessions: individuals alone, parents/caregivers alone, and individuals and parents/caregivers together. According to the individual's needs and self-assessment of happiness in multiple life areas, clinicians choose from a variety of A-CRA procedures that address, for example, problem-solving skills to cope with day-to-day stressors, communication skills, and active participation in positive social and recreational activities with the goal of improving life satisfaction and eliminating alcohol and substance use problems."[27]

Model Resources	
Introduction to Model	This Program Profile provides an overview of the model[28].

Components	Practicing new skills during sessions is a critical component of the skills training used in A-CRA. Each session begins with a review of the homework assignment from the previous session. Every session ends with a mutually-agreed-upon homework assignment to practice skills learned during sessions. Other components include:
	• Assessment of happiness across multiple life domains to guide individualized treatment.
	• Selection of procedures based on individual needs, including:
	  ○ Problem-solving skills for stress and challenges
	  ○ Communication skills (especially within families and peers)
	  ○ Encouraging participation in pro-social activities (e.g., recreational, school-based)
	• Skills training

Settings	Outpatient, intensive outpatient, and residential treatment settings.

Contingency Management (CM)[29]

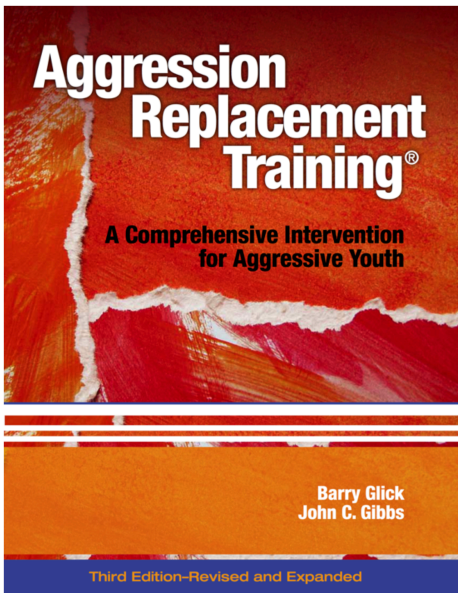
Contingency management programs are primarily used to treat substance use disorders. CM is typically delivered directly by program staff in treatment facilities, but can also be used in outpatient settings. Goals of CM include weakening the influence of substance use reinforcements while increasing reinforcements from alternative activities, with particular emphasis on activities that are incompatible with ongoing use.[30]

Model Resources	
Introduction to Model	• This video provides an overview of the CM model[31]. • The Recovery Research Institute website provides additional information on the CM model.
Components	CM is grounded in the principles of operant conditioning and includes the following components: • "(1) Identify and specifically define target therapeutic behaviors, such as drug abstinence • (2) carefully monitor the target behavior(s) objectively on a prespecified schedule • (3) deliver reinforcing or punishing events (eg, tangible rewards or incentives and loss of privileges) when the target behavior is or is not achieved."

Settings	Can be used in a variety of settings, including outpatient and residential treatment.
Other Resources	Contingency Management for the Treatment of Substance Use Disorders: Enhancing Access, Quality, and Program Integrity for an Evidence-Based Intervention[32].

Aggression Replacement Training (ART)[33]

"Aggression Replacement Training® is a cognitive-behavioral intervention that targets aggressive and violent adolescent behavior"[34]. When used in the juvenile court setting, ART can be implemented by trained court probation staff. Youth are eligible for ART if a formal assessment tool indicates a moderate to high risk for reoffending and identified challenges with aggression or prosocial functioning. ACT uses repetitive learning techniques to help youth develop skills for managing anger and utilizing alternative behaviors. Guided group discussion is also used to modify antisocial thinking that can contribute to problematic behaviors[35].

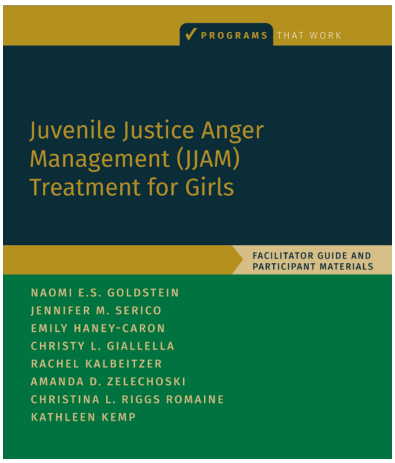


Model Resources	
Introduction to Model	See this website for an overview of the model: https://www.cebc4cw.org/program/aggression-replacement-training/
Components	ART is a 10-week, 30-hour cognitive-behavioral program administered to groups of 8 to 12 youth involved in the legal system three times per week. There are three main components, with each component specifically matched across each week and integrated for content and process. Each week builds upon the week before. Clients attend a one-hour session for each component, with the sessions occurring at the same time each week. The ART components include: 1. Social Skills Training: Teaches social skills 2. Anger Control Training: Teaches youth a variety of ways to manage their anger 3. Moral Education: Helps youth develop a higher level of moral reasoning.

Settings	Juvenile justice facilities, schools, outpatient clinics, and community-based agencies
Other Resources	Link to ART manual

Juvenile Justice Anger Management Treatment for Girls (JJAM)[36,37]

JJAM Treatment for Girls is a structured, manualized intervention aimed at helping adolescent girls and young women in juvenile justice residential facilities manage aggression and anger. The model is grounded in the developmental and gender-specific needs of the youth and the sessions incorporate real-life experiences shared by participants, allowing the content and activities to be customized to the unique needs, backgrounds, and interests of each group.



Model Resources

Introduction to Model	This Program Profile provides an overview of the model[38].
Components	JJAM is a 16-session, manualized group intervention using a cognitive-behavioral framework. Sessions are 90 minutes each and run over the course of 8 weeks. The components include: • Focuses on emotion regulation, coping, communication, cognitive restructuring, and problem-solving. • Sessions include psychoeducation, skill-building, and applying skills to real-world situations. • Sessions 1–3: Teach anger, physical vs. relational aggression, and differentiate anger from aggression. • Session 4: Introduce cognitive restructuring for reframing anger-provoking situations. • Sessions 5–6: Identify physiological cues and triggers for anger. • Sessions 7–10: Build skills for managing arousal and preventing aggression. • Sessions 11–14: Teach and practice problem-solving and communication skills. • Sessions 15–16: Practice generalizing and applying all learned skills.

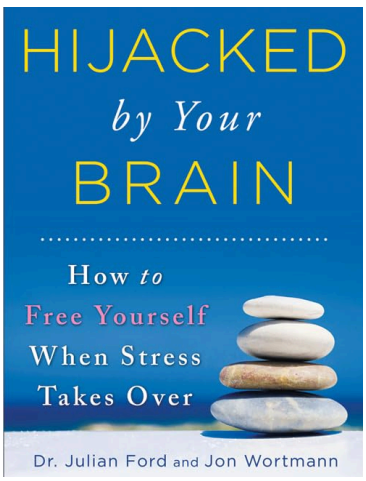
Settings	Juvenile justice residential facilities
Other Resources	The facilitator manual includes a user-friendly, session-by-session guide, along with the accompanying workbook materials for youth participants. The facilitator manual can be found here.

Trauma-Specific Interventions for Youth in the Juvenile Justice System

Below are examples of trauma-specific EBTs that are commonly used to address traumatic stress among youth in the juvenile justice system. Further information on the effectiveness of trauma specific treatments for youth in juvenile justice settings can be found in this CTRJJ Science and Services Spotlight and corresponding systematic review[39].

Trauma Affect Regulation: Guide for Education and Treatment (TARGET)[40]

TARGET is a strengths-based therapeutic intervention for the treatment of traumatic stress in youth and adults. The TARGET curriculum focuses on a set of skills to help survivors of trauma manage traumatic stress reactions and increase self-regulation. The curriculum can be delivered by mental health clinicians and front-line staff in a group or individual format. TARGET has been used with youth impacted by the juvenile justice system in a variety of settings, including community and residential treatment programs, probation, and detention.

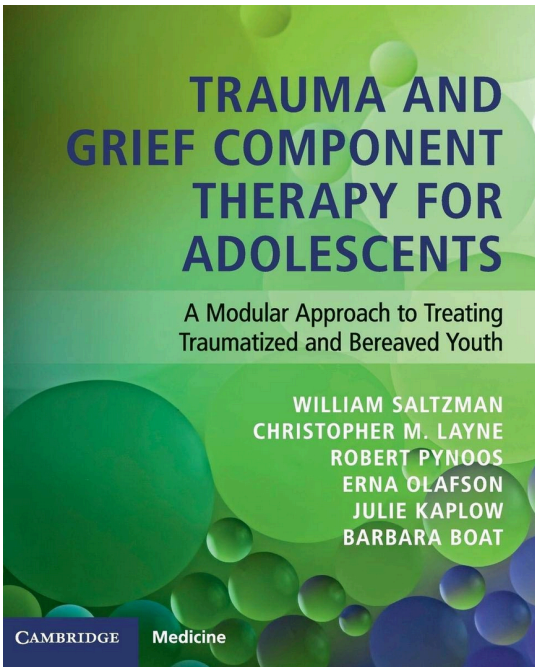


TARGET was originally developed in order to make two fundamental therapeutic mechanisms that are universal across multiple approaches to psychotherapy for PTSD and Developmental Trauma Disorder (DTD) transparent and practically accessible for clients and therapists: trauma processing and emotion regulation. TARGET's psychoeducation was designed to enable clients (and therapists) to understand and mentalize (i.e., visualize the internal workings of) the networks within the brain that are responsible for stress reactivity and emotion dysregulation in PTSD and DTD. Clients are provided with pictures and an accurate but non-technical description of how stress reactions involve an interaction of the stress/salience network (represented by the amygdala as an "alarm"), the self-referential memory encoding/retrieval network (represented by the hippocampus as a "memory filing center"), and the executive function network (represented by the prefrontal cortex as a "thinking center"), and how these neural systems are altered in PTSD and DTD and can be re-set with a seven-step sequence for emotion regulation skills that is summarized by the acronym, FREEDOM (described below).

Model Resources	
Introduction to Model	This fact sheet provides an overview of the TARGET model (National Child Traumatic Stress Network). This program profile provides additional information about the model and evidence behind it's effectiveness. TARGET adaptations include: • TARGET 1,2,3,4 (T4) • T4 for Caregivers • TARGET for Families • TARGET-based Trauma Informed Care for Staff (T-Care) • TARGET-based Trauma Informed Care for Supervisors (T-Care Plus)
Components	TARGET is a manualized intervention for youth and adults (ages 11+) that can be used as an individual or group treatment. The model is typically delivered over 10-12, 50 minute sessions. Sessions are centered around a seven-step sequence for emotion regulation skills that are summarized by the acronym FREEDOM. The FREEDOM steps include: **F**ocal point: choosing an adaptive focal point or orienting thought **R**ecognizing triggers that set off the alarm, followed by reappraisal in four domains, including **E**motional awareness **E**valuation of thoughts and beliefs **D**efining goals **O**ptions identification **M**aking a contribution The final step involves taking responsibility for using the first six skills in the sequence in order to make decisions and take actions that increase the safety of the individual and others, and that honor the individual's core values and life goals.
Settings	Schools, hospitals, community-based organizations, justice systems, outpatient clinics, and residential facilities

Other Resources	Research on TARGET as an individual, group, and family therapy intervention has been done with children and adolescents of diverse backgrounds and developmental trauma histories, including studies showing evidence of reductions in behavioral incidents and mental health problems and increased prosocial behavior when TARGET was provided to youth involved in the juvenile justice system.

Trauma and Grief Component Therapy for Adolescents (TGCTA)[41]



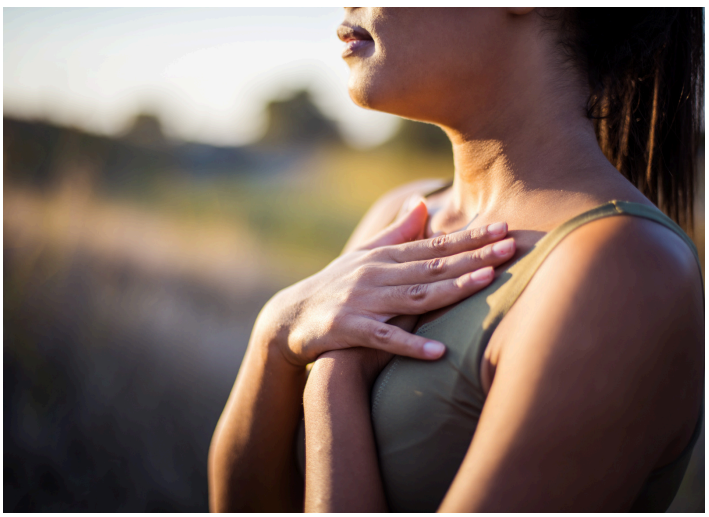
TGCTA is a therapeutic intervention that was designed for older adolescents who have been impacted by trauma, loss or traumatic loss. TGCTA focuses on the interaction between grief reactions and traumatic stress reactions. TGCTA is a modular intervention that can be customized to fit the needs of the individual youth, as well as the needs of the setting and time available for treatment. TGCTA has been shown to be effective in reducing behavioral incidents and trauma-related symptoms[42], and prolonged grief reactions[43] in youth in juvenile detention. TGCTA's modularized, flexible design allows clinicians to customize their intervention according to the specific needs, strengths, and life circumstances of specific youth and the time available.

Model Resources

Introduction to Model	The TGCTA website provides comprehensive information about the model. This fact sheet provides additional information about the TGCTA model (NCTSN).
Components	TGCTA includes four modules but the selection and sequencing of the modules are left to the clinician's discretion based upon a youth's needs, strengths, and availability for treatment. Depending upon the number of modules delivered, the treatment may be completed in 8 to 24, 50 minute sessions. The TGCTA modules and general components include:

Components	Module 1: Emotion Regulation • Build skills to identify and manage emotions • Develop coping strategies for distress Module 2: Trauma-Focused Interventions • Psychoeducation on trauma and its effects • Process traumatic events and reduce distress • Address maladaptive trauma-related beliefs (e.g., guilt, self-blame) Module 3: Grief-Focused Interventions • Differentiate normal vs. maladaptive grief • Support expression and processing of grief • Foster meaning-making and healthy connections to the deceased Module 4: Developmental Progress • Rebuild routines and peer/school involvement • Promote identity development and future planning
Settings	Schools, community clinics, and juvenile justice facilities
Other Resources	An annotated bibliography of empirical studies supporting the effectiveness of TGCTA can be found here.

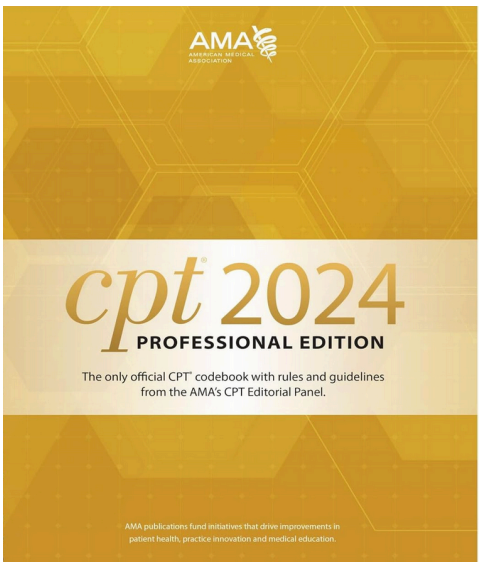
Trauma-Focused Cognitive Behavior Therapy (TF-CBT)[44]



TF-CBT is an evidence-based treatment for children aged 3-18 that focuses on providing psychoeducation about trauma, enhancing coping, relaxation, and interpersonal skills, altering problematic cognitions, processing traumatic memories, and enhancing safety. TF-CBT also includes parallel sessions for non-offending caregivers. A study with detained adolescents found that TF-CBT led to a reduction in PTSD symptoms following treatment[45].

Model Resources	
Introduction to Model	An overview of the model and certification process for therapists can be found here.
Components	TF-CBT is delivered in 8-25 individual sessions. The **PRACTICE** acronym is used to describe the model components, including: **P**sychoeducation about trauma and positive and Parenting skills **R**elaxation **A**ffective expression and modulation **C**ognitive coping and processing Trauma narration and processing **I**n vivo mastery of trauma reminders **C**onjoint child caregiver session **E**nhancing future safety and development
Settings	Outpatient, community-based organizations, group homes, schools, hospitals
Other Resources	• TF-CBT research supports its efficacy with children and adolescents from diverse cultural backgrounds, varied types and number of types of potentially traumatic experiences including abuse and family and community violence, in the United States and internationally in Europe and Africa. TF-CBT was implemented in a randomized controlled trial with 81 adjudicated youth in residential treatment facilities, with improvements found in PTSD and depression symptoms[46]. TF-CBT also has been integrated into Multidimensional Treatment Foster Care, later renamed Treatment Foster Care Oregon, in which trauma-affected girls at risk for justice involvement received TF-CBT with the active participation of specially trained therapeutic foster mothers[47]. • Use this link to find a TF-CBT certified therapist: https://tfcbt.org/therapists/

Cognitive Processing Therapy (CPT)[48]



CPT is a cognitive therapy approach that is primarily used to treat PTSD in adults, although studies have supported its use with adolescents as well[49]. In CPT, patients are taught to use cognitive restructuring skills to challenge and modify unhelpful, trauma-related beliefs. This enables patients to create a new and more balanced view of the traumatic event, thereby reducing the negative impact of the traumatic experience on daily life. "To accomplish these treatment goals, the patient first learns cognitive restructuring through Socratic questions. The goal is to help the patient begin to challenge and modify stuck points, particularly assimilated stuck points involving self-blame, shame and hindsight bias."[50]. Original versions of CPT included a narrative exposure component, but this is no longer a necessary component of the model.

Model Resources

Introduction to Model	• These treatment guidelines provide an overview of the model: https://www.apa.org/ptsd-guideline/treatments/cognitive-processing-therapy • Additional information about CPT can be found at the National Center for PTSD.
Components	CPT is delivered across a variable number of sessions. It can be delivered as an individual, group or combined treatment. Two versions of CPT are available; the original manual, which features the creation of a detailed trauma narrative, and the CPT-C which focuses on the construction of an "impact statement." The overall CPT components include: • Psychoeducation – Learn about PTSD and how thoughts influence emotions. • Impact Statement – Write about how the trauma affected beliefs about self, others, and the world • Identify "Stuck Points" – Spot unhelpful or distorted beliefs related to the trauma. • Cognitive Restructuring – Challenge and modify negative thoughts using techniques like Socratic questioning

Components	• Trauma Narrative (optional) – Write and process the trauma story to reduce avoidance and emotional distress • Address Core Themes – Explore beliefs around safety, trust, power/control, self-esteem, and intimacy. • Homework Assignments – Practice skills between sessions to reinforce learning.
Settings	Outpatient, groups, hospitals, juvenile justice facilities

Skills Training in Affect and Interpersonal Regulation for Adolescents (STAIR-A)[51]

STAIR began as an individual therapy for adults with PTSD related to childhood abuse. An adaptation for adolescents (STAIR-A) was designed as a brief group therapy, with psychoeducation on psychological trauma and emotion identification followed by modules on emotion regulation and interpersonal communication skills. When delivered in urban schools and psychiatric inpatient settings, adolescents have reported decreases in PTSD and depression and increased coping self-efficacy[52,53].

A quasi-experimental evaluation of STAIR using with groups in two locked, secure juvenile justice facilities showed evidence of decreased rates of youth violent incidents when staff were carefully trained to support youth in using the skills on a daily basis and when at least one in seven youth in the facility participated in the intervention.[54]

Model Resources	
Introduction to Model	An overview of the STAIR model can be found here.
Components	The overarching components of the STAIR model include: • Emotion Regulation • Interpersonal Skills • Cognitive Coping • Stress Management • Problem-Solving • Self-Esteem & Identity

Settings	Outpatient, schools, residential facilities, groups
Other Resources	https://istss.org/clinicians-corner-skills-training-in-affective-and-interpersonal-regulation-stair-marylene-cloitre-phd/

Trauma-Informed, Mindfulness-Based Yoga (TIMBY)[55]

TIMBY is a twice weekly, 1-hour long group-based Hatha Yoga intervention adapted for youth in juvenile detention facilities. A yoga teacher guides youths in practicing a varying series of yoga poses designed to lead to physical and mental relaxation and mindful present awareness. Security staff, teachers, case managers, and behavioral health professionals in five juvenile detention centers where TIMBY was being conducted reported increased prosocial behavior and mindfulness, and decreased PTSD-related symptoms (hyperarousal, emotional numbing), anger, impulsivity, and sleep problems among youth participating regularly in TIMBY[56].

Youth participants (N=70; >80% Black or Hispanic) reported appreciating being treated with respect and empathy by yoga instructors, and changes in their daily lives including reduced stress, anxiety, anger, and need for psychotropic medication and improved emotion regulation, mental focus at school, and sleep[57].

Model Resources	
Introduction to Model	This website provides an overview of the model: https://www.charliehealth.com/post/trauma-informed-yoga#:~:text=Trauma%2Dinformed%20yoga%20often%20incorporates,therapeutic%20benefits%20for%20trauma%20survivors.
Components	TIMBY is a twice weekly, 1-hour long group model. The components include: • Safety and Consent • Mindful Awareness • Gentle Movement • Emotional Regulation • Empowerment • Consistency • Trauma-Informed Teaching

Settings	Juvenile Justice settings, school, community-based organizations, and outpatient settings
Other Resources	This video takes participants through a trauma-informed yoga class: ww.youtube.com/watch?v=GR-5dcyFpv4[58]

Good Lives Model for Girls (GLM)[59] *

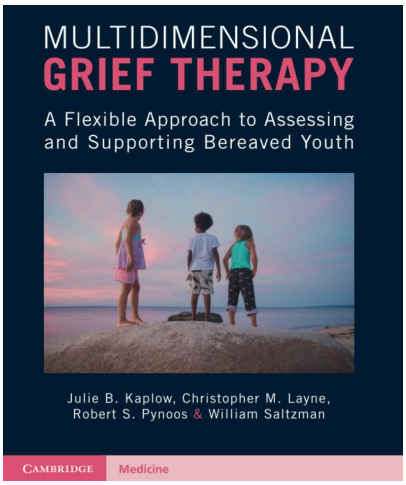
GLM is a strengths-based, person-centered framework for rehabilitation that can be implemented alongside evidence-based treatments for traumatic stress with female adolescents in the juvenile justice system. GLM includes six phases and focuses on reducing the risk for offending through empowerment and identification of primary values and goals[60,61].

GLM supports parents, teachers, and the broader community in helping girls acquire the tools required develop prosocial internal and external resources[62]. GLM focuses dual attention to females' internal values and life priorities and external factors such as resources and opportunities (see more here).

Model Resources	
Introduction to Model	The Good Lives Model website website provides an introduction to the model.
Components	Components of GLM include: • Core Goods • Personalized Goals • Skills Development • Well-being • Treatment Integration • Strengths-based • Recidivism Prevention
Settings	Juvenile justice settings
Other Resources	https://ecsa.lucyfaithfull.org/good-lives-model#:~:text=The%20GLM%20treatment%20and%20case,corrections%20and%20the%20custodial%20setting.

*The Good Lives Model is not yet considered an evidence-based practice, as more rigorous and high-quality research is needed to determine its effectiveness in reducing recidivism.

Multidimensional Grief Therapy (MGT)[63]



Multidimensional Grief Therapy (MGT)[64] is an evidence-based intervention for children and adolescents, ages 7 and up, designed to reduce unhelpful grief reactions (grief that keeps kids "stuck"), promote adaptive grief reactions (grief that helps kids to cope better after a death), and help children and adolescents who have experienced loss lead healthy, happy, productive lives.

Model Resources	
Introduction to Model	https://health.uconn.edu/trauma-recovery-juvenile-justice/resources/introduction-to-multidimensional-grief-therapy/
Components	• Grief Psychoeducation: Provide education about grief and its impact. • Emotion Identification: Help express emotions related to the loss. • Loss Narrative: Create a coherent narrative of the loss experience. • Cognitive Restructuring: Modify unhelpful thoughts about the loss. • Behavioral Activation: Encourage engaging in activities for well-being. • Caregiver Involvement: Involve caregivers in the process. • Future Planning: Support the development of future goals and hope.
Settings	Schools, community-based organizations, outpatient therapy, hospitals
Other Resources	A link to the MGT manual can be found here: https://www.amazon.com/Multidimensional-Grief-Therapy-Assessing-Supporting/dp/1107566509

Juvenile Justice Specific Initiatives

Organization	Initiative	Website/Contact
National Child Traumatic Stress Network (NCTSN)	A Trauma-Informed Guide for Working with Youth Involved in Multiple Systems	https://www.nctsn.org/resources/a-trauma-informed-guide-for-working-with-youth-involved-in-multiple-systems
	Essential Elements of a Trauma-Informed Juvenile Justice System	https://www.nctsn.org/resources/essential-elements-trauma-informed-juvenile-justice-system
National Council for Juvenile and Family Court Judges (NCJFCJ)	Trauma-Informed Courts	https://www.ncjfcj.org/child-welfare-and-juvenile-law/trauma-informed-courts/
National Center for State Courts (NCSC) and Institute for the Advancement of the American Legal System (IAALS)	Family Justice Initiative (and Court Readiness Assessment for Implementing FJI Principles)	https://www.ncsc.org/services-and-experts/areas-of-expertise/children-and-families/family-justice-initiative

References

1. Abrams, Z. (2022). The psychological science of adolescent behavior and decision-making is reshaping the juvenile justice system. APA Monitor, 53(8), 43. https://www.apa.org/monitor/2022/11/juvenile-justice-system-teens
2. Missouri Department of Mental Health and Partners (2014). Missouri Model: A developmental framework for trauma informed. https://www.traumainformedcare.chcs.org/wp-content/uploads/MO-Model-Working-Document-february-2015.pdfMissouri Model: A Developmental Framework for Trauma Informed, MO Dept. of Mental Health and Partners (2014) https://www.traumainformedcare.chcs.org/wp-content/uploads/MO-Model-Working-Document-february-2015.pdf
3. http://www.mysiconsulting.org/index.php
4. Missouri Youth Services Institute (2018). [Video]. YouTube. https://www.youtube.com/watch?v=4A8sXYGOLto (Running time: 6 mins 48 sec).
5. http://www.mysiconsulting.org/MYSI_Booklet_16p-web.pdf
6. Henggeler, S. W., Sheidow, A. J., & Lee, T. (2009). Multisystemic therapy (MST). In J. H. Bray & M. Stanton (Eds.), The Wiley-Blackwell handbook of family psychology (pp. 370–387). Wiley Blackwell. https://doi.org/10.1002/9781444310238.ch25
7. https://www.cebc4cw.org/program/multisystemic-therapy/detailed
8. MST Services (2020). [Video]. YouTube. https://www.youtube.com/watch?v=GUhcojAeC9E&list=TLPQMjgwNTIwMjDNJu5iXn6njQ&index=35 (Running time: 5 mins 51 secs).
9. Alexander, J., & Parsons, B. V. (1982). Functional family therapy. Brooks/Cole Publishing Co.
10. https://www.fftllc.com/fft
11. (2012, February 1). [Video]. https://www.youtube.com/watch?v=U7q8caTSyow&feature=youtu.be (Running time 41 mins 20 secs).
12. Prevention and Early Intervention Network (2015, April 7). [Video]. YouTube. https://youtu.be/ZRF-q59jr1w (Running time: 12 min 54 sec).
13. https://www.fftllc.com/fft
14. Liddle, H. A. (2009). Multidimensional family therapy: A science-based treatment system for adolescent drug abuse. In J. H. Bray & M. Stanton (Eds.), The Wiley-Blackwell handbook of family psychology (pp. 341–354). Wiley Blackwell. https://doi.org/10.1002/9781444310238.ch23
15. https://www.mdft.org/what-is-mdft
16. Multidimensional Family Therapy. (2017). Alexander Street Press: MDFT A Research-Proven, Innovative Treatment for Adolescent Substance Abuse. [Video]. YouTube. https://www.youtube.com/watch?v=wWSaebHdsSo (Running time: 1:24:27).
17. Liddle, H. A. (2009). Multidimensional family therapy: A science-based treatment system for adolescent drug abuse. In J. H. Bray & M. Stanton (Eds.), The Wiley-Blackwell handbook of family psychology (pp. 341–354). Wiley Blackwell. https://doi.org/10.1002/9781444310238.ch23
18. Fisher, P. A., & Gilliam, K. S. (2012). Multidimensional treatment foster care: An alternative to residential treatment for high risk children and adolescents. Intervencion Psicosocial, 21(2), 195–203. https://doi.org/10.5093/in2012a20
19. https://crimesolutions.ojp.gov/ratedprograms/multidimensional-treatment-foster-care-adolescents#1-0
20. Multidimensional Treatment Foster Care (2014, October 28). https://www.youtube.com/watch?v=oXw1F1WgoyI&feature=youtu.be (Running time:

10:48).
21. Apsche, J. A., & Ward Bailey, S. (2003). Mode deactivation therapy: A theoretical case analysis (Part I). The Behavior Analyst Today, 4(3), 342–353. https://doi-org.ezproxy.lib.uconn.edu/10.1037/h0100023
22. Apsche, J. A., Bass, C. K., & DiMeo, L. (2011). Mode deactivation therapy (MDT) comprehensive meta-analysis. International Journal of Behavioral Consultation and Therapy, 7(1), 46–53. https://doi.org/10.1037/h0100926
23. Apsche, J. A., Bass, C. K., & DiMeo, L. (2011). Mode deactivation therapy (MDT) comprehensive meta-analysis.International Journal of Behavioral Consultation and Therapy, 7(1), 46–53. https://doi.org/10.1037/h0100926
24. Apsche, J. A., Ward, S. R., & Evile, M. M. (2003). Mode deactivation therapy (MDT): Case conceptualization. The Behavior Analyst Today, 4(1), 47–58. https://doi-org.ezproxy.lib.uconn.edu/10.1037/h0100010
25. Apsche, J. A., & Ward, S. R. (2003). Mode deactivation therapy and cognitive behavioral therapy: A description of treatment results for adolescents with personality beliefs, sexual offending and aggressive behaviors.The Behavior Analyst Today, 3(4), 460–470. https://doi.org/10.1037/h0100003
26. Godley, S. H., Smith, J. E., Meyers, R. J., & Godley, M. D. (2009). Adolescent community reinforcement approach (A-CRA). In D. W. Springer & A. Rubin (Eds.), Substance abuse treatment for youth and adults: Clinician's guide to evidence-base practice (pp. 109–201). John Wiley & Sons Inc.
27. https://www.chestnut.org/ebtx/treatments-and-research/treatments/a-cra/
28. Crime Solutions (2011). Program profile: Adolescent community reinforcement approach (ACRA). National Institute of Justice. https://crimesolutions.ojp.gov/ratedprograms/adolescent-community-reinforcement-approach-cra#0-0
29. Stanger, C., & Budney, A. J. (2019). Contingency management: Using incentives to improve outcomes for adolescent substance use disorders. Pediatric Clinics of North America, 66(6), 1183-1192. https://doi.org/10.1016/j.pcl.2019.08.007
30. Stanger, C., & Budney, A. J. (2019). Contingency management: Using incentives to improve outcomes for adolescent substance use disorders. Pediatric Clinics of North America, 66(6), 1183-1192. https://doi.org/10.1016/j.pcl.2019.08.007
31. National Center on Substance Abuse and Child Welfare (2023). [Video]. YouTube. https://www.youtube.com/watch?v=ptC2XAhfZjA&t=2s (Running time 1:27:22).
32. U.S. Department of Health and Human Services (2023, November 7). https://aspe.hhs.gov/sites/default/files/documents/a0cc6fcdb2968be95f60bb1c2c94eb70/contingency-management-sub-treatment.pdf
33. Goldstein, A. P., Glick, B., & Gibbs, J. C. (1998). Aggression replacement training: A comprehensive intervention for aggressive youth. Champaign, Ill: Research Press.
34. https://www.cebc4cw.org/program/aggression-replacement-training/
35. https://nationalgangcenter.ojp.gov/spt/Programs/7
36. Goldstein, N. E., Serico, J. M., Riggs Romaine, C. L., Zelechoski, A. D.,Kalbeitzer, R., Kemp, K., & Lane, C. (2013). Development of the juvenile justice anger management treatment for girls. Cognitive and Behavioral Practice, 20,171–188.http://dx.doi.org/10.1016/j.cbpra.2012.06.003
37. Goldstein, N. E. S., Giallella, C. L., Haney-Caron, E., Peterson, L., Serico, J., Kemp, K., . . . Lochman, J. (2018). Juvenile justice anger management (JJAM) treatment for girls: Results of a randomized controlled trial. Psychological Services, 15(4), 386-397. https//doi:10.1037/ser0000184
38. Crime Solutions (2019). Program profile: Juvenile justice anger management (JJAM) treatment for girls. National Institute of Justice.

https://crimesolutions.ojp.gov/ratedprograms/juvenile-justice-anger-management-jjam-treatment-girls
39. Baetz, C. L., Branson, C. E., Weinberger, E., Rose, R. E., Petkova, E., Horwitz, S. M., & Hoagwood, K. E. (2022). The effectiveness of PTSD treatment for adolescents in the juvenile justice system: A systematic review. Psychological Trauma: Theory, Research, Practice and Policy, 14(4), 642–652. https://doi.org/10.1037/tra0001073
40. Ford, J. D. (2020). Trauma Affect Regulation: Guide for Education and Therapy (TARGET). In J. D. Ford & C. A. Courtois (Eds.), Treatment of complex traumatic stress disorders in adults (2nd Edition) (pp. 390–412). Guilford Press.
41. Saltzman, W., Layne, C. M., Pynoos, R. S., Olafson, E., Kaplow, J. B., & Boat, B. (2016). Trauma and grief component therapy for adolescents: A modular approach to treating traumatized and bereaved youth. Cambridge: Cambridge University Press.
42. Olafson, E., Boat, B. W., Putnam, K. T., Thieken, L., Marrow, M., & Putnam, F. W. (2016). Implementing trauma and grief component therapy for adolescents and think trauma for traumatized youth in secure juvenile justice settings. Journal of Interpersonal Violence, 1–21.
43. Clow, S., Olafson, E., Ford, J., Moser, M., Slivinsky, M., & Kaplow, J. (2022). Addressing grief reactions among incarcerated adolescents and young adults using trauma and grief component therapy. Psychological Trauma: Theory, Research, Practice and Policy. https://doi.org/10.1037/tra0001364
44. Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2006). Treating trauma and traumatic grief in children and adolescents. Guilford Press.
45. Calleja, N. G. (2020). Assessing and treating trauma in detained adolescents: A pre–post within subjects evaluation. Journal of Child and Family Studies, 29, 934–941. https://doi.org/10.1007/s10826-019-01564-9
46. Cohen, J. A., Mannarino, A. P., Jankowski, K., Rosenberg, S., Kodya, S., & Wolford II, G. L. (2016). A randomized implementation study of trauma-focused cognitive behavioral therapy for adjudicated teens in residential treatment facilities. Child Maltreatment, 21(2), 156–167. https://doi.org/10.1177/1077559515624775
47. Smith, D., Chamberlain, P., & Deblinger, E. (2012). Adapting multidimensional treatment foster care for the treatment of co-occurring trauma and delinquency in adolescent girls. Journal of Child and Adolescent Trauma, 5(3), 224–238.
48. Ahrens, J., & Rexford, L. (2002). Cognitive processing therapy for incarcerated adolescents with PTSD. Journal of Aggression Maltreatment and Trauma, 6(1), 201–216.
49. LoSavio, S. T., Murphy, R. A., & Resick, P. A. (2021). Treatment outcomes for adolescents versus adults receiving cognitive processing therapy for posttraumatic stress disorder during community training. Journal of Traumatic Stress, 34(4), 757–763. https://doi.org/10.1002/jts.22668
50. Galovski, T. E., Norman, S. B., & Hamblen, J. L. (n.d.). Cognitive processing therapy for PTSD. National Center for PTSD. https://www.ptsd.va.gov/professional/treat/txessentials/cpt_for_ptsd_pro.asp#:~:text=Cognitive%20Processing%20Therapy%20(CPT)%20is%20based%20on%20cognitive%20theory%20(,and%20control%20over%20their%20experiences.
51. Cloitre, M., Cohen, L. R., Ortigo, K. M., Jackson, C., & Koenen, K. C. (2020). Treating survivors of childhood abuse and interpersonal trauma: STAIR narrative therapy (2nd ed.). The Guilford Press.
52. Gudiño, O. G., Weis, J. R., Havens, J. F., Biggs, E. A., Diamond, U. N., Marr, M., Jackson, C., & Cloitre, M. (2014). Group trauma-informed treatment for adolescent psychiatric inpatients: a preliminary uncontrolled trial. Journal of traumatic stress, 27(4), 496–500. https://doi.org/10.1002/jts.21928

53. Gudino, O., Leonard, S., Stiles, A., Havens, J., & Cloitre, M. (2017). STAIR narrative therapy for adolescents. In M. A. Landolt, M. Cloitre, & U. Schnyder (Eds.), Evidence-based treatments for trauma related disorders in children and adolescents (pp. 251–271). Springer International Publishing/Springer Nature. https://doi.org/10.1007/978-3-319-46138-0_12
54. Baetz, C. L., Surko, M., Moaveni, M., McNair, F., Bart, A., Workman, S., Tedeschi, F., Havens, J., Guo, F., Quinlan, C., & Horwitz, S. M. (2019). Impact of a trauma-informed intervention for youth and staff on rates of violence in juvenile detention settings. Journal of Interpersonal Violence, 36(17-18), https://doi.org/10.1177/0886260519857163
55. Owen-Smith, A., Coldiron, J., Bradfield, H., Karim, M., Malone, J., Cotner, L., DeBar, L., Ford, J., DiClemente, R., Hayat, M., Emerson, D., Jackson, D., Black, H., Lewinger, V., Reiser, A., Elmore-Moore, I., & Coles, G. (2023, October). A trauma-informed, mindfulness-based yoga intervention with justice-involved youth: Satisfaction and perceived impact. Paper presented at the International Association of Yoga Therapists Symposium on Yoga Research, Stockbridge, MA.
56. Owen-Smith, A., Coldiron, J., Bradfield, H., Karim, M., DeBar, L., Ford, J., DiClemente, R., Hayat, M., Emerson, D., Jackson, D., Black, H., Reiser, A., Moore, I., Tchakarov, V., & Lewinger, V. (2022, November). Understanding Department of Juvenile Justice stakeholders' attitudes towards a yoga intervention for justice-involved youth with a history of trauma. Paper presented at the American Public Health Association Annual Meeting, Boston, MA.
57. Owen-Smith, A., Coldiron, J., Bradfield, H., Karim, M., Malone, J., Cotner, L., DeBar, L., Ford, J., DiClemente, R., Hayat, M., Emerson, D., Jackson, D., Black, H., Lewinger, V., Reiser, A., Elmore-Moore, I., & Coles, G. (2023, October). A trauma-informed, mindfulness-based yoga intervention with justice-involved youth: Satisfaction and perceived impact. Paper presented at the International Association of Yoga Therapists Symposium on Yoga Research, Stockbridge, MA.
58. Uiri, H. (2021). Trauma Informed Yoga. [Video]. YouTube. https://www.youtube.com/watch?v=GR-5dcyFpv4 (Running time: 17:19).
59. Willis, G. M., Ward, T., & Levenson, J. S. (2014). The good lives model (GLM): An evaluation of GLM operationalization in North American treatment programs. Sex Abuse, 26(1), 58-81. https://doi.org/10.1177/1079063213478202
60. Van Damme, L., Fortune, C., Vandevelde, S., & Vanderplasschen, W. (2017). The Good lives model among detained female adolescents. Aggression and Violent Behavior, 37, 179-189. https://doi.org/10.1016/j.avb.2017.10.002
61. Van Damme, L., Fortune, C., Hoeve, M., Vanderplasschen, W., & Colins, O.F. (2021). The role of personal resilience and interpersonal support in building fulfilling and prosocial lives: Examining the good lives model among young women four years after youth detention, International Journal of Offender Therapy and Comparative Criminology, 1–22. https://doi.org/10.1177/0306624X21994055.
62. Ward, T., & Stewart, C. A. (2003). The treatment of sex offenders: Risk management and good lives. Professional Psychology: Research and Practice, 34(4), 353–360. https://doi.org/10.1037/0735-7028.34.4.353.
63. Kaplow, J.B., Layne, C.M., Pynoos, R.S., & Saltzman, W. (2023). Multidimensional grief therapy: A flexible approach to assessing and supporting bereaved youth. Cambridge University Press.
64. Kaplow, J.B., Layne, C.M., Pynoos, R.S., & Saltzman, W. (2023). Multidimensional grief therapy: A flexible approach to assessing and supporting bereaved youth. Cambridge University Press.