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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON JUVENILE JUSTICE
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B E F O R E: FERNANDO CABRERA
Chairperson

COUNCIL MEMBERS: Inez D. Barron
Rory I. Lancman
Barry S. Grodenchik
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A P P E A R A N C E S (CONTINUED)

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Division of Youth and Family Justice, DYFJ

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[sound check, pause]

CHAIRPERSON CABRERA: [gavel] Good afternoon. I am Council Member Fernando Cabrera, and I am the Chair of the Juvenile Justice Committee. During today's oversight hearing we'll be hearing trauma-informed services in the City's Juvenile Justice system. I want to thank you all who are here today to discuss this important topic concerning our city's court involved youth. As we all know, children have a tendency to deviate from their character and at times make irrational judgments resulting in their exposure to the city's Juvenile Justice System. I believe we need to offer this population the opportunity to get back on track, and not recidivate back into the system. This starts with properly identifying special needs of court involved youth as it relates to particular types of trauma they may have experienced. I cannot overstate the importance of ensuring that our youth get their best possible treatment when they fall into the hands of the Juvenile Justice system. Certainly and more so we have the responsibility to secure the needs of our youth, and give them provisions of appropriate trauma services. Today, we look forward to finding

out in greater detail about the trauma-informed care that DYFJ is providing to young people detained and placed in its custody. Additionally, we are interested reviewing and understanding DYFJ's various approaches to trauma-informed care including partnering with contracted providers to screen all youth for trauma exposure, post-traumatic syndromes, depression and substance abuse at intake, as well as requiring youth to participate in skill building groups where they can develop knowledge of trauma and become more aware of how it may impact their emotions and behavior. We are all interested in how DYFJ's application of trauma-informed programs increase positive outcomes for youth in the Juvenile Justice System. It is through this holistic approach that we will assist court involved youth to be contributors to society, and help steer them away from the justice system. Inclusion, I want to thank my staff for helping put this hearing together, and thanks to all the Council Members attending this hearing, including Council Member Perkins. We look forward to hearing testimony from representatives of DYFJ as well as advocates and non-profits that have signed up to testify. I will currently ask for the representatives

of the Administration to please state their names and for the record so that they committee counsel can administer the oath, and let me acknowledge that Council Member Barron has joined us as well.

LEGAL COUNSEL: Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this committee, and to respond honestly to Council Member questions?

DEPUTY COMMISSIONER FRANCO: Yes.

ASSOCIATE COMMISSIONER BARRIOS: Yes.

ASSOCIATE COMMISSIONER HEMMETER: Yes.

DEPUTY COMMISSIONER FRANCO: Good afternoon, Chair Cabrera and members of the Committee on Juvenile Justice. I'm Felipe Franco, Deputy Commissioner for the Division of Youth and Family Justice, DYFJ within the Administration for Children's Services, ACS. With me today are Charles Barrios, Associate Commissioner for Juvenile Justice Programs and Services, and Sarah Hemmeter, Associate Commissioner for Community Based Alternatives. Thank you for the opportunity to testify this morning-I mean this afternoon. We look forward to discussion with you the trauma-informed services and support that the Division of Youth and Family Justice

provides for youth and families throughout the Juvenile Justice continuum. ACS has an agency wide focus on trauma responsive care. In partnership with the agency, many community based providers and not-for-profit partners, ACS serves hundreds of thousands of children and families each year through our agency's Child Welfare and Early Care and Education and Juvenile Justice Programs. Many of our city families are facing immense challenges: Poverty, inequity, isolation and trauma, and that's why the Commissioner Hansell has made it an agency wide priority to provide trauma responsive services and support in every facet of our industry's work. In the Division of Youth and Family Justice, we strive to improve the lives of children and both in Juvenile Justice while advancing public safety by providing supportive services that promote the rehabilitation and are responsive to the needs of individual youth and families. We have made tremendous strides in expanding our continuing community based services for youth and families improving the provision of mental health services, and cultivating positive youth development programs.

Preventive Services: First and foremost, we aim to divert youth from the Juvenile Justice system whenever possible. ACS Family Assessment Program known to us as FAP, is available to all families and supports parents and guardians who are struggling to address difficult teenage behaviors. FAP offers intense in-home therapeutic services that are designed to improve family functioning and avoid involving in Persons In Need of Supervision System, PINS. ACS also runs the Juvenile Justice Initiative, JJI, which have been adjudicated juvenile delinquents in Family Court, and provides intensive services to these youth to keep them in their communities with their families. Both FAP and JJI have parents develop skills and support their children, enforce limits, steer them toward positive activities.

I want to talk to you guys today about the Crossover Youth Practice Model. As I—as I have discussed previously, the vast majority of young people in the Juvenile Justice System as high as 90% regardless of gender have experienced some sort of trauma. We know that there is a close relation—correlation between childhood treatment and official delinquency. So, we have partnered with multiple

stakeholders to support children who have experienced abuse, neglect with the goal of preventing their entry into the Juvenile Justice System. In addition to expanding and strengthening alternative to justice involved youth and continuing to reduce the number of young people entering foster care, ACS is committed to investing in work. The focus is specifically on duly (sic) involved youth such as the Crossover Youth Practice Model, which was developed by the Center for Juvenile Justice Reform and Georgetown University. The term Crossover Youth describes a young person who enters the Justice system while involved in the Child Welfare System. These young people essentially cross over from the Child Welfare system into the Juvenile Justice system. The Crossover Youth practice Model, CYPM, is a multi-agency effort across-system approach that seeks to improve outcomes for young people who are involved in both systems. The model allows for a number of city agencies working with the youth to share information, collaborating—collaborate on solutions, and involve the youth and their family in order to prevent further involvement in either system. While youth crime in New York City has declined and the number of youth remanded to

detention has decreased substantially over the last four years, the youth workplace and detention are often among the highest needs youth in the city, and present extremely challenging behaviors. Our work in detention is focused on helping youth reserve, develop those skills to control and manage their emotions and behavior. ACS contracts with the Bellevue Hospital Center, and NYU Langone Medical Center to provide psychiatric and psychological services. Each secure detention site has a full-time psychiatrist and psychologist who are available to all youth, including those in non-secure detention. Youth are systematically screened with developed instruments for trauma exposure, depression, and problematic substance use. For youth who need more support, Bellevue Psychology and psychiatrist staff are available to provide diagnostic evaluations, psychiatric assessments, intensive psychotherapeutic interventions, and medication management if necessary. Our partnership with Bellevue and NYU has allowed ACS to recommend trauma informed screening and care for youth in secure and non-secure detention facilities. In 2012, Bellevue in partnership with ACS was awarded a four-year grant from the Substance

Abuse and Mental Health Services Administration, SAMSA. As part of this national dramatic stress initiative to infuse trauma-informed care in to secure and non-secure detention in New York City making us one of the first secure detention systems in the country to implement trauma-informed practices and training. Bellevue and NYU has trained all secure detention staff in dealing with the various types of trauma that that impact the youth in our care, which increases the staff's ability to identify traumatic exposure and work with traumatized youth and reduce secondary trauma issues among the staff. In 2016, Bellevue and YU were awarded a second five-year grant from Chancellor to expand this foundational work in detention through the allocation of TARGET, Trauma Affect Regulation Guide for Education and Treatment. TARGET is a comprehensive trauma intervention specifically assigned for the youth in Juvenile Justice settings, and—and it includes evidence-based trauma—trauma training for front-end staff and skills development for groups for residents. This effort is designed to increase staff understanding of trauma, and its impact on youth and staff, Youth Institution on Violence and increase

youth and staff members sense of safety. Addressing the staff's stress and safety are a priority for ACS, and integrity creating a trauma-informed system. The Division of Youth and Family Justice also partners—partners with START Treatment and Recovery Center to provide general mental health services. START staff at our facilities with licensed mental health providers includes social workers, mental healthy counselors and Certified Alcohol and Substance Abuse Counselors CASAC to conduct screening intake interviews, treatment planning, socialization (sic) in groups, and supported individual group and family counseling, including cognitive—cognitive behavioral therapy.

In Close to Home, our Close to Home non-secure and limited secure placement residences are located in 29 sites throughout the city and in Dobbs Ferry, and are owned by seven not-for-profit provider agencies. Close to Home is grounded within a shadow of a framework and all of our providers are deeply experienced in serving complex needs of our youth. Each program employs an evidence-based basic model that serves as the primary mechanism for behavioral—behavioral support. This includes the Integrated

Treatment Model, the Missouri—the Missouri Model Sanctuary or Positive behavior Interventions, known as PBIS. Additionally, Division of Youth and Family Justice requires that all youth in Close to Home have access to individual services provided by licensed mental health professionals. So, our NSB, Non-Secure Placement and our LSB, the Limited Secure Placement Programs, is staffed a clinical theme that provides mental health screening, comprehensive assessments and treatment as needed. Trauma related interventions are part of the Clinical Continuum for youth in placement. In addition, our programs are required to have an established relationship with a Board certified psychiatrist who can assess the need for psychotropic medication help and refer them. As we discovered in the community in October, most of the people in Close to Home return to their home communities on aftercare where youth and their families receive individually returning aftercare resources for the remainder of their placement period. ACS is currently working to implement a Risk and Responsibility framework, R&R that will drive case planning to ensure that services are based on the youth assessed needs, and youth receive the newly

designed (sic) services that target the behaviors that are likely to result in subsequent criminal activity. Thanks for the opportunity to discuss Trauma-Informed Services for justice involved youth and their families. We are proud of the work that we have done to connect youth, young people and their families with evidence-based, evidence informed and Trauma-Informed interventions provided by licensed and experience treatment providers through our Juvenile Justice Continuum. The assessment practices to better identify the needs of young people involved in our system create a more informed treatment and placement option for our young—young people with complex emotional and behavioral issues, and ensure the consistent quality services is maintained over time. We know that there is still more work to be done, and we're happy to partner with the City Council, our staff and others in our continuing efforts to improve the Juvenile Justice System, and services for the city, youth and families. We're happy to take your questions now.

CHAIRPERSON CABRERA: Thank you so much, Commissioner and thank you for all the work that you do. In the—in the last four years of the

collaboration we've been able to work together, and literally I—I could truly say that you—you alongside with the work that you're doing and—and the advocates and all the organizations that are involved in the detention center and Close to Home has done a fabulous job. I have a few questions before I—I turn it over my colleagues for some questions. I was curious to know what metrics the youths are to make sure the level of effectiveness, and the trauma-informed therapy.

DEPUTY COMMISSIONER FRANCO: Sure. Let me begin and go see if the others can help me out. So, I mean one of the things that I'm—is primarily importantly when you're trying to develop a system that is trauma responsive is actually to ensure that you can capture or ascertain trauma or PTSD as you mentioned earlier in the opening. One of those things that actually we have done in New York City because we—we've been working in detention where every young person goes first. We actually are able to ensure that 100% of all the kids that come through the Juvenile Justice System in detention are actually getting the right screenings so their needs can be identified. Once that happens because we're now

working with—in close collaboration with NYU Bellevue—and Bellevue we can actually drive a treatment plan that could be either implanted at detention while the kid is in detention or we'll follow the young person when he moves into placement if that so happens.

CHAIRPERSON CABRERA: But how—how do we know it's working?

DEPUTY COMMISSIONER FRANCO: You know, the—our—our—our main focus right now is to ensure that young people are getting the services that they need based on the right diagnosis. I think that ultimately, the right information that we are building in are actually about helping young people develop new coping mechanisms. So, at the end of the day, we expect to see and be able to manage conflict differently. Were able to develop their own competency skills to be able to develop coping mechanisms that in the past when they would have actually gotten into a fight or reacted explosively, now they're able to step back, stop, think, and do things differently. So, the ultimate goal at the end of the day for our young people in the Juvenile Justice System and Program to be able to use more

pro-social basic reading with conference, and the emotional sum behavior.

CHAIRPERSON CABRERA: So, so for example, if you have—if you are identify—it's one of the young person struggling with clinical depression--

DEPUTY COMMISSIONER FRANCO: Uh-hm.

CHAIRPERSON CABRERA: --and I'm sure you're this scale--

DEPUTY COMMISSIONER FRANCO: Uh-hm.

CHAIRPERSON CABRERA: --to determine, you know, the level of depression--

DEPUTY COMMISSIONER FRANCO: Uh-hm.

CHAIRPERSON CABRERA: --that he's going to take. So you go ahead later on assess the young person--

DEPUTY COMMISSIONER FRANCO: [interposing] Right.

CHAIRPERSON CABRERA: --again to see where he is in the scale, and then to really keep a track record of, for example, categories--

DEPUTY COMMISSIONER FRANCO: Yes.

CHAIRPERSON CABRERA: --kids are going through clinical depression, and such interviews and so forth and so forth?

DEPUTY COMMISSIONER FRANCO: Yeah. I mean I think we—we do—sometimes do a pre and opposed approach where we do the mission and twice. Audibly it was the most important for our clinical staff is to make sure the—in the case of depression is this person stayed at the level of activity, are they more engaged in school? Are they more engaged in the preventive as compared to all the work doing before? So, it's actually done through a couple of ways. Through measurements, as you mentioned, but more importantly observations of the behavior and the youth interaction with others.

CHAIRPERSON CABRERA: I mean I'm—I know for the culture of the detention center and Close to Home, that what you just mentioned matters greatly, but I think also the vary—the variance for me that was used to assess if there was a problem in the accounting to be reliable, that we—we should use again to be able to assess is—is-is the therapeutic approach, and sometimes the problem is not the model. Sometimes the people who are using the model are they really using the model the way it's supposed to be use? And how do we assess that? How do—how do we know that we are literally implementing that. And

along side with that question, I wanted to ask you since you got the grant twice through Santa, does Santa require you to report data and what kind of data are you reporting, if could and if you could share what that data is showing.

DEPUTY COMMISSIONER FRANCO: I—I see the principal investigator in the room, Dr. Surko from NYU Langone. I believe he's going to testify about the research that's actually being conducted on both grants.

CHAIRPERSON CABRERA: Okay, so we'll leave that for later.

DEPUTY COMMISSIONER FRANCO: [interposing] I think he will be much better in answering those questions.

CHAIRPERSON CABRERA: Okay, great. Did you wanted to add? I know you—you say you were going to add something to it?

ASSOCIATE COMMISSIONER BARRIOS: Well, just—just quickly. So, just to be clear, all the kids that are in detention are systematically screened through the use of two separate tools. So one measure is trauma exposure. The other one measures exposure—depression levels, and the third is

problematic substances, and then all that information is obtained and collected within the detention facility and shared between the Bellevue staff, the Star Staff as well as our staff, and then interventions are developed or designed specific to how kids fare on those different screens, and then the plans are developed and those recommendations are shared when the kids move onto placement, and the screens just to be clear, for example the Trauma Exposure Screen is initially implemented by Family Court Mental Health Services prior to a kid being adjudicated. Then, while they're in detention the screen is re-administered and if they move into placement depending on how much time they spent in detention, it's free administered again. So, to your question, there are different points at which you can re-administered this screen, and the provider agencies are required to do their own assessment as well.

CHAIRPERSON CABRERA: So, later on we'll hear the pre-imposed with how we're doing with that? Is that what you're saying? I just want to make sure that I get data. I'm big on data--

ASSOCIATE COMMISSIONER BARRIOS: Uh-hm.

CHAIRPERSON CABRERA: --and interpreting data.

DEPUTY COMMISSIONER FRANCO: I—I think we've made a question on it, Council Member Cabrera. I mean you want to see the difference in between the score from the PTSD throughout the continuum. We don't have the data now, but we will look into it.

CHAIRPERSON CABRERA: Okay. So, but there's—there is—there's a plan in place to collect the data, and to interpret the data.

DEPUTY COMMISSIONER FRANCO: Yeah, and I mean in the deeper level the screens are used as part of the treatment plan. So, you know, the clinicians and the team are actually consistently reviewing how the youth is progressing and, you know, if we have to—to revamp an intervention we do so.

CHAIRPERSON CABRERA: Yeah. It just has been my experience that a lot of times treatment takes place and it's a one-to-one basis, and then sometimes there's not an overall system place to measure how we're doing, are we being effective because you could try a treatment. It doesn't mean that it's working.

DEPUTY COMMISSIONER FRANCO: Yes.

CHAIRPERSON CABRERA: And—and then to look at. You know, how we could get better based on that treatment. I notice that there—there is a different model that you use with—in the Detention Center than you do Close to Home. Is there a particular reason why you--?

DEPUTY COMMISSIONER FRANCO: I mean I think in—when talking to Detention about the use of targets, which again is a new intervention that again our partners from Bellevue are going to talk in length about is particularly addressing new issues of trauma—trauma in youth in that—in that population. It's actually a short-term intervention. I think it's actually less than ten sessions. I may not— Yeah, I got it right. It's about ten sessions. In Close to Home we have young people for a longer amount of time. So, some of the other group interventions that we use like the Missouri Model or actually IPM, actually were designed for working with young people for five, six, seven months that we have in Close to Home.

CHAIRPERSON CABRERA: And do they—do they have components of target?

DEPUTY COMMISSIONER FRANCO: Yeah, with those in—in a way you're want to look a little about the work that is done through YPM. It's very similar to the skill building that we do in TARGET. But again, TARGET was developed for short-term stay settings. Young people are learning the skills in a shorter amount of time. IPM actually has a family component because you have more time with the kid, but again I think at the end of the day, many of these interventions that we are learning about as we get a better understanding trauma and its impact, are about mindfulness, about helping young people develop coping mechanisms, or helping them how to understand how their think and perceive reality in a way that keeps them out of trouble.

CHAIRPERSON CABRERA: Let me just share we've been joined by Council Member Barry Grodenchik. One last question before I turn it over to my colleagues. I know they had a question. You mentioned the R—N-R model. Can you be a little bit more specific as to what involves that model?

DEPUTY COMMISSIONER FRANCO: Yeah, you know, we—we have are investing a significant amount of time working in collaboration with our partners at

the Department of Probation and, you know, we are proud to have alignment between both agencies and New York City Juvenile Justice System now where we think about youth, criminogenic needs where we think about their likelihood of getting into trouble from different work, which is risk need with positivity, to make it very, very simple. You know, we—we have assessments and how we can actually make sure domains are wide so they can prepare actually were relying to someone (sic) before. It could be negative peer networks. It could be lack of leisure time. It could be the way they think about reality, and you use those assessment to drive treatment planning and helping young people do better.

CHAIRPERSON CABRERA: Great. Let me turn it over now to Council Member Perkins followed by Council Member Barron.

COUNCIL MEMBER PERKINS: Thank you very much. I have—what—do you have demographics on the young people that you are dealing with?

DEPUTY COMMISSIONER FRANCO: We do.

COUNCIL MEMBER PERKINS: You do. Can you give us a—sort of a breakdown--

DEPUTY COMMISSIONER FRANCO: [interposing] Yeah, and I think what--

COUNCIL MEMBER PERKINS: --geographically where is the section, you know--

DEPUTY COMMISSIONER FRANCO: Yeah, I mean I think one—one thing to keep in mind is that actually I think I mentioned the—in the testimony the number of young people in the Juvenile Justice System continues to go down. As that has happened, there's two things, the big picture that I could tell you. I mean the majority of young people in the Juvenile Justice System are—are boys, are men. The majority of them are actually boys of color. They're black and Hispanic boys. There's a—about ten percent of them that are girls, and again they actually are represented Black and Hispanic girls. They come from poor neighborhoods in New York City.

COUNCIL MEMBER PERKINS: And did you have any idea why these numbers are so dominant in terms of children of color?

DEPUTY COMMISSIONER FRANCO: I mean, your guess reflected earlier on in terms of, you know, kids will drop out of school. Kids were actually struggling in other ways. Juvenile numbers of

arrests actually drew the by second neighborhoods more than others, and I think that's—would reflect that we--

COUNCIL MEMBER PERKINS: Those are the facts, but—but I'm trying to get behind the facts. There's no question that there's a disproportionate number of these young people in comparison to others that are in—in contact with the Justice systems that have these kinds of problems.

DEPUTY COMMISSIONER FRANCO: Uh-hm.

COUNCIL MEMBER PERKINS: But how do you account for that from the perspective of youthful person?

DEPUTY COMMISSIONER FRANCO: Yeah. I mean many way of thinking--

COUNCIL MEMBER PERKINS: [interposing] What's going on wrong in our city, in our communities?

DEPUTY COMMISSIONER FRANCO: Yeah, maybe—maybe a way of thinking about it that will be useful for me is when I think about when it goes away. I mean, so--

COUNCIL MEMBER PERKINS: When it goes wild?

DEPUTY COMMISSIONER FRANCO: Well, when—when it—when it goes away. So, I mean we--

COUNCIL MEMBER PERKINS: [interposing] Well, what way?

DEPUTY COMMISSIONER FRANCO: So, when we—when we encounter young people and families and struggling in, you know, in the Family Assessment Program, we are able to connect them to right support, you know, through evidence-based programs and home, where we're able to connect those young people to the right mentors, to the right prosocial activities. Most of those young people are treated and they go around. So, a lot of our work and a lot of our effort I mean is to help young people to develop the skills to continue their emotions and behavior, but more importantly is to connect them to prosocial activities of young—of all the people who can influence them positively.

COUNCIL MEMBER PERKINS: So, so, these right supports and the lady mentors and attendees that resulted in—in some measures of success.

DEPUTY COMMISSIONER FRANCO: Uh-hm.

COUNCIL MEMBER PERKINS: How do we—do you have report that reveals how—what is—what is being

done with the right supports, mentors, activities that's making the difference?

DEPUTY COMMISSIONER FRANCO: Yes, we have a—we have some data that actually shows them when young people are connected to the right sets of supports, they do better.

COUNCIL MEMBER PERKINS: Can you—can we get that data?

DEPUTY COMMISSIONER FRANCO: Yeah.

COUNCIL MEMBER PERKINS: Can we see that data?

DEPUTY COMMISSIONER FRANCO: I mean files that it will be particular to New York City. Some of it will be national data, but yes, we—we—we—we—I think we—we're getting better in the field to understand them when we put the right pieces in place. The have to put the pieces in place. (sic)

COUNCIL MEMBER PERKINS: [interposing] I'm trying to—I guess your—the idea is to prevent all this from happening, and how does that data would help us prevent that which you're--?

DEPUTY COMMISSIONER FRANCO: [interposing] Yeah.

COUNCIL MEMBER PERKINS: --you understand?

DEPUTY COMMISSIONER FRANCO: Yeah, yeah, no, I think actually you're—you're getting to one of the things that we talked a lot about recently. I mean so, we work more closely with the Department of Probation for example, and we understand those issues of risk needs, risk conservatively, and we look at the—the kids who actually finish up in the deep end of the system Close to Home, and we see patterns of many of them are in Close to Home because they have negative influences. They have a lack of structured leisure time. We're actually leaning to design our preventive programs so there are those issues. So, when we—you think about some of the work that we have done recently with support of the City Council like Cure Violence, it's about taking what could be a negative, you know, hanging around with a group of peers that could be doing something wrong, which happens to many of our kids, how we turned that on its head, and got a group of young people hanging around to make a difference in their community.

COUNCIL MEMBER PERKINS: So, cure violence is an initiative that's making a change?

DEPUTY COMMISSIONER FRANCO: It's making a difference yes.

COUNCIL MEMBER PERKINS: Do have reports or studies that reflect that? I don't—I don't—

ASSOCIATE COMMISSIONER BARRIOS: [off mic] Yeah, we do. [on mic] We do, we can share that with you.

COUNCIL MEMBER PERKINS: Yeah, please. Uh-hm, thank you very much. So, that—would you—is that what you would consider the metric accessor used to Cure Violence metrics?

DEPUTY COMMISSIONER FRANCO: No, Cure Violence is one of the interventions that we see as promising that it's working.

COUNCIL MEMBER PERKINS: Okay, so one, you said you—you have certain metrics or matrix that you use. Could you sort of explain that a little bit? I'm not too sure.

DEPUTY COMMISSIONER FRANCO: Yeah, in—I—I think, you know, I think your question was it was, you know, it derived one. I mean we know what gets a kid in deep into the Juvenile Justice System. How could we be building the preventive programs to prevent them—to prevent all of the kids from getting

into the system? And I gave you an example around one of the things that we have seen in the case where it's deep into the Juvenile Justice System may finish up deep into the Juvenile Justice System because of their peer—negative peer networks. So, Cure Violence is a good example of how you create a peer network in a positive way. There's other factors that would identify for getting kids deep into the Juvenile Justice System like substance abuse, lack of educational connection. So, all of those factors when addressed earlier on could help young people not having to finish up, you know, some of the Juvenile Justice System.

COUNCIL MEMBER PERKINS: And you—and-and again the—the demographics of the kids?

DEPUTY COMMISSIONER FRANCO: We—we—we could provide you site—site demographics by race, gender, age.

COUNCIL MEMBER PERKINS: Off hand you can ensure or have an idea?

DEPUTY COMMISSIONER FRANCO: Yeah, and I think as I mentioned before the majority of kids that we serve in the Juvenile Justice System in New York City are Black and Latino kids. Most of them are

boys. Maybe I can even get you more specific. So two-thirds of them are Black, one-third of them are Hispanics. [pause] Yeah, I mean that's—that's what we serve and most of them come from, you know, poor struggling neighborhoods.

COUNCIL MEMBER PERKINS: So, happens with the poor White kids? How do they manage to stay—stay off this at least from my neighborhood? [background comments, pause]

DEPUTY COMMISSIONER FRANCO: Yeah, we don't—we don't—we don't have that many then. I mean we do—we have—we don't get them into the system. I asked--

COUNCIL MEMBER PERKINS: [interposing] What's—what's--

DEPUTY COMMISSIONER FRANCO: [interposing] I aske you--

COUNCIL MEMBER PERKINS: [interposing] What's going right for them?

DEPUTY COMMISSIONER FRANCO: Yeah, I asked Young. There is actually maybe durations in their neighborhoods that are actually capturing them sooner. I mean we were growing. That's not available. They are different.

COUNCIL MEMBER PERKINS: So, have you looked at those interventions that are working for them as maybe as a model that could work for others?

DEPUTY COMMISSIONER FRANCO: We should.

COUNCIL MEMBER PERKINS: Yeah. You should

DEPUTY COMMISSIONER FRANCO: See there.

COUNCIL MEMBER PERKINS: Okay. Thank you, sir.

DEPUTY COMMISSIONER FRANCO: Thank you.

CHAIRPERSON CABRERA: Okay.

COUNCIL MEMBER BARRON: Thank you, Mr. Chair and thank you to the panel. I just have a few questions. So the, there are non-secure placements and there are secure placements and there are limited secure placements, right?

DEPUTY COMMISSIONER FRANCO: Well, it depends on if you're talking about detention we only have two categories. The detention, which is pre-adjudication is when the young person is our custody waiting for finalization of their trier. They have secure detention. There's two of those facilities, and then we have non-secure detention.

COUNCIL MEMBER BARRON: Those are the Horizons and the Crossroads?

DEPUTY COMMISSIONER FRANCO: Exactly. Those are the secure facilities.

COUNCIL MEMBER BARRON: Yes, the Chair had us take a visit, and we were able to visit those facilities, and it's very interesting that these are children who have a range of cases or charges that have been placed on them, and the ability to yeah and still provide them with the opportunity to have classes and to have other kinds of counseling services. Do you find that there are more opportunities or should we create more opportunities for these children who are detained to have interactions with family members who might be a positive influence on them? Because it was very limited in terms of the number of contacts that they would have with their families as I recall.

DEPUTY COMMISSIONER FRANCO: Yeah, I mean any—any interaction with family is essential and important. I mean we know that at the end of the day, we have them for a short amount of time, and there's going to be how supportive we are helping parents that's going to make a difference in the lives of these young people. We have done a lot of work to expand, you know, a few things like in

particular who can visit kids, when they can visit them. So, there's actually visiting. There is most every day of the week, and on the weekends. In particular in the last four years we have gone out of our way to ensure that is not just parents who can come in, but siblings and extended family, and—and we are proud of doing that, and we want to do as much as we can. We also know that visiting is just one aspect of the family engagement work. So, we are doing more around events and activities so that, you know, families consider kids and their accomplishments and their art and their music. And I think we're going to—you're going to hear more about the work that we're doing around engaging families through trauma-informed practice. But we also know that we want—many of these parents have gone through similar situations with all of their kids, and we want to provide more of the family's support that they need.

COUNCIL MEMBER BARRON: How long do the children normally stay in the secure facility?

DEPUTY COMMISSIONER FRANCO: So, it is--

COUNCIL MEMBER BARRON: [interposing] You said it's pre-adjudication. So, how long is that period of time?

DEPUTY COMMISSIONER FRANCO: Yeah, I mean it's—I think average is not the best word to describe it. In my mind, I tend to thank about juvenile delinquents it's a group of them that actually spend with us a very short amount of time, you know, less than five days. They usually come in. Their case—their case gets disposed in court. They may get connected to probation or around ATV, and that—that's about 30% of kids. There's another cohort of kids that actually are the ones who have cases that go on a little longer 27 to 30 days, and many of those young people get placed in Close to Home, and then we have a group--

COUNCIL MEMBER BARRON: [interposing] What percentage is from 25 to 30, 27 to 30 days? Do you have an idea?

DEPUTY COMMISSIONER FRANCO: Yeah, I could get you the numbers.

COUNCIL MEMBER BARRON: Okay.

DEPUTY COMMISSIONER FRANCO: I mean I know there's about 40% of them that leave with the ten days--

COUNCIL MEMBER BARRON: Okay.

DEPUTY COMMISSIONER FRANCO: --and then there's a significant other number about this other 60% advocates all juvenile delinquents that are most likely to get placed in Close to Home, and those numbers are getting smaller and smaller as we move forward. Then in detention and secure detention you have—still have juvenile offenders, and those are young people who are going through the treatment in court. Those cases tend to go through longer, and I think, though obviously first time juvenile offender and looking at sad eyes (sic) that about 90 days or a little bit more. So, the other thing I'll say for JVs is that, yeah, yeah, but I mean the—the difference here between the juvenile delinquents is shorter than juvenile offenders, which is longer.

COUNCIL MEMBER BARRON: So, what's the longest period of time that a child might say there?

DEPUTY COMMISSIONER FRANCO: A juvenile offender case could go for a significant amount of

time. I mean sadly we have kids who have been there a year or more.

COUNCIL MEMBER BARRON: I thought so.

DEPUTY COMMISSIONER FRANCO: Yeah.

COUNCIL MEMBER BARRON: So, that was, you know, what I what I was referring to when I asked about the visits and the ability to be able to have those contacts, as it was—there were some cases that were cited where children have been there for over a year in this--

DEPUTY COMMISSIONER FRANCO: [interposing] Yeah.

COUNCIL MEMBER BARRON: --kind of facility based on what they're alleged charges were. And when you talk about trauma, what are the instances or what are the measures that are part of that screening tool that you talked about that identified--

DEPUTY COMMISSIONER FRANCO: Uh-hm.

COUNCIL MEMBER BARRON: --an instance as an instance of trauma or a condition--

DEPUTY COMMISSIONER FRANCO: Okay.

COUNCIL MEMBER BARRON: --as a condition of trauma or a condition.

DEPUTY COMMISSIONER FRANCO: Okay.

COUNCIL MEMBER BARRON: As a condition of trauma.

DEPUTY COMMISSIONER FRANCO: I think Charles BARRIOS is able to respond to that one.

COUNCIL MEMBER BARRON: Okay.

ASSOCIATE COMMISSIONER BARRIOS: So, it's a combination of different factors, and our colleagues at Bellevue will elaborate on this more later on during the hearing, but it could be anything from an experience in the home related to abuse, neglect and maltreatment. It could be an experience in the community where a young person may have been victimized, or a young person may have witnessed someone else being victimized whether it be a family member or significant other, a friend, et cetera or even an experience where a kid may have been arrested and depending on how the kid was treated in the process. So, it's a combination of things.

COUNCIL MEMBER BARRON: Is poverty considered a trauma in this screening document, a fact that a child lives in an impoverished community?

ASSOCIATE COMMISSIONER BARRIOS: So, looking at living conditions in the context of

whether a kid was neglected, certainly would be a consideration. Kids who are subject to extreme poverty where they have been deprived of meals or may not necessarily have access to the resources that kids generally should have access to would be one of the conditions that would be considered.

COUNCIL MEMBER BARRON: So that would be one of the considerations. What about the fact that a person lives in a—in a community where there are high levels of unemployment? And I'm not thinking just individually about a person, but as you said before, perhaps not personally victimized but in a society and in a community where those are the conditions that they experienced regardless of what might be in their own individual home?

ASSOCIATE COMMISSIONER BARRIOS: So, and that's a very good question because if you're using the screen that may not be something that the screen itself may necessarily pick up on, but the screen is just a beginning. So, after the screen, the clinician is required to do an assessment and within that full assessment, they are required to include socio-environmental factors including employment. So, that if part of the reason why the family is

struggling is because parents or the guardians have not been able to obtain employment and that's impacting the kid, and that should also factor into the assessment.

COUNCIL MEMBER BARRON: Well, I think that that's in part a look at what we have to look at more closely when we talk about that. We talk about children who are living in impoverished conditions who are in an education system that's really not meeting their holistic needs, and trying to get them to just pass a test without looking at the holistic child and giving them an opportunity to be expressive, and to go through some of the experiences that would really enrich their educational process. That we—it's a—it's a problem that I think we have to really look at in terms of communities particularly of color that are subjected to these shortcomings, and as you said, in response to the question from my colleague, what about those children in the White communities? They seem to not have it to the degree of communities of color, and I think it's a systemic issue that we're looking at, and we need to really look at it in the broad picture, and implement those kinds of initiatives and programs that will address

it systemically so that we can be more cognizant of what are the conditions that children are living under.

ASSOCIATE COMMISSIONER BARRIOS: Absolutely.

CHAIRPERSON CABRERA: Thank you so much, Council Member. I just want to follow up with a question. In your Psychosocial, when you do the psychosocial, and you identify the issue of poverty and perhaps a parent being unemployed for a prolonged amount of time, is there a system in place to help those parents gain employment?

ASSOCIATE COMMISSIONER BARRIOS: So, when the kids transfer into placement, the placement providers are required to do an assessment or synth— they synthesize all of the information that's been collected from detention. If poverty happens to be one of those issues, which is prevalent, then they're supposed to engage the families from the very beginning and then not only focus on what the child needs, but in addition to that, try to help the parent identify and locate whatever resources are necessary.

CHAIRPERSON CABRERA: So, I'm curious to know how many—how many families have you identified under this circumstance?

ASSOCIATE COMMISSIONER BARRIOS: So, families that are specifically impacted by poverty or unemployment?

CHAIRPERSON CABRERA: Yes. So, do you have data on that?

ASSOCIATE COMMISSIONER BARRIOS: We'd have to extract that information.

CHAIRPERSON CABRERA: Okay because, you know, when I—the next logical question is out of those on that last, how many were you successful in helping them get employment?

DEPUTY COMMISSIONER FRANCO: Yeah, I mean I think we did look onto some detention, Council Member and our practice have changed significantly in the last few years. Our staff, and I'm not sure who they are, I mean and, you know, I think you have met our admissions team and Horizons and—and some of the folks in closures. They—they—they—they go beyond what they are required. So, I mean it's not unusual for them to identify and meet some families and—and to feel that, you know deeply and kind of go out of

their way in trying to connect them to services. One of the things that we have been doing, not that long ago, beginning this year, is that I think you may have noted, but we invented a parent coalition at admissions. So, we work with a group out of the Bronx, Community Connections for Youth that actually was able to identify parents of young people who have been in the Juvenile Justice System before, and now we have a few of these parents that actually are available at Admissions that actually are kind of a peer. They can talk to the parent about, you know, I've been where you are. I know how difficult it is, and these folks actually have the capacity to be better at navigating how to get resources in the community. It's something that we want to do more of. I mean one of the things that we're beginning to do more of is be more intentional about every kid that we meet in detention being able to remind them that, you know, detention is a moment in your life, but should you--hopefully, you won't come back, and there's things out there in the community that are better poised to help out something like our Family Assessment Program for example.

CHAIRPERSON CABRERA: So, I—I certainly don't want the staff to be doing things, to be honest with you, above what they're supposed to do because then they can't do what they are supposed to do as effective. So, maybe the next step will be to hire somebody with a solid responsibility is to help find employment for the—the family members, parents or guardians, and also for the youth. I—I think you mentioned something that is very significant earlier that kids who have a structured scheduled throughout the day tend to get involved in this trouble, and there's something to be said about jobs that-that does that, you know, kind of by default. And so, I—I think this might be the next. Out of all of the great things that you're doing, I think this will be a key, key component that I think that will get us, because this is reality. They're going to go back home, right. You know, as great a services that we provide, they still got to go back home, and—and for most—most of the time, the should go back home as long as they're in a safe situation, but they're going to be back all with the same triggers, stressors, and this is a big stress trigger to anxiety, to inclusivity. I just want to really

define those, and in a situation where they're constantly lacking and kids still in a—in a position where they're always comparing themselves to other kids.

ASSOCIATE COMMISSIONER BARRIOS: Uh-hm.

CHAIRPERSON CABRERA: I know what it was to have, and I know when my parents got divorced not to have, and then you're looking in the other side and saying, you know, I wish I had—I had that, and that's where they become vulnerable, and when they become vulnerable, that's when they become at risk. And I think that this—this is a—I think it will be a forward step.

DEPUTY COMMISSIONER FRANCO: One we're taking. I mean I—I think we have a lot to improve access to family—family connections and family support and family therapy, and we have done a lot of the youth specific site or unemployment and pro-social activities. What I'm hearing from the Council is like a call to there's—there's this some of them for the families, too.

CHAIRPERSON CABRERA: Okay, fantastic. Well, I don't have any more questions I have another panel. Thank you so much, Commissioner and all your

staff for the great work that—that you're doing. Looking forward to getting any data that you have.

ASSOCIATE COMMISSIONER BARRIOS: Uh-hm.

DEPUTY COMMISSIONER FRANCO: Thank you.

ASSOCIATE COMMISSIONER BARRIO: Thank you.

CHAIRPERSON CABRERA: Thank you so much. [background comments, pause] Okay, Michael Surko from Bellevue NYU School of Medicine, Miles Jackson from Good Shepherd Services; Grant Coles from Citizens Community for Children; Joseph Boyd from Children's Village and Jerome Boyd from Children's Village, and we're going to put the time at three minutes, three minutes each. (coughs) Okay. [background comments, pause] You may start.

MICHAEL SURKO: No, go ahead. Dr. Michael Surko. Thank you. Good afternoon Chairman Cabrera and Members of the Committee on Juvenile Justice. My name is Dr. Michael Surko. I'm a Psychologist from Bellevue Hospital Center. I'm a Clinical Assistant Professor at the NYU School of Medicine and I'm the Principal Investigator on Bellevue-NYU's Trauma Informed Care Grant from SAMSA. As Commissioner Franco said, we've been collaborating with ACS since

2012, and in our first round of the grant we focused on secure detention, and as Commissioner Franco and Commissioner Barrios outlined, we really had two focuses of the work. One of them was the screening from trauma and related problems for all kids coming into detention. And then the other main focus of our work was to put supports in place so that frontline staff could work more effectively with-with kids. We also established skills groups for the young people sot that they could begin to learn a little bit about the effects of trauma and—and gain some initial skills in order to cope better with stressful situations, and the kinds of problems that traumatize kids' experience. That—that grant went for four years, and-and so there is now the screening that's in place within the secure facilities. There are skills groups that all kids are able to participate in, and the model that we picked was specifically designed for detention because as you've heard, the length of stay for kids in detention can be very short. And so, what we wanted to do was put something in place where we would be able to have some kind of meaningful impact even for the kids with the shorter stays. So, that's—that's been going

since 2012. In 2014, we assumed the contract for psychiatric and services within detention. We also established the Psychology Service. So, again, as you've heard, kids within detention any of them who screen positive on the initial measures, kids who have a history or receiving medication previously or kids that any staff have a concern about on the mental health front are able to be referred for an assessment and appropriate treatment during the time that they're in detention. Our—our current cycle of our grant began last year, and we're going to be using a system of interventions called TARGET. Our colleague Dr. Christopher Branson from NYU who serves as our Senior Consultant with the TARGET intervention appeared before this committee I believe [bell] and has given an overview. The—the TARGET interventions will again include staff training, and skills practice for staff with a focus on helping staff manage the stressful situations that they face in detention, minimize the chances of secondary trauma and—and minimize burnout for staff. These are high stress positions. They're hard on staff, and the better that the staff do, the better that the kids will do. There will be skills groups. Again, a free

session. It allows us to add a ten-session group for longer staying kids, and there is a family skills component. [bell] So, we will be able to use the same language and concepts for the kids, the staff, family members and it could also be extended into individual treatment.

MILES JACKSON: Yeah. Hi. Good afternoon, Chair Cabrera and Colleagues. I'm Miles Jackson. I'm the Division Director at Good Shepherd Services where I manage our residential Juvenile Justice Services. Good Shepherd has the leading use in family services throughout the agencies serving about 30,000 participants a year through 86 programs. We operate two non-secure placement programs, one for up to 12 boys in Park Slope, and one for up to 12 girls in East New York. About ten years ago, we were concerned by the increasing mental health and behavioral acuity among the girls that we work within our residential programs, and realized we needed to do better and needed to take account of the traumatic histories that they had. We settled on the Sanctuary model, which we implemented, and it caused us to change the paradigm from asking what's wrong with you to that people question: What happened to you? It

opens the door to a therapeutic supportive non-blaming relationships that take into account what may be multi-generational histories of trauma. We learned a lot about trauma particularly from the Kaiser Permanente Adverse Childhood Experiences, ACEs Study, and recognized that we needed to assess trauma in the kids we worked with. As Felipe said, 90% at least of the youths we worked with have been exposed to one or more of these adverse childhood experiences. The studies are very clear that without intervention high numbers of ACES through adverse childhood experiences lead to poor outcomes in areas such as health, behavioral health, substance abuse, all of which impact global functioning. Left untreated, young people with significant traumatic experience do not do well. Staff in overly stressed programs suffer vicarious trauma and ongoing internally (sic) trauma. They burn out and can't provide services to youths. Designing RNSP programs in 2012, we knew that the young people coming into placement would share at least that level of traumatic history, and that we needed to use trauma responsive in directions. We chose Missouri, and we married it with the sanctuary. So, for instance, we

used the Missouri based phase system, but the content, the expectations of each of the phases is based on sanctuary concepts. As our staff have learned better how to integrate these two models, we see our kids being able to regulate themselves better and showing fewer signs of emotional stress, and these days as we know gets referral packages, we get information from Dr. Surko's team on some history about the a traumatic experience. In fact, one of the instruments that we have used in our own programs as well [bell] we also get a CAD passport that lays out some of the youth triggers, some of the warning signs, some of the coping mechanisms that a young person has and tips for our staff. We use that to build a sanctuary safety plan that the youth develops and also to help us with our behavior management support. All of our staff in the program not just clinical staff get Trauma Informed Practice Training ongoing. They develop insight, skills, tools that allow themselves to manage themselves better in the stressful situations that they're in. In this way, they can help the youth and families and create a mutually supportive and more healing community within the program. We really strive to ensure that our

programs help everybody resist re-traumatization. To promote ongoing success, we encourage the youth and their families to use some of the skills and the tools that they've learned with us back in the community. As an example, one of our boys recently talked about using the Sanctuary Community Meeting questions, which are: How are feeling, what's your goal, and who can help you with his mother on home visits. He tells us that it helps them understand each other better. Another boy just very recently told us that coming back from the community visit on the train he used his safety plan to help manage his reaction in confrontation with peers that could otherwise have gone bad. So, young people begin to learn that what they're learning is portable and can be applied more widely. Finally, I do want to mention that we are so pleased that you've been supportive of Cure Violence, and the way that it's now becoming available as a resource for kids on after care. As you know well, it's a public health approach to gun violence, and trauma informed in its nature. The response to community violence, which is one of the main sources of traumatic exposure for our Juvenile Justice involvees. We're beginning to see

the emergence of the continuum of care that is trauma-informed from detention through placement and into aftercare. The aim must be [bell] to help them maintain the growth and changes that we have helped them achieve so that they are able to do better managing their stress responses to the past, and to resist future traumas. The goal is for the youth and families to become more resilient. I'm happy to take questions.

CHAIRPERSON CABRERA: Thank you.

JOSEPH BOYD: Good afternoon, everyone. My name is Joseph Boyd. I'm the Senior Transitional Coach at the Children's Village. I work with teens who have Juvenile Justice involvement. The Children's Village was founded in 1851. Today we work with some of New York City's most vulnerable children and families through a wide range of programs including community prevention, foster care, affordable housing and mentoring. We are a lead partner with New York City's Administration for Children's Services and the Department of Probation Can for Teens and Families in the Juvenile Justice System. I want to briefly describe our Trauma-informed services, but let me first begin by stating what is probably the most

obvious that the Juvenile Justice System in New York City is predominately black and increasingly brown with black teens penetrating systems fastest and furthest. The disproportionality by race and place is a fact. Disproportional impact directly contributes to the high levels of trauma that we see in New York City's Juvenile Justice System. At the Children's Village we use and Integrated Treatment Model or ITM to address trauma. While in residential care, the intervention is a million based clinical protocol commonly known as Dialectical Behavior Therapy or DBT. It's a lot of acronyms here. When juveniles return home to their families, the clinical intervention includes DBT and the addition of Multi-Systemic Therapy Family Integrated Transitions or MSDFIT. The Core of DBT is based on accepting and validating our youth and the trauma that they have experienced while pushing them to change and develop skills to better cope with emotions in stressful situations. The skills are broken down into five modules, which are: Mindfulness, Interpersonal Effectiveness, Emotional Regulation, Distress Tolerance, and Walking the Middle Path. We highly encourage our staff to use these skills as well.

Once released, MSTFIT is evidence-based protocol that provides intensive short-term family support because children are strongest when their families are given the skills and support they need to be successful as the caregivers. Both DBT and MSTFIT are evidence-based protocols with long histories of documented success, and helping teens in the Juvenile Justice system. These clinical approaches are dependable and they work, but in the end, family or at least one appropriate dependable adult relationship is the key to long-term success. This means that while it is not always easy as a system and as individual providers, they must find ways to engage families in the decision making process. The teens in our custody do not belong to us and should not belong to a system. Success is only assured when each teen has at least one appropriate and willing adult relationship that provides unconditional belonging. In our experience, this relationship is most often found within the family. In those rare instances when the immediate family fails to provide us with this appropriate and willing adult, it is our responsibility to then find and create such a relationship. Let me also add that in most

instances, our parents and our families have the solutions and often the best advocates for their teens. Thank you for the opportunity to speak on this important topic.

GRANT COLES: (coughs) Good afternoon. My name is Grant Coles. I'm the Senior Policy Associate for Youth Justice at Citizens Committee for Children. City Committee for Children is an independent multi-issue child advocacy organization dedicated to ensuring that every New York child is healthy, housed, educated and safe. Thank you, Chair Cabrera and Council Members for holding today's hearing on trauma-informed services in the city's Juvenile Justice System. CCC appreciates all the efforts of the de Blasio Administration including the Department of Probation and ECS as they talked about today of undertaking the trauma-informed Juvenile Justice System. CCC is also very thankful for the City Council's support for trauma-informed principals, and your guys' commitment to strengthening policies and practices to make them more trauma-informed, but an effective and comprehensive trauma-informed Juvenile Justice System is not a single step solution, but is a continual

process that requires ongoing refinement. In our written testimony we provide a host of background data and research, and it could be succinctly summarized trauma does have profound and negative impacts on youth's lives. Trauma is a huge risk factor for youths' participation in the Juvenile Justice System, and that youth in the Juvenile Justice System have dramatic histories of trauma both in the numbers of traumas that they've experienced and the severity of those traumas. One point of background research I do want to highlight, as hasn't been mentioned yet, is the issue or the trauma's impact on girls. Studies have consistently— consistently found that exposure to trauma in girls leads to higher rates of PTSD than boys and men. Trauma in girls has also been found to lead to higher rates of unhealthy strategies for resolving conflicts such as physical and relational aggression and regulation emotion such as drug and alcohol use. And in addition, girls who experience trauma, are more likely than male peers to have co-morbid disorders, particularly depression, but also substance abuse, self-harm and participation in risky sexual behaviors, and that would lead us to one of our—our

recommendations. As mentioned, the—the prevalence of trauma is—is—is throughout the Juvenile Justice system is either for rec—offer three recommendations to strengthen the trauma-informed Juvenile Justice System. First is to ensure New York City has a fully funded continuum of trauma-informed services for youth in the Juvenile Justice system. This includes having a universal system wide trauma-informed emphasis. That includes things like training for all staff, written policies and procedures. Essentially having a—a comprehensive uniform universal trauma awareness. It also includes screening for all youth, assessments for youth, and targeted treatment for youth as kind of demonstrated by our colleagues up here, and as ACS mentioned in their testimony. Our second recommendation is to expand the successful and promising trauma-informed practices. There's an expanding and spreading existing trauma-informed practices, it has benefitted having local buy-in and demonstrated success as well as being typically easier to expand. And finally, we recommend expanding targeted trauma services for Justice Involved Youth or Justice Involved girls through

gender responsive programs. Thank you for the opportunity to testify. [bell]

CHAIRPERSON CABRERA: Thank you so much. That was very informative, which leaves me with more questions. [laughter] So, the—let me work it out backwards. You mentioned that young ladies are—are more impacted by traumatic experiences, and yet I see more boys in detention centers and Close to Home. What accounts for that? Is it their willingness to take more risks?

GRANT COLES: Yeah, that's--

CHAIRPERSON CABRERA: That's up there?

GRANT COLES: Yeah, that's a fascinating question, and I—I couldn't answer or explain, you know, the causation of that numbers and why, you know, there are more males in the system, but we do know that the research that the impact that trauma has on girls is actually more pronounced than the—than boys. I means it has—there's ton of research around the negative impact it has on boys, but trauma particularly in girls' lives has been documented to show increased risk factors and increased symptoms. We have on our panel today someone who helps run a girls' facility that can also probably comment on

some of these ideas. But it is—you do notice within the literature around and the research around the country, around Criminal Justice reform that the importance of effectively helping girls in the Juvenile Justice System really is vital that that trauma and their histories be addressed through trauma services.

CHAIRPERSON CABRERA: So, it's not—does that—does that affect our treatment approach? Did we change our treatment approach? Did we have a different type of treatment approach that we do with young ladies that we do with young men who have been traumatized?

MILES JACKSON: Yes, I—we are more and more aware of some of the special needs of girls. One aspect I think you touched on it, is a very high prevalence of involvement in sexual activity for money. We work with a couple of providers who work well with those issues in that population. We're increasingly looking to find more specifically girl gender responsive and, in fact, one of the conversations that is just ongoing with DYFJ is about where the two adult—that kind of programming more

wholesale than any of the girls' programs that we use.

CHAIRPERSON CABRERA: So, we do have such a model out there that-

MILES JACKSON: [interposing] We are looking for it.

CHAIRPERSON CABRERA: Okay, so I'm assuming we don't have one.

MILES JACKSON: Yep.

CHAIRPERSON CABRERA: I'm going to tell you probably why we don't have one because the data that we just received right now is probably fairly new and, therefore, there's no need. There was no desperation. Now, that we have a desperation point, probably.

MILES JACKSON: I think to respond to the question about disproportionality, not only is the system, law enforcement and the Justice System racially biased in many ways, I think it has also tended to see males as likely to be more criminal whereas whatever girls do may not be regarded as so much criminal as maybe deviant in other ways. I think that's some of the reason why we don't see as many girls, thankfully, in many ways as we might.

CHAIRPERSON CABRERA: Okay. I—I want to go back to the previous question that I had asked the Commissioner and he deferred to you. I don't know if you need me to reiterate the question, but it was regarding data. You—you had the grant twice so I'm assuming that when you resubmit it, you have data from the first time around. What—what is that data showing us about the young people in detention center?

DR. MICHAEL SURKO: Well our—our grant is a—is a service grant and not a research grant, and—and it has a requirement for evaluation, but—but there aren't a lot of kid level outcomes, you know, because you're—you're talking about how do you look at whether a particular kid is getting better or worse, and then can you aggregate that and see how a program is doing? And so, there—there was not a great emphasis on that with our grant because in order to—in this funding stream they asked people to—to do an intake and asked kids to complete a lot of measures. But it's really geared to a mental health setting where it's very easy to get consent from families, and—and so, in—in this setting that's not easy, and so our agreement with SAMSA doesn't—did not

involve those measures. So what we have been doing instead to evaluate our work is—I looking at the data from the kids who participated in the STAIR groups. So, we have that. We have screening results for each young person that completed a screening, and then ACS has been very helpful in sharing incidents of aggression within the facilities. And so, what we are looking at with STAIR Groups is--and those analyses are underway right now--is do kids have lower levels of incidents after they've completed the three sessions of the—the STAIR skills training. I mean it's a—it's a small intervention, but—but it does teach the kids and it allows the kids to engage with some of the treatment providers. So, we are looking at that data now.

CHAIRPERSON CABRERA: You know, the challenge of what you just presented, which I was hoping to get data on. Let me tell you why because you are in a controlled environment and though you might even see a level of effectiveness, it might not change their belief systems, their values which it determines their behavior. And so, I want to insist on measuring that. We're not going to be able to see long-term—whether we have long-term positive effects

here in light of the fact that the last time I checked, 70% of the young people who are going through our detention centers and Close to Home are coming back. So, which tells me that it's not really working for 70% of the kids. So, then again in a controlled environment it's just a lot different than when you're out there. I like to see long-term effect. I don't want to see this kid and neither do you just the parents or just—or I don't know anybody who does. We want them to stay out. So, I'm—I'm wondering if SAMSA is assuming that the parents would not be cooperative if it's presented in a way that will benefit the child? I mean I—if I was a parent, I'd like to know if my kid is getting better based on data. I mean I think maybe it's—it's the way that it needs to be presented, and if it does, why not take a chance and start asking?

DR. MICHAEL SURKO: It—it could be done that way. It's not—it's not the way that—that we did it for this grant cycle, but I—I think your point about what—what's going on with young people that makes it more likely that they're going to become rearrested later on, and what's going to make it more likely that they're going to take another path. The—

the risk responsivity framework that Commissioner Franco talked about is that's really where you can—can look at that and—and then start to track some changes in—in kids' attitudes or behavior. I'm not—I'm not expert in that model, but I am familiar with it and that's the one that really is going to give you the best prediction about which way the kids are going to go.

CHAIRPERSON CABRERA: You know, I—you know, I want to encourage again—

MILES JACKSON: [interposing] Can I comment a little--

CHAIRPERSON CABRERA: Yeah, please.

MILES JACKSON: --a little bit on that. Although the domains that the risk need and responsivity instrument that is being used don't exactly correlated the trauma, many of them are certainly influenced by trauma and the traumatic history. So, the domains are things like family circumstances and parenting, behavior and the educational setting, peer affiliates, use of leisure time, personality and then attitudes and orientation amongst others. That instrument is going to be re-administered at different points from the points,

well, from—by probation at the very front end when at intervals all the way through to the expiration after care, and it will drive the way the interventions that we're going to be making in placement are targeted. And everyone who is looking to see risk scores in various high schools and domains begin to calm down, and that's going to be the measure.

CHAIRPERSON CABRERA: Okay. I—I was just hoping at this hearing somebody could give me some data, okay, here's what we got. This is how we've done. This is based on that data. This is what we need to do next because, you know, and—and properly I've been able to interpret that data. I have a couple of more questions, but I'll turn it over to my colleagues.

COUNCIL MEMBER PERKINS: Well, I don't really have a question but, you know, these high rates of recidivism as it relates to asthma, is—is that—are we saying that's environmental? [pause]

JOSEPH BOYD: I'm sorry, related to--?

COUNCIL MEMBER PERKINS: Asthma.

JOSEPH BOYD: I'm not aware of that—of that connection.

COUNCIL MEMBER PERKINS: Oh, okay.

JOSEPH BOYD: As I say, it's not—it's not my area of expertise.

COUNCIL MEMBER PERKINS: Alright, then.

CHAIRPERSON CABRERA: Okay. [laughs] Okay, good. Alright, I meant to ask you, you're a coach you mentioned?

JOSEPH BOYD: A Transitional Coach.

CHAIRPERSON CABRERA: A Transitional Coach. You are on the front lines? Yes, what do I need to hear?

JOSEPH BOYD: Well, I—I think that it comes down to—to the staff buying into the model because like you said before like you've seen a lot of models. Right, we've seen many models. I might even have seen our share of models as well. I think it comes down to the staff really buying into it, and I think that's what the Children's Village does in terms of kind of acting as salesmen to the staff and really getting to buy in and use the skills in their real life. And someone mentioned before, it's a difficult job being on the front lines with these kids. You know, you can go through trauma yourself on a shift--

CHAIRPERSON CABRERA: Very much.

JOSEPH BOYD: --with some of these kids. So, like just in terms of that, our staffing foundation, our staff need to be accepted, and—and really for that, that will help the kids then get that better service because if our staff aren't feeling like they—that they're deserving or that they have the power to do this work, then they're not going to deliver that the same way that--

CHAIRPERSON CABRERA: So why don't we work backwards? Why don't we ask the staff and say hey, what do you think that works, right, which they have a hunch, right? And then find a model that resembles that? Because this is what I learned from Psychology 101. I'm a Doctorate in Counseling, but my very first class that I ever took let's—look, most therapies do work--

JOSEPH BOYD: [interposing] Yes.

CHAIRPERSON CABRERA: --if you work it right and if you are good at. So, why don't we work it backwards so there is a buy-in from the staff, and then find a model that resembles that, and they say oh, thank you so much, you're listening to us, and then being able to implement that model?

JOSEPH BOYD: I think—I think that it, you know, it would—it would have been great for us to start backwards, and ask first, but I think that like with a lot of things, just two years ago I was the Director of Care Staff so the—the model was pushed on me, and I was saying well, you know, what is this and why do I do have to do this? But I think what happens is now that I'm in—you know, I'm in a role that I'm—I'm trying to teach these staff and trying to implement this stuff, that I think that it comes down to just highlighting the things that the staff are already doing on a day-to-day basis, and making it in a—in a friendly way in which I can relate to the—the therapy that you're implementing. So, it's not about teaching them something new. It's just about giving a name to the things that they're already doing. And so, it's—it's not a—it's not a complex idea of what—what works with these kids. You know, it's about building relationships--

CHAIRPERSON CABRERA: [interposing] Right.

JOSEPH BOYD: --and validating them. That's—that's what the core of a lot these work—this work is—and when you—you try and deliver a new way of

doing things to the staff, they—they become resistant, but if you just tell them that it's just the way they were doing it, just in a different way, then they're—they're a lot more receptive and so are the kids, too.

CHAIRPERSON CABRERA: Indeed. I love that approach.

JOSEPH BOYD: Yeah. Well, there I—I would say if-if you're concerned with outcomes, there—there can be a lot of benefit using a treatment model that's been proven somewhere else and evaluated. And so, for example with the Integrated Treatment Model, you know, I—I had the opportunity to visit Echo Glen in Washington State where they had kind of years of experience getting staff to buy into the model. And I remember asking one of the psychologists there how, you know, because, you know, we've been doing that similar work, how long did it take for people to buy in? He said the first five years were difficult, and—and so, then Children's Village is able to benefit from that five years of experience about okay, what are things that staff that really matter to staff so that you can kind of build that in? And so, I—I think that there could be

a lot of benefit with—with some of these models that have a track record.

CHAIRPERSON CABRERA: So, let me make a suggestion. In my other life I'm a pastor, right? We do more models as well, church growth models. Whenever I want to see a systemic change, I don't go by myself. I take—I take the key players with them so they could download their DNA of that new culture. Of that new, you know, approach. It may be the way to handle this in the future. I don't know if you're doing it right now, maybe you are, is to take from my staff with you so that when they come back others—they-they could buy enough from somebody in the administration from people that say, hey this thing works. It really works. It's that the way it's done now, and if not what can we do to--

JOSEPH BOYD: I will speak on two years ago we did that. We went to Echo Glen and it was my supervisor, and at this point I was just a Director of Staff. So, it was my supervisor, and then Assistant VP and another Assistant VP and we went out to Echo Glen, and we toured the facility.

CHAIRPERSON CABRERA: And how many—how many frontline people were there?

JOSEPH BOYD: Just one. There was just one.

CHAIRPERSON CABRERA: Okay, so that's what I'm saying. Take five with you.

JOSEPH BOYD: Yep.

CHAIRPERSON CABRERA: 80 because five years is a long time. I know it sounds like a lot of money, but it takes more—it takes—it's more costly to wait five years to see a program work when you know that it works and I agree with you. We've got to take a research based approach, therapeutic approach, but if they don't buy into it. So, maybe that's something that you could go back and talk to your people. So, it could change the DNA wherever you're working.

JOSEPH BOYD: I would just comment right now that we're in the process of—of doing kind of that exactly where we're—we're bringing up a lot of direct care staff, and making them kind of like coaching us through this model and taking them out of the cottage for a few hours, and getting—giving them an opportunity to teach the model and train on different things to other staff, putting them other programs aren't doing as well as their programs, and

just getting a little exposure so that the message is—is a lot more receptive like you said, hearing it from the direct care staff when you're a direct care staff. You know, you buy into it more when you see somebody who's in your same position teaching you that model as opposed to somebody who you might think hasn't been in their shoes or hasn't experienced the true space. It's a lot more buy-in with that. So, we are doing that in the process, right.

CHAIRPERSON CABRERA: I just got a couple of—

MILES JACKSON: [interposing] Can I add—can I add—

CHAIRPERSON CABRERA: Yes, absolutely.

MILES JACKSON: --a brief comment. Certainly as far as our experience with the sanctuary model, which is now an 8 to 10 years worth and Missouri five years worth, it does take a good five years. For Sanctuary, we line staff in monthly to Trauma-Informed Practice Core Team, which is very, very participatory. Those line staff are expected to present on a rotation. Out of the charge is become champions for Sanctuary and take it back into their programs. Beyond that, the Andrews Institute, which

sort of housed Sanctuary for many years offered an annual conference. We presented many, many times. Some years we had five or six different presentations. The presenting teams we chose really carefully so, they would include frontline staff as well as more managerial staff because I think we understand that unless you win the hearts of your frontline staff to really allow them to see why this is a model they can commit to, nothing is going to happen.

CHAIRPERSON CABRERA: Rapid fire questions here that are in: How many kids are under medication under your program? What percentage do you see?

MILES JACKSON: Of our boys probably around, and this is off the top of my head--

CHAIRPERSON CABRERA: Uh-hm.

MILES JACKSON: --20% to 30%. Of our girls probably 60%.

CHAIRPERSON CABRERA: Oh, a big difference.

MILES JACKSON: It's the psychotropic medication. Yes.

CHAIRPERSON CABRERA: And dealing with what diagnosis?

MILES JACKSON: Again, mood disorders, depression--

CHAIRPERSON CABRERA: [interposing] Right.

MILES JACKSON: --other anxiety disorders, a lot of attentional disorders, some frank PTSD symptomology, that kind of thing.

CHAIRPERSON CABRERA: And how many suicidals are you dealing with?

MILES JACKSON: We have very few instances of young people really voicing a suicidal ideation, or making suicidal gestures.

CHAIRPERSON CABRERA: Uh-hm.

MILES JACKSON: While unknown and if that happens then it would still be we'd take them to the Psyche, the Emergency Room and then put them on a one-to-one but not that often.

CHAIRPERSON CABRERA: That's interesting. I expected a different answer to that.

MILES JACKSON: Yeah, these kids are--

CHAIRPERSON CABRERA: [interposing] You're dealing with a lot of mood disorders. You're

dealing with a lot of depression. Usually, that's the next step.

MILES JACKSON: Yes.

CHAIRPERSON CABRERA: Somehow they're getting hope. That's awfully good.

MILES JACKSON: Well, I—I would hope it's because of the healing and therapeutic and respectful environments we try to maintain.

CHAIRPERSON CABRERA: That's great, and the other programs?

JOSEPH BOYD: So, I don't have exact numbers, but yeah, I know it's around 20% for both our populations the girls and the boys.

CHAIRPERSON CABRERA: Okay.

JOSEPH BOYD: And—and low—low instances of—of Suicide ID.

CHAIRPERSON CABRERA: Do you both consider that high or low? [laughter] Well, let—let me, I mean, comparing it to the general population I guess, they're high right?

JOSEPH BOYD: We like to say skills and pills. So, we don't want to just throw medication out of the way, and say like, you know, some of these kids really need medication often. You know, some of

them really do, but it's—it's always with—with the integration of the skills, and—and there shouldn't be a kid out there that is just receiving the medication and not being taught skills and how to maintain behavior.

MILES JACKSON: I—I don't think it's surprising that we see our girls needing the support of psychotropics more than the boys. I think some of the data you presented so the impact of traumatic experience on girls versus boys really speaks to that. I wish it were otherwise, but--

CHAIRPERSON CABRERA: [interposing] It is what it is right now? Well, I want to thank you all. Thank you for the good work that you're doing. I do want to encourage you to as much as possible get creative, to be able to get data. Let's get more data. It's—it's just going to make us better to service these young people. They're in dire need, and also the staff is going to be able to better equip the staff and for the staff to deal with post-secondary—secondary post-traumatic stress, and so thank you so much, and with that, we conclude today's hearing. Thank you so much. [gavel]

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date December 14, 2017