

EXPERIENCE OF CLINICIANS WHO PROVIDE THERAPEUTIC INTERVENTIONS TO
YOUTH WITH INVOLVEMENT IN THE JUVENILE JUSTICE SYSTEM

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Abstract

Youth in the U.S. have an astounding amount of contact with the juvenile justice system. Statistics in this area highlight the need for effective interventions to prevent delinquency and reduce the potential for recidivism in this population. Research literature on juveniles is focused primarily on the efficacy of specific interventions conducted in controlled trials. A gap exists between our understanding of treatment of juveniles, and the real-world application of treatment. A comprehensive understanding of treatment requires both an examination of the treatment process, and a thorough assessment of treatment outcomes. Clinicians play a major role in the delivery of treatments and are at the forefront of efforts to implement effective practice. This qualitative study explored the experiences of clinicians conducting therapy with youth who are or have been involved in the juvenile justice system. Although essential to a rich understanding of intervention efforts within the field of juvenile justice, the clinician perspective on treatment of this population remains unexplored. The goal of this study was to gather ethnographic information about the issues faced by clinicians who provide treatment in the community, in order to guide future research, policy, and practice that will better meet the needs of both clinicians and clients. Twelve clinicians were interviewed using a semi-structured questionnaire, and themes from these responses were analyzed using grounded theory techniques. Themes present in participant responses included: (a) the qualities of clinicians who work with this population; (b) the experience of working within various justice system frameworks; (c) types of interventions used; (d) challenges regarding outcomes; and (e) the availability and use of training and literature. Also discussed were implications for the following areas: future research, clinical practice, training for clinicians, juvenile justice policy, and practices in institutions that house

youth. The perspectives of study participants provided valuable insight to help guide clinicians, researchers, and policymakers invested in the juvenile justice field.

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CHAPTER 1

Experience of Clinicians who Provide Therapeutic Interventions to Youth with Involvement in the Juvenile Justice System

As of 2011, there were over 73.9 million children under the age of 18 in the United States (Puzzanchera, Sladky, & Kang, 2012; see also Sickmund & Puzzanchera, 2014). According to the most recent data, in 2011, juvenile courts in the US handled more than 1.2 million delinquency cases that consisted of juveniles involved with criminal law violations (Hockenberry & Puzzanchera, 2014a). These criminal acts included person offense cases, drug law violations, public order offense cases, and property offense cases. In addition, thousands of children who commit status offenses also go through the court system (Coalition for Juvenile Justice, 2011). Unlike criminal acts, status offenses are acts that are not deemed criminal when committed by adults, but carry sanctions for youth, such as truancy, running away, and incorrigibility.

An estimated 5,400 of the juvenile cases were waived to (adult) criminal court (Hockenberry & Puzzanchera, 2014b). An analytical report of 1997 and 1998 state legislation, released by the Department of Justice, indicated that it was at that point that many states started allowing more serious and violent juveniles to be tried as adults (Torbet & Syzmanski, 1998; see also Moak & Wallace, 2000). According to this report, many states increased the decision-making power of victims, de-emphasized confidentiality provisions, and emphasized sentences focused on punishment and offender accountability. This effort is axiomatic of the camp within the US that is oriented toward penal consequences over rehabilitative consequences for youth with juvenile justice system involvement.

The original justification for separating juvenile from adult offenders was to provide care and direction for youngsters viewed as lost and without guidance (Meng, Segal, & Boden, 2013).

Taking into consideration developmental factors and the potential of these youth, an emphasis on punitive measures seemed inappropriate (Shook, 2014). In the 1950s and 1960s, public concern about the perceived lack of effectiveness of this approach and lack of juvenile rights resulted in the creation of an adversarial structure that standardized rights, including the rights to have an attorney and to have charges proven beyond a reasonable doubt (Meng et al., 2013). In the 1980s, following an increase in crime, the public view shifted: the juvenile court was now considered too lenient. As a result, legislation was proposed in various places across the country to treat juveniles as adults in certain cases (Shook, 2014; Torbet & Syzmanski, 1998). The pendulum is now swinging back towards the middle, between punishment and rehabilitation. While there is still significant support for punishment across the US, increased emphasis on rehabilitation is evident in several ways.

One way is through restorative justice programs, which refer to a range of practices that attempt to repair the harm done by a crime (Sherman, Strang, Mayo-Wilson, Woods, & Ariel, 2015). This approach requires the various stakeholders involved with the youth or affected by the offense to collaborate to determine the best course of action. A typical element of this process is the restorative justice conference, during which the offender, victim(s), and representatives of the community come together to decide what needs to be done to repair the rupture. Youth referred to restorative justice programs have been found to remain offense-free significantly longer than youth with similar demographic factors who were referred to a traditional court (Bergseth & Bouffard, 2013).

In addition to restorative justice as a means for rehabilitation, major efforts have been made to create clinical interventions specifically to treat youth with involvement in the juvenile justice system. These treatments are generally found to be effective, with some more effective

than others, but most producing positive outcomes (Lipsey, 2009). Blueprints for Healthy Youth Development provides a registry of evidenced-based programs for treatment of children and teens endorsing various problem areas, including but not limited to: child maltreatment, illicit drug use, teen pregnancy, sexual violence, and of particular interest here, delinquency. These programs are reviewed by an independent panel of evaluation experts and determined to meet a clear set of scientific standards, and are therefore considered model interventions (Blueprints for Healthy Youth Development, 2015). Research such as that used to define these programs and others available in the efficacy literature can provide information on what techniques may be effective. But, they fall short of providing the necessary information about the treatment needs of the clinical population in community settings.

Clinicians, as intervention providers, are in a unique position to provide their perspectives on the current clinical practices in the field. They carry out the interventions and make efforts toward achieving the desired outcomes. However, their perspectives regarding their experiences in the juvenile justice system have not been considered in the empirical literature. The same cannot be said for other treatment areas, as studies have been conducted on clinicians' perspectives on treatment in multiple areas of psychology, such as the development of the therapeutic alliance (Hilsenroth, Peters, & Steven, 2004); treatment for PTSD (Frueh, Cusack, Grubaugh, Sauvageot, & Wells, 2006; Salyers, Evans, Bond, & Meyer, 2004); and couples therapy (Whisman, Dixon, & Benjamin, 1997). These studies suggest that clinician perspective is considered valuable in psychological research. The present study further demonstrates the value of the perspective of clinicians, specifically within the field of juvenile justice, in order to enhance research in this area.

CHAPTER 2

Review of the Literature

Research on the Perspective of Clinicians

A review of the literature conducted for the present study, uncovered no empirical studies that specifically assessed the perception of clinicians who provide interventions within the juvenile justice system. Although no published research examines all of the factors of interest combined—clinician perspectives, juvenile justice, and clinical treatment interventions—some research addresses one or two of these factors. Scholars have studied practitioners' reactions to implementing treatment in areas outside of the juvenile justice system (Godley, White, Diamond, Passetti, & Titus, 2001), the integration of assessments into daily practice within the juvenile justice system (Ferguson, 2002; Young, Moline, Farrell, and Bierie, 2006), and perspectives of various juvenile justice employees on policy in the field (Mears, Shollenberger, Willison, Owens, & Butts, 2010; Moak & Wallace, 2000). A review of the literature in these three areas is delineated below. Although generalizability of each of these findings is limited, combined, the research is useful in providing an initial foundation to our understanding of the perspectives of clinicians who implement treatment interventions with youth in the juvenile justice system.

Treatment implementation in related fields. The context of treatment research differs markedly from that of clinical practice and brings into question how and whether it is possible to generalize efficacy results to practice. Psychotherapy research is generally focused on symptom relief of specific maladies and rarely addresses the multiple issues or stressors that are more likely to come into play in clinical practice (Kazdin, 2008). As indicated above, research on clinician perspectives can provide valuable information.

There is no research on the experience of therapists implementing treatment specifically within the context of the juvenile justice system. The literature on criminal justice is limited to adults, the literature on children and adolescents focuses on populations outside of the juvenile justice system. Further, the available empirical literature is generally limited to one specific treatment modality, cognitive behavioral therapy (Kazdin, 2008), therefore failing to incorporate the variety of perspectives and treatment modalities that exist within the field.

Godley and colleagues (2001) assessed reactions of therapists implementing several different manualized interventions with adolescents using marijuana. Reactions from the therapists centered around six major themes: structure/consistency, ease of use of the protocol, focus, restrictiveness, potential to incorporate personal style/creativity, and flexibility/opportunity for client centeredness. The therapists' consensus was that while the manuals provided structure and consistency (which was positive), they were also restrictive (which was negative). Those who said they did not feel restricted expressed that they were able to infuse their own personal style into treatment while maintaining adherence to the manual. These findings highlight the impact of provider innovation in the ease of manualized treatment implementation. One critique is that the sample may have been biased in favor of the utility of manualized treatments, as recruiters targeted individuals amenable to manual use.

Assessment implementation. Research on the use of risk assessments within the juvenile justice field provides useful information on the challenges that come with implementing practices in “real-world” service settings. Although the focus of this project is on implementing clinical interventions, as treatment and assessment are distinct yet related some concepts, principles, or practices may be utilized or translated.

In one study, researchers attempted to implement structured assessments into juvenile centers within Maryland's Department of Juvenile Services while monitoring reactions and challenges throughout the process (Young et al., 2006). The most often cited blocks to effective implementation were practitioners' concern about a lack of resources and follow-through to implement the new initiatives and the belief that administrators do not understand the needs of the population and providers. To a lesser extent, practitioners expressed some preference for an intuitive method and skepticism of the utility of structured assessments. Although this study was limited to Maryland, thereby limiting generalizability across states, this case example points to some considerations for future exploration with regard to clinicians' reactions to assessment implementation.

Similar research was done with the Maricopa County Adult Probation Department in Arizona (Ferguson, 2002). Although this study was conducted on a much smaller scale, it is similar to the one mentioned previously in that they both describe practitioners' experience of implementing structured risk assessment tools and therefore have similar utility in highlighting the practitioner perspective in this area. The study results were similar as well; the providers were concerned that implementing a structured risk assessment would mean losing the potential to use their own professional judgment, and that they would receive only limited resources and support to execute the changes in the long run. In addition, the providers expressed some confusion about the new technology and concern over the reliability of the client reports used for the assessments.

Of relevance to this current study is that clinicians in both of the above case studies had concerns about the utility and sustainability of the new protocols and their own ability to implement them. Clinicians might have similar concerns regarding implementation of

interventions. It would be valuable to the field to determine whether the same concerns exist for implementation of new treatment approaches within juvenile justice system as were brought up for the structured assessments.

Perspectives on policy. Research focused on the perspectives of juvenile justice personnel regarding policy in the juvenile justice system was also available in the literature (Mears et al., 2010; Moak & Wallace, 2000). Although the participants of these studies included a variety of individuals working in the field, such as lawyers, judges, and probation officers, and not exclusively clinicians, the results provide an important glimpse into the perceptions of insiders in the field and the overall climate of the juvenile justice system. This insight can point to factors that may merit more or less scholarship and highlight areas where change may be warranted. In one study assessing attitudes of practitioners toward the notion of rehabilitation of juvenile offenders, attorneys, judges, social workers, and correctional facility employees were surveyed (Moak & Wallace, 2000). Support of rehabilitation tended to be higher in the following groups; older, more educated, nonwhite, and female. Also, those who believed that crime rates were rising were less likely to support rehabilitation. In addition, participants identified as casework practitioners were more likely than legal professionals to feel that the justice system was too lenient. The authors suggested two possible explanations for this difference in opinion: 1) the legal professionals in their study were mostly judges and defense attorneys, whose focus would be on advocacy; and/or 2) caseworkers may have been more inclined to interact with juveniles when they were not on their best behavior. Despite these differences, professionals were overall inclined toward rehabilitation more so than punitive punishments.

A similar study collected quantitative and qualitative survey data to examine perceptions of senior practitioners in large, densely populated areas of the US on policies, priorities, and

practice within the juvenile justice system (Mears et al., 2010). According to the responses from the practitioners (juvenile court judges, prosecutors, public defenders, and court administrators), the juvenile justice system falls short in addressing factors they consider key to successful outcomes, such as gender-specific and culturally appropriate programming (Mears et al., 2010). There was less consensus regarding policies that were considered effective. For example, prosecutors and defense attorneys disagreed most often on the effectiveness of particular interventions. These biases can have significant implications for youth within the system. If prosecuting attorneys and defense attorneys differ dramatically in their perception of the most effective approach for youth, it will be exceedingly difficult to come to a consensus on the best course of action. Lastly, there was considerable variability in responses to the question of possible solutions, suggesting that there is no simple answer for the problems in the system. Policy makers may need to creatively integrate several alternatives to help improve effectiveness.

The studies discussed above are characteristic of the few existing efforts to examine the perspectives of practitioners in the juvenile justice field. The majority of the literature focuses on the practitioner's view of overall policy. Taken together, the findings brought to light some ambivalence in the field, and suggest potential future directions. Although in general, some individuals in the juvenile justice field may be amenable to a pendulum swing back toward rehabilitation and an increase in the use of clinical interventions, disagreement as to the appropriate balance between punitive and rehabilitative efforts still exists. The variations in perspectives are likely the result of differences in positions and roles within the field, as suggested by Mears and colleagues (2010).

Clinicians may struggle with similar challenges related to balancing rehabilitation goals with punitive sanctions, and determining the best course of action when confronted with issues not well-addressed by the system. Given the emphasis of clinicians toward promoting psychological health and wellness, they would likely lean more towards rehabilitation generally. However, there may be particular obstacles to rehabilitation efforts, or preference may shift depending on circumstances. It is not possible to know the specifics regarding this issue without getting data from the clinicians themselves.

Juvenile Justice Treatment

There are multiple empirically-supported juvenile justice treatments available in the literature. In addition to programs identified as models by Blueprints for Healthy Youth Development, there are several other interventions with support for their effectiveness in treating violence and delinquency including dialectical behavior therapy and trauma-informed cognitive behavioral therapy

Blueprints models. Several treatment programs identified in the efficacy research qualify as empirically supported interventions for youth in the juvenile justice system. Blueprints offers a summary of the research and designates ratings for programs based on the available evidence. They have identified three programs—Functional Family Therapy, Multisystemic Therapy, and Treatment Foster Care Oregon—as model interventions for youth with delinquency and criminal behavior (Blueprints for Healthy Youth Development, 2015). Although other interventions are noted, they are either more focused on other target areas or do not yet have the required research backing to be considered a model.

Functional Family Therapy. Functional Family Therapy (FFT) is a short-term, family-based therapeutic intervention for delinquent youth at risk for institutionalization and their

families (Blueprints for Healthy Youth Development, 2015). FFT is designed to improve within-family attributions, family communication, and supportiveness, while decreasing intense negativity and dysfunctional patterns of behavior. Studies conducted across the United States (Baglivio, Jackowski, Greenwald, & Wolff, 2014; Celinska, Furrer, & Cheng, 2013; Darnell & Schuler, 2015) and abroad (Graham, Carr, Rooney, Sexton, & Wilson Satterfield, 2014) have demonstrated program benefits for recidivism among juveniles. A meta-analysis that included “seven rigorous evaluations of the program” (Aos, 2007, p. 19) estimated that the average FFT program for youth on probation (with quality control) can be expected to reduce juvenile recidivism rates by 15.9%.

Multisystemic Therapy. Multisystemic Therapy (MST) is an intensive family- and community-based treatment that addresses a variety of factors thought to cause serious antisocial behavior in juvenile offenders (Blueprints for Healthy Youth Development, 2015). The MST program seeks to improve the functioning of youth by changing their home, school, and neighborhood, in ways that promote prosocial behavior while decreasing antisocial behavior. Therapists generally spend more time with families in the initial weeks and gradually taper their time over the course of treatment. For more than 30 years, MST has consistently demonstrated positive outcomes with chronic juvenile offenders (Multisystemic Therapy [MST] Services Inc., 2015). A report summarizing the research to date indicates that as of January 2015, MST Services Inc. had a record of 48 published outcome, implementation, and benchmark studies, resulting in almost 100 published journal articles using a variety of samples. The studies that had focused on juvenile offenders linked MST with decreased criminal offending generally (Butler, Baruch, Hickley, & Fonagy, 2011), decreased sexual offending specifically (Letourneau et al., 2009), decreased arrests and convictions (Fain, Greathouse, Turner, & Weinberg, 2014;

Schaeffer & Borduin, 2005; Timmons-Mitchell, Bender, Kishna, & Mitchell, 2006; Wagner, Borduin, Sawyer, & Dopp, 2014), shorter sentences (Wagner et al., 2014), improvement in family relations (Schaeffer & Borduin, 2005), and decreased out-of-home placements (Glisson et al., 2010).

Treatment Foster Care Oregon. Treatment Foster Care Oregon (TFCO), formerly Multidimensional Treatment Foster Care, is an alternative to residential treatment, incarceration, and hospitalization for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency (Blueprints for Healthy Youth Development, 2015; Leve, Fisher, & Chamberlain, 2009). Trained foster families provide placed adolescents with treatment and intensive supervision at home, in school, and in the community; clear and consistent limits with follow-through on consequences; positive reinforcement for appropriate behavior; a relationship with a mentoring adult; and separation from delinquent peers. Individual and family therapy is provided, and case managers closely supervise and support the youth and their foster families through daily phone calls and weekly foster-parent group meetings. Placement in foster parent homes typically lasts for about six months. Aftercare services remain in place for as long as the parents want, typically about one year.

When implemented with delinquent boys, significant program effects, relative to a comparison group, were found. They included: 1) a larger drop in official criminal referral rates (no criminal referrals, compared with 7% of the comparison) at one-year follow-up (Chamberlain & Reid, 1998); 2) fewer violent offense referrals (21% in treatment, compared to 38% of comparison) two years after intervention (Eddy, Whaley, & Chamberlain, 2004); and 3) fewer subsequent arrests at one-year follow-up (Chamberlain & Reid, 1998). A randomized control study found positive treatment results for children with severe behavioral problems in

Sweden, suggesting applicability internationally (Westermarck, Hansson, & Olsson, 2011). When implemented with delinquent girls, researchers found significant reductions on a combined measure of days spent in locked settings, criminal referrals, and self-reported delinquency at two years post-treatment (Chamberlain, Leve, & DeGarmo, 2007). Further, this program has demonstrated prevention applications. One group conducted multiple randomized trials with younger children, and their evidence suggests that the intervention leads to the development of resiliency mechanisms, including improved interpersonal relations and adapted neurobiological functioning (Leve et al., 2009).

Other potential interventions. Notably, all of the model interventions include biological and/or foster families. As designed, they would not be appropriate for custodial facilities or situations where family is not involved. Other interventions, though not indicated as models, have some evidence base to treat issues such as violence and delinquency. These interventions, dialectical behavior therapy and trauma-informed cognitive behavioral approaches (described below), might be more appropriate for a wider array of situations.

Dialectical behavior therapy. Dialectical behavior therapy (DBT) has had demonstrated effectiveness with adolescent participants in a variety of settings (Miller, Wyman, Huppert, Glassman, & Rathus, 2000; Nelson-Gray et al., 2006). DBT for adolescents has been adapted from its traditional format to meet the needs of the population. These modifications include shortened treatment, integration of family members into the process, and simplified language appropriate to the developmental level of adolescents (Rathus & Miller 2000). Just as DBT has been adapted for use with adolescents, it has also been systematically modified for use with forensic populations (McCann, Ball, & Ivanoff, 2000). There have been multiple clinical research projects conducted on the use of DBT with adult forensic populations, although no

empirical studies have been published (see Berzin & Trestman, 2004; Quinn & Shera, 2009, for a summary of findings). The summary of these results indicate that DBT is potentially effective with adult forensic populations.

One study was uncovered that examined the utility of DBT specifically with youth in the juvenile justice system. The results of this study, which involved female juvenile offenders in state custody, were mixed (Trupin Stewart, Beach, & Boesky, 2002). The treatment groups included female juveniles at the mental health cottage and the general population cottage at a residential program. Residents of an additional general population cottage served as the treatment-as-usual comparison group. Youth who received DBT at the mental health cottage demonstrated significant reduction in behavior problems, while youth who received DBT at the general population cottage did not. While use of punitive actions by the staff at the mental health cottage was not reduced during the DBT intervention, and actually significantly increased at the general population cottage. Given these mixed results, study replication and expansion with male juveniles would help to parse out the actual effects of the treatment for this population. Another study, not exactly focused on juvenile justice involved youth, assessed the effectiveness of a DBT skills program for adolescents diagnosed with Oppositional Defiant Disorder (ODD; Nelson-Gray et al., 2006). Researchers found an increase in interpersonal strength and a reduction in ODD symptoms and externalizing behaviors.

Trauma-informed Cognitive Behavioral Therapy. Trauma-informed cognitive behavioral therapy (CBT) programs offer another alternative. Until recently, no CBT program for PTSD had been tested systematically with delinquent youth (Ford, Steinberg, Hawke, Levine, & Zhang, 2012). To date, Trauma Affect Regulation: Guide for Education and Therapy (TARGET) is the only trauma-focused approach to have been subjected to empirical review,

having undergone an initial test of efficacy in 2012 (Ford et al., 2012). Researchers found that the time-limited individual therapy was effective in reducing PTSD symptoms for girls living in the community who were involved in delinquency. TARGET was more effective than the enhanced relational supportive therapy in addressing DSM-IV PTSD Criteria B (intrusive reexperiencing) and C (avoidance and emotional numbing) in delinquent girls. This assessment demonstrates the potential impact of trauma-focused interventions on justice-involved youth, but these interventions do not focus on delinquency. According to another article published by Ford's group, youth who participated in the TARGET program that included groups and milieu interventions at multiple juvenile correctional facilities, showed improvement compared to a matched comparison group (Ford & Hawke, 2012). These specific improvements included fewer disciplinary incidents and punitive sanctions, and more prosocial behavior.

The Gap between Efficacy and Implementation

Given the unique circumstances that surround juvenile justice treatment, the juvenile justice population is likely to differ from other groups in terms of motivation for treatment, focus or goals of the intervention, and complexity of interactions of the systems involved. The youth who these interventions target are generally court-mandated, so may be less interested in treatment. Further, the treatment with this population requires interactions within the multifaceted juvenile justice system, whose complexity may be an obstacle. In order to determine the effectiveness of any treatment in practice, the treatment needs to be implemented in the actual juvenile justice settings.

The above referenced programs provide evidence supporting the efficacy of the interventions in treating youth who have been involved in the juvenile justice system. However, the literature suggests limitations to the utility of dissemination of prescribed programs without

consideration of several key factors related to the potential for adapting them to community populations. According to the dissemination literature, the process of dissemination consists of three dynamic and nonlinear stages: adoption, implementation, and routinization (Mayer & Davidson, 2000). Sturza and Davidson (2006) illustrated some of the roadblocks to dissemination of juvenile justice interventions that might occur at each stage, using the example of an adolescent diversion program.

In the adoption phase, the concern is whether the intervention will be used by the system. Even if the intervention is effective and cost-effective, its implementation in a juvenile justice setting is dependent on an established system for referrals (Sturza & Davidson, 2006). There are likely multiple obstacles to consistent and appropriate referrals, for example with diversion programs, youth diverted successfully will reduce the demand for court processing. Paradoxically, if effective, these intervention programs would reduce the need for the established system, this knowledge may be threatening to referral sources.

The concern at the implementation phase is how the intervention will be carried out. The likelihood of new services being utilized is influenced by organizational facilitators, individual provider characteristics, provider dispositional innovativeness, and social networks (Aarons, 2005; Mitchell, 2011). High-fidelity implementation is more likely to occur when requirements for implementation are similar to those that exist for treatments already in practice (Sturza & Davidson, 2006). For example, implementation of a diversion program is less likely if the treatment perspective among providers is that youth need to face the consequences of their actions, because diversion might be seen as a way of avoiding punishment.

The concern at the routinization phase is whether the intervention will be integrated as part of standard practice—which is the goal of this phase—or considered an ancillary alternative.

Such integration is essential for long-term stability, yet integration into standard practice too quickly may impact fidelity due to limited structured oversight (Sturza & Davidson, 2006).

These various concerns regarding dissemination highlight the gap between efficacy and implementation. Closing this gap requires understanding the issues and concerns of practitioners in the field, as their perspectives can provide important insight towards smoothing the transition between treatment research and clinical practice.

Summary of the Literature

While current research on interventions effective with juveniles in the justice system highlights several programs that address the behavioral symptoms and areas of concern for this population, the gap in this literature is evident. A complete understanding of treatment requires an examination of which treatments are being used, the issues surrounding use of these clinical interventions, and the effectiveness of evidence-based interventions when implemented in “real-world” contexts—none of which have been thoroughly explored.

As described in previous sections, the literature in closely related fields provides some insight as to the state of interventions in this area. We can surmise that conflicts and disagreements exist in the juvenile justice field (Mears et al., 2010), and challenges come with implementation of new technologies (Ferguson, 2002; Young et al., 2006). The potential for effective implementation is partially influenced by the technology itself and the professionals’ ability to work with the technology. Another concern is whether the new tools being implemented are easy to use (Ferguson, 2002; Godley et al., 2001). Also, practitioners are particularly worried about the loss of their individuality and professional judgement (Ferguson, 2002; Godley et al., 2001; Young et al., 2006). However, these implications barely scratch the

surface, especially since they are deductions made based on assumptions of similarity to closely related fields.

Although various programs have been developed targeting the juvenile justice population and demonstrated their efficacy in clinical research, input from clinicians who work in the system provides value beyond general efficacy. With this additional perspective, it may be possible to improve interventions and uncover new directions for treatment. Assessing clinicians' perspectives provides the potential for an in-depth understanding of clinical practice as a whole, and treatment practices more specifically. Currently, however, there is a dearth of literature on the practitioner perspective on implementation of interventions within the juvenile justice system. These untapped perspectives could provide information on important issues, including: 1) the factors to consider when determining the appropriateness of specific interventions for specific clients; 2) the problems that arise in implementing interventions; and 3) challenges related to the clinical environment and the climate of juvenile justice policy.

The current study examined the experience and perspectives of therapists within the juvenile justice field, offering ethnographic information specifically related to providing treatment interventions for youth within the juvenile justice system. Using grounded theory techniques (Corbin & Strauss, 2014), the experiences, challenges, and rewards of conducting treatment with youth who have had involvement in the juvenile justice system were explored. "There may be external events... but these are not themselves as important as how persons experience these events and respond to them" (Corbin, 2009, p. 38). Clinicians play a major role in the delivery of treatments and are at the forefront of efforts to implement effective practice; their experience is key to a rich understanding of intervention efforts within the juvenile justice system.

CHAPTER 3

Method

Participants

Although effort was made to represent a broad range of clinical experiences by recruiting participants from diverse demographic backgrounds and work settings, participants were not a comprehensive representation of clinicians within the juvenile justice field.

A total of 13 clinicians agreed to participate and were interviewed. Due to poor audio quality, one interview was not included in the study. Of the remaining 12 participants, four (33.3%) were male and eight (66.7%) were female. Four (33.3%) participants identified as Black or African American, five (41.7%) as White or Caucasian, one (8.3%) as Asian American, one (8.3%) as multiple ethnicities (African American and Caucasian), and one participant chose not to specify. Two (16.7%) participants were ages 26-30, five (41.7%) participants were ages 31-35, two (16.7%) participants were ages 36-40, and three (25%) participants were over age 40.

The majority of the participants (seven, 58.3%) were in the psychology field. Of these, six had doctorate degrees and one had a master's degree. Three (25%) participants were master's level clinicians in the social work field. One (8.3%) was a master's level clinician in the mental health counseling field and one (8.3%) was an alcohol and drug abuse counselor with advanced certification. Participants' time in the field, working with youth with juvenile justice involvement ranged from 1.5 to 20 years (mean=6.3 years, median=7 years).

During the interview, the participants spoke about their current and previous experience treating youth with juvenile justice system involvement. One (8.3%) participant was not working with this population at the time of the interview, so her interview focused solely on past experience. The settings of these experiences included outpatient and residential settings. The

outpatient settings consisted of public or community mental health centers (one participant, 8.3%), private practice (two participants, 16.7%), and mental health treatment in community-based agencies such as schools, libraries, and courthouses (three participants, 25%). The settings in which the youth were detained consisted of residential programs (five participants, 41.7%), wilderness programs (two participants, 16.7%), jails (two participants, 16.7%), and prisons (five participants, 41.7%). More than half of the participants (seven, 58.3%) referenced experience with juvenile justice-involved youth in more than one setting.

In terms of the treated population, the participants were asked to describe a typical juvenile justice-involved client. The resulting demographic information revealed a picture of the populations served by these participants. In terms of age, the youngest client specified was 4 years of age, the oldest was 23 years of age. Every participant identified that they worked with adolescents; all except one specifically mentioned teen ages. All participants had experience with male youth, and over half (58.3%) also mentioned experience treating female youth. Of the seven participants who identified the race or ethnicity of their clients, seven (100%) stated that their work included experience with African American or Black youths, seven (100%) stated that their work included Hispanic or Latino youth, three (42.9%) stated experience with White or Caucasian youth, and one (14.3%) participant indicated experience that included work with “Indian” or Native American youth. Several identified clients as low-income. Half of the participants indicated working with youth from inner cities. One (8.3%) participant indicated working with youth from suburban areas, and two (16.7%) participants indicated experience with youth from rural areas. Problem behaviors ranged from truancy and curfew violations to murder, arson, and sexual offenses. The most often-cited youth offenses were fighting or physical aggression, substance use, and drug sale or possession.

Given that the demographic information was provided at the discretion of the participants, it is likely that the demographics are not an accurate representation of their total experiences with youth in the juvenile justice system, but rather are suggestive of the salient experiences for the participants.

Materials

The main instrument for this study was a semi-structured interview protocol (Appendix D) developed by the principal investigator in order to gain detailed descriptions of participants' experiences working with youth with involvement in the juvenile justice system. The protocol started with prompts exploring participants' experiences of working in the juvenile justice field, including roles and responsibilities, rewards and challenges, motivations for entering the field, and understanding of and relationship with the various systems involved. In addition, the protocol explored participants' experience of providing treatment to youth in the juvenile justice system, with prompts designed to illicit descriptions of the population, services rendered, challenges and rewards of providing interventions, literature and training available and utilized, and factors surrounding success or lack thereof.

The semi-structured interview format provided the principal investigator with ample space and opportunity to explore concepts as they were introduced by participants, through follow-up questions and prompts. Further, the participants were given an opportunity at the end of the interview to introduce any concepts that had not been addressed during the course of the interview or expand on concepts not explored to their satisfaction.

In addition to the interview protocol, each participant completed a demographic questionnaire (Appendix C) prior to the start of the interview. This questionnaire was designed to

collect background information, including each participant's age, ethnicity, training, and a summary of experiences.

Procedures

Recruitment and consents. Recruitment was limited to clinicians with experience providing treatment to youth with juvenile justice system involvement. The goal at the outset of the project was to recruit 10-15 participants using a network sample. Potential participants were those who met the research criteria, and were previously known to the principal investigator, recommended by colleagues in the field, or recommended by other study participants.

As potential participants were identified, they were contacted via phone or email to determine interest in participation. Initial participants were met at a mutually agreed-upon private location. The investigator provided a brief overview of the study and the clinicians provided informed consent to participate in the investigation at that time. The consent form explained the purpose and procedures for participation, risks and benefits of the study, and confidentiality and limits to confidentiality, and provided contact information for all individuals affiliated with the study (Appendix A). The consent form also explained that the study was completely voluntary and participants had the right to decline participation at any time during the process. An addendum to the consent form asked for consent to audio record the interview (Appendix B). An individual was still allowed to participate even if he or she refused to be recorded.

Recruitment was initially focused on the New York and New Jersey areas. However, in an effort to increase the diversity of the sample, some participants were recruited from Oregon. These participants were contacted via email and phone. The principal investigator provided a brief overview of the study and documents were sent to the participants via the U.S. Postal

Service mail. Each of these participants was sent the informed consent materials (Appendices A and B), and the demographic questionnaire (Appendix C), along with return postage. It was not possible to meet with these participants in person due to the significant distance, so once the documents were completed and returned, a Skype interview was scheduled.

Data collection and storage. Each participant was interviewed by the principal investigator. The interview was designed to be administered in approximately one hour. In-person interviews took place in a mutually agreed-upon location that offered quiet and confidentiality. In most cases, the interview occurred at the participant's home or office. In the cases that distance precluded meeting in person, interviews were conducted via Skype. During the Skype interviews, the interviewer was alone at her residence and the interviewee was instructed to find a location that offered quiet and confidentiality.

Participants were made aware of the voluntary nature of their participation. They were able to decline answering any question or discontinue the interview at any point without penalty. They were also able to decline audiotaping the interview. Each participant provided voluntary consent and completed a short demographic questionnaire before participating.

Each participant was assigned a number at random to maintain confidentiality. This number was attached to the demographic questionnaire and interview data. Hard copies of interview data (including printed transcripts and demographic questionnaires) and audiotapes were stored in a locked filing cabinet in the researcher's home and no one other than the research team had access to this information. Computer copies of this information were stored on a password-protected computer database at the researcher's home. The consent forms, the only documents that contained participant names, were kept in a locked storage file at the home of the principal investigator, separate from all other study materials.

Data analysis. Data was analyzed using a qualitative method based on Corbin and Strauss's (2014) grounded theory method. Grounded theory is a research method in which the researcher generates theory based on the data collected from the interviews. The analysis involved several steps: 1) the responses were first broken down by specific concepts; 2) the concepts were then developed into more refined categories; and 3) themes were then identified from the categories.

Open coding examined the interviews in their entirety and information was broken up to identify general concepts. This was intended to provide a foundation for understanding the data and further coding procedures. For this portion of the analysis, a colleague on the research team provided frequent consultation on coding to best summarize the content of the interviews. Further, this colleague coded one of the interviews, in addition to the principal investigator. Both sets of codes for the dual-coded interview were then reviewed jointly, by the principal researcher and colleague, and a consensus was reached on any coding discrepancies. This allowed for a comparison of the content as determined by two separate raters and the clarification of concepts as needed. The next level of coding, axial coding, involved collapsing the concept categories by finding connections and relationships between the different concepts obtained through open coding. The final step in the process was selective coding. The purpose of this step was to generate a select group of core or central themes based on the categories created, which encompassed the content and feel of all the responses.

CHAPTER 4

Results

Characteristics of Clinicians who Conduct Interventions

The semi-structured interviews revealed a particular type of person who works as a clinician treating youth with involvement in the juvenile justice system. The characteristics of effective juvenile justice therapists are described below, and include their personality characteristics, such as strength and passion, and their perspective on the youth with whom they work. This initial focus on clinician attributes and their connections to the work will provide a context for the insights provided in the remainder of the study results.

Personality characteristics. As noted previously, providing interventions for juvenile justice clients is a unique responsibility, thus requiring a unique set of characteristics for success. Clinicians indicated particular personal attributes within themselves (or advisable for those considering the field) as valuable for working in this field: strength and passion.

Strength. The clinicians who participated in this study indicated a willingness and ability to handle difficult situations, such as verbal and physical attacks from youth, most often experienced by clinicians who worked in locked detention facilities. The quote below offers an example of common slights.

People are going to be throwing stuff at you, cussing at you, you're dealing with all sorts of different things. It's not a glamorous job where people are going to show you the utmost, show you respect. They're going to be cussing you out. "You ain't anybody, who are you?"

Further, difficulties were not limited to interactions with the youth. Participants reported difficult interactions with clients and their peers, family members, other service providers, as well as

other challenges related to the nature of the correctional environment. Participants indicated that they remained unfazed. As one participant reported, “People are like, ‘How do you do that all day?’ I’m like, ‘What do you mean, do what?’ Like it’s no big deal, that’s what happens, I work in jail.” Another participant advised, “You have to have, so-called, thick skin. You can’t be easily emotionally injured. If you are a highly, highly sensitive individual, this is not an easy place to work.”

Passion. The majority (8, 75%) of the participants in this study reported either a desire to make a difference in the lives of youth in the juvenile justice population, or some personal gratification from helping others. “When you want to get into social work or whatever... You have this idea about how things are going to be like, you’re going to save the world.” Although not explicitly stated by all participants, the passion evident in this statement was evident throughout each interview. One clinician reported being drawn to the “helping profession” in high school. Even those who indicated that they were not initially drawn to the work (i.e., they took the job because it was an available opportunity at a time of need) reported that they had some particular connection or passion. For some the connection was about working with youth; for others it was about working in forensic settings; for still others it was about helping an underprivileged or disenfranchised group of people. For most, the connection to this work was some combination of the three.

I was always interested in correctional and forensic psychology in general. I also had quite a bit of experience, working, or going to work with my mom, [who] was a school teacher and she taught primarily middle school. So I guess in some ways my interest in working in forensics and corrections meshed with experience working, at least initially in the educational sort of realm, with adolescents, sort of drew me to an interest in how

adolescents think and behave and learn, coupled with and particularly because she worked in an inner-city impoverished school district and area, working with juveniles who in addition to educational problems, also experienced problems with the law. So they were ... at-risk kids, or potentially at-risk kids who also struggled with getting their sort of educational, social, financial, and physical needs met.

In addition to feeling a connection to the work, the clinicians felt that their work was a viable means for making the impact they desired: a sense of competence. Three clinicians (25%) explicitly indicated that a part of their connection to their role as a clinician was a sense of competence. They were able to commit to making an impact, because they believed that they were capable of success.

Perspective on the youth with whom they work. The clinicians generally viewed their clients positively. Over half (51%) of the attributes that the participants associated with the justice-involved youth were positive. The other half of the attributes identified were either neutral (15%) or negative (34%). The negative attributes included “aggressive” and “impulsive,” which described behaviors. Also included were phrases such as “throw away,” “jaded by the system,” and “damaged,” which spoke to the effect life had on the youth more than their personalities. “Antisocial,” “criminalistic,” and “blockheaded” are examples of the few negative personality characteristics mentioned.

The positive attributes, on the other hand, were predominantly personality characteristics. “These kids tend to be pretty spunky.” “He was a super interesting guy.” These statements suggest that the clinicians saw the youth as characterologically good people. Even when there was discussion of some negative or inappropriate behavior, there remained a belief in the goodness of the person within: “The most important thing is that I see resilience. I mean the fact

that they've gone through whatever they've likely gone through and still they're able to ... be present with you in, even in that moment. I think it's something that's huge." Acts that might otherwise be seen as delinquent were reframed as a use of available resources with good intentions: "I think having the experience of working with teenagers [whose] involvement in the justice system is a way that they're trying to do their best, if that makes any sense; so using substances or getting involved in illegal activities with their peer group because they're trying to feel better."

Explanation of behaviors. The participants in this study understood client behaviors as reasonable given certain contexts. According to these clinicians, actions could be explained when the environmental and personal factors were considered. The environmental factors that youth faced were purported to shape behavior. One participant talked about it from a research standpoint, "All the current research is showing us ... what happens to children as they're trying to continue to grow and develop as they're living in a traumatic environment." Another clinician referenced an experience with a client:

Maybe you shoplifted because no one was buying you underwear. When you actually look at what the kid shoplifted, he stole socks, an underwear, and a hat. For him to really be able to come out and tell his story and understand that he's not a bad kid intrinsically. He made some bad decisions because he was not in the best situation.

In addition to the environment, personal factors were also deemed to play a role. Several clinicians reported that behaviors were due to limitations in development: "They're still developing. They're still very much children.... I think there was a lot of the growth we expect to see during adolescence. But it was almost like he had gotten stalled." There was also mention of limitations in perspective. Youth were described as "short-sighted" or unable to think of life

being any different from what they had learned. As one participant reported, “[The client] saw no way out... [He was] feeling that helpless about having no other options for his life. He didn’t want to be involved in the lifestyle but he didn’t ever think he was going to get out of it.” These personal factors were characteristic of youth in general, suggesting that participants did not view their clients with juvenile justice involvement in a pejorative manner. They viewed their clients as young people, similar to others at the same developmental level, “trying to do their best” given their situation.

Roles of the Clinician

Clinicians take on various roles in addition to therapy as part of their practice in the juvenile justice field. Descriptions of these roles, the constraints that exist, such as limitations, and how clinicians deal with those constraints, are described below.

Description of roles. All clinicians who participated in this study performed some type of therapy as part of their practice. They also described additional roles and responsibilities, including direct interventions for youth, indirect responsibilities in the service of youth, and roles not involving youth. In addition to therapy, direct services entailed assessment and case management. The preponderance of clinicians conducted both individual and group therapy (nine, 75%). Only one clinician did not indicate providing group therapy, and two clinicians did not provide individual therapy. Notably, both of the latter clinicians worked in Oregon; so the increase in generalizability afforded by the regional diversity may not be applicable to individual therapy.

Over one third of participants provided some degree of assessment, which included psychological evaluations with testing batteries, as well as less formal clinical assessments. Some participants specified providing assessments to determine level of functioning and fitness

for trial. Case management included both direct interactions, such as providing clients with information, and indirect interactions, such as coordinating vocational training and communicating with others on the client's behalf.

Five participants (41.6%) described indirect service work, including documentation completed as part of the treatment, as well as interactions with other individuals (such as support staff or community agencies). Documentation included reviewing records, and writing intake reports, discharge reports, evaluations, and treatment plans. The indirect service responsibilities most often described were treatment planning and participating in or leading a treatment team: "Originally the psychologist was just a member of the team, but over time the psychologist became a coordinator of the team. They would write the treatment plans and every month each kid would have a treatment meeting." One participant also added advocacy as one of the clinicians' roles.

In addition to these roles, which are generally related to treatment of the justice-involved youth, participants described taking on responsibilities such as becoming involved in community task forces, research, or administrative work, or providing training and supervision. These tasks, though identified as part of the clinical role, directly impacted the systems in which the youth exist, and impacted the youth only indirectly.

Clinicians also spoke about the impact of having several different roles. The dual role for some clinicians included treatment and case management services. One clinician mentioned that being involved in the daily routines of their clients' lives provided her with greater insight into the youth's problem areas. At the same time, the roles of other clinicians combined treatment with supervision and rule enforcement, without creating an issue. Another participant discussed how competing roles limited the amount of time he spent in his preferred role as clinician: "I

thought that I'd have more time to do clinical work. I find myself pulled out of that clinical role more than I would have liked to or more than I realized in the beginning." A clinician who spoke about the dual role did so matter-of-factly, suggesting that this was not a challenge for all clinicians.

Notably, clinicians also described some specific activities as outside the clinicians' role. One clinician working in a locked correctional facility reported that it was not his job to police the department of corrections. He emphasized the importance of keeping mental health separate from custody. Another clinician stated that it was easier to build rapport with clients because she was not involved in the initial transport to the facility or any aspect of the youth's incarceration.

Constraints within the roles. Some participants mentioned feeling limited in their roles as clinicians. Several made statements implying that there were things they wished they could do, but felt constrained. For some it was due to other obligations: "I find myself wishing to be able to do more, but constrained by many of the other responsibilities that I also have, that I'm not as excited about, but it comes with the territory."

Limitations imposed by the environment. For others the constraints were due to the nature and setup of the system and environment in which they work. Several of the clinicians who worked in a correctional facility noted that in those environments the first priority was incarceration. Mental health was secondary, and in some cases treatment was a means to promote behavioral adherence to the rules surrounding the incarceration. The implication was that this priority might be emphasized over interventions targeted at improving quality of life or at other long-term gains.

The report of the two participants from Oregon offered restorative justice as an alternative perspective:

A very simple definition of restorative justice is that the person who has caused harm has to repair the damage to both the person who was harmed and the community. The community has a responsibility to help the person who was harmed and to help the person who harmed, and so it's a triangle.

This perspective is very collaborative and does not necessitate the same emphasis on balancing custody needs with mental health needs.

In the security-focused environment, clinicians reported having to consider the rules and regulations of the facility before taking action in their work with clients. One participant offered an example highlighting this point:

One of my girls was in the hole, in security. She kept getting in trouble cause she would bang on the walls. I'm like, "Why are you banging on the walls?" "I have to pee Ms. J." Come to find out that she just wanted to get out of her room. They couldn't let her out. I said, "Well, if you really got to pee," because she was getting rewritten every time she would bang on the walls. I said, "Just pee in a cup, if you really have to go. If that's your excuse, and you really have to go, just pee in a cup."

I get a call from the staff, and they were like, "Miss J, did you tell such and such to pee in a cup because that's a violation of X, Y, and Z. It's unsanitary, Da, da, da, da. She's going to get rewritten for it." I was like, "Whoa, whoa, whoa. Okay. I did tell her if it was a dire emergency." I had to tell my supervisor I told her to pee in a cup and not realizing that she could get rewritten, and that was just as serious a violation.

Limits to confidentiality. In addition to the above constraints, clinicians in a variety of work environments noted limits to confidentiality and consistency, which impacted their clients' treatment. Each of the five (41.7%) clinicians who spoke about this reported that confidentiality

was limited, however there was variation in the details offered. Several of the clinicians pointed out that in the jail or prison environment, it is easy for someone to overhear. Knowing the limits, one person reported limiting the content of the session at times. Another participant noted that she insisted on a custody officer being present if a client had been unsafe in the past, consciously choosing her own safety over client confidentiality. Another talked about sharing the client's personal information with different disciplines who are involved in the client's care.

Confidentiality was also impacted by the age of the client, type and significance of court involvement, and the need to report information for mandated clients. Clinicians advised that anyone entering the field become familiar with "the nuances of confidentiality, knowing who holds privilege, who holds the key to the confidentiality, all that kind of stuff" because the issue could be complicated.

Limits to consistency. Many factors impact consistency, and most of the participants who discussed this issue cited unexpected events impacting scheduling and treatment consistency. The consensus among participants was that security and crises took precedence over general treatment: "Sometimes we just have to drop everything we're doing ... because sometimes crisis happens." These disruptions appear to be quite common in the field. Several participants made statements regarding their inability to predict for themselves or their clients when they would conduct sessions: "Say I have five people on my list and hoping I get five people because the code might be called.... So when a code is called, the building shuts down and there's no movement until the code is cleared." "I may have a kid scheduled for Monday but I may see him Monday, Wednesday, and Friday because something happened in the school or he was upset or mom called and told him he's not coming home that weekend."

These interruptions to the milieu would explain the claim made by a few of the clinicians that there was no such thing as a typical day:

The other thing that I think is *very* important to have ... is the ability to be flexible.

You're working in the correctional field. It's an ever-changing kind of situation, where you don't quite exactly ever feel settled. You actually don't ever feel complete. You don't feel like anything is ever satisfied. And it's an environment where in any given time something could disrupt your plan or your focus. Fights break out, riots happen, codes are called, mass movements are stopped, shift changes interrupt therapy sessions, a crisis with a resident who just got a phone call from home that his mom died, and mental health needs to respond to that or a resident accused another resident of sexually assaulting him and "Dr. F what do you think?" So I find myself pulled and pushed in a lot of different directions throughout the day, which is why my typical day never really is a typical day for me because I end up being and doing a lot of different kinds of things.

Managing constraints. These constraints limited the clinicians' ability to fulfill the responsibilities of their roles as clinicians. Clinicians indicated responding in various ways. Some clinicians reported working within the confines of these boundaries:

There's a fine line we have to walk, a balance, and not overstep our boundaries as mental health clinicians. We basically have to, the challenge is working and staying within our boundaries, our professional boundaries and keeping within our purview. Some things are outside of our purview.

This statement and similar statements by other participants suggest that some of the clinicians struggled with the notion of "not overstep[ing]," implying that these clinicians would like to step outside their role in certain cases, but chose not to.

Other clinicians reported stepping outside their role if the need arose. These clinicians reported teaching reading, working with clients on college applications, talking with clients about social justice and creating projects on societal issues, and coaching clients after treatment has officially ended. Two of these clinicians reported backlash from supervisors or administration: “I was trying to do the writing thing, and I got in trouble for that.” An African American clinician described her position on the matter, after being given a mandate from a supervisor to limit her interactions to therapy:

Particularly as a supervisor, you have certain things you have to, you know, administer and I understand that. Like for example, I’m not supposed to be doing any longer college applications and financial aid forms or teaching, but that’s just not in my spirit and I can’t, I can’t do my job and be okay with my job, if I let someone down. Like not to, be they black, white or whatever, but again since the majority of these kids are our kids, I have an obligation.

For this particular supervisor who is only doing ... And he’s a good clinician, he’s a very good clinician, but I do feel like he is once removed from the reality of these kids and I’m not removed. I’m printing out handwriting, cursive papers and we’re going over that tomorrow. I’m going to do an application, as long as we do our clinical work, then I don’t see anything wrong with it.

The thing is, and the reason why the mandate came down too, is that we did have to be reminded and we have to remind the officers because they’re always like, “You didn’t fix them, or they came back,” and really our purpose in the jail..., we’re actually there to maintain the juveniles, particularly on our special needs roster, their adjustment while they’re in jail. ... I mean really if you’re a psychologist, that’s just not immediately

who you are as a professional or you wouldn't be in the profession. So, we get why he said it and I think, all our staff ... we were just like okay and, you know, we just do what we need to do.

Although clinicians varied regarding whether or not they expanded their roles beyond the restrictions they felt, it was clear that they desired to provide useful treatment for their clients.

How Clinicians and Clients Approach Treatment

Both clients and clinicians come to treatment with their own approach and various preconceptions. The following sections describe the clinicians' frameworks and approaches to treatment and their experience of the preconceptions and approached of the clients with whom, they have worked.

Clinician framework. Clinicians approached treatment with justice-involved youth from a particular framework. Two participants did not mention their theoretical approach. Of those who specified, the overwhelming majority (7 of 10) identified cognitive-behavioral therapy, either alone or in combination with some other orientation. One clinician specified having received psychoanalytic training; she mentioned integrating play therapy and object relations into treatment where appropriate, "but when [I] started working with the kids at [the detention center], that's when [I] realize[d] it really had to be like cognitive behavioral." Other frameworks mentioned included motivational interviewing (four participants), dialectical behavior therapy (one participant), and solution-focused therapy (one participant), all of which are similar to or have a basis in behavioral theory (Barlow, 2014).

Client preconceptions. Clinicians are not the only ones that come to treatment with preconceived notions about the process. Clients present for treatment with certain preconceptions

about mental health and/or therapy. Based on participants' reports, client preconceptions were predominantly negative. For some, client perceptions were that they don't need treatment:

It's hard to get them to understand, they have things they need to work on. All of them I would say, not all, 99.99% of them don't have problems. They don't need to be there. They don't have a thing they need to work on, despite the fact that they've been in the youth house, six or seven times. This one kid, who I may just take off the roster today, he's got a 10 year sentence but he doesn't have any issues that he needs to work on, really because you're in for murder. I'm thinking that you might need to be talking about some things.

According to participants, other clients believed that treatment would not be helpful. Some youth were noted to purport that therapy was only useful for a select group of individuals, specifically White people or "crazy" people. One clinician reported that part of the work included:

... educating someone as to why therapy could potentially be helpful, when they initially started therapy and just thought it was for losers. I've had kids say, "Therapy is just for white people who got money.... Therapy can't help me.... As soon as I go back to the housing unit, you telling me about all this anger management stuff. I can't count to ten ... you know calm down, when somebody's up in my face, pointing in my face, telling me they gonna take my sneakers, and talking about my mother, and talking about my sister, and what they gonna do to her. How am I supposed to stay calm? How am I supposed to just look away?"

Other clients had the negative impression that treatment was a burden or additional obligation.

Some clients were reported to have found it boring or uninteresting; others expected that the

clinician would not understand their issues or problems or would criticize their thoughts, feelings, or actions. ““They’re going to tell me that everything I do is wrong.””

For the most part, youth didn’t want to be there. Whether they had prior negative experiences with treatment or no experience with treatment, the preponderance of youth had a negative perception, and some level of resistance to the process. Those who had a positive initial impression were noted to be interested or open to gaining from the experience.

Positive feelings tended to surface during or after treatment. One clinician referenced a client who, upon “graduating” from her group, reported being surprised that he had a good time. Another clinician indicated that many of her clients were hesitant initially, but once they began to participate, they found the experience beneficial.

Therapeutic Environment

Each participant spoke about the necessity of creating an emotionally safe treatment environment to work with youth who have had involvement with the juvenile justice system. It is important that this environment be a place with appropriate boundaries where the client feels free from judgment.

Emotional safety. Clinicians warned against forcing client participation, and instead the consensus was that, in treatment, creating a positive environment should be a central focus. According to participants, this environment would ideally be a space for youth to be able to speak freely about their issues, a space of emotional safety. Whereas those clinicians who spoke about physical safety did so in terms of the overall experience in the juvenile justice field, emotional safety was specifically identified as an important characteristic of treatment. This emotional safety is maintained through creating structure and nurturing a judgment-free atmosphere.

Structure. The majority of the participants (10, 83.3%) mentioned the importance of consistency. One clinician introduced the phrase, “maintain the frame” to emphasize importance of maintaining consistency as part of a positive environment. The notion of consistency included setting limits and maintaining boundaries. This was necessary because of the inappropriate boundaries exhibited by the clients. Participants who spoke about youth demonstrating inappropriate boundaries in treatment attributed this behavior to poor boundaries with adults in their lives in general. To maintain boundaries, clinicians emphasized a clear, defined structure. According to participants, youth should know the limits, which will increase that feeling of safety:

You have to have a lot of consistency and structure. I think more so than any population, this is a population that needs to have very firm understanding of structure and limit-setting because, a lot of times, they don't have that and they didn't have that for a long time so they can't really ever feel comfortable and safe until they have that. So I think that that would be a really important thing. You have to be very consistent. You can't be the flighty person who's all over the place.

Participants presented two specific considerations regarding structure. First, creating structure may be a specific challenge in certain settings. More so than others, clinicians in locked facilities, such as prisons, jails, and detention centers, spoke about the need for flexibility and the likelihood of unpredictable events impacting their schedules. To a certain extent, the unpredictability was out of the clinicians' control, and the need for flexibility in this regard appears to be due to the setting, regardless of the potential benefit or harm to the assigned individual case:

No matter how much you try to plan, it's, you know, like even like with the guys that I work with, like I don't have a set schedule on even days when I see them because I know if I say to you, I will see you every Monday, and then Monday comes and, you know, this other kid is trying to kill himself and I'm stuck in crisis with this kid all day and I don't see that kid ... [he's] like, "You said you were gonna see me and you didn't see me and you lied," and this and that, and you're like, "No, sorry, I had to deal with this," and a lot of times they don't care about the other kids, they don't care what the other kids problems are and that you were busy. And you said that you were gonna do it and now you've just disappointed them like everybody else.

Second, males and females relate differently, and thus have different needs regarding structure. One clinician noted that she found that a less formal initial presentation was useful in working with females, but not with males, suggesting that there was some variance between gender groups in the amount and type of structure needed to establish emotional safety.

Judgment free. The other important part of the emotionally safe environment was a space without judgments. Participants emphasized avoiding criticism and shame. Half of the participants mentioned validation as a useful tool, specifically empathizing with the client's feelings and providing positive feedback when possible. One participant offered that the acceptance of each client as a person should be balanced with acknowledgment of behaviors that needed to be targeted and changed.

Conveying that supportive stance of I don't agree with what you did. I don't agree that's the best way to do things, but I don't think you're bad. I don't think there's anything wrong with you but I do think you're making poor choices.

Interpersonal Interactions with the Client

Another aspect of treatment is the relationship with the client. Certain things were important to consider around interpersonal interactions with clients including rapport building, specifically fostering trust and respect; meeting the client at their level, and “being real.” Each of these is described below.

Rapport building. The significance of rapport-building was plainly evident in the participants’ statements. All of the clinicians spoke about the importance of having a positive relationship with clients, asserting that once a connection was made, youth tended to open up about their experiences and change their behavior. This connection consisted of mutual trust and respect.

Trust. Trust and rapport came up in this study as being intricately related. One participant asserted that rapport-building was a key factor in developing trust, three participants (25%) asserted the reverse—that trust was needed to develop rapport: “Be patient and put a lot of energy into building strong relationships with the kids because that will go a long way. Be someone they can trust.”

As the statement suggests, establishing trust was indicated to be a significant challenge. Four participants (33.3%) reported that youth lacked trust, and not necessarily because of the relationship they had with the clinician. Potential reasons suggested included early training—“Some of them have been taught specifically not to trust authority and not to trust the system” — and negative experiences with trusting others— “The people that they’ve trusted most, have been the ones who’ve hurt them, their parents, or siblings, or so, they have a lot of reasons not to trust you.” One clinician indicated that lack of trust interferes with the clinician’s ability to be

effective. Another participant advised that trusting the client allowed the client to build trust in turn. Trust begot trust.

Respect. The other component of rapport building was establishing respect. On the one hand, this meant interacting with the youth in a way that demonstrated respect: “Talk to them like they’re intelligent human beings,” “not dumbed down for kids.” On the other hand, this meant fostering respect; as clinicians noted that without the client’s respect, little work was possible: “If they don’t trust me and respect me, I really don’t feel like I can be effective. If they do, I feel like they might actually listen to me and I can call them out or challenge them in various ways.” As this statement suggests, a respected clinician was a thought to be an effective clinician.

According to several participants, youth were significantly disrespectful at times. This was primarily a struggle for female clinicians, who cited multiple instances of profanity use, verbally aggressive comments, and sexual language or gestures. They all indicated that the solution to this challenge was addressing these behaviors and insisting on respectful interactions. There was some variability in terms of how the issue was addressed, but all reported using some form of direct communication with the youth.

Meeting the client at their level. In terms of therapeutic interactions, the participants consistently emphasized adjusting their interactions depending on the client’s presentation, “because they’re all different kids.” As expressed by one participant:

If you talk down to them, they see that ... and they all think as they say, “I’m a grown-ass man.” Okay, well [they’re] not, but [they] want to think that. I usually let them know, I always phrase it like, “You’re coming into your manhood.” And so I gauge myself on those different levels with them.

In treatment, meeting the client at their level involved following the lead of the client, relating therapeutic content to the client's interests, and supplementing difficult established curriculum with material that was easier to understand. One participant noted, "If this kid is the kind of kid who is just really so disturbed but she loves to play this one little puzzle, we'll play that puzzle every week. That's okay because in that puzzle we'll develop a relationship."

Being real. Eight of the 12 participants (66.7%) specifically used the term "being real" to describe another key factor in their interpersonal interactions with clients. Being real involved two major components: being genuine and being open. According to participants, to be genuine meant to be honest with the client about who you are. In particular, they warned against using language or speech that is not authentic to one's normal presentation:

People think you have to come at these kids in a way they understand, like, get into the gangster talk, with the slang, and that kind of stuff. I'm the farthest thing from that and so I don't try to be like that. And even though I did not grow up in the same place or even same environment, under [the] same circumstances, if I'm just me and comfortable with me, you know, the kids ... are fine. But the minute you try to fake being you, they can tell. They can tell. And they'll be like, why you trying to talk all tough and everything. And forget it, you're just going to lose them because they just think you're faking them out.

Related to this was the idea of allowing the youth to see beyond the clinician's professional persona to the person underneath. Clinicians reported that admitting their own imperfections and acknowledging their own limits allowed the youth to view them as real people who were more relatable. Most clinicians specified that they participated in a certain level of

self-disclosure specifically in the interest of demonstrating their human side or their personal experience with a particular issue:

I'll disclose, because so many of these boys think that we're all perfect. They think all of the staff have no problems ... I have disclosed like my birth father was physically abusive to my mom. I have disclosed that my older brother has been in [multiple prisons] ... I'm like yeah, our lives are not perfect. The question is, how do you get past. You know, I'll say like my brother and I are two years apart, that does mean he probably has some more memories of the abuse, because we were little, but what led him to using drugs to cope and being in and out of jail, and what led me to becoming a doctor still... And I think that it's important for them to know, that we are human and our lives aren't perfect.

Because when they think you're perfect, they can't relate to you.

Alternately, some participants also warned about the dangers of sharing too much information.

One clinician who addressed this notion specifically, emphasized not disclosing information that could be used to find the clinician or a member of their family.

Another aspect of being real involved openness. According to clinicians, this meant being able to have a forthright and direct conversation with clients about what was going on.

When the secrets are out in the open, when parents and schools and all of that know about the substance use or the illegal behaviors or whatever the choices have been, I feel like then the conversation gets real and we don't have to pretend that these things aren't happening or sweep them under the rug.

Clinical Interventions

Next is a summary of the various treatment interventions described by clients. This consists of the content covered in and missing from treatment as well as the specific techniques and activities that clinicians reported using during therapy.

Content of treatment. The content covered in treatment varied greatly amongst the participants, and the work of each participant included multiple treatment foci. There were a wide array of issues and topics addressed in treatment. No demographic factor or participant characteristic was found useful in predicting the content of treatment.

In select cases, participants used treatment targeted to a specific subgroup within the juvenile population, such as sex offenders, fire starters, and trauma and abuse victims. The overarching treatment goal, in these cases, was related to the specific issue. Aside from these specific cases, a variety of other content areas were indicated, discussed below under two broad categories: reducing targeted behavior deemed inappropriate and increasing targeted behavior deemed appropriate or beneficial to the youth.

Targets. Behaviors targeted to be reduced included fighting, substance abuse, suicide attempts, and gang association. Behaviors targeted to be increased were prosocial interpersonal interactions, and skills. Skills targeted included life skills (activities of daily living), parenting skills, and social skills. Other skills included identifying and managing thoughts and emotions. Participants more frequently referenced interventions targeting emotions than interventions targeting thoughts or thinking patterns. In addition, goal-setting (which included both “What are we going to work on together?” and “What would you like to see different in your world?”) was prominent, as was assessing consequences (determining the effectiveness of behaviors to determine which behaviors “work” for the client and learning to predict potential consequences of actions). Lastly in terms of skill development, medication management and symptom management were also mentioned. Regarding the target of increasing prosocial interpersonal interactions, participants predominantly focused on helping the youth have positive interactions. This involved helping them develop empathy, use conflict resolution techniques with their

families and those in the correction environment or treatment facility, and build connections to resources.

Missing content. There were some areas that clinicians felt were not well addressed in treatment. In some cases, the treatment focus was not predetermined; two clinicians reported that a major challenge was having no clear goal for treatment. In other cases, the content of treatment was deemed insufficient in some way. Three participants (25%) indicated that treatment did not focus on rehabilitation. As one participant explained, “[The client’s] behavior is born out of antisocial, behavioral, personality, conduct disorder, period. And we’re not set up for that.” Another participant more specifically asserted that, in his experience, mental health for juvenile justice clients was oriented more towards stabilizing clients rather than creating lasting change.

Well the goal is so that they don’t kill themselves while they’re in jail, and they do their time and they don’t give everybody a hard time, and they stay alive so they can’t sue the frigging city, and they don’t commit suicide. But this program is not designed to stop people from coming to jail. If you think it is, then you’re wrong.

Given the short length of stay inherent in incarceration in jails, this focus on stability is more likely in jails than other juvenile justice settings, but still bears noting as part of the overall picture. Participants also noted that racism and societal bias were not addressed in treatment, with one participant reporting he was reprimanded for addressing these issues in his treatment program. That the participants discussed these missing content areas without prompting suggests that they felt that their absence from the treatment program should be noted and rectified.

Techniques and activities. All of the participants reported using a range of activities and interventions in their treatment practices. Psychoeducation was referenced most often (nine instances), and predominantly focused on symptom development and the utility of therapy.

Activities conducted during therapeutic interventions included mindfulness, meditation, relaxation, role plays, and incentive programs. There were two activities mentioned specific to group formats: establishing a community agreement and implementing team-building exercises. Other noted interventions included cognitive restructuring (one clinician mentioned reframing a client's negative childhood as life lessons that helped him become a man) and personal histories (e.g., trauma narratives and legacy work, or what the client identifies as their legacy thus far and what they would like the legacy to be going forward).

Treatment Outcomes

The above mentioned factors are those that clinicians point to as essential components of the therapeutic intervention. This section will contain a review of effectiveness and outcomes of those interventions including a description of the limited feedback clinicians receive about their treatment effectiveness, the difficulty labeling a case as successful or unsuccessful, measures clinicians use to assess progress and the personal, interpersonal, environmental clinical factors that impact treatment outcomes.

Issues around determining outcome. One of the major obstacles to determining treatment outcomes is that in many cases involving youth with juvenile justice involvement, the clinician was not aware of the long-term outcomes of their interventions: "I would be failing myself ... if I were expecting to see the product of my work, for lack of a better word, at the end." Five of the respondents (41.7%) pointed out that their clients leave them—not necessarily because treatment has been completed or because there is agreement that the client is in a better place psychologically. For the most part, the clinicians who worked in facilities had no way of knowing the impact of their interventions once clients were released. As one person indicated, "This might not translate when they go into the community and actually have to face real-life

situations, but at that point we don't have any control over that, because they're gone, they're either on parole or they've maxed-out." The long-term effects of treatment therefore remain unknown, and for the most part, clinicians had to find other ways to measure treatment outcomes (discussed below).

Defining successful. When participants were asked to describe a successful case, many noted progress but were unable to definitively categorize a case example as a success. For some, the issue was that steps taken did not meet some identified goal:

[My interventions are] not going to solve the problem totally or completely enough. In other words, what we're doing here is not going to stop kids from coming to jail.... It's not going to get black people jobs, really. I don't do any of that.... But it does give you something.... It's better than nothing, let me put it to you that way."

Even some of the participants who identified a case as successful specified a limitation or a caveat to that descriptor, such as: "a case that's successful although the kid is back." In other words, success must be defined more broadly in terms of progress toward, and not necessarily achievement of, a goal. One participant noted, successful cases are those that "aren't unsuccessful," although there were concerns raised about the term "unsuccessful" as well, which are described next.

Defining unsuccessful. The word "unsuccessful" (as opposed to a harsher term like "failed") was intentionally chosen for a moderate tone, aimed at gleaning information about cases in which goals were not met or significant progress was unattained. Clinicians more easily identified unsuccessful cases or indicated a larger pool of cases to choose from, compared to successful cases, suggesting that more cases fit the definition of unsuccessful than successful. Yet, several clinicians were hesitant to label particular cases as unsuccessful. "Unsuccessful ...

for me I don't want to say there's ever a case that I would say was unsuccessful because that sounds like so finite. I would more phrase it as not forthcoming, [nervous laugh] that was not really going anywhere, stagnant." One participant reported that an unsuccessful case was one where the client regressed, which she had not experienced before. Another stated that the client was just not ready to move forward: "So, unsuccessful is that you can't, you want them to do better and they're not ready to do better." However, as a third participant noted, treatment may still be beneficial even when there was no noticeable change or investment in treatment. It is possible that something the clinician said or did "stuck" with the client, and made an impact that only became apparent at a later date.

Measures of success or progress. In general, success was measured in terms of tangible progress, most often by long-term indicators, many of which would occur after the end of treatment, if at all, and require continued contact to verify. Examples included the pursuit of higher education or employment, the ability to acquire material things through legitimate means, sobriety, or taking responsibility for a child at home. Other indicators of progress included factors typically seen during the treatment process, such as increased self-esteem, use of skills learned, and teaching others skills learned. Often progress was witnessed in subtle ways. One clinician spoke of hearing one client tell a peer about a skill he had learned. Another clinician offered an example of progress on a group level:

These are girls that don't necessarily like each other, have said mean things to each other, there's a lot of drama in the school and I got all these girls to do this [trust exercise]?

They loved it and they trusted each other, they kind of threw out the window, for this 30 minute period of time to do this activity, all of their other stuff because I just said to them we have to trust each other and I went first. ... They're like, "Oh my gosh, you really

trust us.” I was like, “Yeah, I do. I’ve known you all school year, it’s like of course I trust you and I wouldn’t be doing this if I didn’t.” ... Then when I asked who’s next, I had a volunteer and then we just ran through, not all the girls did it but most of them did ...

That was just a really cool success for me because it just worked. It took so long for these girls to get to this place, I could never have pulled this activity off even in December even though I had been working with them since October. That was pretty cool for me.

Another indication of success was the non-occurrence of some negative event, such as re-incarceration or death. Re-incarceration was the most often indicated. The majority of the participants (10, 83%) spoke about the high likelihood of recidivism. Clinicians, therefore, considered a young person successful when he or she was able to continue life after treatment without violating probation or parole, or not “graduating” to the adult justice system. One clinician indicated that success and failure was to a certain extent measured by whether the client continued to live. This clinician particularly struggled with the issue of progress because he felt that his main objective, according to the administration, was to prevent suicide. Therefore, any case in which the client lived was not a failure, regardless of whether or not there was noticeable improvement in functioning.

Several participants advised that the expectations of progress should be small, and multiple participants warned against expectations to “change the world.” They indicated that change was incremental, and success stories are few and far between: “Your rewards come in that if you have one child who makes it, unfortunately you can’t say I have 16 on my caseload right now, 15 are going to make it. Sadly, it’s hopefully one. You can’t even say positively that one is going to make it.”

Factors impacting outcomes. In an effort to understand the factors important in eliciting the signs of progress noted above, clinicians were asked to describe cases and factors impacting treatment outcomes of those cases. Participants identified several personal, interpersonal, environmental, and clinical factors that impacted outcomes in their cases.

Personal factors. Participants identified personal factors, more specifically, client characteristics, that were associated with positive outcomes. These characteristics included intelligence, a commitment to change, openness, and engagement in the treatment process. One participant's description provides a good example of how this manifests:

So something about him was that he took it seriously and maybe not that he was like excited about it, but he was sort of, "I don't want to be on probation. This is not good."

So he showed up when he was supposed to. He showed up to group. He showed up to individual. He showed up to his P.O. [probation officer] meetings. He called his P.O. The consequence for him, the structure was good and the consequence of, "I don't want to do this forever. I don't want this to get extended."

On the other hand, client factors associated with more negative outcomes included high symptom severity, immaturity, impulsivity, and a resistance to change. Participants described multiple situations in which their clients were resistant. Some clients were invested in their lifestyle, typically a gang lifestyle, and did not want a different lifestyle. One clinician defined these youth as "hardened." Other clients were reported to believe that change was not possible for them, suggesting a sense of hopelessness: "[He] wanted a different maybe potential life for himself. He believed that there was no way he was going to be able to ever pull that off, or ever get out of the gang." Participants also described clients who just weren't ready to do the work: "You can't force someone, to work on things that they're not ready to work on."

Interpersonal factors. Interpersonal factors increasing the likelihood of success included close relationships and prosocial interactions with significant others. Examples included positive family interactions, particularly parental support. Clinicians spoke about “supportive parents who understood his diagnosis and helped him work through it.” Participants found parents who were not supportive of treatment to be counterproductive. For example, one clinician described a situation in which the client’s father refused to follow any plan the clinician proposed, and the client’s mother would not set boundaries because she did not want to be the “bad guy.” In a situation such as this, the client would likely receive very different, conflicting messages from home and from the treatment team. This supports the participants’ assertions regarding the importance of a good relationship between the clinician and client’s parents. Frequent contact and open communication between the clinician and family was associated with successful outcomes.

An extension of family support was a larger system of support. The clinicians from Oregon who espoused restorative justice emphasized the importance of community involvement. Other clinicians indicated other treatment providers as important additional sources of support. “I think what makes any of these things more successful is having a system of care and so you find the most successful treatments are ones that go in, not just as individual therapy or individual whatever, but ones that connect with the entire system. Like, for the program I’m with now, we’re connect[ed] with the administration. We’re connected with everyone.... [There is] a system of care that goes into their home, helps their parents with parent strategies, works on basic fundamental needs that they have, maybe around getting jobs, food ... it’s a system of care. You just can’t do this stuff in spots.”

Environmental factors. Another factor impacting successful outcomes was the home environment. Although participants did not specify aspects of the home environment that related to success, they did offer those aspects that were related to unsuccessful outcomes. Some clinicians identified names of specific neighborhoods where their clients resided, others were more general. Common environmental factors included gang presence, drugs, and high criminal activity. There were frequent reports of the futility of interventions in residential settings without changes to the post-incarceration environment.

They're going back to the same exact environment with the same exact stuff going on, yeah so you understand that it's also hard for them.... When you spend that much time and effort like trying and they get it, that's the thing too, that's what's so hard too, it's like when they're there with you they get it and they're so motivated and they're like, "I'm not gonna do this again, you know." And then they get out and six months to a year goes by and they've violated parole and they're coming back.

Clinical factors. Clinical factors impacting outcomes were treatment-specific factors. More than half of the participants mentioned the importance of working on a specific problem area, and more than half of this group mentioned addressing family difficulties as one target important for successful outcomes. Lack of a clear focus was a factor associated with unsuccessful treatment.

Clinicians also described specific interventions that positively impacted treatment. Specific examples included integrating music and writing (commensurate with the client's interests) and physical movement. Although several clinicians reported using physical movement, one specified that she finds it more useful with males than females. Other clinical factors included creating a positive treatment experience, making treatment relevant to engage

the youth, creating a safe space, adjusting to the clients' needs with regard to depth of exploration and desire for distance, and medication management.

The participants also identified various challenges to successful outcomes, particularly roadblocks to implementing interventions. Clinicians indicated that at times treatment was intermittent due to poor attendance or penal restrictions. Participants also talked about having to find a balance between the needs of an individual client with other obligations or other clients, suggesting that their time or attention was limited. This appeared to be particularly salient for group therapists who interacted with multiple youth at one time.

Successful case example. The following case was defined by a participant as successful, and illustrates many of the concepts described above:

Seventeen-year-old Hispanic male, terrible history of physical and sexual abuse on him as a child. Both parents were substance abusers and had significant mental health histories. He had four siblings who were all younger than him, and because of his parents' substance abuse and mental health issues, most of the time they were out of the home. So essentially he was, he was the mother and father; he was the protector; he was the kid that would absorb the abuse to prevent his siblings from, you know, sort of, having to face that ... or even see that in his family.

So what he grew to develop was a lot of street-smart skills, a lot of survival skills that enabled him to keep his siblings fed, keep his siblings clothed, keep them going to school even when he was skipping school, missing school, bailing out of school. He was basically holding together his family and caught in the middle because he was essentially sort of sacrificing himself in more ways than one to hold together things for his siblings who he deeply cared for. When times got rough, Dad would leave ... Mom would be

home but because she was struggling with her own issues, and she was leaning a lot on him ... she would get verbally abusive or sometimes physically abusive. Because he was respectful of his mom despite her issues he would never fight back, he would just sort of, kind of, take it.

When things got particularly rough, he started selling drugs started running the streets, got involved in a gang; in his mind helping to support his family and bring money home to his family. Admirable stepping-up on his part, but also he found himself very much and deeper involved in this negative lifestyle. All the while in his mind he thought that the benefit would be supporting his family. He also had significant issues with men in his life, authority figures. So he was the kid at school who would get in fights with the security officers if they caught him in the hallway doing something he wasn't supposed to, a lot of anger for the principal, a lot of anger for the probations officers when he would get in trouble for stealing from stores. So he was doing a lot of stuff, stealing from the grocery store, not candy bars, but he'd have like, ground beef, and a loaf of bread, and eggs and he's running out the store with it to go home, cook something for the family, make a meatloaf or something like ... that was one of the stories he told me.

So he comes to our department, fortunately he didn't have significant mental health issues, but he drank a lot and a lot of the drinking was his way of just sort of coping and dealing with the fact that he had this, you know, very stressful responsibility. The drinking also caused him to miss school, pass out at home after he dropped his kids ... I say his kids, they're really his siblings.

So he came to the mental health department primarily because he had significant coping skills issues, also a lot of anger at basically every adult that was in his life. And

what made it successful is that I helped him realize that, or we helped him realize that the responsibility for caring for his siblings, while he accepted it, wasn't necessarily his and that he needed to find out, in order for himself, in order to, live his life, and have a life, he needed to figure out a way to separate his role as their protector and parent, separate that from what he needed to do in his own life to better himself, so that he would actually have, in the end, a better future with which to provide for them. His end goal was always, "I gotta provide. I gotta do the best thing I can for them," but he was sort of looking at the short-term. "Let me steal. Let me sell drugs. Let me do this to meet their needs..." rather than "Let me go to school. Let get myself some help so ultimately, I could have a job and have a career where I can be the person that I really want to be for them and give them what I didn't have." ... What made therapy successful with him was that he ... was motivated enough to accept what it was that I was sharing with him in working through the therapeutic process because his goal was always to be a better person for his siblings. So he was, within that, open and willing and able to accept, "Well I tried this my way, it didn't work."... because he trusted also that I had his best interest and his siblings best interest at heart, that he was willing to try things and was willing to expose himself to things. He was willing to be honest with me in a way that he and I ultimately knew if we worked hard enough, would lead him on a path to be able to successfully, you know, be there for his siblings.

So he ended up getting out after two years, kept up with him, in contact.... He ended up coming back though on a violation of his parole because, due to a curfew violation.... His siblings got removed from the mom due to her relapsing and having substance abuse issues.... He found out or suspected that the foster father had hit one of

his siblings. He was gonna go and settle it, straighten it out. For one, he wasn't supposed to go there at all. Two, he wasn't supposed to go there with a bracelet on his leg and that was a violation of his curfew. He's out of range. But again, it was one of those situations where he wasn't trying to do anything wrong. He was trying to figure out how to help the situation....

He has probably another eight months to do with us but overall successful ... he's back though, he's found ways to improve the quality of his own life while also staying true to his desire to be there for his siblings and also recognizing that he can be there for his siblings in more ways than just, sort of, physically giving them stuff in the present time, here and now, and doing stuff for them. So fortunately, he got himself, finally got himself his GED, while he's with us. He's taking some college courses now. So I'm hoping that ... his kids, somebody just took them to foster care. His goal is to get out, finish out his parole and be able to, sort of like, adopt them, so that they can come live with him. That's his ultimate goal.... So successful because he's, he's gotten it and he's lived through a lot, he's experienced a lot and he's suffered a lot of the consequences that really are other people's responsibility and other people's doing that he's found himself caught with and he accepts responsibility for.

This is an example of a case that was considered successful despite recidivism. The client entered treatment with an open mind and developed a positive relationship with his therapist. He was exposed to an alternative perspective and demonstrated some changes in thinking before he was released. Unfortunately, once released he reverted back to old habits due to challenges he faced in regards to his family, which is an outcome many clinicians warned about. Despite this,

the clinician was able to identify several indicators of progress and described the client's growth in detail.

Unsuccessful case examples. Below are two vignettes that demonstrate the concepts about unsuccessful cases described in the sections above:

1) I had [a] guy who was pretty gang involved, he was from [an urban area], he had some depression, don't know if it was more related to being incarcerated though. That's a whole other thing, sometimes it's just related to being incarcerated and not necessarily, you know, and on the other hand you don't really know because they were doing so much drugs before they came in that they didn't know who they were and never mind where their mood was at. You know, most of the kids I work with smoked weed, at least weed every day, you know, or other kids who smoked wet.... They dip like blunts and stuff in embalming fluid, it's like PCP.... I've had kids who just like nobody's there. And then all of a sudden they'll snap out of it, it's the weirdest thing you've ever seen.

But anyway, this kid, had substance abuse history, was raised by grandparents.... Where were his parents? Mom used substances too, think Dad was in and out of jail, if I remember correctly. He was a nice kid but you just, you know, he also had mild mental retardation, I don't remember if I said that. So he was limited and he went back home. A couple months after he went home he was shot and killed. They found him like at the side of the road somewhere in [his neighborhood], and for him I don't know that anything would have changed, you know, anything other than, you know, his family picking up and moving somewhere else, you know, outside of [the state], you know. He was pretty involved and he didn't really want to not be involved.

2) This one guy, he was a squirrely little thing. He was seventeen, but he spent the last two years in the prison because he could not get through groups. Basically, when they come to the prison, they get assigned groups, whether it be anger management, substance abuse, you name it, they'll give it to them. They can't do them all at the same time. They have to do one, then the other, then the other, and go to school. So he would get to like week ten of a twelve-week group and fight and have to restart. So he was there since he was fourteen. I got him when he was seventeen, had just started seventeen. Once you're seventeen, they can't extend your sentence. When you're sixteen years, nine months and thirty days, they can bring you to court and say we're extending you till you're eighteen. For him, his extension worked out, so he could leave when he was seventeen and a half and be done.

I would see him in therapy. He would just want to talk about music, talk about like typical teenage stuff, but I couldn't get through to him why it was important to finish groups so he can get out. I think he was institutionalized. I think he had a lot of clout. He's gang-involved, and even though they try to say that the institution doesn't have gangs, it's really hard for them to, to not do that.... He did get out, went to a group home and was back within two weeks. It was like, "Really, we worked so hard," and he was like, "But it's not [my] fault Ms. J. This and this and this happened." I wouldn't call it a failure as much as I couldn't get through to him. Our therapy, I never want to say therapy was useless or anything like that because something might have stuck. He came every week; wanted to see me twice a week sometimes. But it wasn't focused therapy. It was very like superficial. We never actually worked on anything as to why was he in a gang,

why does he have such a hard time with his father, why does he not want to live with his mother, you know, all that stuff....

I was probably the third therapist, if not more. So he was used to seeing interns coming and going.... I had a hard time holding him accountable.... I probably should have approached him differently from the beginning. I tend to have a buddy-buddy kind of approach, and I think that didn't work for him because he saw me probably as, not a peer, but maybe didn't take me seriously as somebody who could really help him.

Whereas it works with my girls where I kind of come in and we'll talk about hair or I'll bring in a magazine and try to befriend them and be their therapist, but with this particular kid, I think that was the wrong approach. He needed somebody, not stern like yelling at him, but somebody more like, "Cut out the BS. You know you did this. What could you have done differently?"

Both vignettes are examples of cases in which progress was significantly limited. In the first, the client was involved with gangs and substance abuse. Also, he had deficits in intellectual functioning. His family had multiple risk factors. Further, he wasn't interested in making changes to his life. This latter characteristic is also true of the client in the second vignette. The participant notes that she could have possibly done things differently to increase the client's engagement and sense of responsibility for his actions, which is related to the impact of clinical factors in the intervention.

Preparation and Training

Almost half of the participants in this study mentioned a lack of available training for working with this specific population. "To be perfectly honest, really, really be honest, I feel like this is a population where people don't really understand, and there's not a lot of trainings

specifically for them.” One clinician stated that she had not planned to work with justice-involved youth or juvenile populations, and thus was not looking for training in this area initially. However, all others reported that they had some intention of working with the population during their graduate education, but found that opportunities for specific training, prior to employment, were limited. In terms of coursework, only one clinician mentioned doctoral coursework on youth offenders, which she reported was particularly useful:

One of the things that does stand out in my mind, which was pretty interesting and also helpful, is our professor was an active psychologist and, at the time, she was working with this kiddo who she had been seeing for a while, who she was pretty sure had psychopathy, like was a psychopath. So she walked us through this case over the course of the term. And so it was really helpful to learn about him and her work with him and have that as sort of a yardstick.

During graduate school, specialized training was more likely obtained through experiential components, such as practica and internships. One clinician reported learning about “clinical populations and the forensic populations that [he] wanted to work with, kids and adults involved in the foster care system, the children and family [Division of Youth and Family Service] system, the substance abuse system.” However, this clinician reported that he made a concerted effort to seek out those experiences.

Interestingly, the supervision that came with these experiences was identified as significantly helpful for the clinicians in their practice. “I don’t think too much that I had specific training, as much as I had hands-on experience and good supervision.” Several clinicians commented on the importance of good supervision:

Good supervision is weekly, uninterrupted supervision for an hour, going in with your cases and having your supervisor train you on techniques that you haven't done yet. It's not just enough to staff cases because you can staff cases with anybody, but good supervision is when you're actually learning more about what you're doing.

Despite the praise offered for good supervision, only four (33.3%) clinicians reported having experiential learning and supervision. The majority of participants reported that their training was either employment-based (eight, 66.7%): "I don't think there's really any specific interventions that the juvenile justice commission has taught me per se, like, in a training. It's kind of like trial by fire," and/or self-selected continuing education (seven, 58.3%), that allowed for clinicians to pursue additional knowledge in areas that were lacking or to "keep up" with recent developments in the field. A few clinicians pointed out that in their jobs, they were more likely to be training others than receiving training.

Utility of the training. For the most part, clinicians found the training they have had to be helpful. The exception was in instances in which the training was too remedial:

They do have some in-service training here that they, you know, open up if mental health wants to go.... With all the training we've had it's, it's usually, oh, you know, we've heard that before.... We're polite and we'll sit through it and stuff like that.

One clinician attended a seminar on "oppositional kids" and left with a sense that the kids discussed in the seminar had significantly fewer issues than her typical client and that the tools offered would not be appropriate for her to use. Another clinician mentioned augmenting treatments learned with prior clinical skill and knowledge.

Overall, however, the participants generally felt positively about training. They identified three broad categories of content as particularly helpful: issues impacting the youth,

interventions, and systems work. Regarding issues impacting youth, several clinicians found it helpful to gain an understanding of gang culture, trauma, substance abuse, and gender identity and sexuality issues. In terms of interventions, clinicians felt that training on specific interventions for youth in juvenile justice was helpful. These included specific treatment protocols like TARGET (see Ford et al., 2012), Think Trauma (see Marrow, Benamati, Decker, Griffin, & Lott, 2012), and Power Source (see Leonard et al., 2013), as well as overall frameworks such as restorative justice (see Sherman et al., 2015). In addition, participants also found general therapeutic skills training to be helpful. Clinicians specifically appreciated the skills of clinical interviewing, boundary setting, and joining with clients. The systemic aspects reported as helpful involved understanding the justice system and appropriate protocols for interactions, as well as networking and interacting with agencies in order to facilitate services for the youth.

In addition to helpful training received, clinicians were asked about additional trainings that they believed would be helpful for themselves or individuals entering the field. The participants who did not receive (or did not receive enough) training in the topics mentioned above identified many of the same topics as ones that would be helpful in preparation for work with justice-involved youth. Clinicians were also specifically interested in learning other treatments, such as collaborative problem solving (see Greene & Ablon, 2006), trauma-focused CBT (see Cohen, Mannarino, Deblinger, 2012), and dialectical behavior therapy (see Linehan, 1993). They felt these approaches might be useful for working with this population. Participants also mentioned that training on social media would be helpful.

Integrating Literature into Practice

Given the gap that exists between literature and practice, the use of literature in clinical practice is important to consider. The literature that clinicians have access to and how that literature is used in their practice is described below.

Literature accessed. Overall, the participants felt that literature specific to the treatment of juvenile justice clients was not available to them. Only two participants felt particularly connected to the literature in the field. Three clinicians suggested that they may not be looking hard enough into what is available, and one reported that she doesn't have the time to seek it out. However, one-third of the participants reported the belief that the literature doesn't exist. Therefore, combined, over half of the participants reported outright that they did not have access to literature in this area. Participants made only two references to literature specifically focused on youth with juvenile justice involvement, both in the area of solitary confinement.

The literature that clinicians did report accessing focused on other various topics related to working with juvenile clients, and not precisely on the treatment of clients with juvenile justice involvement. These topics included substance abuse, gang culture, trauma, sex trafficking, social issues, and neurological development given certain circumstances typical for this population (i.e., during drug use or after trauma). Clinicians also accessed materials on mental health issues, including general psychopathology, PTSD, the use of medications, and evidence support for interventions, such as eye movement desensitization and reprocessing (EMDR), mindfulness, and trauma-focused interventions. Participants accessed relevant literature via research studies, books, reference materials (such as textbooks and the Diagnostic and Statistical Manual of Mental Disorders), and newsletters.

Use of literature. Participants used the literature primarily for the purposes of training and obtaining information. Nine clinicians (75%) reported that they used the literature to learn about topics and stay current on the issues impacting their practice. Further uses for the literature included adapting existing treatment, enhancing a therapeutic program, changing policy related to the treatment of inmates, and sharing information with clients (each of these was mentioned once by different participants). Two participants stated that the literature was not helpful. As one clinician stated:

Even when I first started out here, and so wanted to find more guidance, something like that, I didn't find as much that really fit into this population and nothing that was positive. A lot of it was about recidivism rates and ... You know, kind of disheartening. Another said, "I don't read a lot of articles. When I've read them, they haven't been helpful. So as of late, the training for me comes from being there with the boys. They are definitely a breadth of training."

Overall, it appears that the clinicians who are making use of literature are combining material in a piecemeal manner, finding relevant pieces of material useful to understanding a specific aspect of the clients they serve, and applying that information to their practice.

CHAPTER 5

Discussion

This study explored the experiences of clinicians in their treatment of youth in the juvenile justice system. Specifically, participants were asked to reflect on their understanding of treatment with this population; their experience of the settings in which they work, including challenges, rewards, and their preparation to enter the field; and their reflections on the research available to them. Outlined below are the major themes discussed by participants, limitations of the research, and potential implications for various stakeholders.

Key Themes

Several themes emerged from the participants' responses, including (a) the qualities of clinicians who work with this population, (b) the experience of working within various justice system frameworks, (c) types of interventions used, (d) challenges regarding outcomes, and (e) the availability and use of training and literature.

Qualities of clinicians in juvenile justice work. Participants described the characteristics ideally possessed by a clinician who works with youth in the juvenile justice field. More specifically, they provided ideas about the type of person who works best in this setting, including the personal characteristics that will help the clinician succeed and the interpersonal characteristics that contribute to building strong relationships with clients.

Personal characteristics. According to participants, clinicians must have both strength and passion. They spoke of determination and connection with the population. They described the environment as harsh and filled with challenges, so the ability to exist under constant attack with limited gratification was indicated as a must. Several participants referenced the need to have a "thick skin." At the same time, clinicians also reported feeling very connected to their

work. All of the participants spoke about a personal connection to the work or feeling especially passionate about a particular aspect of the work. Most participants reported a desire to make an impact; they saw something in the youth they served that inspired them to commit to improving the lives of these young people.

Interpersonal characteristics. Another important factor in serving this population is developing a close interpersonal relationship. Participants described several characteristics as paramount in developing this relationship. The treatment setting should be a positive environment, and therapy should be consistent, judgment free, and characterized by mutual respect and trust between client and clinician. Further, the clinician should “be real,” or authentic, with their clients.

Most of these factors have been previously highlighted in the literature as elements underlying effectiveness of the psychotherapy relationship (Norcross & Wampold, 2011). What is unique to this study is the notion of “being real,” likely because such authenticity is particularly essential with youth with juvenile justice involvement.

The framework of the justice system. The participants from Oregon espoused the restorative justice framework in the treatment of youth who have juvenile justice system involvement, an approach not mentioned by participants from New York and New Jersey. Restorative justice is an approach that attempts to “create nonadversarial dialogue among victims, offenders, and other affected individuals to address the harms caused by crime and promote offender accountability” (Bergseth & Bouffard, 2013, p. 1055). According to participants, the approach focuses on making amends and reintegrating youth into the community. Proponents of this approach represent a perspective that is more aligned with a rehabilitation approach for juvenile offenders.

The system in New York and New Jersey, as described by participants, is more aligned with a punishment approach to juvenile offenders. Whereas the court and correctional staff are focused on confinement and punishment, clinicians are oriented toward preserving and increasing mental health. The presence of two separate parties with two distinct goals working alongside each other creates an environment with conflicting cultures. Some researchers have elaborated on these conflicts within forensic settings, where the priority is security. The environment is typically controlled through punitive sanctions and enforcement of authority and rules (Appelbaum, Hickey, & Packer, 2001). On the one hand, most correctional staff members view many of the behaviors exhibited by inmates with mental health problems as intentional violations or manipulation. On the other hand, mental health providers view these behaviors as maladaptive attempts at coping, and seek to provide treatment to the individual. This typically entailed negotiation of goals and expectations for compliance.

The study results appear to support the literature, as the participants spoke about mental health being secondary to, and in some cases a means to promote, behavioral adherence to the rules surrounding the incarceration. The clinicians had to constantly negotiate a security-oriented system—in which general practice included policies that undermined mental health—while trying to create an atmosphere that encouraged mental wellness. Navigating this imbalance was one of the major challenges in the clinicians' role as service provider.

Theoretical orientation and treatment. The clinicians indicated their desire to have a better understanding of various treatments available for use with their clients. Interventions of interest included collaborative problem solving (CPS), dialectical behavior therapy (DBT), and trauma-focused cognitive behavioral therapy (TF-CBT). However, the utility of these programs

in juvenile justice practice is uncertain without systematic research as to their effectiveness with this population.

Intervention programs of interest. Of those mentioned above, DBT has the greatest research assessing efficacy with juvenile justice populations. There is consistent evidence for improvements in forensic (Berzin & Trestman, 2004; Quinn & Shera, 2009) and adolescent (James, Taylor, Winmill, & Alfoadari, 2008; Katz, Cox, Gunasekara, & Miller, 2004; Miller et al., 2000) populations, with the implementation of adaptations of DBT (see McCann et al., 2000; Rathus & Miller, 2000, for a summary of respective adaptations). However, as noted in the review of literature, the one study which assessed the efficacy of DBT with juvenile justice youth found mixed results (Trupin et al., 2002).

As for the others, no CBT program for PTSD had been tested systematically with delinquent youth until recently (Ford et al., 2012). There is significant evidence for the incidence of traumatic stress in justice system-involved youth, however, the effectiveness of TF-CBT with this population has little research support. Although no published studies exist regarding the effectiveness of collaborative problem solving (CPS) with juvenile justice populations, a summary of unpublished research findings suggests that the treatment shows promise (Pollastri, Epstein, Heath, & Ablon, 2013).

There is little support for widespread training and dissemination of any of the above interventions. While each has potential, none have yet been proven efficacious for treatment with the juvenile justice population. Interestingly, the approach used by most participants, CBT, does have some support in the literature.

Intervention techniques in use. Most participants primarily used CBT and related frameworks (e.g., motivational interviewing), while integrating other techniques and activities

based on the interests of the clients. Psychoeducation was the most referenced intervention. Other interventions focused on emotion regulation, cognitive skills, and cognitive restructuring. Some participants also emphasized interpersonal interactions, which was more common in group therapy settings.

CBT programs have been shown to be effective with adult and juvenile offenders (Lipsey, Landenberger, & Wilson, 2007). According to meta-analyses, certain elements are more associated with positive outcomes. Most significant for this study, Pearson, Lipton, Cleland and Yee (2002) found that cognitive-behavioral programs were more effective than behavioral programs. Landenberger and Lipsey (2005) found that a program that included anger control and interpersonal problem solving was associated with larger recidivism reductions than those that included victim impact or behavior modification components. Participants in this study were intuitively using these types of interventions, which bodes well for the state of the field.

Missing the models. Curiously, there was no mention of the programs identified as models by Blueprints for Healthy Youth Development (blueprintsprograms.com). As detailed in the review of literature, Functional Family Therapy, Multisystemic Therapy, and Treatment Foster Care Oregon have consistently demonstrated evidence of their efficacy in addressing delinquency and criminal behavior with youth. Yet, participants did not discuss these interventions. One possible explanation for this is that these interventions are not viable in the settings where these participants worked. If this is the case, further evaluation is needed to determine the ways that facilities or programs can be more accommodating to efficacious treatment models. The first step would likely be determining realistic means for integrating family involvement into practice, as it is a necessary component in each of the models described above. Another possible explanation is that the clinicians were not interested in using these types

of interventions, or were not aware of them and their potential impact on justice system-involved youth. The participants' lack of awareness or interest in efficacious treatment models would highlight the disconnect between the research literature and practice. More information is needed to understand why clinicians were not using or even considering the "model" interventions. Also, more research is necessary to determine how the interventions currently in place are being implemented and the actual impact on the clients.

Outcomes. Participants raised several points about assessing outcomes for treatment. They reported that making a lasting impact with their clients was difficult, and that success could not be consistently measured through the assessment of long-term improvements in functioning.

Limited impact. The first issue brought up by participants related to outcomes was the notion of limited impact. Participants noted that their clients seemed resistant to treatment, which was a major obstacle in obtaining investment in the intervention and encouraging a commitment to change. Further, for those clients who committed to making changes and/or actually followed through, there was no certainty of any lasting impact. The participants spoke at length about the potential for a reversal of progress due to social stressors in their clients' lives. They indicated that youth returning to or immersed in dysfunctional environments were likely to have difficulty sustaining changes in thought patterns and behaviors, particularly when they returned to their communities from residential facilities. Clinicians noted that the home environments typically contained family strife, financial distress, and gang involvement. Further, clients treated in an environment characterized by few (or none) of these stressors, would have only practiced any skills learned within this less intense environment. Upon discharge, the client would not have had the chance to practice their new skills in the difficult situations with the help and support of the treatment team.

It is for these reasons that clinicians could not be sure how well youth fared once discharged or released. Many of the participants noted they received most of the feedback they got regarding the success of their treatment when a former client returned. Returning would be an indication that the client was not able to maintain a legal, prosocial life, so the majority of the feedback participants received was negative. Some participants reported finding satisfaction in one or two clients who made contact post-release, and whose success stories represented an assumed larger sample of success stories. However, given that there is no reliable method of assessing long-term outcomes of the clients, no accurate information exists, so this would be an area for future research.

Alternate measures of success. Because the participants were unable to determine the long-term effectiveness of their interventions, they tended to use alternative measures of success. Some added a caveat when defining a case as successful. These statements suggested that even though there continued to be some concerns (e.g., re-incarceration), the cases met the clinicians' limited definition of success. Participants tended to focus more on progress in a wide array of areas in the client's life, rather than a pre-established target. These signs of progress included, but were not limited to, changes in the clients' perceptions of themselves, application of a skill learned, and prosocial interpersonal interactions demonstrated in the milieu. Even with the recognition of this impact, participants still recognized the small scale on which they worked. Several participants noted that such a narrow focus was necessary, as they were certain they would be disappointed if they attempted to make changes affecting the broader system.

Literature and training. Training and literature were intertwined in the experience of the participants. The participants indicated that the literature could potentially be used to inform and enhance training practices and content. For example, professors could develop a curriculum

for future clinicians based on the latest research in the field. Further, both literature and training were seen as similarly related in that they could both be used to inform treatment. Published studies could also become the basis for further information and continuing education for those in practice. Despite all of this potential usefulness of literature and training, participants reported a minimal number of relevant literature and trainings available to clinicians. The majority of them reported that, instead, they were combining related pieces of information on their own.

Over the course of her doctoral training and in the process of reviewing the literature for this study, the primary researcher had difficulty accessing content specifically on juvenile justice-involved youth. It was therefore necessary to expand the literature review to related populations, such as the adult forensic population and the general adolescent population. Doing so offered some insight and provided some basis for hypotheses regarding youth with involvement in the justice system. Participants reportedly utilized a similar piecemeal, integrative process. Few clinicians reported having received training specifically on interventions for youth in the juvenile justice system. Instead, they reported learning about theoretical frameworks, clinical skills, typical child and adolescent development, and psychopathology. A similar pattern was evident in terms of literature accessed: participants accessed literature on topics related to the experiences of their clients, such as substance abuse, gang culture, trauma, sex trafficking, social issues, and adolescent development.

The limitation of this piecemeal approach is the assumption of generalizability. These results suggest that clinicians who work in this field have no choice but to hope that the limited literature and trainings accessible will be transferable to their treatment population and context. Given the unique issues and challenges specific to this population, this is not likely to be a

completely accurate assumption and attempts to apply research and trainings from other areas should be made with caution.

Limitations of the Study

Because of the small sample size, there are limitations to the generalizability of these results to the larger population of clinicians working with juvenile justice involved youth. The qualitative method chosen for this study was selected in the interest of gaining insight into a unique subsection of mental health professionals, specifically, clinicians providing treatment to youth with current or previous involvement in the juvenile justice system. The results obtained in this study provide depth, rather than breadth, in understanding the experiences of these clinicians and their treatment interventions.

Each participant that agreed to participate was recruited using a network sample. Due to the exploratory nature of this research, there was no comparison group included. A randomized-control trial, considered the gold standard in quantitative research, allows for comparison between groups and the potential to assess the relationship between outcomes or themes and the various between-group differences. This was not possible in this study as each participant was assessed using the same semi-structured interview instrument.

This study was also limited in the demographics of the research participants. Diversity was lacking in terms of age, time in the field, and the gender of the client served. The experiences explored in this study may be more representative of mid-career clinicians than clinicians at other points in their careers. Clinicians of different ages or at the beginning or later career stages in their careers would likely have differing experiences, which is an area for future research. Participants' diversity was also limited in terms of geographic location. The majority of the participants were from New York and New Jersey, and though efforts were made to increase

diversity through recruitment of several participants from Oregon, the settings are likely not representative of the variety of settings in which clinicians treat youth with justice system–involvement. Further, the generalizability that is afforded by this regional diversity may not be as readily applicable to individual therapy, since 2 of the 3 participants based in Oregon did not conduct individual therapy. Also, all participants worked predominantly with males. Several reported having some interactions with female clients, but female clients were not the clinical focus in the work of any participant. Differing perspectives from clinicians who primarily work with males and those that primarily work with females is another area to be further explored with additional research.

A final limitation was the potential for researcher bias, as one researcher was predominantly responsible for the study’s conceptualization, implementation, and analysis. There may have been some bias or leading inherent in the wording of the questions. Further, given the examiner’s interest and personal experience with this subject, along with the more subjective quality inherent in qualitative analyses, it is possible that there was some bias in the analysis of the data.

Several measures were put in place to balance for these potential biases. First, interview questions were carefully considered, then reviewed by the researcher’s dissertation chair and the members of her dissertation seminar to avoid bias in wording. During study implementation, there was an instance in which several participants found particular wording to be inconsistent with their experience, which was noted in the results. That several participants made comments in reference to this word choice suggests that they felt able to openly address any perceived bias, and that the interview was likely otherwise free from pejorative or suggestive language. In terms of the data analysis, the principal investigator enlisted a colleague to code a randomly chosen

interview transcript, and collaborated with this colleague to reconcile inconsistencies in coding. This collaboration improved the definition of codes and consistency of analysis. Further, the researcher was aware of the potential for bias and made conscious efforts to avoid this in her work.

Implications

For future research. This study is a starting point for future research to replicate and expand on findings. As this study was of an exploratory nature, many themes arose that have not been addressed in the literature found to date. Several limitations mentioned above could be addressed through additional study with a larger, more diverse sample. Additional research would also be helpful in further exploring the conclusions drawn and supplementing the findings regarding the experience of clinicians in this field.

In addition, this study brought to light some of the gaps in the research that should be addressed. Not currently addressed is the effectiveness of several interventions, for treatment with this population: general cognitive behavioral therapy, dialectical behavior therapy, collaborative problem solving, and trauma-focused cognitive behavioral therapy, all of which were proposed or used by the clinicians in practice but have few or no published studies. Each of these interventions should be systematically studied with the juvenile justice population in order to accurately determine their efficacy.

Relatedly, clinicians have a limited understanding of the short- and long-term impact of the interventions they are already providing to this population. Assessing treatments already in use would be an ideal starting point in the broader task of assessing appropriate treatment, particularly which interventions are working and which need to be halted or changed. Once

limitations in the current practice are understood, exploration of alternate approaches might be pursued.

For clinicians in the field. This study offers several considerations that can help prepare those entering the field and provide further context for seasoned professionals. One important consideration is the work environment, which entails involvement in highly stressful situations, and necessitates that clinicians espouse multiple and at times competing roles. They may be required to balance the needs of the broader system against that of the individual client. They may work with potentially dangerous and violent youth. Considering these issues beforehand could help clinicians determine which settings and responsibilities they wish to pursue. Participants suggested that working in this environment requires certain qualities in order to thrive. Ideally, clinicians treating this population should possess a high tolerance for this emotionally demanding work, as well as the ability to be supportive and understanding of the stressors impacting the youth.

A second important consideration is best practices in treatment, as a mental health provider's main responsibility is promoting the mental wellness of their clients. Common factors associated with treatment in general are important in this respect, including building rapport, creating a therapeutic environment, and adhering to a theoretical orientation. There are also certain factors that impact treatment, which are specific to working with youth in the justice system. Aspects in the environment limit the effectiveness of any intervention, such as the unpredictability of the schedule due to crises that can result in delays and cancellation of sessions. Additionally, forces outside of the treatment room may be encouraging the youth in a direction opposite that deemed therapeutic by the clinician. These are struggles that clinicians

need to manage in their quest to “make an impact.” They must be prepared for the certainty that they will not “change the world.”

For clinician training. Many participants emphasized the lack of training specific to working with youth with juvenile justice system involvement. Participants who had the intention of entering the field in graduate school mentioned that they had to seek out relevant training because such material was not a part of their regular curriculum. Similarly, they reported that continuing education seminars and trainings, even those purported to focus on this population, did little to enhance their knowledge base. Several noted that they have been more likely to provide training to other disciplines than to receive such training.

Given the challenges unique to this population and the justice system environment, it is of paramount importance that clinicians are well prepared. As such, there is significant need for training in interventions and issues specific to juvenile justice clients. Participants suggested that particularly useful training would be in the areas of child psychopathology, the best way to approach clients, and tools for working within a custodial environment. One clinician lauded the use of clinical case examples, and others emphasized the effectiveness of experiential learning. Both are possible starting points for developing trainings. It is important that these trainings be available at the graduate and post-degree levels. One possibility is that experienced clinicians provide these trainings, as they are well-versed in the trainer role, and could then help shape future clinicians in the field.

For institutions housing juvenile justice clients. Inherent challenges exist when overlapping systems have differing priorities. Hopefully, institutions of custody, such as prisons, jails, and residential facilities will come to understand the importance of balancing custody and security with mental health needs. According to the clinicians who participated in this research,

the focus in these settings is generally on incarceration over and sometimes at the expense of mental health, and clinicians may be required to take on responsibilities that can be detrimental to the therapeutic work. Examples that were offered included cases in which the clinician had a disciplinarian role and instances in which the clinician must routinely put treatment with one patient on hold in order to deal with crises with another resident. The impact of these policies should be considered, to ensure that clinicians can be effective in their roles as mental health providers.

For policy. Over time, the intentions of the juvenile justice model has vacillated between rehabilitation and punishment/security (Meng et al., 2013; Scott & Steinberg, 2008). Two frameworks described in this study represent both ends of the spectrum. The experiences of the clinicians brought to light an important issue regarding the treatment atmosphere from the perspective of each framework: namely, in environments where the primary focus is on security there are more obstacles to psychological wellness than in environments where the primary focus is rehabilitation.

The majority of the clinicians worked in environments where security was paramount. Correctional staff and mental health providers have different goals, perspectives on target populations, and customs associated with the work environment. Because of these differences, when mental health providers enter forensic settings there is a potential for conflict and misunderstandings. A social context of punishment for juvenile offenders at best contradicts the work of treatment providers and at worst invalidates their efforts.

Alternately, the restorative justice model necessitates collaboration amongst the various stakeholders involved with the youth and his or her offense (Bergseth & Bouffard, 2013; Sherman et al., 2015). This perspective aligns more with the goals and objective of mental

health. However, policies are based on the goals of government and public opinion regarding the appropriate course of action. This study offers additional policy considerations for the benefit of the youth, the community, and the clinician.

Conclusions

The mental health needs of youth with juvenile justice involvement have been woefully under researched. This study was designed to gain initial insight into the experience of clinicians who provide services to youth in the juvenile justice system. Although there are limitations to the potential to generalize these findings, the participants provided insight about some unique issues that should be considered when addressing the needs of this population. These included important systemic issues related to working within custodial environments, best practices for creating an effective treatment environment, and limits to our understanding of the effectiveness of interventions. Many of the common themes amongst the clinicians have not been previously considered in the research literature.

This study was a starting point for future research. Possible next steps include further exploration and critique of policies and practices impacting the treatment of youth who have had juvenile justice system involvement and the clinicians who offer therapeutic interventions. Although participants in this study described many practices that might make intuitive sense, the impact of these efforts remains unknown without systematic assessment. Each clinician that participated in this study expressed a desire to make a lasting impact in the lives of these young people: this was their central goal. As one participant said:

You get upset at the system, because you know there's so many broken pieces of the system that has failed the children, that has failed you in terms of serving the children and, you know, it can get frustrating in that sense.... But then, you know, you get a part

of projects that you feel the people are genuine, the work is well put together for the youth and then you have hope. At the end of the day, it's hope. That's why I'm still in it. That's why I'm still doing it.

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Appendix A

Informed Consent Agreement

Study Title: The Experience of Clinicians Working with Youth in the Juvenile Justice System

Invitation to Participate: You are invited to participate in a research study that is being conducted by Robin Dean, Psy.M., MS.Ed, an advanced doctoral candidate in the Clinical Psychology Psy.D. program at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University. Before you agree to participate in this study, you should know enough about it to make an informed decision.

Purpose: The purpose of the study is to explore the experiences of therapists working with youth who have or have had involvement in the juvenile justice system. Research literature on juveniles is focused primarily on the efficacy of specific interventions or categories of interventions. However, a complete understanding of treatment requires an examination of the process by which the treatment produces the outcome in addition to a thorough assessment of those outcomes. Clinicians play a major role in the delivery of treatments and are at the forefront of efforts to implement effective practice; their experience is a key to a rich understanding of intervention efforts within the juvenile justice system.

Participants: This study will use a network sample of approximately 10-15 experienced practitioners working with youth who have had involvement in the juvenile justice field and will be conducted at various settings based on your geographic location. You will only be considered for participation in this study if you return a signed consent form.

Procedure: If you participate in the study, you will be interviewed individually during a designated time at an agreed upon location. It is expected that the interview will take 60-90 minutes to complete. However, the length may vary greatly depending on the depth of the answers provided. All interviews will take place in-person at a location in New York or New Jersey, mutually agreed upon by you and Robin Dean or via phone or Skype. All in-person interviews may be conducted in your home or office or in a secure room at Rutgers University to assure that settings that are private, comfortable, and convenient for the interviewees. For those interviews taking place via phone or Skype, it is important to choose a place to talk that is comfortable and private. In these cases the interviewer will be alone, at home or in a secure room in the Psychology Building at Rutgers University.

Risk/Benefit: There are no known risks associated with your consent and participation in this research study. Participation in this study may not benefit you directly; however you will play a major role in helping other researchers, social workers, psychologists, and others understand the experiences of providing treatment to the juveniles with involvement in the justice system.

Compensation: There will be no compensation for your participation in this research study.

Cost: There will be no cost to you for participating in this research study.

Confidentiality: This research is confidential. The research records will include some information about you and this information will be stored in such a manner that some linkage between your identity and the response in the research exists. Some of the information collected about you includes: your name, age, ethnicity, education history, and employer. Also, you will be asked to talk about clients as part of this interview. You will not be asked to disclose any confidential information about clients. Please refrain from providing identifying information.

Initial _____

Any information that you provide which may be used to identify the client will be removed from the transcript. Names of people and places will be replaced with pseudonyms.

Please note that we will keep information confidential by limiting individual's access to the research data and keeping it in a secure location in the researcher's residence. Hard copies of interview data and audiotapes will be stored in a locked filing cabinet and no one other than the researcher will have access to this information. Transcriptions will be stored on password protected computer database. In addition, you will be given an identification code and a pseudonym in which only the researcher will have access to the code key. The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law.

If a report of this study is published, or the results are presented at a professional conference, your information will be disguised to not have any identifiable information. All study data will be kept for at least three years after completion of the research, all documents with identifying information will be shredded, audio and video tapes will be erased, and any computer files will be erased by the researcher at this time.

Risks/ Benefits: Talking about challenging experiences may create discomfort for the participants. However, it is expected that this discomfort would be similar to the level experienced sharing the same information in a supervision session. You may receive no direct benefits from participation in this study. However, the present research will contribute to the literature on therapists' experiences working with this population. Participants will play a major role in helping other researchers, social workers, psychologists, and others understand the experiences of practice in this setting.

Withdrawal: Participation in this study is voluntary. You may choose not to participate, and you may withdraw from the study at any time during the study procedures without any penalty to you. You may refuse to answer any questions with which you are not comfortable.

If you have any questions about the research, you may contact me, Robin Dean at (732) 470-0665 or email me at rmdean@eden.rutgers.edu. You can also contact my dissertation faculty chairperson Dr. Nancy Boyd-Franklin at boydfrank@aol.com.

If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at:

Rutgers University, the State University of New Jersey
 Institutional Review Board for the Protection of Human Subjects
 Office of Research and Sponsored Programs
 3 Rutgers Plaza
 New Brunswick, NJ 08901-8559
 Tel: 848-932-0150
 Email: humansubjects@orsp.rutgers.edu

I have read and understood the contents of this consent form and have received a copy of it for my files. By signing below, I consent to participate in this research project.

Participant (Print) _____

Participant Signature _____ Date _____

Investigator Signature _____ Date _____

Appendix B

Consent to Audiotape and/or Videotape

You have already agreed to participate in a research study entitled: The Experience of Clinicians Working with Youth in the Juvenile Justice System, conducted by Robin Dean, Psy.M., MS.Ed We are asking your permission to allow me to audiotape/videotape the interview as part of the research study. This procedure is optional; you do not have to agree to be recorded in order to participate in the main part of the study.

The recordings will be transcribed to ensure the authenticity of your responses, which is important for data analysis to ensure that information from the research study has been recorded accurately. This analysis includes reviewing the transcripts to discover common themes, similarities and differences across all subjects.

The recordings will include the responses that you provide throughout the interview. Please avoid mentioning names of individuals or any identifying information of clients. Any names of people or places which are disclosed will be replaced with pseudonyms. If the interviews are video-recorded, recordings will include full facial features. We will not attach your name to any of the recordings. Instead, you will be given an identification code and a pseudonym. Only the researcher will have access to the code in a password secured database.

The investigator will keep this information confidential by limiting access to the research data. The recordings will be stored on a password protected computer and any hard copies of transcriptions will be stored in locked filing cabinet in a secure location. This information will be permanently erased and destroyed three years after the study ends.

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

Participant (Print) _____

Participant Signature _____ Date _____

Investigator Signature _____ Date _____

Appendix C

**Clinician Experience Study
Background Information**

ID _____

Age _____

Gender _____

Ethnicity _____

Title/ Position at Work _____

Field of Specialization (*circle one*)

1. Psychology
2. Social Work
3. Mental Health Counseling
4. Education
5. Other (*please specify*) _____

Highest Level Education Achieved in Field of Specialization (*circle one*)

1. High School Graduate or GED
2. Some College
3. Associates
4. Bachelors
5. Masters
6. Doctorate
7. Advanced Certificate
8. Other (*please specify*) _____

Name of the Degree Granting Institution _____

Year Degree Granted _____

How long have you worked (and did you work) as a mental health professional in the juvenile justice field? _____

List all fields you worked in prior to (or after) working in the juvenile justice field.

Appendix D

Clinical Experience Study Questions

1. What drew you to the field of juvenile justice?
 - What special connection do you have?
 - Give some example for how this work is personal for you?
2. What is it like to work in this field?
 - Describe a typical day. What types of setting do you work in?
 - What other systems have you interacted with? What has been your experience of working with those systems? (Probation, corrections, administration, schools)
 - What qualities or techniques have been most useful in working with this population?
 - What are some of the challenges you have faced in working with this population?
 - What are the rewards of working with this population?
3. What has surprised you about your position? How is it different from what you expected?
4. Describe the typical juvenile justice client.
5. What are some of the similarities and differences between youth and adults involved with the justice system?
6. Identify something you do or a technique you use that you feel is effective in reaching juvenile justice clients?
7. What training did you get on interventions specific to juvenile population? How useful has this training been?
 - What training would you have like to have gotten?
8. What has been your experience of implementing therapeutic interventions with juvenile clients?
 - What are some of the challenges in implementing treatment?
 - What would be some advice for someone interested in treating this population?
9. Describe a case that you feel was very successful. What made it successful?
 - Specify therapeutic and personal factors.
10. Describe a case that you feel was very unsuccessful. What made it unsuccessful? What might have made it more successful?
 - Specify therapeutic and personal factors.

- Is there something you could have done differently?
11. Think of a time when you deviated from the expected course of action or the typical protocol. What did you do? Why did you do it? How did it turn out?
 12. What part, if any, does the literature play in your practice with juvenile justice clients?
 13. Is there anything I didn't mention that you think is important to add?