

Moving the Needle: Cultivating Systemic Change in Juvenile Services

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ABSTRACT

Approximately 1.7 million delinquency cases are disposed in juvenile courts annually (Puzzanchera, Adams, & Sickmund, 2011). Of these youth, tens of thousands experience confinement in the US (Sawyer, 2019), while hundreds of thousands experience probation or are sentenced to community based programs (Harp, Muhlhausen, & Hockenberry, 2019). These youth are placed in the care of programs overseen by directors and clinicians. A survey of facility directors and clinicians from member agencies of the National Partnership for Juvenile Services (NPJS) Behavioral Health Clinical Services (BHCS) committee identified three primary concerns practitioners face in caring for these youth; 1) low resources to recruit and retain quality staff, 2) training that is often not a match for, and does not equip staff to effectively manage the complex needs of acute youth, and 3) the perspective of direct care as an unskilled entry-level position with limited impact on youth's rehabilitation. This article seeks to address these issues and seeks to highlight potential best practices to resolve for those obstacles within juvenile services.

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INTRODUCTION

Every day “over 48,000 youth in the United States are confined in facilities away from home as a result of juvenile justice or criminal justice involvement” (Sawyer, 2019). That number includes detention, residential treatment, long-term secure facilities, group homes, adult prisons or jails, ranch or wilderness camps, shelters, boot camps, and diagnostic centers. In addition to out-of-home placement, many juve-

niles charged with criminal law violations receive alternative sentencing. Of the 818, 900 delinquency cases in 2017, “69,700 were placed out of home, 283,600 were placed on probation, and 194,700 received other sanctions” (Harp et al., 2019). The Office of Juvenile Justice and Delinquency Prevention (OJJDP) reports “[i]n 2018, an estimated 260,200 delinquency cases resulted in a term of probation - 29% below the number of cases placed on probation in 1985” (Office of Juvenile Justice and Delinquency Prevention, 2020). Many of these youth on probation

receive services within their homes and communities designed to divert them from further engagement with the system.

With such an enormously important task and so many moving parts, it can be difficult to pinpoint specific impediments to the effective treatment of youth in the Juvenile Service continuum. To better serve the youth in our care the NPJS BHCS committee sought to identify specific obstacles our membership face in providing the best care for youth. A survey of BHCS committee members revealed three primary obstacles; 1) low resources to recruit and retain quality staff, 2) training that is often not a match for and does not equip staff to effectively manage the complex needs of acute youth, and 3) the perspective of direct care as an unskilled entry-level position with limited impact on youth's rehabilitation. This article provides a roadmap to aid facilities in addressing these concerns, help guide best practices, and move the industry forward.

Survey Methodology and Results

During a May 2019 conference call, members of the NPJS BHCS Committee shared common obstacles to providing the best care for youth. BHCS members from 20 States, representing myriad treatment providers; private and state-run, short-term detention, long-term residential placement, secure and staff-secure facilities, participated in the information gathering call. The issues identified within that meeting were used to create a google survey which was emailed to committee members.

The survey asked BHCS Committee members to identify the primary obstacles they face in providing the best care for youth. Seventy percent responded to the survey. Forty percent of respondents identified low resources to recruit and retain quality staff, including that training is often not a match for, and does not equip staff to effectively manage the complex needs of acute youth as the primary obstacle. Forty percent of respondents identified improper

placement of youth as the primary obstacle. The complexity of improper placement of youth is dynamic and beyond the scope of this paper and should be explored more fully in future research. Twenty percent of respondents identified the perspective of direct care as an unskilled entry-level position with limited impact on youth's rehabilitation as the primary obstacle.

The aim of this article is to highlight each of the key obstacles behavioral health and clinical services practitioners face in providing the best care for youth in the system, and help facilities identify best practices to address these concerns to move the "best practices" needle forward in Juvenile Services.

LOW RESOURCES TO RECRUIT AND RETAIN QUALITY STAFF

Quality direct-care staff, also recognized as frontline staff, in both out of home placement and community-based services are the backbone of every successful program. Direct care refers to staff who work directly with youth in out of home placements i.e. detention, residential, and group homes. Frontline refers to staff who work directly with youth and families in community-based settings. Direct care staff are the primary care provider for youth within facilities. Of the 16 potential treatment hours each day, the majority are spent with direct care staff. Direct care staff guide youth through hygiene, chores, school, violent outbursts, meals, homework, behavioral programming, phone calls, visits, and bedtime routine. Every minute of a youth's day, even their sleeping hours is supervised by direct care staff. Community-based frontline staff work with youth and families in their homes. They make valuable connections between families and other community-based resources. These connections build healthy and productive supports which enhance academic, peer, physical health, mental health, and family relations.

Direct care and frontline staff are central to the day-to-day success of these programs.

The safety of juvenile service facilities and the longer-term outcomes that derive from positive adult relationships can be linked to staffing. Milieu under the care of experienced, well-trained direct care staff who are well supported by their administration, often experience lower rates of restraint, youth and staff injury, critical incidents, and unsolicited visits from regulatory agencies. Resources to recruit and retain quality direct care staff are often scarce. Low resources allocated to staff retainment plays a role in the steady flow of quality direct care staff leaving the milieu for higher paying administrative positions within the facility, or out of the field altogether. As a result, treatment units in facilities across the nation are often manned with new and inexperienced staff. Ultimately low resources for quality staffing impact the health and safety of youth and staff within facilities, and in some cases can put a facility's license in danger.

One key factor in the longevity of direct care staff is pay. Compensation for direct care staff across the nation often rivals retail and fast-food wages. Although the Bureau of Labor Statistics (BLS) by grouping direct care staff with probation officers and correctional treatment specialists, report a median salary of \$54,290 per year, or \$26.10 hourly (U.S. Bureau of Labor Statistics, 2019), reality is that employment listings throughout the country for direct care staff positions in 2019 were between \$12 and \$17.50 hourly, approximately \$31,000 yearly—well below BLS data. Such wages are not sufficient to compel qualified higher-performing individuals to remain in direct care positions. Moreover, juvenile services compensation ladders mirror similar industries. Higher salaries are allotted to positions with decreasing levels of direct engagement with the client base, supporting NPJS BHCS committee members' frustrations that funding for direct care staffing and retainment is inadequate.

Impact of Turnover

Despite cost rates for confinement of youth in juvenile facilities running between \$10,000 and \$60,000 annually (Tyler, Ziedenberg, & Lotke, 2006), juvenile services budgets are notoriously small. In US Jails, labor is consistently the largest portion of operating budgets (Leip & Stinchcomb, 2013). While this data is difficult to find for juvenile services, it is reasonable to assume that labor accounts for a majority of youth facilities budgets as well. Frequent turnover in direct care positions is a persistent issue and an added impediment to the quality care of youth (E. G. Lambert, 2001; E. Lambert & Hogan, 2009; Leip & Stinchcomb, 2013; Matz, Wells, Minor, & Angel, 2012). "Given that correctional organizations rely heavily on staff to meet objectives, problems associated with attrition (e.g., staffing shortages) can feed on themselves and ultimately exacerbate turnover (K. I. Minor, Wells, Angel, & Matz, 2011; Mitchell, Mackenzie, Styve, & Gover, 2000)" (Matz et al., 2012). Resources that might otherwise be used to strengthen direct care wages are regularly applied instead to the urgent need to recruit, hire, and train new staff to maintain adequate staffing levels in the face of turnover.

Federal and State funding

In addition to internal fiscal factors, federal and state resources allocated toward juvenile services are continuously dwindling. "Since correctional expenditures typically consume a substantial slice of government's shrinking fiscal pie, jails [including juvenile facilities] represent a sizeable economic burden to many counties (Kieckbusch, Price, & Theis, 2003)... When deciding where to make painful cut-backs, it is logical to focus on the largest line item" (Leip & Stinchcomb, 2013). Several factors can impede accurate assessment of the needs and funding requirements associated with the care of youth in the juvenile services continuum; concept measurement differences—meaning the absence of common definitions for basic terms, population shifting, and the

vulnerability that accurate reporting of data can bring to individual facilities or states. These factors can be detrimental to juvenile services funding at local, state, and national levels, which directly impacts resources for quality staffing.

Possible Solutions

Facilities might redirect available resources from recruitment budgets to staff retainment efforts by investing in known measures of direct care staff intention of turnover (Kiebusch et al., 2003; Matz et al., 2012; K. I. Minor et al., 2011). Staff bonuses and pay raises could be tied to reductions in restraints, injuries, and critical incidents. Direct care staff could be trained and titled as mentors to access grant funding allocated to mentoring programs through OJJDP.

Training Does Not Equip Staff to Effectively Manage the Complex Needs of Acute Youth

Youth sentenced to out of home placement are often experiencing complex behavioral needs. Youth typically present with complex trauma histories and are frequently diagnosed with comorbidities; PTSD, affective, anxiety, substance use, conduct and behavioral disorders (Abram, Teplin, King, Longworth, & etc, 2013; Angola & Costello, 1993; Jozefiak et al., 2016; Lader, Singleton, & Meltzer, 2003; Livanou, Furtado, Winsper, Silvester, & Singh, 2019; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Teplin et al., 2015). In one study, “93 percent [of juvenile detainees] had at least one comorbid disorder and more than half had two or more types of comorbid disorders” (Abram et al., 2013). In some cases, youth presenting with acute behavioral needs are inappropriately placed in Juvenile Services facilities due to a lack of appropriate alternative placement, posing a potential liability for those facilities. While juvenile services training and programming are well-intended, many of these programs do not adequately equip staff to effectively manage and therapeutically care for the

complex medical and behavioral needs of the youth in their care.

Budget Constraints

Youth with multifaceted treatment needs exhibit a range of behaviors for direct care staff to effectively and therapeutically manage. Equipping direct care staff with science-informed and evidence-based tools to effectively manage for these myriad issues can be challenging. Budget constraints and a predisposition to access familiar training and modalities can impede these efforts. A majority of training budgets are spent on federal and state mandated programs; de-escalation techniques, medication, trauma-informed milieu management, restraint, and legal issues. Any adjunct training resources are often redirected to urgent safety and turnover related expenses; temporary staff, restoring property damage, maintenance, and overtime. Additionally, title XX federal block grant funds for social services have been severely diminished in many states during 2020 putting even more austere restraints on training budgets.

Addressing Underlying Causal Conditions

Training targeted towards direct care staff often fails to address the physiological and biological origins of the emotions and behaviors of youth. Focusing instead on crisis management and response rather than anticipation and prevention. Federally funded multidisciplinary research offers insight into areas of improvement toward best practices. Primary elements are 1) that emotions are homeostatic, preset biological adaptations that drive behaviors (Bechara, Damasio, & Damasio, 2000; Damasio & Carvalho, 2013). 2) That the emotions and behaviors of youth in treatment may not be maladaptations, or the consequence of dysfunctional thinking, rather they are healthy adaptations deployed in response to the environmental conditions youth are navigating (Boutwell et al., 2015; Del Giudice, Ellis, & Shirt-cliff, 2011; Ellis, Bianchi, Griskevicius, & Franken-huis, 2017;

Ellis et al., 2012; Ellis, Figueredo, Brumbach, & Schlomer, 2009; Figueredo, Vasquez, Brumbach, & Schneider, 2004; Figueredo et al., 2005; Johns, Dickins, & Clegg, 2011; Reynolds & McCrea, 2015; Rhodes & Rhodes, 2017; Simpson, Griskevicius, Kuo, Sung, & Collins, 2012). “Our job isn’t to stop the youth’s alarm bells from going off. Our job as youth treatment practitioners is to recognize the specific alarm and help youth change the conditions that cause their alarm bells to be activated” (Rhodes, 2020). There is a growing push among academia and juvenile services professionals for prevention and treatment programs to “move beyond Band-Aid solutions, which attempt to stop problem behavior without addressing underlying causal conditions” (Ellis et al., 2012) (see also Ellis et al., 2017; Rhodes & Rhodes, 2017).

Because youth in detention present complex problems, one might assume that interventions must also be highly sophisticated. But as Abraham Maslow (1959) observed, most emotional and behavioral problems are the result of unmet developmental needs, and meeting these basic needs is the most direct pathway to growth. A synthesis of research by ecological psychologists indicates that developmental relationships are the active ingredient in all successful interventions with children and youth at risk (Bronfenbrenner, 1979; Li & Julian, 2012). Developmental relationships are designed to meet the core growth needs of youth for Attachment, Achievement, Autonomy, and Altruism (Jackson, 2014). In the Circle of Courage model, these correspond to universal, cross-cultural needs for Belonging, Mastery, Independence, and Generosity (Brendtro, Brokenleg, & Van Bockern, 2019). Thus, in order for training to impact outcomes, it should focus like a laser on youth development needs. Even when youth have histories of relational trauma, healing and resilience are less dependent on formal therapy than relationships with caregivers in “the other 23 hours” (Bath & Seita, 2018).

Direct Care Delivery

Youth spend a dominant portion of their time in detention, short-term or long-term treatment with direct care staff. However, training that addresses the behavioral needs of youth is largely designed for and delivered by, and to, supervisors, clinicians, and leadership staff. Leaving a majority of available therapeutic application time untapped. This design also disregards the important science of dopamine and its impact on learning, and behavior (Egelman, Person, & Montague, 1998; Glimcher, 2011; Schultz, 2007, 2016b, 2016a). This gap necessitates a shift in the focus of training to direct care staff who are continuously navigating dynamic events on unit. Equipping direct care staff with effective techniques to both prevent escalation, and successfully address crisis events, in the moment has the potential to dramatically improve milieu safety, training application, and youth outcomes.

Similar training for frontline staff in community-based programs has the potential to abate youth’ entrance into more secure and costly placement. Their unique engagement with families offers frontline staff greater opportunity to address the underlying causal conditions that bring youth into the system. Additionally, a growing number of youth who enter the Juvenile Services continuum labeled with conduct disorder may have underlying mental health needs or brain injury. Frontline staff and Probation officers who are well-trained to recognize or screen for these issues could effectively connect youth to services that are better designed to address their needs.

Judicial Awareness

Judicial training that continues to highlight corticocentric (Lecciso & Colombo, 2019; Parvizi, 2009) deficit-based (Ellis et al., 2020, 2017) perspectives contribute to a limited Judicial awareness that often excludes the spate of federally funded multidisciplinary research identifying emotions and behaviors as healthy neurobiological responses to environmental

cues. Most youth in juvenile services are court ordered to complete specific behavioral management courses (Lizama, Matthews, & Reyes, 2014). Youth attend these trainings and obtain certificates of completion, yet upon release into their home environment it is not uncommon for youth to reoffend perpetrating their original referring behaviors, which contribute to higher rates of recidivism (Office of Juvenile Justice and Delinquency Prevention, 2017; Winokur, Smith, Bontrager, & Blankenship, 2008). Without judicial awareness of these pivotal concepts it is difficult to shift resources to advanced training and treatment techniques that may prove more effective than existing training.

Possible Solutions

Youth in facilities and community-based programs might be best served by introducing training that integrates contemporary multidisciplinary research identifying the physiological origin of emotions and behaviors (Rhodes & Rhodes, 2017), and is designed specifically for application by Direct Care and Frontline staff. “Many programs serving youth and families apply one or more homeostatic system processes. None apply all relevant homeostatic elements... While their success can be measured and is often marketed, that success for system-involved youth and families is incremental in comparison to their mainstream counterparts who enjoy comprehensive predictable homeostatic resources”(Institute of Limbic Health, 2020). Providing training that equips staff to effectively manage the complex needs of acute youth requires including all basic homeostatic elements. Through these measures, facilities could answer the growing call to implement prevention and treatment programs that address the underlying causal conditions for youth behaviors (Ellis et al., 2020, 2017; Rhodes, 2020).

PERCEPTION OF DIRECT CARE AND FRONTLINE STAFF

Acknowledging the pivotal role direct care and frontline staff play in youth rehabilitation is vital to creating the system-wide shift that is necessary within juvenile services. In the industry and the general population, direct care and frontline work has long been considered an unskilled entry-level position and direct care staff as inexperienced, expendable, and not a primary component in youth rehabilitation and therapy. This misconception negatively impacts youth and families, direct care and frontline staff, facilities, and the industry. Organizational culture can contribute to the prevalence and endurance of this misconception. Direct care and Frontline staff are the engine of juvenile services. Facilities and the industry writ large rely heavily on direct care and frontline staff to carry out the day to day tasks of juvenile services.

Unique Value of Direct Care Staff

The time direct care staff spend with their youth is the cornerstone of successful treatment. While a heavy task of transforming the emotions and behaviors of youth in treatment is placed on the shoulders of clinicians, the bulk of that weight is carried by direct care staff, often with a fraction of the recognition or respect. Direct care staff have valuable insight into what is and is not working on their units. They have visceral and intimate knowledge of what dynamics elicit specific behaviors from specific youth, what truly works to deescalate their youth, and what components of behavior modification programs exacerbate escalations. They know which staff are beneficial to the health and safety of the milieu and which staff they would prefer just left them to run the unit by themselves. Because of the nature of their role, veteran direct care staff are often intensely aware, and have anecdotal evidence of, milieu-relevant information before research that supports their visceral

knowledge ever makes its way back to their milieu by way of an evidence-based program. Integrating the knowledge of these expert direct care staff might save precious resources on trainings whose content staff decline to apply because it is not relevant or therapeutically impactful on unit. This valuable knowledge often goes untapped in juvenile service agencies. Particularly in facilities whose pre-shift meetings resemble information released at staff like water from a fire hydrant, rather than a collaborative discussion. Agencies that do not actively encourage direct care staff input and incorporate staff feedback, experience greater staff turnover, and related expenses. This dynamic negatively impacts staff perception of their contribution to the success of the youth in their charge.

Staff perception is pivotal, it has a profound impact on myriad outcomes within juvenile services. Research demonstrates that the perception of direct care staff can impact team cohesion (Barsade, 2001), job stress and staff turnover (Matz et al., 2012; K. Minor, Dawson-Edwards, Wells, Griffith, & Angel, 2009; Misis, Kim, Cheeseman, Hogan, & Lambert, 2013), even the success of treatment (Rhodes & Rhodes, 2017). While staff often state or check the box marked “low wages” as the reason they threaten to quit, it is rarely the reason they actually leave a facility. Turnover is more often attributable to staff perception that they are not a valued asset (Matz et al., 2012; K. Minor et al., 2009; K. I. Minor et al., 2011). Staff morale and turnover make recruitment and retainment efforts a constant and expensive cycle (E. G. Lambert, 2001; E. Lambert & Hogan, 2009).

Investing in Direct Care Staff

Direct care staff who do not feel safe, heard, or valued do not stay long enough to gain valuable expertise. Investing in direct care staff in ways that ensure long-term commitment can make facilities safer, more therapeutic, and successful. Investment in direct care staff is not merely financial. Facilities also invest in direct care staff by ensuring their safety,

fostering cohesion, valuing and integrating their feedback, and celebrating their successes. Creating and maintaining dedicated intact teams is an important investment in direct care staff. Effectively preparing new staff to therapeutically manage the complex needs of youth before introducing them into the milieu is an investment in direct care staff. Promoting the perception that direct care staff are invaluable within an agency is also an investment in direct care staff. These monetary and nonmonetary investments in direct care staff have the potential to increase staff wellbeing and decrease unit aggression, restraints, and staff attrition.

Emotional Contagion and Organizational Culture

An organizational culture that overlooks the importance of direct care and frontline staff cannot be addressed without also addressing emotional contagion (Barsade, 2001; Christakis & Fowler, 2011; Hatfield, Cacioppo, & Rapson, 1993). Emotional contagion can wreak havoc within a facility. A single person can infuse negative emotions into a group, causing the entire group “to feel apprehensive, angry, or dejected, leading to possible morale and cohesion problems” (Barsade, 2001). Researcher Sigal Barsade warns “lack of awareness of the mood-process/performance connection could have serious ramifications for organizations” (Barsade, 2001). The impact of emotional contagion isn’t isolated to staff, it can also affect milieu safety and youth outcomes. Facilities that allow overt or covert disrespect of direct care staff set themselves up for negative emotional contagion. Direct care staff must be held in high esteem, and that perspective must be cultivated and safeguarded at every level of juvenile services agencies.

Possible Solutions

Diligently cultivating a more accurate perception of direct care and frontline staff as the cornerstone of Juvenile services treatment and rehabilitation might correct the widespread misunderstanding in facilities, the field, and throughout society. Direct care

staff who feel they are valued, whose organizations demonstrate their value; provide a decent wage, actively solicit and integrate the input of direct care staff, and diligently maintain dedicated teams, tend to remain direct care staff longer (Matz et al., 2012). Direct care staff who are supported by their clinicians and administration provide safer, more therapeutic milieu for the youth in their care. Additionally, educating staff and administrative teams in the pervasive effect of emotional contagion on treatment milieu invites the potential for facilities to monitor and resolve negative emotional contagion. Resolving negative emotional contagion can reduce the potential for the contagion to be attributed to an individual staff, which may foster team cohesion and improve morale (Barsade, 2002). Implementing these practices has the potential to cultivate system-wide recognition of the therapeutic importance of direct care and frontline staff. Authentic appreciation and acknowledgement of direct care staff's value may itself circumvent the concerns identified in this article.

CONCLUSION

This article sought to address the three primary concerns identified by behavioral health and clinical staff in Juvenile services programs across the nation. Low resources to recruit and retain quality staff, training that is often not a match for, and does not equip staff to effectively manage the complex needs of acute youth, and, the perspective of direct care as an unskilled entry-level position with limited impact on youth's rehabilitation have negatively impacted Juvenile services for decades.

Unlike sister industries of nursing and dental hygienists, the absence of national guidelines requiring direct care and frontline staff possess a basic understanding of the neurobiological systems involved in

emotions and behaviors has long haunted the juvenile services field. Over time, it has been replaced by myriad Band-Aid interventions that represent one or two components of those systems and treat the symptom rather than the cause. To date, a youth treatment facility might choose from hundreds of competing programs to invest their training dollars. Staff might possess countless certifications, yet no comprehensive knowledge of the collaborative systems involved in producing the emotions and behaviors of the youth in their charge. National standardized guidelines for direct care and frontline staff that include these systems may improve youth outcomes, reduce iatrogenic effects of system-involvement, and provide the basis for the systemic career-sustaining increases in salary necessary to maintain quality staff, changing the field from a competitive conglomeration to a highly sought after career.

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Wayne R. Bear, MSW is the CEO of the National Partnership for Juvenile Services (NPJS), the Project Lead for Juv-CMS Data Management System, and the Chairperson of the NPJS Critical Issues and Policy Direction Committee, which is responsible for developing and promulgating all of the Position Statements for the organization. His 40+ year career path includes work as a detention front line staff, juvenile probation officer, residential program management and private practice as a licensed social worker. In his current role with NPJS, he has unwaveringly led the organization down the path which lifts up evidence-informed decision making but also acknowledges the wealth of wisdom that comes with the vast expertise from within the field. Wayne continues to challenge the system to pursue a balanced approach that supports the implementation of good operational practice supported by research as well as intensive staff development that advances positive developmental relationships. In his mind, his single most important role is to guide the field to ensure appropriate care, supervision and connections to family support is provided at every touch point within the juvenile justice system.

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