Service plans and treatment plans provide a critical foundation for delivering essential treatment services to youth in custody. This chapter presents basic information on the fundamentals and characteristics of these two types of plans, which are used in various types of short-term or long-term confinement facilities. Typically, short-term facilities develop service plans for youth, while long-term facilities use treatment plans to address the needs of youth in confinement. Both service plans and treatment plans should incorporate a strength-based approach, rather than focusing primarily on problems.

As noted elsewhere in this Guide, confinement facilities provide secure care and services for youth under age 18 in a number of different settings, including:

- Pre-adjudicated youth who have been taken into custody by law enforcement or the juvenile court and are currently awaiting a hearing before a juvenile court judge as to the need for continued detainment.
- Pre-adjudicated youth who have had a hearing on the need for their detainment and are now waiting an adjudication hearing for their alleged offense.
- Youth who have been adjudicated for a juvenile offense and are awaiting a disposition hearing.
- Youth who have gone through a dispositional hearing and are awaiting placement.
- Youth who have been committed to a confinement facility as a sentencing or dispositional option. Historically, these youth have been placed in longer-term juvenile correctional facilities. More recently, there has been an increase in the use of formerly short-term programs to accommodate longer-term placements as a local option to placement in another institution.
• Youth placed in adult institutions (jails or prisons) as a function of state statute related to age of jurisdiction.

Common Elements for Consideration in the Development of Treatment and Service Plans for Youth in Confinement Facilities

As noted earlier, the scope and complexity of service and treatment plan development will vary depending on the setting the youth is confined in and how long he or she is confined, but in developing service and treatment plans for youth in confinement, there are a number of common elements to consider, including:

• Who is involved in the planning.
• The focus and scope of the service or treatment plan.
• The nature of information that is gathered as part of the planning process.
• How the service or treatment plan is integrated into the overall intervention plan for the youth’s involvement in the justice system, including transition back to the community.

Some guidance about each of these elements follows, but the key principle is that, no matter how long or in what setting, having youth in confinement facilities represents an opportunity to assess a youth’s needs, begin (and in some cases complete) services that can help address those needs, and teach youth new skills that can be helpful upon reentry.

Who Should be Involved in Plan Development?

The juvenile confinement facility should use a collaborative, multidisciplinary planning approach with facility team members, including:

• **Clinicians and caseworkers.** These are professionally trained staff who are engaged in a variety of functions within the facility, including conducting assessments; providing individual and group counseling; gathering social history and prior treatment information; engaging families; and appropriately sharing information with the court, probation or parole officers, social workers, and others who will be involved in the long-term supervision of the youth after reentry. Most often, this caseworker or clinician is the person primarily responsible for organizing and documenting the service and treatment planning.

• **Managerial, supervisory, and direct care workers.** These are the staff members who have day-to-day involvement with youth. Their duties include maintaining safety and security by constant line-of-sight supervision, role modeling, enforcing program rules, rewarding youth, issuing disciplinary actions,
redirecting youth, and employing crisis intervention and de-escalation methods, as necessary. These staff members are present during all daily activities, including all treatment activities. Direct care workers can assume an additional mentoring role for two or three identified youth and can review treatment assignments with the youth, offer crisis counseling, and—with proper training and qualification—teach psycho-educational courses, such as anger management and life skills. Well-trained direct care staff that work in an environment that is well structured can provide valuable insights into a wide range of psycho-social characteristics of youth in custody such as how they manage interactions with peers and how they respond to adult direction. And, most importantly as it relates to service planning, direct care staff also play the most direct and crucial role in ensuring that a plan is implemented with fidelity—consistent with the plan’s design.

- **Teachers.** Teachers play an integral role in both developing and implementing effective service and treatment plans for youth in custody. They provide an initial assessment of educational skills, gather prior educational records, help move the youth forward, and have a strong voice in transition planning.

- **Medical personnel.** Agency nurses, physicians, and dentists are responsible for providing medical care in accordance with state regulations and facility policies. This includes all physical and dental examinations, immunizations, and prescription medication. Medical staff are responsible for providing triage care as first responders and for referring youth for advanced procedures, physical therapy, or emergency care at the local hospital or children’s hospital.

- **Mental health, Alcohol and Other Drug Abuse (AODA), and other specialists.** Some facilities—particularly those with longer-term programs—may have psychologists, psychiatrists, AODA, and other mental health specialists either on staff or on a contract basis. All of these staff and contractors should be considered regular members of the team and should share all pertinent information on the youth’s assessment, service, and treatment and participate in the youth’s service planning. For example, psychiatrists are typically responsible for conducting psychiatric evaluations, prescribing and monitoring psychotropic medication as needed, and consulting with staff related to supervision issues as they may arise. Clinical psychologists will often perform assessment and counseling services, and auxiliary clinical staff or contractors will provide specialty treatment to address specific, individual needs.

- **Parole, probation, and aftercare caseworkers.** This team member can be one of many roles, depending on the jurisdiction and legal status of the youth. This worker usually has some continuing responsibility for the case during the youth’s treatment or placement and receives copies of the treatment and service plans and court summaries. Most often, this person is a county or state probation officer, social worker, or a state aftercare worker. However, in a growing number
of situations (e.g., wraparound programs), additional professionals may be involved. Case planning works best when the individual responsible for implementing the elements of the aftercare plan participates as a member of the planning team throughout the youth’s confinement. The aftercare worker—in collaboration with the clinician, other members of the team, the youth, and the youth’s family—plan the reentry process. The aftercare worker actively links the youth and family with necessary community resources after release. Also at this time, the aftercare worker should take over the supervision of the youth. For more detailed information about the role of confinement facilities in supporting successful reentry, refer to the *Desktop Guide to Reentry for Juvenile Confinement Facilities*.[1]

- **Family members.** Family members are stakeholders and, in many cases, are active clients. They are essential to the service delivery process. When there is a history of abuse or neglect, family members may be restricted from participating in planning. In general, family members should be considered as part of the team, and their participation diligently pursued.

Other community representatives may serve on the service or planning team on an ad hoc basis, depending on the facility.

The Focus and Scope of Services and Treatment Planning

Planning for treatment varies by the type of facility, the length of stay, the youth's problem behaviors, the requirements of community safety, the remediation of the youth's treatment issues, and the needs of the legal system. Planning, care, and treatment of youth in confinement requires an understanding of adolescent developmental psychology, cognitive and behavioral psychology, the environmental and social shaping of delinquent behavior, risk assessment, psychosocial assessment, the legal needs of the justice system, and the safety of victims and society.

Service and treatment planning is an approach to service delivery that ensures that delinquent youth with multiple, complex problems receive the services that they need in an appropriate and timely manner. In shorter-term situations, this planning may include conducting further specialized assessments, identifying targeted educational needs that can be addressed in the short run, developing individualized behavioral or skill development goals, and taking initial steps to link the youth with ongoing support. Longer-term situations produce a more comprehensive treatment plan that is individualized to meet each youth’s needs and is focused on successful reentry.

Information Gathered in the Planning Process
Facilities should use custody as an opportunity to gather as much information as possible and to help build and support the larger system goals of successfully intervening in the youth’s life. A variety of mental health, trauma, AODA, health, and other screening tools can be used even in short-term programs to help identify potential treatment needs. And, more comprehensive assessments should be a routine part of all longer-term youth confinement facilities as well as any adult institution that hold youth. (See Ch. 9: Admission and Intake).

Integrating Service and Treatment Planning with Transition Planning

The facility’s multidisciplinary approach to reentry planning begins at the youth’s admission and continues as the youth progresses through placement and is discharged from care. Some form of aftercare or supervision services typically begin following release from the facility, and the planning for this should be completed during placement. However, the facility does not usually provide supervision services. Aftercare plans are developed by the team and should be driven by the youth’s need for success, community safety, and the achievement of permanency. The plan should identify community resources that released youth can access directly or through a referral. The plan should include measurable goals and detailed timeframes for aftercare services. (See Ch. 18: Transition Planning and Reentry).

Creating Culturally and Developmentally Appropriate Service and Treatment Plans

For both short- and long-term confinement facilities, it is important to take note of critical cultural and developmental characteristics of the youth in placement. We know from research that **responsivity**—making sure that the match of programs and service providers—is one component of best practice that increases the likelihood of overall effectiveness. With that in mind, service and treatment plans need to consider the following:

- **Cultural sensitivity.** Service planning should integrate evidence-based and culturally sensitive programming in the treatment and supervision of youth. The confinement facility should have clear policies and procedures and ongoing staff training on cultural competency education and practices, to ensure the preservation of the youth’s rights to maintain his or her language and cultural heritage and to increase the likelihood that the youth will respond to services and treatment.
- **Sexual orientation.** To ensure the humane and fair treatment of Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) youth, the facility
should have clear policies and procedures and ongoing staff training on how to respond appropriately to a youth’s sexual orientation and gender identity. Staff members should participate in ongoing cultural competency training that outlines policies that prohibit the discrimination or harassment of youth who identify or are perceived as being LGBTQI by any staff member or other youth in the program.[2] Resources for the treatment of LGBTQI youth can be found online at the Equity Project (2013).[3]

- **Spiritual and religious beliefs.** Most states have rules that support access to appropriate religious and spiritual services, which has long been recognized as a constitutional right for both youth and adults in confinement. Therefore, service and treatment plans need to take into account the youth’s spiritual and religious beliefs, ensuring there is no conflict between services provided and those beliefs. The youth should have voluntary access to spiritual services on a consistent basis.

- **Gender-responsive programming.** The predominance of males in confinement facilities has long been recognized as a challenge for juvenile justice professionals. For too long, programs designed to work with boys were, at best, merely modified for girls. Only in the last decade has there been substantive progress in developing gender-appropriate programs and services for girls and young women. Even short-term detention programs should offer gender-responsive service elements that recognize that the lives of girls in the juvenile justice system mirror the experiences of all girls in our society. Gender-responsive services emerge from a desire to recognize the needs of girls and the differences in the way they experience gender. It is generally understood that society exerts a powerful influence over female behavior. Gender-responsive services seek to understand societal influences and educate girls about them, while offering alternatives and opportunities for social action. For both boys and girls, service plans and programs should seek to create healthy gender identity development during adolescence, enhance protective factors that are likely to build resiliency, curb negative behaviors, nurture personal and social competence and enhance self-esteem.

- **Medical and physiological issues.** Youth in custody may have unique medical or physiological issues or restrictions that programming should address. Youth may not always be readily forthcoming about the challenges they face, making the assessment and observation processes even more important to developing realistic expectations. For example, youth may have special dietary needs that can be confirmed by a medical professional and that the facility can accommodate. Or, a youth may have a disability or other restriction that could impact his or her ability to participate in recreational activities.
• **Issues related to developmental disabilities or differences.** It is rare that youth in confinement facilities have been adequately screened or assessed for developmental disabilities that may impact their interactions with peers and adults or their ability to learn and process information in new settings. Some youth behaviors are easily misinterpreted as uncooperativeness. It is important that the staff who assess youth have the training and tools to identify potential developmental differences and to make sure that those youth receive a more thorough evaluation by specially trained professionals.

• **Issues related to trauma.** It is widely recognized that a majority of delinquent youth have a history of trauma, and a growing body of relevant research can inform best practices for developing service and treatment plans. Trauma-informed care, a general term for policies and practices that take these trauma histories into account, is being implemented in a variety of facilities (short and long term) in a way that impacts rule development, behavior management, services delivered, staff training, and other basic program elements.

### Plans Transition with Youth through the Criminal and Juvenile Justice Systems

For most youth in the justice system, time in confinement is only one aspect of their overall system involvement. Youth on probation or other juvenile supervision will typically have some form of treatment or supervision plan in place that outlines a range of behavioral expectations and other program requirements. These youth are usually confined for new offenses or violations of their existing community supervision plans. For youth that are new to the system and are confined pending adjudication or conviction, the confinement period can be the impetus for long-term planning. In both scenarios, it is all too common that communication between the confinement facility and other components of the system is not as strong as it needs to be. Therefore, it is important for confinement professionals to proactively engage with other parties to develop plans that are consistent with existing plans or that help set the stage for new plans.

Youth are more likely to make positive changes if the expectations, the language, the reinforcements, and the programs they are involved in are consistent from one system component to another. Although some aspects of plans need to be modified based on the setting the youth is in, approaching service and treatment plans as youth centered or youth focused rather than being facility focused will increase the likelihood of consistent and positive outcomes.
Different Types of Facilities Affect the Service and Treatment Plan and Process

Although components of service plans for youth in short-term detention facilities provide a start in treatment planning for youth in juvenile correctional facilities, the scope, complexity, and comprehensiveness of treatment planning in long-term facilities will be much greater. The following discussion provides guidance in thinking about service and treatment planning for youth in various types of placements: youth in juvenile correctional facilities, youth in short-term detention settings, and youth confined in adult facilities.

Treatment and Service Planning for Youth in Juvenile Correctional Facilities

For youth who have been appropriately placed in a juvenile correctional facility by court order for the purposes of rehabilitation, community safety, and accountability, treatment plans need to be highly individualized based on quality assessments, to set both short-term and long-term goals for rehabilitation, and to clearly link with long-term reentry planning. The treatment planning process should begin with reentry in mind and should represent an approach to service delivery that ensures that delinquent youth with multiple and complex problems receive the services that they need in an appropriate and timely manner. The product of this effort is the treatment plan, which is individualized to meet each youth’s needs.

A written, individual treatment plan is a must for every youth. A one-program-fits-all approach to treatment is unacceptable and destined for failure, especially with the chronic and violent youth in the modern day juvenile justice system. The treatment plan should accurately and meaningfully identify the major areas of treatment, based on the information obtained during the assessment period. For many youth—particularly those with identified AODA needs—some form of relapse planning also has to be integrated into the plan, so that if youth relapse (as they often will) a plan of action is already in place.

Assessment, planning and treatment in juvenile correctional facilities are often thought of as sequential and separate processes. In reality, they are interrelated and circular in nature. Most facilities start with an assessment, then planning, and then treatment; but treatment for the youth also starts with self-discovery during the assessment phase. Assessments and plans are often reformulated during the activities of treatment. Consequently, all three activities can be considered as continuous, interrelated parts of treatment planning.
Assessment and planning fall into four broad sub-categories: 1) the detailed gathering of a criminal, social, developmental, and psychological biography and autobiography of the youth; 2) the development of a clinical formulation on which a treatment plan can be based and developed; 3) an assessment of risk, or the likelihood of the youth’s dangerous behavior continuing; and 4) an assessment of the motivation of the youth to accept and engage in treatment.[4]

The clinical assessment and autobiographical material should examine what came before the current law-breaking behavior, the development of and enactment of that behavior, the causes of other, noncriminal problem behaviors, the context and environment of the offending behaviors, and the context of the youth's early development. The assessment should also consider the youth’s developing personality traits, strengths and weaknesses, trauma experiences, and the existence of other mental health or behavioral pathologies.

The assessment is intended to foster a better understanding of the youth, including his or her social functioning, emotional stability, behavioral patterns and responses, behavioral control and self-regulation, cognitive abilities, interests and attitudes, thought processes, belief, self-talk, cognitive distortions, and mental status. The assessment should lead to an understanding of the details and circumstances of the law-breaking behavior and how the behavior developed over time. These understandings should be incorporated into an initial treatment plan that will be subject to changes, as new assessment information emerges and as the youth changes during treatment.

Finally, the assessment (and subsequent services) should point to a plan for the youth's return to the community. Assessment with juvenile offenders strives to understand causality, motivation, formulation of treatment needs, a treatment plan, risk of re-offending, risk of self-harm, the youth's community reintegration needs, judicial needs and community safety. Community safety should not be thought of as incidental, as it should take precedence in release planning in the context of the legal system’s exiting requirements, the safety of previous victims, and the possibility of the youth committing another offense.

The Assessment and Planning Sequence

Generally, the assessment begins with information gathering through an examination of previous case records, court orders, arrest records, school records, medical records, and interviews with the youth, the youth's family members, and previous caseworkers and teachers. Additional information is usually assembled in the areas of new or updated psychological testing, educational testing, medical testing, the use of
assigned questionnaires or essays, and ongoing group and individual interviewing with the youth. \[5\]

The gathered information is then analyzed and interpreted to lead to a diagnosis of the current problems and to a risk assessment of imminent or eventual outcome if things remain the same. Finally, the assessment leads to a formulation of cause, problem development, and written treatment plan along with an evaluation of the motivation of the individual to accept and engage in treatment.

Components of the Assessment

There are a number of common processes or elements that make up a complete assessment process, such as interviews. In confinement facilities, assessment is usually done with a combination of face-to-face interviewing, testing, and behavior observations. These interviews typically start at admission and continue through the first couple of months of treatment. (See Ch. 9: Admission and Intake) \[8\]

- **Psychological testing.** A thorough clinical assessment should also include a series of assessment instruments and psychological tests designed to explore and yield information about many facets of the individual's personality, functioning, thinking, attitudes, and propensities. \[7\]

- **Behavior observation and recording.** The daily observation and charting of a youth’s behavior during the assessment period is useful to establish baselines for anger, deception, authority issues, conflict resolution skills, sleep patterns, medical and pharmacological issues, social skills, and levels of empathy and violence. Youth workers, teachers, and caseworkers often accomplish this by taking notes. However, information is often more easily and accurately recorded by using a token economy scale. Observing and charting behavior on a daily basis may not accurately reveal the causes of criminal behavior, but it is still meaningful—if staff carefully observe, evaluate, and interpret youth behaviors. These baseline observations will be useful in evaluating progress of treatment and risk reduction. \[8\] (See Ch. 16: Behavior Observation, Recording, and Report Writing) \[7\]

- **Social skill assessments.** Most delinquent youth are weak in the area of social skills, life skills, problem-solving, and conflict resolution. The treatment plan should identify specific intervention needs and goals and point to utilizing one of a number of well-researched social skill programs that help assess current skills, provide skill-building activities, and include benchmarks to measure a youth’s progress in acquiring critical pro-social skills.

- **Assessing risk.** There are a number of instruments specifically designed to assess risk, so that reassessment is based on a consistent model and structure, rather than on clinical judgment alone. The use of anger management and
empathy scales along with the daily observation of the youth's treatment progress and behavior will also help in formulating a clinical judgment of risk.[9] Also, with the enactment of standards to implement the Prison Rape Elimination Act (PREA), youth need to be assessed for their risk of being victimized or victimizing others.

- **Physiological testing.** Juvenile correctional facilities may use physiological testing to learn more about the individual and to establish baseline data against which to make later measurements. For example, urine testing is widely used in substance abuse programs. Although used infrequently, there are also various tests that may be used for sex offenders such as the Abel Assessment for sexual interest-2—a test that measures the amount of time (in milliseconds) that the individual spends viewing photographed material that may be of sexual interest. [10] Physiological testing methods are controversial in current work with youth. Facilities should have written policies regarding their use and ensure that youth’s rights are not violated.

- **Educational Assessments.** Each youth should undergo a complete educational assessment that determines his or her current level of performance in core academic areas and the need for special education services. The educational assessment should help in designing an individual learning plan that meets state standards and federal standards, particularly with regard to special needs. A thorough check of prior educational records can prevent the youth from having to repeat completed course work. The initial educational plans should be regularly reviewed and modified, as needed, according to a youth’s actual progress and performance.

**Effectively Using the Treatment Team**

Treatment team members should meet regularly to discuss a youth’s treatment progress. The treatment team is one of the most powerful tools in the juvenile correctional facility. The team’s observations and judgments are essential to the facility caseworker to use in exploring and reviewing cases, getting advice and direction, and receiving feedback about the effectiveness of treatment planning and methods. The ongoing responsibilities of the treatment team include the following:

- **Reporting.** Most agencies require initial and monthly (or at least quarterly) treatment summaries and may use formatted reports and structured assessment tools to document and review treatment progress. These reports should measure treatment progress and adjust plans and treatment goals. They should be used as the focus of discussion in case conferences with the youth’s family and stakeholders.
• **Quality assurance activities.** A staff member should be responsible for collecting, compiling, and reporting data to the treatment team members and the facility director. These data should include audits of case records, a review of assessment scores and educational achievement, a review of youth progress overall, compliance with laws and agency contracts, and recidivism tracking.

• **Ensuring adequate time and attention for planning.** Planning for the care and treatment of youth is a demanding and essential task if it is to lead to rehabilitation. Planning calls for an understanding of the need for community safety, remediation of the youth's treatment issues, and the needs of the legal system. Planning requires an understanding of the youth as an adolescent and as a juvenile offender, an understanding of the cognitive, behavioral, environmental, and social shaping of criminal behavior and knowledge of the theoretical and practical techniques to reshape and habilitate that behavior. But in the relatively long-term environment, it is also important to understand the nature of planning and treatment over time. Time overcomes mistrust and resistance to treatment. Time is needed to accurately assess youth problems and needs, create the capacity to build advanced treatment on earlier treatment, assess and reassess treatment goals and the impact of the treatment process. Spending the right amount of time in treatment is in the best interest of youth, their families, and the communities to which youth are ultimately released. It takes time to do real treatment of serious issues and to bring about change in the youth, but such an investment in treatment may prevent a future lifetime of crime and misery.

**Treatment Plans: Transitioning from Admission to Aftercare**

An initial treatment plan is written at the end of the assessment period or at a time required by state regulations, whichever is sooner. These initial treatment plans are then supplemented by case record materials, weekly case notes, educational reports, staff observations, behavior management program records, incident reports, therapy session notes, and other available information. The supplemental information leads to updated plans of care—usually written at set intervals—release plans, and termination or release reports. At a minimum, these plans should do the following:

• **Include treatment goals.** Treatment goals should be developed with the youth, the family and an identified parole or aftercare worker. Goals should focus on the key issues that brought the youth into custody and on the essential psychological, social, behavioral, relapse prevention, and safety issues that will lead to a successful exiting of the program. The goals should be concise, understandable, and reachable. Plans should clearly present benchmarks.
(indicators) of progress and specify actual treatment interventions to help the youth accomplish the goals. The plan's benchmarks should be measurable, and define the orientation and direction of treatment, as well as all planned behavioral and clinical interventions.

- **Be confidential.** Plans should be kept confidential except when information is needed to implement the plan and in a manner consistent with state and federal regulations. Treatment plans and case records in a juvenile correctional facility are formulated within a legal context and often have exclusions on confidentiality (e.g., plans, notes, and records may need to be provided to the court or parole authority, and the concept of privileged communications does not apply). The lack of privileged communication applies to the disclosure of unknown criminal acts (in many states), and this does have some impact on initial youth disclosures and family disclosures. This lack of legal case privilege will often slow or impede the treatment process. Practitioners in a juvenile correctional facility should be familiar with state law and agency policy regarding confidentiality of records and must comply with those expectations.

### Service Plans for Youth in Juvenile Detention Facilities

The primary objective of a short-term detention facility is to offer a safe, secure, highly structured and stable environment for youth awaiting their hearings, but variations in the types of facilities, the length of confinement, and the nature and purpose of programming are readily apparent.

Regardless of the type of facility and the duration of confinement, there is a need for planning effective services and coordinating service plans that optimize positive outcomes for youth and the community.

Youth in detention are usually kept in secure custody 24 hours a day. Detention facilities should provide these youth with a range of planned, basic residential care services, assessment services, education, counseling, crisis intervention, medical care, and other services as necessary to address individual needs and promote overall goals of the justice system. For shorter placements, services are generally meant to conclude in 30 days or fewer. However, in instances in which youth remain longer, due to barriers encountered in the referral and placement sequence (e.g., waiting lists and special needs placements) or delays in judicial processing or when secure confinement serves as a longer dispositional placement, the scope and comprehensiveness of services will vary accordingly. *(See Ch. 9: Admission and Intake)* [3]
Service planning in short-term confinement settings is generally not thought of as treatment planning but usually includes basic casework and assessment services and, more importantly, requires basic legal services, safety and security, and crisis intervention. The short-term services in juvenile detention apply to both adjudicated and non-adjudicated youth. Many youth are released within a few days of admission, and service planning for this group is usually standardized. Services typically are more individualized, complex, and comprehensive the longer the youth is confined. In all cases, service and treatment planning includes at a minimum the broad areas of case record documentation, the provision of basic care, medical screening and services, dental services, educational assessment and programming, access to appropriate legal services, mental health and counseling services, protection from harm, and a variety of programs.

Assessment, Case Planning Services, and Case Records

As a best practice, detention facilities should have qualified social services casework staff that can supervise case planning, conduct assessments, and deliver casework services. More often they collaborate with juvenile probation officers or state caseworkers in matters relating to the service plan, court hearings, and placement planning.

An important planning requirement is to ensure that each youth receives assessment services that identify problems, assets, immediately needed services, short-term goals, and future service recommendations, including an appropriate type of release placement. While the service planning process begins when the youth is admitted to the program, placement planning is integrated and finalized at an assessment conference.

Even in short-term, pre-dispositional programs, it is helpful to hold some kind of assessment and planning conference within ten days of admission. The purpose of the conference is to integrate comprehensive diagnostic and needs assessments, risk assessment information, and detention behavior reports to help identify problems, immediate needs, risk and security level, and services needed to accomplish goals and make placement decisions.

Assessment conferences should include the detention caseworker, the probation officer (or state or county caseworker), the youth, and parents or guardians. The assessment conference is designed to bring together persons essential for planning the safe release of the youth and to present, discuss, and refine diagnostic information. The conference should also consider future treatment needs and
services if it appears that the youth is destined for placement or continued court supervision.

In preparation for the assessment conference, the caseworker should complete a social history and a behavioral observation report, which summarize a youth’s behavioral strengths and weaknesses observed at the detention facility. The detention facility school should provide educational reports and diagnostic information. The assessment conference should also cover new or current psychological testing, psychiatric evaluations—including evaluations for psychotropic medications—and current medical.

Information shared at the assessment conference can be used by the detention caseworker and the county or state supervisory authority's caseworker to write the youth’s initial service plan. These service plans include specifications of the service elements necessary to accomplish immediate behavior and educational goals and the appropriate type of release or treatment placement for the youth. Typical detention facility case reports may include the following:

- Initial assessments and an initial service plan.
- Educational assessments.
- Updated assessment reports.
- Updated service plans.
- Program termination reports.
- Excessive length of stay reports,
- Daily behavior observation reports.
- Incident reports, arrest records.
- Intake records, and youth and family social histories.

**Service and Treatment Planning for Youth in Adult Detention and Correctional Facilities**

There is substantial research showing that outcomes for youth placed in adult facilities are worse than similar youth placed in juvenile facilities or youth in the community who are receiving developmentally appropriate services.[11] However, there are nonetheless thousands of youth at any given time under age 18 confined in adult institutions. In the vast majority of states, statutes permit housing youth under age 18 in adult facilities based on their age, the exclusion from juvenile court for specific offenses, or waiver to adult court.
Redding suggests that the significant contributing factors for the higher recidivism rate for youth in adult prisons are a lack of age-appropriate services and restricted access to rehabilitative and family support. Furthermore, he suggests that these youth may be stigmatized by being labeled as convicted felons, and may harbor resentment and a sense of injustice about being tried as an adult. These youth perspectives may not only reinforce their delinquent disposition, but may prompt the youth’s transitory self-identification as a victim—which are counterproductive to the goals of rehabilitation. He adds that, the negative culture of peer deviance reinforcement and criminal “group think” among youth in adult prisons further counteracts the process of rehabilitation.

In addition to worse outcomes after release, youth in adult facilities face a much higher risk of physical and sexual abuse, depression, suicidal behavior, and isolation than adult offenders or than youth in juvenile facilities. Research about the risks faced by youth in adult facilities led to adoption of PREA in 2003 and the more recent adoption of Standards to implement its protections for all individuals in confinement.

At the same time, adult facilities are often ill prepared or in adequately funded to provide developmentally appropriate services and programs, making it even more important that leadership and confinement professionals in adult facilities pay attention to critical elements of service and treatment planning. Although the need for differential placement and specialized services for youth in the adult correctional system is almost universally acknowledged, it is less costly to house youth in adult facilities within the general correctional program.

In reality, there is good reason to develop service and treatment plans for youth placed in adult facilities. Research supports including specialized programming for youth based on their developmental amenability for rehabilitation. Recent research in the fields of neuroscience and pediatrics help us understand the functions of the adolescent brain, as it relates to a youth’s propensity for offending behavior and capacity for cognitive change. According to studies, the adolescent brain is not fully developed until approximately age 25, and adolescents have underdeveloped impulse control, which makes them more likely to commit certain crimes. [12] (See Ch. 6: Adolescent Development).

Research also suggests that youth who commit crimes or engage in socially deviant behavior are not necessarily destined to be adult criminals. This research provides the basis for requesting legislative policy reforms in state justice systems and also suggests that prison facilities should adopt evidence-based practices to treat the
emotional and behavioral functioning of the youth incarcerated in the adult correctional system.[13]

Consequently, service and treatment plans should be individualized and developmentally appropriate. Although implementing standardized treatment programs for youth in the adult correctional system may cost more, the research suggests that investing in the youth’s rehabilitation stands to improve overall outcomes for youth and public safety as a whole. In the long run, investing in youth who in the adult correctional system can save money; effective rehabilitative treatment correlates with lower recidivism rates. From a more global, sociological perspective, strategically investing in treatment and education for the nation’s most damaged and dangerous youth moves us closer to interrupting the intergenerational cycle of crime.

Engaging Families and the Community

It is common knowledge that almost all youth who are confined return to their community—and most often to their home—upon release. This is true for youth placed in both short- and long-term youth confinement facilities. Therefore, it is important for youth confinement professionals to think of their time with youth as important opportunity to build on the resources and strengths of families and the community and create successful release and reentry plans.

Focus on Families

For families, the juvenile justice experience is too often viewed as a confusing, intrusive, and blaming process that diminishes the important role they play in the life of their child. Although family voice and engagement may look different when comparing short- and long-term programs, it is very important that facility leaders set a tone for respectfully engaging families—demonstrating an important value that all staff should adhere to. In terms of service and treatment plans, successful family engagement can be incorporated in a variety of ways, including the following:

- **Ensuring that important family members receive appropriate information** about the nature of the facility and how their child is being cared for during his or her stay.
- **Involving parents or guardians in actual service and treatment planning.** This will be more critical in longer-term programs in which family engagement needs to begin at admission, continues as progress in the program is evaluated and plans are adjusted, and is critical to the development of successful reentry planning.
• **Reaching out to parents and guardians** to keep them informed about the progress of their child in the program, answering questions or simply promoting a helping relationship between the facility and the family.

• **Visitation policies and practices.** Most states will set minimum requirements related to allowable visitation for youth by family members, but minimum standards do not always represent the most effective practice. Rather than base family visitation on minimum standards, service and treatment plans should include opportunities for visitation that are the most likely to promote needed family supports and successful reentry.

• **Providing clear opportunities for parents and guardians** to ask questions and address concerns they may have relative to their child’s care. This may take the form of clearly defined guidelines for filing grievances or, more creatively, may include providing someone to serve in the role of a parent, peer support, or ombudsman.

(See Ch. 10: Effective Programs and Services: Family Involvement [7]; Ch. 18: Transition Planning and Reentry [9])

### Engaging Service Providers and the Community

The facility should welcome community support and volunteers from local organizations. The facility may greatly benefit from the regular volunteers who can help with a wide variety of educational, social skill development, treatment, and recreational services. Both behavior or facility management and system improvement are good reasons to proactively reach out to the community to provide services.

First, using community volunteers and providers can increase the amount of time youth are engaged in enrichment and productive activities. Vendors, community volunteers, and recreation staff can support direct care staff in enriching free time.

Secondly, psycho-education classes, targeted treatment activities (e.g., AODA-focused programs), writing workshops, performing and visual arts, tutorial services, spiritual enrichment, and experiential learning activities can be integrated into the overall service and treatment plans and goals for individual youth or the program as a whole. In short, adolescence and time in placement is precious; consequently, the modern facility should transform its program to provide 14–15 hours a day of constant educational and psycho-educational classes and constructive activity. School and mentoring programs should be extended to evenings and Saturdays to remediate learning and credit deficiencies. Youth should be required to do homework and treatment task work (therapeutic assignments) each day.
Getting Past the Notion that It Can’t Be Done

Engaging outside vendors and volunteers is sometimes seen as disruptive to the secure facility, particularly in the areas of security and daily schedules. Security issues can be easily overcome by vetting volunteers with the same procedures used for screening employees and by offering them an adequate orientation program. Coordinating volunteers and outside providers with existing facility programs can be complicated, but approaching scheduling with an attitude of making it work rather than finding reasons it cannot work is more likely to succeed. In many schedules, program time is wasted by giving youth early bed times, providing excessive television time, and not making use of time available on weekends. These old scheduling habits make youth supervision seemingly easier for direct care staff, but do not help youth.

Conclusion

The vast majority of youth can be dealt with successfully in the community without the need for even short periods of confinement, but there will inevitably be some who end up in secure detention centers, in juvenile correctional facilities, and in adult jails and corrections facilities.

Confinement professionals have both a moral and economic duty to ensure that—along with other aspects of programming—service and treatment plans are designed to promote positive outcomes for the youth, their families, and their communities.

Much has been learned in recent years about what works with youth, and those lessons apply to both confinement facilities and community settings. Working collaboratively with families, community providers, and a myriad of other system professionals, confinement professionals play a vital role in the success of the criminal and juvenile justice system. Properly developed service and treatment plans provide a foundation and roadmap for progress in the facility and successful reentry to the community.

References


**Bibliography**


https://info.nicic.gov/dtg/print/20


Endnotes


[6] Ibid.

[7] Ibid.


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