Covered Bridge Treatment Center

Program Description (*Draft*)
January 21, 2021

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The Covered Bridge Treatment Center (CBTC) is designed to meet the safety and stabilization needs of up to 6 male Vermont youth ages 12-19. Under the direction of a PhD level clinician, the CBTC will deliver trauma informed care and rehabilitative behavioral interventions that encourage the development of accountability, critical thinking and responsible decision making. ***The mission of CBTC is to offer a secure short-term trauma informed treatment opportunity for youth to establish safety and stabilization so they can further develop their inherent strengths and potential for success and realization of their goals.*** Since the aim of the program is to stabilize high-risk youth with complex needs, including juvenile justice involvement, a major program development consideration is the likelihood that the youth to be served are survivors of trauma. As trauma survivors, most youth will have comorbid psychiatric disorders such as anxiety disorders, mood disorders, attention deficit disorders, oppositional defiant and conduct disorders, posttraumatic stress disorder, and substance use disorders. Additionally, it is likely that a subset of these youth have demonstrated a degree of resistance to positive behavior change. Based on these considerations, it is critical that a systemic model be in place to serve as a foundation for treatment that supports the development of positive relational aspects of treatment such as attachment and consistent and effective caregiver response and support. The program length of stay is variable and intentionally flexible in order to meet the individual needs of youth and conduct appropriate evaluations; however, the aim is to transition youth to a less restrictive level of care as safety and stabilization needs decrease.

The Covered Bridge Treatment Center utilizes a programming model that maximizes youth *resiliency factors, strengths and positive assets, is evidence-based, and trauma informed.* In like manner, the program design and operational aspects are in alignment with the Juvenile Detention Alternative Initiative (JDAI) and the Prison Rape Elimination Act (PREA) guidelines and best practices for secure residential treatment. An understanding of adolescent brain development is also central to the development of programming. For many youth involved with juvenile justice, abuse, neglect, traumatic experiences and disadvantaged economic circumstances often result in the development of poor judgement, high levels of risk taking, and an underdeveloped sense of empathy that contribute to behaviors that can be defined as anti-social in nature. Programming informed by an understanding of adolescent brain development and disruptions to social development, particularly as it relates to executive functions and trauma response, is an important element of treatment and may lead to an increase in pro-social behavior. Therefore, multiple elements of the proposed programming model are informed by concepts related to the neurobiology and social influences of adolescent youth development.

Trauma Informed Admission/Intake Process

The program utilizes a comprehensive intake process incorporating a variety of materials which are carefully reviewed and assessed in order to individualize treatment planning efforts. Our team, led by a licensed clinician, will consider the unique challenges of each individual and give direction regarding treatment approaches and accommodations that will afford youth the opportunity for a smooth and supportive transition into the program. As such, residents will be offered the opportunity to call parents and/or guardians once safety and stability needs are assessed. The initial family or guardian contact will include the creation of a Personal Safety Plan (PSP) *(Appendix A*). This is intended to engage youth and family

immediately upon intake by utilizing their input in order to create a plan that will inform staff about possible triggers, helpful coping skills and offer a way in which to individualize a communication approach that is trauma informed. This effort begins the process of listening and valuing recommendations from the youth and family and will promote healthy communications that will in turn minimize or eliminate the need for crisis intervention.

Upon intake, youth will meet intake staff and receive a health screening, brief mental status exam, and assessment of immediate needs. Assessment of immediate needs includes the completion of appropriate versions of the PREA Vulnerability Assessment (*Appendix B)* and the Youth Personal Safety Plan (*Appendix A).* Admission staff will also conduct a search of youth and his possessions upon admission as is consistent with VT RLSI licensing regulations for secure facilities. All searches will be the least intrusive type necessary while satisfying the safety and security needs of the facility and the youth and will be conducted by a staff member who is the same gender as the youth. If there is reasonable suspicion that the youth has on his person; contraband, weapons, or other items that present a threat to the safety and security of the facility youth may be searched by medical personnel or the ED. Strip searches will not be utilized as a safety precaution by program staff. In determining the level of search of youth, factors including the following will also be considered: current charges involving violence, use of weapons, drug related charges, or prior history that includes, arrests, charges or convictions of the aforementioned factors.

Mental Health Screening and Comprehensive Assessment

Early in the intake process, youth will receive a mental health screening and preliminary assessment. When the assessment indicates further risk factors are present, the PSP (*see Appendix A*) will be enhanced to include more detail as discovered to include more comprehensive information regarding triggers, warning signs, additional coping skill suggestions and actions to be taken to respond to identified risks. It shall also include preferred individualized interventions that consider mental health and medical concerns. The youth and family are the key creators of the Individual Treatment Plan (ITP). This plan will also be informed by the clinician's development of a thorough biopsychosocial assessment inclusive of base line data and information to support ongoing development and implementation of treatment and behavior plans.

Additional assessments will include the Child and Adolescent Functional Assessment Scale (CAFAS) and the Child and Adolescents Needs and Strengths (CANS) Instrument. The CAFAS is used to assess current impairments in functioning relative to eight identified domains: School/Work, Home, Community, Behavior Toward Others, Moods/Emotions, Self-Harmful Behavior, Substance Use and Thinking. The administration of the CAFAS not only supports risk assessment but also is designed to determine overall treatment needs and focus. The CANS Instrument will also be administered to assist with service planning and monitoring of outcomes. Ongoing assessment and observations will be thoughtfully utilized, and the level of service and individual treatment plan will be developed and adjusted accordingly in order to meet the specific needs and goals of each youth. Psychiatric consultation will be available for periodic assessment and monthly medication management. The following narrow band assessment instruments may be administered if therapeutically indicated: Beck Depression Inventory-II (BDI-II), Multidimensional Anxiety Scale for Children-2 (MASC-2), UCLA PTSD Reaction Index for Children/Adolescents, DSM-5 Level 2

Sleep Disturbance Measure, DSM-5 Conduct Disorder Scale (CDS), Jesness Inventory- Revised (JI-R), Adolescent Substance Abuse Subtle Screening Inventory-2 (SASSI-A2).

The following "Routine and Typical Assessment Scope and Sequence" will be followed for youth unless clinical judgment indicates otherwise. This flexibility is particularly essential for youth who are survivors of trauma as the both the timing and content of assessment instruments may present a circumstance that contributes to unintended activation of traumatic material.

Routine and Typical Assessment Scope and Sequence	
At Admission	
	Mental Status Exam
	Personal Safety Plan/Parent/Guardian and/or FSW communication
	Initial Individual Treatment Plan (ITP) (Youth and family preliminary goals)
	Child and Adolescent Function Assessment Scale (CAFAS)
	PREA Vulnerability Assessment Tool (PREA Act 2003)
	Suicide/Homicide Screen (MSE)
	Gender Identity/Depression/Other Concerns (MSE)
	Cultural Considerations (note in PSP)
	Chaplain visit scheduled if requested/Spiritual Assessment (RLUIPA)
Within 3-5 days	
	Adverse Childhood Experience Scale (ACE) Trauma Screen
	MID-Dissociative Symptom Scale (if indicated)
	Sleep Disorder Screening
	GAIN Q-3
	ITP-Family input/preliminary goas
	Identify Permanency/Discharge Plan and Concurrent Plan
21-30 days	
	Biopsychosocial Assessment inclusive of Family Assessment
	Child and Adolescent Needs and Strengths Instrument (CANS)
Every 90-Days and at Discharge	

	CAFAS
As Therapeutically Indicated	
	Beck Depression Inventory-II
	Multidimensional Anxiety Scale for Children 2
	UCLA PTSD Index
	Jesness Inventory-Revised
	SASSI

Treatment Plan Process Driven by Youth and Family/Caregivers

Family, Guardian, and Caregiver involvement is central to the mission of the program. As such, CBTC offers a collaborative approach to treatment planning and service delivery. Clinicians partner with families/caregiver(s), permanency coordinators, agencies and milieu staff to coordinate the services outlined in the Individual Treatment Plan (ITP). The clinician provides individual, family, and group therapy as therapeutically indicated**.** Permanency coordinators are embedded into the milieu in order to develop secure attachments with youth which aids in the facilitation of the permanency plan and eventual community and/or family re-integration. They offer support and psychoeducation to families and caregivers on the effects of traumatic stress and other presenting challenges in in order to promote enhanced attunement and increased understanding to develop regulatory strategies.

A Strong Family Engagement Component/Transition Planning

Permanency planning, family/caregiver engagement and efforts toward successful transitions are essential for this population. As such, families will be contacted immediately and welcomed as valuable members of the team in the development of care and treatment plans with the youth. The program structure will include a Permanency Coordinator who will implement an approach to permanency that reflects the values of The Building Bridges and Families First Initiatives including provision of support and service coordination with the youth's home community. Accordingly, a Permanency Coordinator will serve as a liaison between parents, caregivers, agencies, other permanency team members via visits, team meetings, telephone conferences and written reports as indicated by treatment and permanency plans.

Clinical Programming/Theoretical Orientation and Framework/ Behavior Modification Program

Each individual has a distinct combination of strengths and challenges and the ways in which they learn and address these challenges is highly variable. Therefore, the treatment approach will be individualized to meet the unique needs of the youth we serve. Clinical programming will include case management, permanency planning and coordination, individual, group and family counseling as therapeutically indicated. The primary foundational theoretical orientation and framework to be utilized is Applied Behavioral Analysis (ABA) and will include strong positive reinforcement components that value and encourage healthy behaviors and learning new pro-social ways for youth to have their needs met. The program will also utilize the Attachment, Regulation and Competency (ARC) Framework as the primary modality for supporting the provision of comprehensive trauma informed care.

ABA is a scientific approach towards the understanding and treating of learning and behavioral problems. ABA is concerned with describing, explaining, predicting, and changing behavior that creates challenges for youth. The key piece of this approach is looking at patterns of behavior and understanding the influence of environmental variables that occur prior to and after the behavior. Complex skills are broken down into more easily acquired smaller steps, and individualized motivation and reinforcement is used to support the students in their education and treatment milieu. Hundreds of research studies have shown the effectiveness of procedures based upon this behavioral philosophy. This intervention has shown success in application with children through adults, who are both neurotypical as well as intellectually impaired or who display conduct disorders, oppositional traits, and various challenges that impede prosocial development and integration. The approach to social and emotional challenges fits this basic behavioral model. We will engage with each youth to fully understand the environmental variables that precede and follow challenging behaviors. Understanding the motivation behind behavioral deficits and conduct disordered behavior allow staff to identify alternative behavioral and communicative behaviors that students may easily substitute for a more socially appropriate ability to communicate their wants and needs, and to express themselves in age-appropriate ways that work. Plans will be created in collaboration with youth and families or caretakers allowing for the identification of meaningful reinforcements that encourage response flexibility and new behavioral patterns.

The Attachment, Regulation and Competency (ARC) Framework is a flexible, components-based intervention developed for children and adolescents who have experienced complex trauma, along with their caregiving systems. ARC's foundation is built upon four key areas of study: normative childhood development, traumatic stress, attachment, and risk and resilience. Drawing from these areas, ARC identifies important childhood skills and competencies which are routinely shown to be negatively affected by traumatic stress and by attachment disruptions, and which – when addressed – predict resilient outcome. ARC is designed as both an *individual level clinical intervention*, to be used in treatment settings for youth and families, and as an *organizational framework*, to be used in service systems to support trauma-informed care. The concepts identified by ARC may be applied to individuals from birth through young adulthood and have been effectively used with youth with a range of developmental and cognitive functioning levels, and with a wide range of symptom presentations. Caregiver goals are designed to translate across many different types of caregiving systems, including primary (i.e., biological

kin, and foster parents), milieu (i.e., residential, group home), and organizational (i.e., teachers, youth program providers) systems of care.

Certified Educational Services

Students will be offered an Agency of Education Approved Academic Program and course of study that is aligned with Common Core Standards and follows a standard curriculum including Middle and High School courses in Mathematics, Science, English and Social Studies. Academic faculty will include a licensed special educator. The academic experience will be enhanced by small class sizes, utilization of appropriate technology, and differentiated instruction. Principles of Applied Behavioral Analysis will also be utilized to inform pedagogy. Education staff will coordinate with sending and/or receiving school districts to allow youth to remain engaged in materials that will support a continuum of education services.

Daily Recreation Programming

Access to opportunities for physical exercise and recreation are key in the development of healthy coping skills and overall sense of well-being. As such, the program will utilize a model for youth wellness and self-care that offers ample opportunities to explore interests and develop a sense of mastery and competence though participating in a range of individual and group activities. These include but are not limited to; daily access to a fitness center, choices for youth regarding sports activities and weekly access movement classes such as yoga, and daily access to in mindfulness practices.

Restorative Justice Practices Embedded within the Program

The program will have the capacity through assessment and customized treatment planning to address the core principles of restorative justice. Careful assessments will determine the appropriate level of service to address the youth's risk to reengage in at-risk behaviors. Based on the principles of risk, need, and responsivity, faculty will work to support students in both understanding how their past life experiences have impacted their thinking and behaviors and how to learn more productive skills in managing symptoms. Specifically, the goal is to assist students in understanding the 1) importance of taking ownership of their choices both good and bad 2) understanding the potential impact of their choices on others and 3) learning skills that may support them being successful presently and into adulthood.

If a youth has committed a crime, we will maximize their ability to learn from a rehabilitative intervention by providing cognitive behavioral treatment and tailoring the intervention to their learning style, motivation, abilities and strengths. We will also incorporate the principals of restorative justice, ensuring that the child's behavior is understood in its social context, but also seeking to ensure the child realizes he or she is part of a social web of important relationships. Our Restorative Justice Program will support accountability as well as empathy development. All youth will be required to make amends, repair harm and restore relationships affected by the delinquent behaviors. This plan will be developed with the youth, family and treatment team (see *Appendix C).*

Recognized Crisis Intervention Model

The program will promote a culture that de-emphasizes physical interventions and seclusion practices and will utilize the nationally recognized Therapeutic Crisis Intervention (TCI) model as the approved non-violent de-escalation and physical management certification program. Ultimately, TCI is a tool for staff to promote de-escalation and safe interventions, as indicated. A Compliance Officer will provide independent review and oversight of restraint practices. Another key element in this effort will be the program's adherence to the *Six Core Strategies to Reduce Seclusion and Restraint Model* developed by the National Association of State Mental Health Program Directors:

1. Leadership Towards Organizational Change - emphasizing that efforts to create a violence free environment are most successful when facility executives provide guidance, direction, participation and ongoing review of the project, beginning with assuring that the facility's mission, philosophy of care and guiding values are congruent with this initiative.
2. Using Data to Inform Practice - monitoring performance and sharing data.
3. Workforce Development - reshaping hiring, training and job performance practices to promote trauma informed, recovery-oriented, non-coercive care.
4. Use of Seclusion/Restraint Reduction Tools - including trauma assessment, primary prevention and de-escalation strategies, and calming environments. Includes the use of:
5. Consumer Roles in Inpatient Settings - providing full and formal inclusion of consumers and family members in a variety of decision-making roles in the organization.
6. Debriefing Strategies - analyzing restraint/seclusion events to mitigate further trauma and to gain knowledge that informs policy, procedures and practices.

Staff Wellness and Training

It is understood that relational aspects of trauma informed care are crucial in affecting positive change and healing in youth. These relational aspects include caregiver affect management and self-care. As such, staff training and orientation will include wellness and self-care. Additionally, participation in selfcare programming is a requirement for all staff as is the creation of Self Care Plan (*Appendix D*). Orientation and ongoing professional development and training will also include substantive training and immersion in the provision of Trauma Informed Care, Adolescent Development and Related Neurobiology, Communication and De-Escalation Skills, and Cultural Awareness and Competence.

Program Evaluation and Performance Measurement

The program leadership employs both formative and summative evaluation processes which aid in the analysis of service delivery. Summative evaluation includes an annual performance assessment that measures the program's ability to deliver services across multiple indicators. The indicators include, but are not limited to, annual review of the goals including

analysis of strengths, weaknesses, provision of adequate supervision and staff training, grievances heard, resolved and unresolved; staff retention, and annual CAFAS results.

Data will be collected relative to a range of indicators including those associated with effectiveness, efficiency, and experiences of stakeholders. This data will be reviewed, summarized, and analyzed in monthly data review meetings. These meetings will inform various elements of planning including tactical, operational, and strategic efforts. Practices that support this data analysis include daily incident review and weekly critical incident review by key members of the leadership and operational teams and monthly and quarterly committees assembled to support continuous quality improvement and self-evaluation efforts. These committees will include policy review, wellness committee, staff retention committee, safety committee, and document management/data review committee. In like manner, members of senior management will hold regular youth advisory meetings and staff open forums.

Appendix A

CBTC Youth Personal Safety Plan

Youth Information:

Name:_____
Address:_____
City/State/Zip:_____
Phone:_____

FSW Contact Information:
FSW Name:_____
Phone:_____
Email:_____

Emergency Contacts:

Mother's Name:_____
Address:_____
City/State/Zip:_____
Phone:_____
Email:_____

Father's Name:_____
Address: _____ City/State/Zip:_____
Phone:_____
Email:_____

Additional Supportive Adult:_____ Relationship:_____
Phone:_____

Triggers:

☐Being touched	☐Being alone	☐Loud noises
☐Not having a choice	☐A memory	☐Other:
☐Being around women	☐Forced to talk	☐Other:
☐Being around men	☐Raised voices	

Warning Signs:

☐Sweating	☐Red face	☐Rocking	☐Eating less
☐Pacing	☐Isolating	☐Threatening	☐Eating more
☐Loud voice	☐Clenched teeth	☐Wringing hands	☐Racing heart
☐Sleeping less	☐Clenched fists	☐Breathing hard	☐Other:
☐Sleeping more	☐Can't sit still	☐Yelling	☐Other:
☐Swearing	☐Hyperactive	☐Crying	☐Other:

Effective Strategies:

☐Using a firm tone	☐Walking	☐Talking to a female
☐Journaling	☐Exercise/Sports	☐Being alone
☐Drawing/coloring	☐Listening to music	☐Being with people
☐Reading	☐Talking to a male	☐Other:

Behavioral History:

☐Physical aggression	☐Spitting	☐Cutting/Scratching
☐Punching walls	☐Head banging	☐Sexualized behaviors
☐Yelling/Screaming	☐Self Harm	☐Other:

What helps the youth stay in or regain control:_____

What positive behaviors can staff use to help the youth?_____

History of Trauma/Abuse:_____

History of Suicide Attempts:_____

Mental Health Diagnosis:_____
Medical/Health Issues (to be considered if a physical management needed):_____
Comments (Date and time of call or meeting with parent/guardian):_____
Form Completed By:_____ Date Form Completed:_____
Parent/Guardian Signature:_____ Meeting Date/Call Date:_____
Youth Signature:_____ Date Signed:_____

Appendix B

VULNERABILITY ASSESSMENT INSTRUMENT:
Risk of Victimization and/or Sexually Aggressive Behavior/Overall Risk

Youth's Name: _____

DOB: _____ Gender: _____ Courtstream Case ID # _____

Bridges Case #: _____ Bridges Client ID: _____

Ethnicity (check all that apply)

☐ White/Caucasian ☐ Black or African American

☐ Asian ☐ Native Hawaiian/Other Pacific Islander

☐ American Indian/Alaskan Native Tribe: _____ Hispanic Origin:

☐ Yes ☐ No

Date of Assessment _____

Results:

Yes	No	
☐	☐	Vulnerable to Victimization
☐	☐	Sexually Aggressive
☐	☐	

Low ☐ Medium ☐ High

Youth Interview:

1. Experience in Institution

Ask: **Have you been in a locked juvenile facility?**

		Score
No	**Score 2**	
Yes	**Score 0**	

2. Social Skills

Lead in with: **How do you feel being in a facility with so many other juvenile justice youths?**

Then ask: Yes/No

- **Do you feel you get along well with other people?** (Yes score 0, No score 1)
- **Do you find it easy to make friends?** (Yes score 0, No score 1)
- **Do you feel OK about being in groups of people you don't know well?** (Yes score 0, No score 1)

Award a score of 1 for each **No** answer

Score (0-3)		

3. Perception of Risk

Ask: **Do you feel at risk from attack or abuse from other youths?**

For example, have you received threats, insults, and harassment from other youth?

Prompt with options if necessary

Not at all	**Score 0**	
Sometimes	**Score 1**	
Often	**Score 2**	

If sometimes or often, ask for more details and note youth's statements below:

4. History of Victimization

Ask **Have you ever been attacked, bullied, or abused by people your own age (peers)?**

Prompt with options if necessary

Never	**Score 0**	
A Few Times	**Score 2**	
Often	**Score 4**	

Ask **Have you ever had a sexual experience that you did not want to have?** If yes, ask what & if this information was reported to DCYF and law enforcement. If the youth reports abuse that has never been reported, a report MUST be made to DCYF Central Intake.

No	**Score 0**	
Yes	**Score 4**	

5. Offense Type

Ask **Have you ever been arrested on a sexual offense?**

Also check the youth's file for information.

No	**Score 0**	
Yes	**Score 4**	

Ask **Have you ever been arrested on a Violent offense?**

No	**Score 0**	
Yes	**Score 4**	

6.

Ask **Have you ever engaged in behavior that you would consider violent or sexually aggressive?**

No	**Score 0**	
Yes	**Score 4**	

7. Age of Youth

19 years and up to 21	**Score 0**	
16, 17, 18 years	**Score 1**	
13, 14, 15 years	**Score 2**	
10 – 12 years	**Score 3**	

8. Intellectual Impairment

From the file review is there any evidence that this youth has been previously reported to have an intellectual impairment (Low IQ), learning disability, or Special Education?

No Evidence	**Score 0**	
Evidence	**Score 2**	

9. "Lack of fit" with the juvenile justice facility culture

This item requires a judgment by the screener that this youth is unlikely to "fit in" within the mainstream juvenile offender culture.
(Place an X in applicable box)

Look for features of the youth's physical appearance such as:

- ☐ Small Build
- ☐ Looks younger than stated age
- ☐ Impaired vision (requires glasses)
- ☐ Pronounced disfigurement
- ☐ Physical disability
- ☐ Deaf
- ☐ Appears frail, weak

Look for features of the youth's presentation and behaviors such as:

- ☐ Inappropriate verbal behavior (e.g., giggling, odd remarks)
- ☐ Inappropriate physical behavior (boys wearing makeup, sexual behavior)
- ☐ Hunched fearful posture (e.g., very fearful, very shy)
- ☐ Obvious effeminate behavior
- ☐ Acts of Aggression – Observation
- ☐ Youth's behavior with the sibling(s)/residents
- ☐ Youth's behavior in school
- ☐ Speech impediment
- ☐ Appears slow or "dull"
- ☐ Behaviors that are likely to irritate and annoy other youth (e.g., immature, silly)
- ☐ Behaviors that appear related to mental illness (e.g., jittery, crying, bizarre)

Look for features of the youth which make him or her stand out such as:

☐ Having a lack of exposure to criminal lifestyle
☐ Being from an ethnic minority not well represented in the offender population (e.g., Vietnamese, Indian, Middle Eastern)
☐ Membership in a gang that is likely to be a target of attack from others NOTE

OTHER FEATURES NOT LISTED ABOVE:

NONE OR ONLY ONE	**SCORE 0**	
TWO OR THREE FEATURES	**SCORE 2**	
MULTIPLE FEATURES (FOUR OR MORE FEATURES)	**SCORE 4**	

ITEMS 1-9 **TOTAL SCORE**	

FILE REVIEW:

10. Does file indicate the youth has been charged with a sex offense?

INFORMATION NOT AVAILABLE	**SCORE 0**	
NO	**SCORE 0**	
YES	**SCORE 2**	

Any information suggests prior sexual aggression or sexual victimization of others?

INFORMATION NOT AVAILABLE	**SCORE 0**	
NO	**SCORE 0**	
YES	**SCORE 2**	

Overall Risk Score:

VULNERABILITY TO VICTIMIZATION:

1. EXPERIENCE IN INSTITUTION — SCORE: _____
2. **SOCIAL SKILLS** — **SCORE:** _____
3. **PERCEPTION OF RISK** — **SCORE:** _____
4. **HISTORY OF VICTIMIZATION** — **SCORE:** _____
7. **AGE OF YOUTH** — **SCORE:** _____
8. **INTELLECTUAL IMPAIRMENT** — **SCORE:** _____
9. **"LACK OF FIT" WITH JUVENILE JUSTICE FACILITY CULTURE** — **SCORE:** _____

INTERVIEW:

OVERALL SCORE:

MAXIMUM SCORE -20

SEXUALLY AGGRESSIVE BEHAVIOR:

5. OFFENSE TYPE — SCORE: _____
6. VIOLENT BEHAVIOR — SCORE: _____
10. **FILE REVIEW** — **SCORE:**

OVERALL SCORE:

MAXIMUM SCORE -16

RISK LEVEL:	**LOW (1-9)**
	MEDIUM (9-16)
	HIGH (17 & ABOVE)

OVERALL RISK SCORE:

No Designated Roommate (NDR): High Overall score and/or high score in either Vulnerability to Victimization and/or Sexually Aggressive Behavior would indicate need to place on NDR status.

NDR Documentation: ☐ Yes ☐ No ☐ Double Room ☐ NDR

In the event that you need movement to a lesser or higher risk pod or room assignment, the Shift Supervisor will determine movement. Proper documentation must be stated below as to the reason why youth is moved, i.e., behavior, maturity, facility count, etc. In support of an override please attempt to obtain collateral information from file review and/or parent/guardian contact.

Override Documentation:

Supervisor: _____ Date/Time of Override: _____

_____ AM PM

_____ _____ _____ _____

Signature of Screener | Title of Screener | Date | Time

Adapted from the "Prison Youth Vulnerability Scale", New Zealand
Department of Corrections © Crown copyright 2003
Florida Department of Juvenile Justice – Form RC8050-2
Colorado Department of Human Services
Division of Youth Corrections – Attachment A, DYC Policy 9-19

Appendix C

Name: _____

Date:

Restorative Justice Worksheet- #1

Restorative Justice Asks:

What was the harm?

Who was harmed?

How can the harm be repaired?

Who should repair the harm?

1. What happened that caused you to be referred to the CBTC?

2. What were you thinking at the time of the incident?

3. Who do you think was harmed or affected by this incident?
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____

4. What is the harm to each of the people listed in #3?

   a. _____

   b. _____

   c. _____

   d. _____

   e. _____

5. What needs to be done to repair the harm to the people listed in #3?

   a. _____

   b. _____

   c. _____

   d. _____

   e. _____

6. Who needs to repair the harm?

_____

_____

_____

7. How will people know you have taken responsibility for the harm?

_____

_____

_____

8. How can others help you and give support in your decision to take responsibility? and be accountable for your actions?

9. What have you learned from this experience?

Name: _____

Date:

Restorative Justice Worksheet- #2

Restorative Justice Asks:

What was the harm?

Who was harmed?

How can the harm be repaired?

Who should repair the harm?

1. Have you done all the things you said you should do to repair the harm to everyone affected by your behavior?

_____
_____
_____

2. What was the hardest thing you did to repair the harm?

_____
_____

3. How do you feel now about the harm that was done?

_____
_____

4. How do you think the following are feeling about the harm now?

   a. The victim _____

   _____

   b. The victim's family _____

   _____

   c. Your family _____

   _____

d. The community _____

e. Others _____

_____

5. How do you feel about yourself for doing what you needed to do to repair the harm?

_____
_____

6. Are there any other things that you need help with to do well when transitioned to new program/home, school and community?

_____
_____

7. What help and support do you need?

_____
_____

8. If you have not done all the things you need to do to repair the harm, what is your plan to get them done?

_____
_____

9. What special help do you need in finishing the things you need to do to repair the harm?

_____
_____

Appendix D

Staff Self Care Plan

Four Steps to Wellness (From *the Compassion Fatigue Workbook*: Francoise Mathieu,2012)

1. Take stock in stressors

2. Look for ways to enhance self-care and work-life balance

3. Develop resiliency skills

4. Make a commitment to implement change

Basics of Self-Care

1. Sleep, rest, proper diet, exercise, vacations
2. Renewal activities that *replenish you*
3. Nourishing activities…. everyday
4. Access to debriefing

Self- Care Plan

Life Area	What will I do?	When will I do it?	How will I measure it?
Physical			
Nutrition			
Psychological			
Emotional			
Relational			
Spiritual