ILLINOIS BUDGETING FOR RESULTS

Budgeting for Results

Department of Juvenile Justice

Mental Health Program Report

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Introduction

The statute that created Budgeting for Results (BFR) states that in Illinois, "budgets submitted and appropriations made must adhere to a method of budgeting where priorities are justified each year according to merit" (ILCS 20/50-25). The BFR Commission, established by the same statute, has worked since 2011 to create and implement a structure for data-driven program assessment useful to decision makers. The BFR framework utilizes the Results First benefit-cost model[1] and the State Program Assessment Rating Tool to produce comprehensive assessments of state funded programs.

The Pew-MacArthur Results First Initiative developed a benefit-cost analysis model based on methods from the Washington State Institute for Public Policy (WSIPP). The Results First model can analyze programs within multiple policy domains, including: adult crime, juvenile justice, substance use disorders, K-12 and higher education, general prevention, health, and workforce development.

The State Program Assessment Rating Tool (SPART) combines both quantitative (benefit-cost results) and qualitative components in a comprehensive report. It is based on the federal Program Assessment Rating Tool (PART)[2] developed by the President's Office of Management and Budget and has been modified for Illinois use. The SPART provides a universal rating classification to allow policy makers and the public to more easily compare programs and their performance across results areas.

Methods

BFR begins each assessment by examining an Illinois program's design and assessing its implementation. Each program is then matched with an existing rigorously studied program or policy in the Results First model. BFR completes a comprehensive review of related program literature to inform the matching process.

Each rigorously studied program has an effect size determined by existing national research that summarizes the extent to which a program impacts a desired outcome. The effect size is useful in understanding the impact of a program run with fidelity to established core principles and best practices.

The Results First benefit-cost model uses the effect size combined with the state's unique population and resource characteristics to project the optimal return on investment (OROI) that can be realized by taxpayers, victims of crime, and others in society when program goals are achieved.

The SPART contains summary program information, historical and current budgetary information, the statutory authority for the program, and performance goals and measures. The SPART tool consists of weighted questions which tally to give a program a numerical score of 1-100. Numerical scores are converted into qualitative assessments of program performance: effective, moderately effective, marginal and not effective.

[1] https://www.pewtrusts.org/en/projects/pew-macarthur-results-first-initiative
[2] https://georgewbush-whitehouse.archives.gov/omb/performance/index.html

Section 1

Program Overview

Program Overview – DJJ Mental Health Program

A majority of youth who enter the Illinois Department of Juvenile Justice (DJJ) need some level of mental health treatment. Mental health issues are a significant concern for DJJ because of their substantial impact on the youth's welfare and on other outcomes of concern for the criminal justice system. There are numerous benefits to youth and their communities from the provision of mental healthcare in detention, including its role in curbing other destructive and criminal behavior.

Upon entry into DJJ custody each youth is assessed by a Mental Health Professional (MHP) and assigned a mental health level that determines the type and intensity of treatment received (see Supplemental Documentation). Most youth receive individual therapy and participate in group therapy.

- DJJ's comprehensive mental health program for youth in custody includes an initial assessment, individual therapy and group therapy.
- All DJJ facilities provide group therapy using the SPARCS curriculum, which is a cognitive-behavioral program for youth exposed to chronic trauma.

In 2010 DJJ began using the Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) group therapy curriculum. Most youth in DJJ custody have experienced complex trauma. The SPARCS curriculum is a cognitive-behavioral program designed to improve emotional, social, academic and behavioral functioning of adolescents exposed to chronic trauma and stress. It was specifically created for teens who have been traumatized and who continue to live with high levels of stress. Importantly for DJJ, SPARCS was chosen to help youth build skills to handle the effects of trauma without needing to disclose the nature of the trauma they experienced in a group context.

Recent budget appropriations for the comprehensive mental health program are presented in Table 1.

Table 1: Mental Health Program Appropriations and Expenditures by Fiscal Year ($ thousands)

	FY 2015	FY 2016[3]	FY 2017[3]	FY 2018	FY 2019	FY 2020
Appropriated	$6,151	$270	$270	$5,502	$5,358	$6,107
Expended	$5,811	$5,679	$4,923	$4,693	$5,030[4]	N/A

While all aspects of DJJ's mental health program are integrated and important to improving youth outcomes, the benefit-cost analysis portion of this report focuses only on the SPARCS group therapy element. DJJ does not report appropriations or expenditures for the SPARCS therapy in isolation, but information on per-participant cost estimates can be found in Section 2 of this report.

Using national literature and program information gathered with DJJ, BFR matched the SPARCS program

[3] During fiscal years 2016-2017, DJJ received only federal funds appropriations for this program due to the budget impasse. Actual expenditures were higher due to court orders.
[4] Estimated.

with the program profile "Cognitive behavioral therapy (CBT) for juvenile offenders" in the Results First benefit-cost model. This profile is based on national research on a variety of CBT programs offered to juvenile offenders in both detention and community settings.[5] More information on the evidence base for the SPARCS curriculum can be found in the SPART section of this report.

The major takeaways from this analysis can be found in Table 2 below along with the program's comprehensive SPART score.

Table 2: Report Summary

DJJ SPARCS Program Report Results[6]	
Optimal Benefits	**$15,596**
Real Cost (Net) per participant	**$289**
Benefits – Costs (Net Present Value)	**$15,307**
Benefits/Costs (OROI)	**$53.97**
Chance Benefits Will Exceed Costs	**94%**
SPART Score	**65 – Moderately Effective**

This benefit-cost analysis examines the effect of SPARCS group therapy on reducing youth recidivism. It does not include potential effects of the mental health program on other outcomes of interest such as trauma symptoms or non-recidivism behavioral outcomes.

The optimal return on investment calculated by BFR on the SPARCS program determined that for every one dollar spent by DJJ, $53.97 of future benefits from reduced crime could be realized by Illinois taxpayers and crime victims.

[5] Further program profile and meta-analysis information available at: https://www.wsipp.wa.gov/BenefitCost/Program/438

[6] The optimal benefits are the benefits the program can expect to achieve if run with fidelity to best practices or core principles. Benefits per participant are projected over fifty years after program participation. The per participant real costs of the program are the sum of its direct and indirect costs, minus the cost of treatment as usual. The benefits and the costs are discounted to present value. The benefit/cost ratio is the optimal return on investment (OROI) Illinois can expect from implementing the program with fidelity.

Section 2

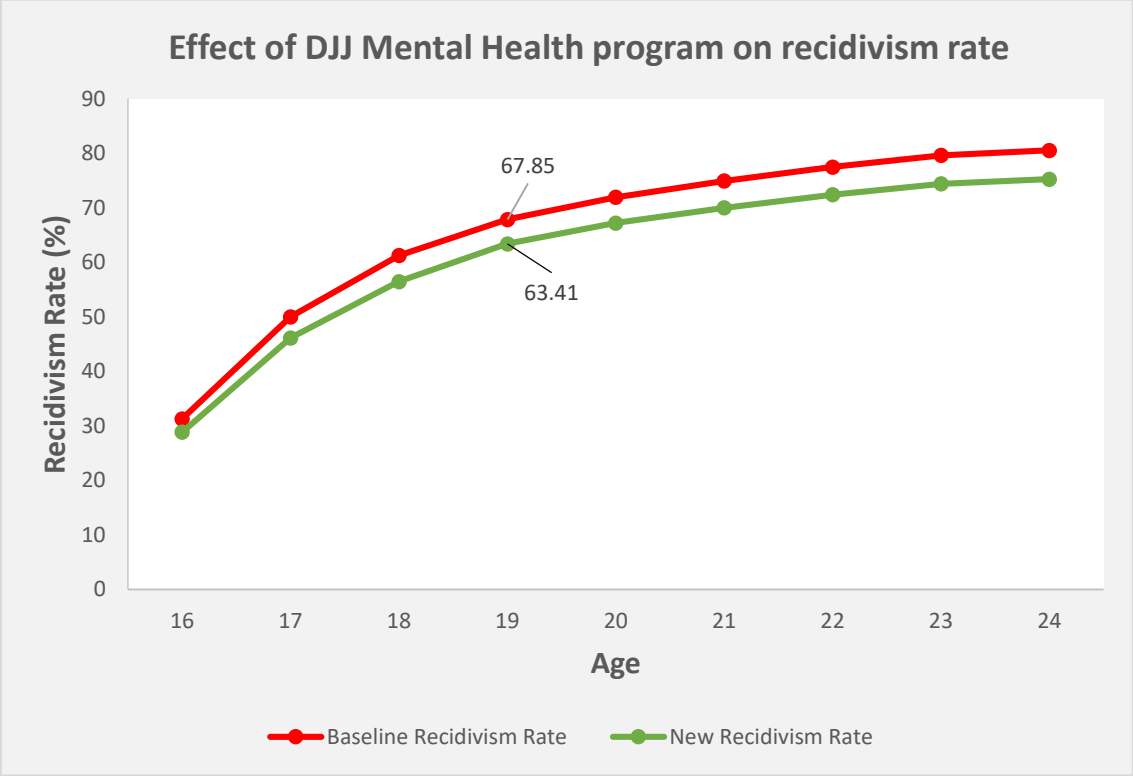
Benefit-Cost Results

Benefit-Cost Results - DJJ Mental Health Program

The Results First benefit-cost model uses the effect size determined by the program profile for "Cognitive behavioral therapy (CBT) for juvenile offenders." The SPARCS program costs were provided by DJJ.

The standard practice in Illinois is to track youth cohorts released from DJJ in the same year and record their recidivism over the next three years. Based on national studies on juvenile offenders in CBT programs, the benefit-cost analysis predicts the three-year recidivism rate[7] for participants in the SPARCS program to be under 64%, compared to just under 68% for the general juvenile population – a decrease of over four percentage points, as shown in *Figure 1*.

Figure 1



The baseline recidivism rate used in the benefit-cost analysis is a predicted likelihood of future adjudication after release from custody. DJJ also tracks the actual percentage of youth who return to juvenile facilities within three years of release. This percentage was 52.1% for youth released in FY 2015. It is lower than the baseline recidivism rate used in the model because it does not include youth who are sentenced as adults and sent to the Department of Corrections, or youth who are adjudicated for a new offense but not returned to detention. DJJ does not currently track SPARCS program completers who return to juvenile facilities, but plans to begin tracking this in the near future.

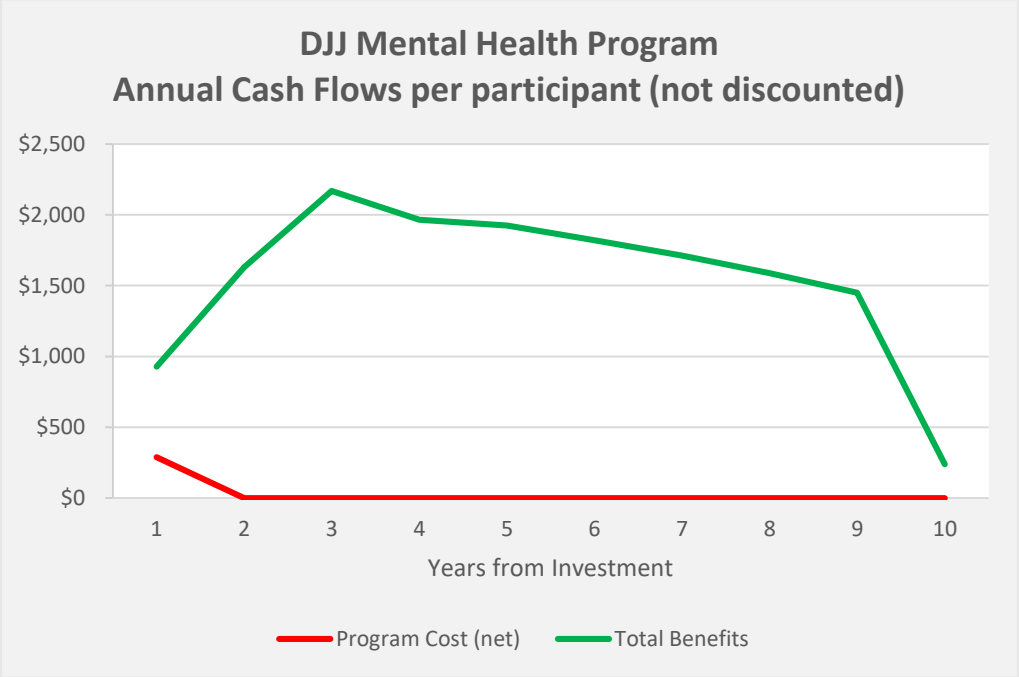
[7] Recidivism for juveniles is defined as an adjudication after release from custody.

The annual costs and benefits for the DJJ SPARCS program can be seen below in *Figure 2*. For this program all costs are incurred in the first year while benefits accrue over time. The red line depicts annual program costs. The cost per person for the DJJ SPARCS program includes staff time and staff training. The curriculum uses journals and other materials. Journals are reused from year to year, while other materials are currently purchased out-of-pocket by program staff.

The green line shows total program benefits. As illustrated, the program benefits exceed the program costs beginning in the first year of investment. Although not depicted in *Figure 2*, BFR projected the program benefits out 50 years and found that total expected program benefits are $15,307 when discounted to present value. Most of these benefits occur in the first ten years after program participation.

The return on investment from the benefit-cost analysis only calculates the benefits from reducing recidivism. Other benefits or costs related to mental health treatment are not included in this report. Based on additional data that will be obtained from future studies this program will be reevaluated to determine outcomes in other result areas.

Figure 2



The DJJ SPARCS program accumulates benefits over time to various groups. The benefits to Illinois are based on avoided criminal justice expenses and avoided private costs incurred as a result of fewer crime victims. The private victimization costs include lost property, medical bills, wage loss, and the pain and suffering experienced by crime victims.

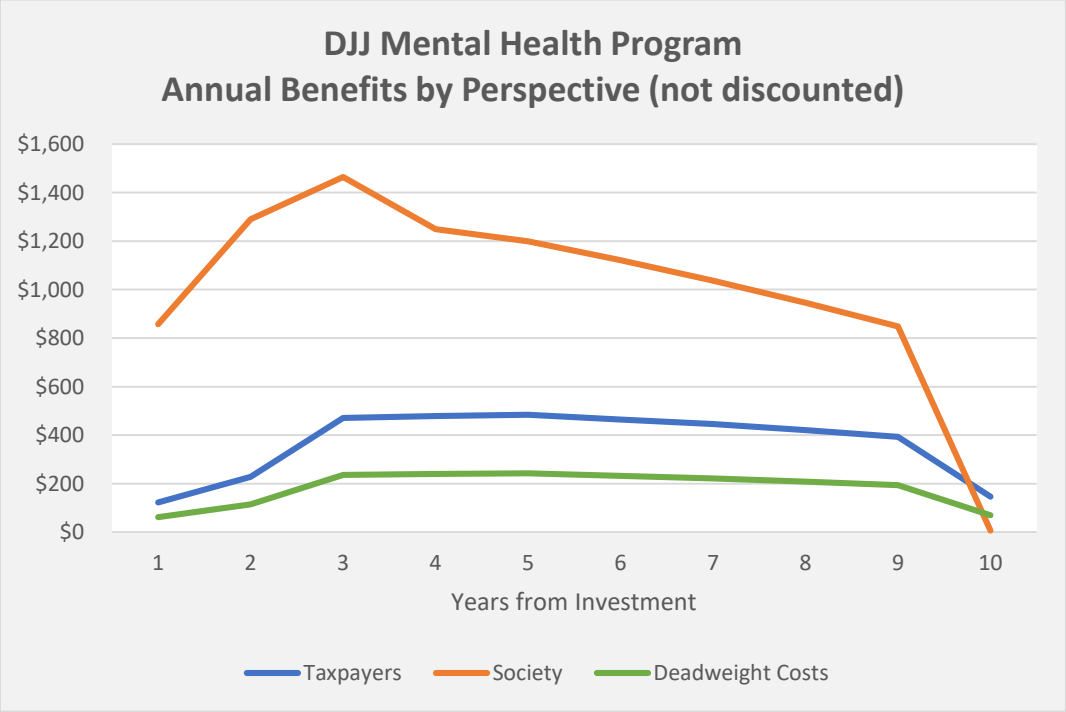
Taxpayers avoid paying for additional criminal justice system costs of arrests and processing; prosecutions, defense, and trials; and incarceration and supervision. Lower incarceration rates lead to

fewer prisoners that need to be paid for by the State. The benefits to DJJ are determined by calculating DJJ's avoided future costs, classified as either fixed, variable or step costs. Fixed costs do not change based on the DJJ population. Variable costs change as the population increases or decreases marginally. Step costs only change once a threshold level of DJJ population numbers are reached. The costs that could be avoided by reducing recidivism are determined by calculating the fixed, variable and step costs that would change with a change in the DJJ population[8].

Additional indirect benefits accrue to society as well. When tax revenue is spent on one program, it has an opportunity cost of revenue that cannot be spent on other beneficial programs and services like public safety or economic development. Money that is taxed is also not available for private consumption and investment. The indirect benefits of making effective, economically efficient investments to reduce criminal recidivism are quantified within the Results First model using the Deadweight Cost of Taxation. This inefficiency creates both a benefit and a cost in this model – the initial spending on the program generates a cost. Later savings for Illinois due to reduced recidivism decrease the deadweight cost of inefficient government taxation and spending. The deadweight cost of initial program spending is subtracted from indirect benefits in the first year.

Figure 3 below illustrates how benefits accumulate to different Illinois stakeholders. The majority of the benefits come from future avoided victimization costs in society. The remaining benefits come from taxpayer costs and other avoided indirect deadweight costs.

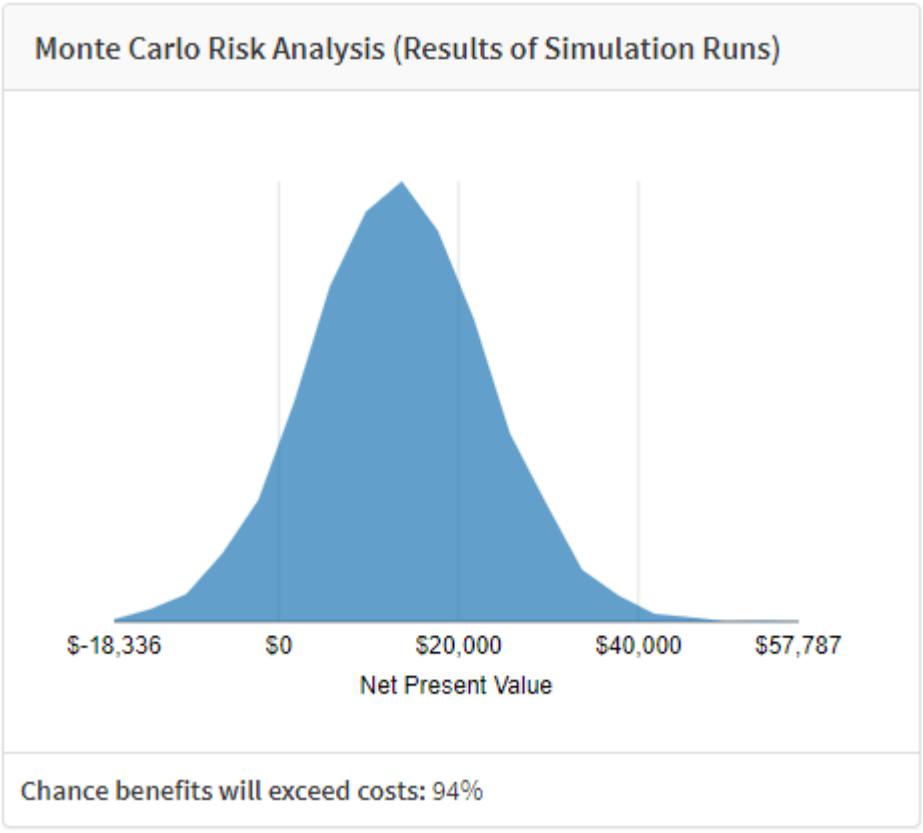
Figure 3



[8] http://www.icjia.state.il.us/spac/pdf/Dynamic_Marginal_Costs_2018_Update.pdf

All program benefits are predictive, and there is uncertainty when forecasting future outcomes. To help account for the uncertainty, BFR runs each benefit-cost analysis 10,000 times with random variations in the costs and benefits. The histogram in *Figure 4* shows the range of OROI resulting from running the simulations. The optimal program benefits exceeded the program costs in 94 percent of the simulations.

Figure 4



Section 3

State Program Assessment Rating Tool

State Program Assessment Rating Tool (SPART)
Mental Health Program
425-Department of Juvenile Justice

This report was compiled by the Budgeting for Results Unit of the Governor's Office of Management and Budget with the support of the Department of Juvenile Justice (DJJ). The SPART is an assessment of the performance of state agency programs. Points are awarded for each element of the program including: Program Design and Benefit-Cost and Performance Management/Measurement. This combined with benefit-cost analysis through Results First establishes an overall rating of the program's effectiveness, which can be found on the final page of this report.

Part 1: General Information

Is this program mandated by law? Yes _X_ No ___
Identify the origin of the law: State _X_ Federal ___ Other ___
Statutory Cite: __730 ILCS 5/3-15-3(a)__
Program Continuum Classification: _____Treatment, Case Identification_____

Evaluability
Provide a brief narrative statement on factors that impact the evaluability of this program.

The SPARCS curriculum is one part of the comprehensive mental health services provided to youth by DJJ. It is challenging to isolate the SPARCS curriculum costs and services within the holistic approach needed for successfully treating DJJ youth.

SPARCS is used to address the mental health needs of youth at all DJJ facilities. DJJ has worked with the authors of the SPARCS curriculum to adapt the length of the program to meet the varying needs of their youth. As the program continues to adapt, research is necessary to understand how well it is achieving its intended outcomes.

Key Performance Measure	FY 2013	FY 2014	FY 2015	Reported in IPRS Y/N
Overall DJJ recidivism rate (return to juvenile facilities)	58.7%	57.8%	52.1%	Y[9]

[9] Illinois Performance Reporting System, Department of Juvenile Justice Performance Metric Reports FY19 Quarter 3. Retrieved from https://www2.illinois.gov/sites/budget/IPRS%20Reports/425-Juvenile%20Justice.pdf

Part 2: Program Design and Benefit-Cost **Total Points Available: 60**

Total Points Awarded: 50

Question	Points Available	Evidence Level	Points Awarded
2.1 What is the program evidence level? - Evidence Based 25pts - Theory Informed 15 pts - Unknown Effect 0 pts - Negative Effect -5 pts (Provide core principles in narrative section)	25	Evidence Based	25

Explanation:

The SPARCS group therapy curriculum is an adaptation of three interventions that have been nationally studied: Dialectical Behavior Therapy for Adolescents, Trauma Adaptive Recovery - Group Education and Therapy (TARGET), and School-Based Trauma/Grief Group Psychotherapy Program. According to DJJ staff, SPARCS is a form of cognitive-behavioral therapy, a widely studied therapeutic approach that encompasses a variety of curriculums.

Although there is not yet sufficient rigorous evidence on the SPARCS curriculum in particular, cognitive-behavioral therapy (CBT) more generally has been studied extensively and found to be effective. The benefit-cost analysis section of this program assessment is based on national research on CBT, including a range of specific curriculums.

SPARCS was developed specifically for adolescents exposed to chronic trauma, and has been used in various settings, including juvenile justice facilities. The core principles of SPARCS align with the general best practices of juvenile justice programming. Programming is most effective when it targets the "specific needs of offenders known to be associated with criminal behavior" and when "the delivery of interventions [is] matched to their learning styles."[10]

In 2006, the Illinois Department of Children and Family Services (DCFS), in partnership with Northwestern University, completed pilot tests of three evidence-based mental health treatment programs for youth who had experienced significant trauma and were wards of the state. SPARCS was piloted for youth aged 12-17. The pilot tests were not intended to establish the evidence-based nature of the treatments, but rather to analyze how well treatment programs could be successfully implemented with fidelity and could be associated with positive outcomes in a complex child welfare system.

The programs were piloted in both Chicago and other areas of Illinois to account for the unique challenges of urban and rural communities. The study concluded that all three treatment programs were "both feasible and effective."

[10] Cann, J., Falshaw, L., Nugent, F., & Friendship, C. (2003). *Understanding what works: Accredited cognitive skills programmes for adult men and young offenders* (Research Findings No. 226). London: Home Office.

According to the pilot study's recommendations, "If the Department decides to implement any or all of these evidence-based trauma practices, such an implementation would best be accomplished within the framework of a monitoring and outcomes management environment."[11]

Question	Points Available	Yes/Partial/No	Points Awarded
2.2 Is the Program implemented and run with fidelity to the program design?	25	Partial	15

Explanation:

Most SPARCS groups are 16 weeks with one hour-long session per week. SPARCS therapy groups are closed. Upon entering a DJJ facility, youth must wait until there is a cohort of youth who can begin a new group together.

With the authors' approval DJJ has been able to develop modified lesson plans depending on youth need. Youth at IYC-Chicago have at times utilized an eight-week curriculum due to shorter lengths of stay for youth at that facility. IYC-Chicago also runs a voluntary, ongoing "Mini-Mindfulness Group" that reviews mindfulness skills taught in SPARCS. Additionally, IYC-Chicago offers a SPARCS alumni group that runs eight weeks and is used to refresh the SPARCS skills for youth who have already completed the 16-week program.

Although altering the length of a program from its original design can impact program effectiveness, these changes were made in consultation with the curriculum authors and reflect a responsivity to youth needs that is crucial to program success. There is a tension within juvenile justice best practices between the need for youth to complete programming in order to maximize benefits and the desire to release youth from detention into the community as quickly as possible, which has been shown to improve youth outcomes. Other DJJ programs such as substance use disorder treatment have also been shortened over time to accommodate shorter detention times for youth.

Staff training is another important element of program implementation. Mental health treatment is delivered by DJJ Mental Health Professionals (MHPs). Most MHPs are provided contractually by Wellpath, while others are state employees. MHPs are trained by certified SPARCS trainers approved by the curriculum authors. Trainers have been affiliated with the Adelphi University Institute for Adolescent Trauma Treatment & Training and with Mindshift Center in Quincy, Illinois. Because the SPARCS training is a six-month program, staff turnover sometimes results in SPARCS groups being run by MHPs that have been trained by other MHPs instead of a trainer approved by the curriculum authors. The author-approved training MHPs receive is not train-the-trainer oriented. Consequently, there is no mechanism to verify that MHPs have validly and effectively conveyed the principles learned at author-approved training to new MHPs, when they provide the training themselves.

[11] Lyons, J. S., Weiner, D. A., & Scheider, A. (2006). A field trial of three evidence-based practices for trauma with children in state custody (Report to the Illinois Department of Children and Family Services). *Evanston, IL: Mental Health Resources Services and Policy Program, Northwestern University*.

Question	Points Available	Yes/Partial/No	Points Awarded
2.3 If the program achieved full credit in question 2.2, can we expect the Optimal Return on Investment (OROI) for this program to be equal to or greater than $1 for each $1 spent?	10	Yes	10

Explanation:

The expected optimal return on investment from this program is $53.97. Please see Section 2 - Benefit-Cost Results for additional information.

Part 3: Performance Management/Measurement **Total Points Available: 40**

Total Points Awarded: 15

Question	Points Available	Yes/Partial/No	Points Awarded
3.1 Does the program regularly collect timely and credible performance measures?	10	No	0

Explanation:

DJJ does not currently collect performance measures for this program. The only measure collected is the average number of youth receiving treatment. DJJ is currently working to identify and implement appropriate pre- and post-test screeners to track youth trauma symptoms, DSM diagnoses and behavioral outcomes. DJJ also intends to begin tracking how many youth complete the SPARCS curriculum, and the recidivism rate of these youth.

Question	Points Available	Yes/Partial/No	Points Awarded
3.2 Do the performance measures focus on outcomes?	10	Partial	5

Explanation:

As stated above, DJJ does not currently collect performance measures for this program. The primary outcome DJJ is seeking from its Mental Health program is the reduction of juvenile recidivism. Tracking youth who participate in and particularly who complete the SPARCS program will enable the department to track recidivism for program completers and compare it with the recidivism rate for all DJJ youth. Additionally, enhancements are being recommended to upgrade the youth data collection system, Y360, to allow better identification of program participants for correlations in data collection.

This in combination with the implementation of pre- and post-test screeners to track behavioral health outcomes will give the department valuable information on the achievement of program goals. Although the department has not yet begun collecting performance measures, the program achieves partial credit due to its concrete plans to implement measures that are specific and clearly focused on outcomes.

Question	Points Available	Yes/Partial/No	Points Awarded
3.3 Are independent and thorough evaluations of the program conducted on a regular basis or as needed to support program improvements and evaluate effectiveness?	10	No	5

Explanation:

The John Howard Association (JHA), an independent monitoring organization, produces periodic reports on each DJJ facility. The most recent reports on each facility included descriptions and commentary on the mental health treatment available, including psychotropic treatment which is beyond the scope of this report.[12]

JHA is dedicated to monitoring both adult and juvenile correctional facilities in Illinois. JHA does not specialize in mental health treatment, nor has it conducted comprehensive program evaluations of DJJ's mental health program specifically. Therefore, a full independent evaluation of the mental health program by mental health treatment experts is recommended.

Question	Points Available	Yes/Partial/No	Points Awarded
3.4 Does the Agency use performance information (including that collected from program partners) to adjust program priorities, allocate resources, or take other appropriate management actions?	10	Yes	5

Explanation:

DJJ uses performance information to make management decisions, for example their pursuit of the 8-week version of SPARCS. This is driven by the number of youth who cannot complete the 16-week program due to having a sooner release date.

[12] See for example the *2018 Monitoring Report for IYC-Harrisburg*, available at http://www.thejha.org/harrisburg.

Concluding Comments

The SPARCS program was adopted by DJJ in 2010 to provide mental health treatment for youth who experienced complex trauma. The SPARCS curriculum design was adapted from three successful evidence based practices. The implementation of SPARCS has varied based on resources available, staff training and youth need. DJJ has not yet begun collecting performance measures. It is vital that the program make efforts to implement a full outcome measurement regime, as such performance measures are necessary for a full assessment of this program. The agency has specific plans to implement program performance measures that focus on outcomes, and the program administrators are commended for their commitment to this important goal.

Final Program Score and Rating

Final Score	Program Rating
65	Moderately Effective

SPART Ratings
Programs that are PERFORMING have ratings of Effective, Moderately Effective, or Adequate.

- Effective. This is the highest rating a program can achieve. Programs rated Effective set ambitious goals, achieve results, are well-managed and improve efficiency. Score 75-100
- Moderately Effective. In general, a program rated Moderately Effective has set ambitious goals and is well-managed. Moderately Effective programs likely need to improve their efficiency or address other problems in the programs' design or management in order to achieve better results. Score 50-74
- Marginal. This rating describes a program that needs to set more ambitious goals, achieve better results, improve accountability or strengthen its management practices. Score 25-49

Programs categorized as NOT PERFORMING have ratings of Ineffective or Results Not Demonstrated.

- Ineffective. Programs receiving this rating are not using your tax dollars effectively. Ineffective programs have been unable to achieve results due to a lack of clarity regarding the program's purpose or goals, poor management, or some other significant weakness. Score 0-24
- Results Not Demonstrated. A rating of Results Not Demonstrated (RND) indicates that a program has not been able to develop acceptable performance goals or collect data to determine whether it is performing.

Please see www.Budget.Illinois.gov for additional information.

Glossary

Best Practices: Policies or activities that have been identified through evidence-based policymaking to be most effective in achieving positive outcomes.

Evidence-Based: Systematic use of multiple, rigorous studies and evaluations which demonstrate the efficacy of the program's theory of change and theory of action.

Illinois Performance Reporting System (IPRS): The state's web-based database for collecting program performance data. The IPRS database allows agencies to report programmatic level data to the Governor's Office of Management and Budget on a regular basis.

Optimal Return on Investment (OROI): A dollar amount that expresses the present value of program benefits net of program costs that can be expected if a program is implemented with fidelity to core principles or best practices.

Outcome Measures: Outcomes describe the intended result of carrying out a program or activity. They define an event or condition that is external to the program or activity and that is of direct importance to the intended beneficiaries and/or the general public. For example, one outcome measure of a program aimed to prevent the acquisition and transmission of HIV infection is the number (reduction) of new HIV infections in the state.

Output Measures: Outputs describe the level of activity that will be provided over a period of time, including a description of the characteristics (e.g., timeliness) established as standards for the activity. Outputs refer to the internal activities of a program (i.e., the products and services delivered). For example, an output could be the percentage of warnings that occur more than 20 minutes before a tornado forms.

Program Continuum Classification: Programs are classified based on the type of service being provided: promotion, prevention, treatment or maintenance. This classification is based on a continuum of intervention developed by the Institute of Medicine (currently known as the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine):

1. Promotion - Promotion interventions aim to enhance individuals' ability to achieve developmentally appropriate tasks (competence) and a positive sense of self-esteem, mastery, well-being, social inclusion and strengthen their ability to cope with adversity.
2. Prevention - Interventions that occur prior to the onset of a disorder that are intended to prevent or reduce risk for the disorder.
3. Treatment - Interventions targeted to individuals who are identified as currently suffering from a diagnosable disorder that are intended to cure the disorder or reduce the symptoms or effects of the disorder, including the prevention of disability, relapse, and/or comorbidity.
4. Maintenance - The provision of after-care services to the patient, including rehabilitation to assist the patient's compliance with long-term treatment to reduce relapse and recurrence. [13]

Results First Clearinghouse Database: One-stop online resource providing policymakers with an easy way to find information on the effectiveness of various interventions as rated by eight nation research clearinghouses which conduct systematic research reviews to identify which policies and interventions work.

[13] https://www.ncbi.nlm.nih.gov/books/NBK32789/

Target: A quantifiable metric established by program managers or the funding entity established as a minimum threshold of performance (outcome or output) the program should attain within a specified timeframe. Program results are evaluated against the program target.

Theory Informed: A program where a lesser amount of evidence and/or rigor exists to validate the efficacy of the program's theory of change and theory of action than an evidence-based program.

Theory of Change: The central processes or drives by which a change comes about for individuals, groups and communities

Theory of Action: How programs or other interventions are constructed to activate theories of change.

Citations

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Section 4

Supplemental Materials

NCTSN The National Child Traumatic Stress Network

GENERAL INFORMATION

SPARCS: Structured Psychotherapy for Adolescents Responding to Chronic Stress

Treatment Description

Acronym *(abbreviation)* **for intervention:** SPARCS

Average length/number of sessions: 16 sessions, 1 hour in length

Aspects of culture or group experiences that are addressed *(e.g., faith/spiritual component, transportation barriers)***:** Meaning making, which is culturally driven, is a central component of SPARCS. Therapists routinely engage group members in discussions around the ways in which trauma has impacted their lives and what it means to them in the context of their culture. See "Culture-Specific Intervention" for further detail.

Trauma type *(primary)*: Complex Trauma, chronic interpersonal traumas.

Trauma type *(secondary)*: Chronic non-interpersonal traumas (e.g. medical illness).

Additional descriptors *(not included above)***:** SPARCS is a manually-guided and empirically-supported group treatment designed to improve the emotional, social, academic, and behavioral functioning of adolescents exposed to chronic interpersonal trauma (such as ongoing physical abuse) and/or separate types of trauma (e.g. community violence, sexual assault). The curriculum was designed to address the needs of adolescents who may still be living with ongoing stress and may be experiencing problems in several areas of functioning including difficulties with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing and avoidance, and struggles with their own purpose and meaning in life as well as worldviews that make it difficult for them to see a future for themselves. The curriculum has been successfully implemented with at-risk youth in various service systems (e.g. schools, juvenile justice, child-welfare, residential) in over a dozen states.

- **Goals of the Program**: include helping teens cope more effectively in the moment, enhancing self-efficacy, connecting with others and establishing supportive relationships, cultivating awareness, & creating meaning in their lives.
- **Youth with Complex Presentations & Histories**. SPARCS is designed to address a range of traumatic experiences and is not based on any one trauma type. The intervention is appropriate for traumatized adolescents with or without current/lifetime PTSD. Since many children and adolescents exposed to violence do not meet full criteria for PTSD, SPARCS also addresses comorbidity and impairments in functioning that stem from trauma but are not captured by a diagnosis of PTSD alone (e.g. behavior problems, delinquency, substance use).
- **Developmentally Sensitive.** SPARCS is designed to address the needs of multiply traumatized adolescents in a manner that incorporates developmental considerations specific to this age group. The manual has been specifically developed for use with adolescents and includes experiential activities that emphasize adolescents' increased capacity for abstract thought as well as areas of development that are particularly relevant for teenagers (e.g. issues related to autonomy and identity).

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Target Population

- Present-Focused. SPARCS is a present-focused intervention, and is not an exposure based model. Although there is no direct exposure component or construction of a trauma narrative, traumas are discussed in the context of how they relate to adolescents' current behavior and to their understanding of their problems and difficulties in the here and now.
- Adaptations. Adaptations are in various stages of development and have been piloted in a number of settings. Adaptations include: a 6-session Skills Training model (SPARCS-ST) for use in short-term facilities; two peer-led curricula (Taking Control for use with youth in foster care, and the RAP Club for use with adolescents with extensive exposure to community violence), SPARCS for use in individual therapy (SPARCS-I), and SPARCS Juniors (for use with children ages 9 to 11).

Age range: 12 **to** 21

Gender: ❒ **Males** ❒ **Females** ☒ **Both**

Ethnic/Racial Group *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** SPARCS has been used with ethnically diverse groups, including African American, Latino, Native American adolescents and refugee/immigrant populations.

Language*(s)***:** Predominantly English. Groups have also been conducted in Spanish and have been adapted for use in other countries (see "Culture-Specific Information" fact sheet).

Region *(e.g., rural, urban)***:** Urban, suburban, rural

Other characteristics *(not included above)***:**
Populations: SPARCS has also been implemented with LGBTQ youth, gang-involved youth, and with adolescents who are pregnant or parenting.

Settings: Groups have been provided in a variety of settings including outpatient clinics, schools, group homes, boarding schools, residential treatment centers and facilities, substance abuse treatment facilities, and juvenile justice centers. SPARCS has also been implemented with adolescents in foster care and in shelters with runaway/homeless youth. It is recommended that SPARCS be implemented in settings where adolescents can remain in treatment long enough to complete the intervention. Sessions can be divided into two segments and conducted twice a week to accommodate class periods in a school setting. SPARCS has been piloted for use in settings with short lengths of stay (see "Adaptations" in "Treatment Descriptions" section above).

Essential Components

Theoretical basis: (DBT: Miller, Rathus, & Linehan, 2006), and Complex Trauma theory. The curriculum also incorporates elements from early versions of Trauma Adaptive Recovery Group Education and Therapy (TARGET: Ford & Russo, 2006), and Trauma and Grief Components Therapy (TGCT: Layne, Saltzman, Pynoos, et al., 2000).

Key components: Mindfulness, Problem-Solving, Meaning-Making, Relationship-building/Communication Skills, Distress Tolerance and psychoeducation regarding stress, trauma, and triggers.

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Clinical & Anecdotal Evidence

Are you aware of any suggestion/evidence that this treatment may be harmful?
❒ **Yes** ☒ **No** ❒ **Uncertain**

Extent to which cultural issues have been described in writings about this intervention *(scale of 1-5 where 1=not at all to 5=all the time)*. 2

This intervention is being used on the basis of anecdotes and personal communications only *(no writings)* **that suggest its value with this group.**
❒ **Yes** ☒ **No**

Are there any anecdotes describing satisfaction with treatment, drop-out rates *(e.g., quarterly/annual reports)*? ☒ **Yes** ❒ **No**

If YES, please include citation:
Briggs-King, E. & Shaw, L. (2009). Durham County ABC Board Year End Report. Unpublished Report. Center for Child & Family Health, Durham, NC.

Mental Health Services & Policy Program & Illinois Department of Children & Family Services (2008). Final evaluation of the pilot implementation of three evidence based practices for the treatment of trauma among youth in child welfare. Unpublished report.

Has this intervention been presented at scientific meetings? ☒ **Yes** ❒ **No**

If YES, please include citation*(s)* **from last five presentations:** ISTSS 2003-2011

Habib, M. (2009, April) Structured psychotherapy for adolescents responding to chronic stress (SPARCS): In C. Lanktree (Chair), *Treatment of Complex Trauma: Multiple Approaches, Practical Applications, and Cultural Adaptations*. Pre-Meeting Institute conducted at the All-Network Conference of SAMHSA's National Child Traumatic Stress Network, Orlando, Fl.

Habib, M. (2010, November). A complex trauma case analysis of "James" using SPARCS (Structured Psychotherapy for Adolescents Responding to Chronic Stress): In J. Spinazzola (Chair), *Clinical Nuance in Complex Trauma Treatment: Analysis of a Single Case from the Vantage Point of Four of the Network's Leading Complex Trauma Intervention Models*. Pre-Meeting Institute conducted at the International Society for Traumatic Stress Studies, Montreal, Canada.

Tandon, D., Tucker, M., Nole, M., & Habib, M. (2011, November). *The RAP Club: A Trauma-Focused Group Delivered by Adolescent and Young Adult Peer Leaders.* Workshop conducted at the meeting of the International Society for Traumatic Stress Studies, Baltimore, MD.

Habib, M., & DeRosa, R. (2008, November). Coping and Meaning Making: Essential components for complex trauma treatment with adolescents. In K. Nader & K. Fletcher (Chairs), *Complex trauma in children and adolescents: Treatment needs and methods*. Symposium conducted at the annual meeting of the International Society for Traumatic Stress Studies, Chicago, IL.

Clinical & Anecdotal Evidence continued

Habib, M. (2011, November). An Experiential Introduction to Mindfulness and MAKE A LINK communication skills in Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), a Group Treatment for Adolescents with Complex Trauma Workshop conducted at the Connecting for Children's Justice Conference, Nashville, TN.

Are there any general writings which describe the components of the intervention or how to administer it? ☒ Yes ❒ No

If YES, please include citation:

Ford, J., Blaustein, M., Cloitre, M., Habib, M., Kagan, R. (in press). Developmental Trauma Disorder-Focused Interventions for Traumatized Children and Adolescents. In: J.D. Ford & C. A. Courtois (Eds), *Treating complex traumatic stress disorders in children: An evidence-based guide*, NY: Guilford Press, p.xx-xxx.

DeRosa, R. & Pelcovitz. D. (2008). Igniting SPARCS of change: Structured psychotherapy for adolescents responding to chronic stress. In J. Ford, R. Pat-Horenczyk & D. Brom (Eds.), *Treating traumatized children: risk, resilience and recovery*, NY: Routledge.

DeRosa, R., Habib, M., Pelcovitz, D., Rathus J., Sonnenklar,J., Ford, J., Sunday, S., Layne, C., Saltzman, W., Turnbull, A., Labruna, V. & Kaplan, S. (2005). *Structured Psychotherapy for Adolescents Responding to Chronic Stress: A Treatment Guide*. Unpublished manual.

Has the intervention been replicated anywhere? ☒ Yes ❒ No

SPARCS has been replicated with foster care youth as part of a project with the Department of Children and Family Services in Illinois.

Other countries? *(please list)* India, Sri Lanka, Israel, Australia, Canada, Liberia

Other clinical and/or anecdotal evidence *(not included above)*:

Generalization of skills has been noted at multiple sites and settings. Group members frequently report use of the skills outside of group and parents and clinical staff have observed that group members use the language and concepts at home, at school, or in their residence. Both boys and girls in a residential substance abuse treatment facility have identified knitting hats and blankets and donating them as ways in which they use their "Distress Tolerance" skills to self-regulate, and ways to make meaning by making a contribution to others. At another site, several gang members voluntarily sought out their group leader for additional practice with the skills they were learning in order to apply them to their specific stressors. One adolescent gave his therapist the crack pipe given to him as a gift by his mother, stating that he no longer needed it because he had learned new ways to cope. Members have asked to bring friends and family to the group and also reported that they teach the skills to others (e.g. one adolescent interrupted a fight between her sister and the sister's boyfriend and taught them to use the "Make A Link" communication skills). Group members across settings have applied affect regulation and communication skills to real-life situations and have initiated and contributed to discussions with staff and teachers about conflicts on their unit or in school.

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Clinical & Anecdotal Evidence continued	Adolescents often request additional group sessions and express dismay upon termination or when groups are cancelled. In one setting group members worked together to write a letter to administrative staff, asking to have additional sessions of group added to their program so that they did not have to terminate. In an alternative school in an urban setting where truancy is a significant problem, clinicians reported that group members who previously refused treatment, began coming to school for the sole purpose of attending group. Administrators, parents, and key stakeholders have shared observations regarding progress as well. Administrators in one school noted a dramatic decrease in physical confrontations between students in the school and in another school a reduction in disciplinary referrals was observed following a shortened psychoeducational adaptation of the curriculum provided for over 200 youth. Upon observing improvement in an adolescent in the juvenile justice system, one judge remarked that he is going to begin referring traumatized youth to SPARCS as an alternative to anger management.	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Published Case Studies	**N=**1 **By gender:** female **By ethnicity:** Latina, African-American, Caucasian	DeRosa, R. & Pelcovitz, D. (2006). Treating traumatized adolescent mothers: a structured approach. In: N. Webb (Ed.), *Working with traumatized youth in child welfare*, NY: Guilford Press, 219-245.
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**24 **By gender:** mixed **By ethnicity:** Latino, African-American, Caucasian, and other **N=**14 **By gender:** female **By ethnicity:** Latina, African-American, Caucasian **N=**44 **By gender:** mixed **By ethnicity:** Caucasian, African-American, Latino **N=**31 **By gender:** mixed **By ethnicity:** African-American, Caucasian, Latino	Habib, M., Labruna, V., & Newman, J. (manuscript submitted for publication). Complex Histories and Complex Presentations: Implementation of a Manually-Guided Group Treatment for Traumatized Adolescents. *Journal of Family Violence*. DeRosa, R. & Pelcovitz, D. (2006). Treating traumatized adolescent mothers: a structured approach. In: N. Webb (Ed.), *Work*ing with traumatized youth in child welfare, NY: Guilford Press, 219-245. Knoverek, A., Underwood, L., Habib, M., Briggs, E. (manuscript in preparation). *Feasibility and Effectiveness of an Adapted Group Treatment for Traumatized Youth*. Briggs-King, E. & Shaw, L. (2009). *Durham County ABC Board Year End Report*. Unpublished Report. Center for Child and Family Health, Durham, N.C.

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GENERAL INFORMATION

Clinical Trials *(w/control groups)*	**N=**41 **By gender:** mixed **By ethnicity:** African-American, Caucasian, Latino **N=**33 **By gender:** mixed **By ethnicity:** African-American, Caucasian, Latino **N=**42 **By gender:** mixed **By ethnicity:** predominantly African-American	Mental Health Services & Policy Program & Illinois Department of Children & Family Services (2008). Final evaluation of the pilot implementation of three evidence based practices for the treatment of trauma among youth in child welfare. Unpublished report. Weiner, D., Schneider, A., and Lyons, J. (2009) Evidence-based treatments for trauma among culturally diverse foster care youth: Treatment retention and outcomes. Children and Youth Services Review, 31, 1199-1205. Tandon SD, Mendelson T, Mance G. (2011). Acceptability and preliminary outcomes of a peer-led depression intervention for African American adolescents and young adults in employment training programs. Journal of Community Psychology, 39, 621-628.
Studies Describing Modifications		See Knoverek and colleagues above. See Tandon and colleagues above.
Other Research Evidence	**N=**184	Unpublished data.

Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any? The Trauma History Checklist, Youth Outcome Questionnaire – Self-Report (YOQ- SR 2.0), UCLA PTSD Reaction Index (RI), the Child & Adolescent Needs & Strengths (CANS). Additional assessments have included: the Ohio Scales, the Structured Interview for Disorders of Extreme Stress – Adolescent Version (SIDES-A), and assorted other instruments.

If research studies have been conducted, what were the outcomes?
Pilot data indicate significant improvement in overall functioning over the course of treatment (as measured by the Youth Outcome Questionnaire SR-2.0 and the UCLA PTSD Reaction Index). Specific findings include:

- Significant changes on subscales measuring conduct problems, inattention/hyperactivity, somatic complaints, high risk behaviors, and interpersonal relationships.
- Significant reduction in PTSD symptoms, with improvements noted in the overall severity of posttraumatic stress symptoms, as well as scores assessing symptoms related to re-experiencing, avoidance, and hyper-arousal (Criterion B, C, and D respectively).

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Outcomes continued	For African-American adolescents (the primary group in the EBPP described above), youth receiving SPARCS: • were less likely to drop out of treatment • improved significantly on the following CANS subscales: Traumatic Stress Symptom, Life Domain Functioning, and Risk Behaviors. Additional pilot data summarized from a variety of sources (including analyses in unpublished reports), found: • decreased alcohol and drug use with 75% of adolescents reporting a decrease in frequency following treatment • significant reduction in attachment difficulties and in behavior problems at school, home, and in the community • decrease in disciplinary referrals in an alternative school (analyses in progress) • significant improvement in interpersonal coping and an increase in support seeking behavior • significant decrease in depressive symptoms in youth exposed to community violence and increase in active coping strategies
Implementation, Requirements & Readiness	**Space, materials or equipment requirements?** • Manual for each group leader • Color workbook with handouts specific to each session (1 workbook per client) • Meeting room large enough to accommodate a group of 8-12 adolescents • Ability to play videos • Assorted supplies for group activities (e.g. flip chart, seltzer water, sandpaper, music). Session supply list available upon request. **Supervision requirements** *(e.g., review of taped sessions)***?** Ability to attend 80% of consultation calls. For certification only: one video or audiotaped session in which one of the core skills was implemented. In cases where it is not possible to tape a group, it may be permissible (with advance notice) to provide a tape of a "mock session" where a core skill is taught with a group of colleagues (e.g. at a staff meeting). **To ensure successful implementation, support should be obtained from:** treatment developers or certified trainers. A list of certified trainers is available upon request.

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Training Materials & Requirements

List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.

DeRosa, R., Habib, M., Pelcovitz, D., Rathus J., Sonnenklar,J., Ford, J., Sunday, S., Layne, C., Saltzman, W., Turnbull, A., Labruna, V. & Kaplan, S. (2005). *Structured Psychotherapy for Adolescents Responding to Chronic Stress: A Treatment Guide*. Unpublished manual.

Habib, M., & Sonnenklar, J. (2005). *SPARCS Group Handouts for Youth*. Unpublished manual.

How/where is training obtained? Contact treatment developers for a list of certified trainers. Trainings can be conducted on-site for agencies who are interested in hosting their own Collaborative. Participants can also join an existing Collaborative that may be taking place in another part of the country. The number of trainers varies depending on the size of the training group. The trainer-participant ratio is generally small in order to allow for adequate interaction and in-vivo consultation during role-plays.

What is the cost of training?

- **Training Costs:** Cost varies depending upon a number of factors including the number of participants and location of training. Cost structure is consistent across all certified trainers and should include all elements described below in "other training materials &/or requirements". One black and white copy of the manual and one color Youth Workbook are typically included in the cost for each training participant. Contact treatment developers for detailed training cost information.
- **Youth Workbooks Costs***: The color Workbooks that are used with each group member can be purchased for approximately $20 each. These are sold at cost. Pricing depends on the size of the order.
- **Manual Costs***: Manuals can be purchased for $75 – $100 each (depending on printing and shipping costs). Cost includes the SPARCS clinician manual, one color workbook, and shipping and handling within the U.S. Implementing the curriculum without formal training and consultation is not encouraged as there are many concepts taught at the training that are not included in the manual and certain skills that appear self-explanatory (e.g. the LET 'M GO problem-solving steps) require in-depth practice and coaching.

**Manuals and workbooks contain copyrighted material and should be purchased from developers.*

Are intervention materials *(handouts)* **available in other languages?**
☒ Yes ❒ No

If YES, what languages? Many of the youth handouts are available in Spanish.

Other training materials &/or requirements *(not included above)*:
SPARCS trainings are conducted using a "Learning Collaborative/ Community" model as this approach has been found to support successful treatment adoption and future sustainability.

Training Materials & Requirements continued

This model differs from many traditional workshops because it involves making a commitment to complete several phases of training and includes the establishment of a 6 – 12 month relationship between trainers and training participants. The training model consists of a planning phase prior to the training, minimally 4 days of training (conducted across two 2-day training sessions), consultation calls, and ongoing email/phone support and ancillary materials provided throughout the duration of the collaborative. Participation from clinical staff (2 group co-leaders), and typically a supervisor and/or administrator (both, if possible) is required for training. We find that this level of commitment is essential in creating systemic change and ensuring the sustainability and availability of this program to youth long after the training has ended.

The SPARCS training model enhances trainees' ability to address the inevitable barriers that arise when implementing a new practice, and is designed to promote a partnership that supports sharing challenges, successes, and employing creative problem-solving strategies. "Stand-alone" trainings that take place during a single face-to-face training session typically do not include a built-in readiness phase with trainers prior to the training or a formal plan regarding consultation and support from trainers following the actual training session. The "Learning Collaborative/ Community" model of training is extensive and enhances the likelihood that the intervention will fully "take off" in the agency following the training. Trainings are intended to enhance implementation efforts and promote the continuation of SPARCS groups within the agency well beyond the scope of the initial training relationship. Many of our partners have been successful in doing this, years after their collaborative has ended.

The SPARCS training package spans 6 – 12 months and includes:

Planning Phase: Consultation calls and organizational readiness work begins minimally a month prior to the first training session. During this phase SPARCS trainers partner with agencies to identify resources that are available to support a new practice, identify potential challenges and solutions, and prepare for the groups so that they are able to begin the first session almost immediately after the initial training session. Readiness work includes issues related to assessment, identifying youth for group, recruiting and orienting adolescents to the purpose of group, getting buy-in from teens, staff, administrators, parents, other caregivers, anticipating barriers to implementation and problem-solving in advance (e.g. how can the program be sustained in light of staff turnover?). During this phase, clinicians, supervisors, and administrators develop in-house SPARCS teams, complete the SPARCS Planning Worksheet as a team, and discuss their findings during conference calls with trainers.

Training Session 1: 2 full days of interactive training typically attended by clinicians, and a supervisor and/or administrator. Training sessions may include clinicians from multiple sites who will have the opportunity to learn from one another. Trainings include a balance of didactic presentations, demonstrations, role-plays, and mindfulness practice.

Training Materials & Requirements continued

Consultation calls: Bi-weekly calls immediately after Learning Session 1. Over time, these taper down to monthly calls.

Training Session 2: Two full days of training to occur approximately 8 weeks after the first learning session. This includes some review of concepts first learned in Training Session 1, as well as new material. At this point, clinicians will have already started their groups so will have an opportunity to bring their experiences to the training. The spacing between learning sessions is such that by the second learning session trainees will be learning new concepts/skills just prior to reaching the corresponding session of the manual.

Administrative/Clinical support: Trainers are generally available via phone/email to problem- solve and talk about things that occur outside of the regularly scheduled calls and learning sessions. Trainers often field emails and calls ranging from small requests for materials (e.g. teen-friendly fliers for recruiting group members, fliers for community stakeholders, group supply list, recommendations for videos) to larger questions regarding implementation stumbling blocks. Each training relationship is different. Please check directly with your trainer about the scope of support to be provided.

Summary of Training Requirements:

- Learning Collaborative participants consist of teams of at least 2 (preferably 3 individuals): 1 administrator/ supervisor and 2 clinicians. Each group is co-led.
- Attendance at both full days of two separate Training Sessions.
- Active participation in 80% of consultation calls.
- Audio or Video-tape of one session in which a core skill is implemented (requirement for certification only).
- Completion of two 16-session cycles of SPARCS groups under supervision of trainers (requirement for certification only).

** **Please note:** Certification can only be offered to individuals who have participated in the full training model, including minimally 4 days of training provided by certified trainers.*

Pros & Cons/ Qualitative Impressions

What are the pros of this intervention over others for this specific group *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?**

This treatment is appropriate for traumatized adolescents with or without current/ lifetime PTSD, and can be implemented while adolescents are still living with unstable/stressful environments. This intervention is strength-based and present focused. Discussions and activities center on enhancing resilience and helping group members identify and build upon existing strengths as opposed to focusing on the elimination of "problem behaviors". It is based on the assumption that the adolescents' symptoms (behavioral, interpersonal, and affective) represent their best efforts at coping with extreme stress. Group members routinely discuss and process their personal experiences throughout the group. The 16-session curriculum has been specifically designed for use with adolescents, with special consideration to the developmental tasks associated with this age group.

SPARCS: Structured Psychotherapy for Adolescents Responding to Chronic Stress

Pros & Cons/ Qualitative Impressions continued

As adolescents increasingly strive toward independence and autonomy from adults and caretakers, the influence of their peer group grows, making the group format of this approach especially powerful for this age group. Clinicians report that members often express feelings of validation simply upon hearing the shared stories and histories of other members. In one setting two gang-involved adolescents who had previously been involved in an altercation (outside of group) that almost resulted in an assault, later became allies when one of them disclosed witnessing domestic violence in the home, resulting in a similar disclosure by the adolescent who had initiated the altercation. As group cohesion builds, members begin to support one another more actively, and will share observations and comments in a way that holds more meaning than when done by the adult co-leaders.

What are the cons of this intervention over others for this specific group *(e.g., length of treatment, difficult to get reimbursement)***?**
Intensive clinician training and consultation is required. Some agencies report difficulty retaining a sizeable group of adolescents for the duration of the intervention.

Other qualitative impressions:
Please see the section on "Clinical & Anecdotal Evidence" for a description of clinical impressions observed.

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References

DeRosa, R., Habib, M., Pelcovitz, D., Rathus, J., Sonnenklar, J., Ford, J., et al., (2006). *Structured Psychotherapy for Adolescents Responding to Chronic Stress.* Unpublished manual.

DeRosa, R. & Pelcovitz, D. (2006). Treating traumatized adolescent mothers: a structured approach. In N. Webb (Ed.), *Working with traumatized youth in child welfare* (pp. 219-245). New York: Guilford Press.

DeRosa, R. & Pelcovitz. D. (in press). Igniting SPARCS of change: Structured psychotherapy for adolescents responding to chronic stress. In J. Ford, R. Pat-Horenczyk & D. Brom (Eds.). *Treating traumatized children: risk, resilience and recovery.* New York: Routledge.

Ford, J. D. & Russo, E. (2006). Trauma-focused, present-centered, emotional self-regulation approach to integrated treatment for posttraumatic stress and addiction: Trauma Adaptive Recovery Group Education and Therapy (TARGET). *American Journal of Psychotherapy. 60*, 335-355.

Layne, C. M., Saltzman, W. R., Pynoos, R. S., & Steinberg, A. M. (2002). *Trauma and Grief Component Therapy.* New York: New York State Office of Mental Health.

Lyons, et al. (in press). Evaluation of the implementation of three evidence-based practices to address trauma for children and youth who are wards of the State of Illinois.

Miller, A. L., Rathus, J. H. & Linehan, M. M. (2007). *Dialectical Behavior Therapy with suicidal adolescents.* New York, NY: Guilford Press.

Agency	Department Of Juvenile Justice
Program Name	Mental Health Treatment
Program Description	IDJJ is developing a more therapeutic model aimed at identifying a youth's needs on the front-end and following a defined treatment model for each youth that is less reliant on confinement and more focused on reinforcing reentry back into the community. By providing the youth with the appropriate mental and emotional tools that they need to be successful post-release, IDJJ increases the likelihood that they will become productive members in society. It is the responsibility of IDJJ to treat, educate, and rehabilitate youth within its custody.
Target Population	Youth in need of services.
Activities	The following types of programming are provided to youth in the Department of Juvenile Justice: assessments, substance abuse treatment, mental health treatment, individual and group counseling, case management, health care, education, chaplaincy, volunteer services, and leisure time services.
Goals	The Illinois Department of Juvenile Justice places a high importance on evaluating the mental health needs of the youth committed to the Department. All youth are screened by a mental health professional upon admission to any of the facilities. The Department also implements evidence-based screening and assessment tools at the Reception and Classification sites. All facilities have mental health professionals available for emergency and on-going mental health services.
Outcome	Meet the Needs of the Most Vulnerable

PROGRAM FUNDING

Appropriations ($ thousands)		
FY18 Actual	**FY19 Enacted**	**FY20 Recommended**
270	5,358	6,106.9

MEASURES

Number of youth enrolled in mental health treatment in youth centers

Reported : Monthly **Key Indicator :** Yes **Desired Direction :** Maintain

Benchmark : Providing individualized mental health services to youth. **Source :** Monthly reports

Baseline : 444 **Baseline Date :** 7/1/2013

Methodology : Number of youth reported to receive individual mental health treatment in a given month. Numbers provided by mental health staff to Chief of Mental Health. A certain percentage of youth will be counted multiple times.

FY 2018	FY 2019	FY 2020 Est.	FY 2021 Proj.
288	247	234	

FY	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
2018	281	256	257	265	291	299	316	303	315	298	281	291
2019	264	266	231	247	244	217	243	257	251	257	247	245

Illinois Department of Juvenile Justice ***Mental Health Protocol Manual***	**MH-003** **Effective Date: 04/01/2016**
MH Mental Health Services	
003 Mental Health Levels	

I. AUTHORITY AND RESOURCES

730 ILCS 5/3-2.5-20
20 Ill. Adm. Code 2415
Administrative Directive 04.04.100 General Mental Health Provisions
DJJ 0284 Mental Health Treatment Plan
DJJ 0282 Mental Health Diagnostic and Treatment Note
Mental Health Protocol Manual Sections IN-003, SA-004, MH-007
Mental Health Needs Assessment

II. POLICY AND PROCEDURE

A. All youth shall be assigned a mental health level (MHL) within one week of arrival to a parent facility. The mental health levels range from zero through four. All mental health levels are indicative of individual mental health services. All MHL 0s and 1s will be reviewed as often as clinically indicated, and all MHL 2, 3, 3.5, & 4s will be reviewed at least monthly.

B. All individual mental health therapy sessions are expected to be at least 45 minutes in duration unless clinically contraindicated and documented in a Mental Health Treatment Plan (DJJ 0284) or on the Mental Health Diagnostic and Treatment Note (DJJ 0282).

C. All youth shall be seen by a mental health professional as often as clinically indicated, regardless of his or her MHL.

D. Mental Health Levels:

1. **MHL 0-None**-reflects a youth with no current noted signs or symptoms of a diagnosis from the DSM-5, excluding substance use disorders or Conduct Disorder. Youth classified as MHL 0 do not require regularly scheduled interactions with a MHP, but can be assigned to individual, group or family therapy. They typically require services as requested by either the youth or staff.

2. **MHL 1-Minimal Need**-reflects a youth who may or may not have a history of mental health treatment, but who is presenting with current mild signs or symptoms from the DSM-5, excluding substance use disorders or Conduct Disorder. These youth have been determined to need a minimum of 90 minutes of mental health services per month. The mental health services can include group and/or family therapy.

3. **MHL 2-Moderate Need**-reflects a youth who typically has a history of mental health treatment and who is currently presenting with moderate signs or symptoms from the DSM-5, excluding substance use disorders or Conduct Disorder. These youth have been determined to need weekly mental health services with a Mental Health Professional. Individual sessions need to be at least 45 minutes in length unless the reason for a shorter session is documented on DJJ 0282 MHDNT. The required weekly mental health services may include family therapy sessions.

4. **MHL 3-Urgent Need**- reflects a youth who typically has a significant history of mental health treatment and who currently presents with severe signs or symptoms from the DSM-5, excluding a substance use related or Conduct Disorder. All youth classified in severe need status shall be assigned to a mental health professional caseload within 48 hours of his or her arrival at the receiving youth center.

These youths will also participate in therapeutic treatment programs, including intensive groups and milieu activities. These youth have been determined to need mental health services that occur a minimum of 2 – 3 times per week. Treatment must include at least one 45 minute individual therapy session, and other supplemental services, such as group and/or family therapy.

5. **MHL 3.5-Critical Need**-reflects a youth who typically has a significant history of mental health treatment and who currently presents with severe signs or symptoms from the DSM-5, excluding substance use disorders or Conduct Disorder. The symptoms may be due to recent serious mental health issues and/or recent psychiatric hospitalization. All youth classified in severe need status shall be assigned to a Mental Health Professional caseload within 24 hours of his or her arrival at the receiving youth center. These youth will also participate in therapeutic treatment programs, including intensive groups and milieu activities. These youth have been determined to need mental health services a minimum of 4 - 6 times per week. Treatment must include at least one 45 minute individual therapy session, and other supplemental services, such as group and/or family therapy.

6. **MHL 4-Hospitalized**-reflects a youth transferred to the Department of Human Services or a mental health inpatient psychiatric hospital setting.

E. Upon transfer to general population status from a Reception and Classification Center, the Treatment Unit Administrator (TUA) shall document any necessary change to a youth's mental health level on the Mental Health Needs Assessment Form. The youth's treating Psychiatrist, primary Mental Health Professional, or the youth center's TUA may assign or change a youth's MHL as the youth's clinical presentation warrants. This MHL assignment or change shall be recorded in the youth data system of record and the clinical rationale for such an assignment or change shall be documented on a Juvenile Clinical Mental Health Evaluation (DJJ 0283) or a Mental Health Diagnostic and Treatment Note (DJJ 0282).

F. When mental health staff members are on vacation for one week or less, they can ask their assigned youth if they would like a substitute therapist for that week and assign a substitute therapist appropriately. If a staff member is gone for more than one week, he or she will need to assign a therapist to cover the assigned caseload. The TUA needs to be informed of therapists that are temporarily assigned and to which youth they are assigned.