Screening & Assessment Manual

Structured Decision-Making across the Jefferson Parish Juvenile Justice System (3rd Edition)

John S. Ryals, Jr.

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This manual establishes guidelines for the use of valid and reliable screening and assessment practices for the Jefferson Parish juvenile justice system, including the Jefferson Parish Juvenile Court Informal Families in Need of Services program, the Jefferson Parish District Attorney's Juvenile Diversion Program, and Jefferson Parish Department of Juvenile Services. These procedures represent a collaborative effort between agencies and can be used in whole or in part to guide structured decision-making within the Jefferson Parish juvenile justice system. For information regarding descriptions, content, administration, or psychometric properties of each tool, please refer to published manuals for each tool. These guidelines are subject to revision.

In 2004, Louisiana solidified its commitment to children, youth, and families by enacting the Children & Youth Planning Boards Act (Act 555, 2003 Regular Session of the Louisiana Legislature). This Act reinforced the importance of collaboration and coordination of services provided by various agencies intersecting with youth and families. Pursuant to this act, in 2004 Jefferson Parish passed a parish-wide resolution to create a Children & Youth Planning Board (CYPB). Among the CYPB's most notable achievements was its functioning as the wellspring for sweeping juvenile justice reform across many local and state agencies. One of the most significant reforms was the expanded use of objective screening and assessment tools to create a structured decision-making process, which was supported by the John D. and Catherine T. MacArthur Foundation's Models for Change initiative. Through the Models for Change Initiative, a study was completed in December 2007 by the LSU Health Sciences Center to determine how many youth were assessed using valid and reliable screening and assessment tools in the Jefferson Parish juvenile justice system. The survey revealed that less than 15% of youth were administered such instruments. The survey concluded there was a lack of structured decision-making across the juvenile justice process and, thus began the journey of developing a high-quality structured decision-making process.

Through assistance from the John D. and Catherine T. MacArthur Foundation's Models for Change initiative, the Jefferson Parish CYPB began the process of identifying and expanding its use of valid and reliable screening/assessment instruments at several decision points of the juvenile justice system. As a result of concentrated effort by Jefferson Parish stakeholders with support of the Models for Change National Resource Bank partners, the use of valid and reliable screening and assessment tools dramatically increased to 100%. Further, in 2008, Jefferson Parish commissioned a Probation System Review under the Robert F. Kennedy Children's Action Corps National Resource Center for Juvenile Justice (RFK-NRC). The intensive review led to many recommendations focusing on enhancing screening and assessment practices. Through

continued involvement with RFK-NRC, a focus on trauma-informed care and dual-status youth highlighted additional dynamic areas of adolescent development requiring targeted assessment and intervention.

As a result of these seminal interventions, objective tools were permanently integrated into every decision point in the Jefferson Parish juvenile justice system. These tools are used to inform decision-making at arrest in the form of a detention admission tool; in a front-end intake center, known as the Juvenile Assessment Center; in an informal, pre-court status youth intervention program, known as Informal Families in Need of Services (FINS); upon entering pre-adjudication diversion; at the pre-disposition investigation phase; and, regularly during the terms of probation.

Currently every youth entering the Jefferson Parish juvenile justice system is administered multiple screening and assessment tools at several decision points in the process. These tools aid in determining a range of risk and protective factors, including community risk, mental health, criminogenic risk, substance use, and trauma response. Combining increased awareness of the impacts of early childhood trauma, adolescent development, childhood abuse, and neglect, an increased use of family engagement practices, and a portfolio of evidence-based practices that respond to the needs of youths and families, these tools have provided a strong foundation for an objective decision-making process. These tools have established rationale for interventions and have guided many crucial decisions regarding the course of youths' lives. Due to the impact these decisions have made on youths, families, and system interactions, there has been an increasing commitment to and reliance on these tools. Further, this commitment has led to increased collaboration and coordination of services across multiple agencies – essential traits of an effective and responsive system. This manual enacts procedures and establishes the policies that govern the administration and use of these tools in Jefferson Parish.

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DEFINITIONS

Assessment: A more comprehensive and individualized examination of the psychosocial needs and problems identified during an initial screen, including the type and extent of mental health and substance abuse disorders, other issues associated with the disorders, and recommendations for treatment intervention. Typically requires individualized data collection, often including psychological testing, clinical interviewing, and obtaining past records from other agencies for review by the assessor. Assessment is usually required for a smaller subset of youths who have been screened or otherwise identified to be in need of more extensive evaluation (Grisso & Underwood, 2003).

Child Trauma Screen (CTS)*:* The CTS was developed as a brief, empirically-based screen for child traumatic stress to be administered by both clinicians and non-clinicians. The tools can be administered in person, on the phone, or by self-report. As per the Child Health and Development Institute of Connecticut, the goals of the CTS are (1) to identify children who are likely to suffer from trauma exposure and who would benefit from more comprehensive trauma-focused assessment, and (2) to function as a tool to engage youth and family members in discussions regarding trauma exposure and youths' reactions to that exposure (Lang & Connell, 2017).

Department of Juvenile Services (DJS): The Jefferson Parish Department of Juvenile Services is the agency responsible for detention, probation, and treatment services for youth involved with the Jefferson Parish juvenile justice system. The department is highly engaged in the development and maintenance of the continuum of supervision and interventions provided to youth and families from across the New Orleans metropolitan area. Programs include evidence-based treatment services, Alternatives-to-Detention, Intensive Probation Program, regular probation, detention, the Juvenile Assessment Center, and collaborative engagement with the District Attorney's pre-adjudication Diversion Program and Juvenile Court Informal FINS program.

Detention Assessment Instrument **(DAI)**: A locally-validated instrument administered to arrested youth that is designed to determine risk to reoffend and likelihood of failing to appear for court hearings within a 60-day period. The instrument was developed as part of the Annie E. Casey Foundation's *Juvenile Detention Alternatives Initiative*, a nation-wide detention reform effort. The DAI has undergone external validation through funding from the John D. and Catherine T. MacArthur Foundation's *Models for Change* Disproportionate Minority Contact Action Network.

Family Engagement: Empowering families, based on their strengths, to have an active role in their child's disposition and treatment (Luckenbill, 2009).

Global Assessment Tool & Risk Indicator Survey: The Global Assessment Tool and Risk Indicator Survey were developed for use by Truancy Assessment and Service Centers (TASC) across Louisiana. The Global Assessment Tool contains 13 items focusing on factors that contribute to truancy. The Risk Indicator Survey is a checklist that consists of 12 sections related to risk for truancy (Joseph, 2008). These tools are similarly used by intake officers within the Jefferson

Parish Informal Families In Need of Services (FINS) program to determine risks and needs associated with a variety of risk and protective factors related to status offending.

Informal Families in Need of Services (FINS): In Louisiana, youth charged with status offenses are categorized as FINS. The informal, pre-petition process to divert youth with status offenses is the FINS program, which provides assessment, case planning, monitoring, and oversight of youth and families. The FINS process involves administering several objective tools, reviewing available records from referral sources, meeting with youth and family members, developing an Informal Family Service Plan Agreement (IFSPA), making referrals to community resources, and monitoring progress of the referral behaviors.

Juvenile Diversion: Under the organizational structure of the Jefferson Parish District Attorney's Office Pre-Trial Diversion unit, the Juvenile Diversion Program diverts youths from formal processing. Charges are screened by prosecutors in the Juvenile Division and referred to Juvenile Diversion for processing. Juvenile Diversion administers several objective measures, engages families, implements numerous agency-based and community-based interventions including restorative practices, monitors case progress, and recommends charge refusal upon completion of the program.

Juvenile Inventory for Functioning **(JIFF)**: A brief computerized interview that screens for potential mental health problems, assists in determining youth's functioning across domains, designs a service plan that can address each of the domains in need of attention, and can be used to assess outcomes (Hodges, 2007).

Massachusetts Youth Screening Instrument-Version 2 **(MAYSI-2)**: A scientifically valid and reliable brief screening tool for use in juvenile justice settings with youths to identify signs of mental/emotional disturbance (Grisso & Barnum, 2006).

Pre-Dispositional Investigation **(PDI)**: In accordance with Louisiana Children's Code Article 890, probation officers conduct pre-dispositional investigations for the purpose of making recommendations for disposition and determining special conditions of probation. The report contains circumstances regarding the commission of the offense, impact on the victim, child's current physical description, and an assessment of the youth's identified behavioral problems and potential for rehabilitation (Harrison, 2018).

Risk and Protective Factors: Identified through 20 years of research on delinquent behavior, risk factors are circumstances that, when present, may increase youths' likelihood of engaging in delinquent behavior. These factors can be static or dynamic. Static risk factors are unchangeable. Dynamic factors can change over time and are targets for intervention. Protective factors are any circumstances that promote healthy youth behaviors and decrease the chance that youth will engage in delinquent behaviors. Risk factors and protective factors are often organized into five categories: Individual, family, school/work, peer group, and community.

Substance Abuse Subtle Screening Inventory (SASSI-A2): A brief, self-report screening tool administered to youth suspected of having substance use disorders. The SASSI-A2 is an adolescent version of a substance use screening tool that is designed to indicate the probability of a youth having a mild, moderate, or severe substance use disorder (Miller, 2013). Results do not indicate a diagnosis, but rather indicate the need for further substance abuse assessment.

Screening: A relatively brief process designed to identify youth who warrant immediate attention, intervention, or more comprehensive review. Screening is a "triage" process employed with a large number of youth that identifies the need for further evaluation (Grisso & Underwood, 2003).

Structured Assessment for Violence Risk in Youth **(SAVRY)**: A valid and reliable professional risk assessment that guides intervention planning for violence risk assessment using risk and protective factors (Borum, Bartel, & Forth, 2006).

Trauma Symptom Checklist for Children (TSCC): A valid and reliable professional tool developed to measure the impacts of trauma on children. Included are symptoms of posttraumatic distress and other symptoms related to trauma exposure, such as anger, depression, anxiety, and dissociation (Brier, 1996).

Validity and reliability: Validity refers to the extent to which a measure reflects the concept it is intended to measure. Reliability refers to the extent to which scores obtained on a measure are reproducible in repeated administrations provided that all relevant measurement conditions are the same (Rossi, Freeman, & Lipsey, 1999).

ASSESSMENT TOOL OVERVIEW

Detention Assessment Instrument (DAI)

1. ***Administration***: The DAI is administered by Juvenile Intake Center (JIC) Correctional Officers and Rivarde Detention Center staff on all youth brought to the JIC or detention center by parish law enforcement agencies to determine their suitability for placement in detention, release to an alternative placement, or release to a parent/guardian. The JIC administers the DAI between the hours of 8:00 a.m. and midnight Monday through Sunday. Rivarde Detention Center staff administers the DAI at all other times. The decision to detain is based on two criteria: risk to the community and risk of failure to appear for court hearings. The DAI may also be utilized to assist the Court in determining whether youths present these risk factors after the Continued Custody Hearing. In such cases, the DAI may be re-scored using revised or updated information as available. See Appendix 1 for Detention Assessment Instrument. Please note that current versions may differ as updates are made in accordance with instrument validation recommendations.

2. ***Scoring***: Consists of seven items each containing scaled scores for each criteria in the item. Points may be added or subtracted for aggravating and mitigating circumstances. Over-rides may be Mandatory or Administrative. Further details regarding scoring of the DAI can be found in the DAI Manual.

3. ***Interpretation***: Total points range from 0 to 35, with 0-9 recommending Release, 10-14 recommending Alternative placement, and 15+ recommending Detention.

Global Assessment Tool/Risk Indicator Survey I©

1. ***Administration***: The Global Assessment Tool is a series of questions completed by Informal FINS Intake Officers. It utilizes information gathered from the family, school, and any additional information the family may have to help complete the 13-question assessment. Areas covered include child mental health; parental practices; parent and family members' mental health; child substance use; parent or family member substance use; child physical health, parent or family member physical health, and basic needs. In addition, there are questions regarding the youth's behavior problems, educational issues, neglect/abuse history, the youth's delinquent history, and the family's criminal history. The Risk Indicator Survey I is completed by the FINS staff or, preferably, the school staff who generates the referral for the youth. The Risk Indicator Survey II is completed by FINS staff. Each area is checked off based on the information received from the school official, family member, Department of Child and Family Services, or other another reliable source of information. It is recommended that multiple sources of information be used to determine whether items are indicated as "Yes" on the Global Assessment or checked on Risk Indicator Surveys.

2. ***Scoring***: The Intake Officer reviews results of the Global Assessment and asks exploratory questions in any of the areas that are indicated with a "Yes". Those areas can be checked off yes, no, or unknown. However, if the question is marked "Yes", the Intake Officer will explore that area with the family to gather additional information. This information is used to assist in determining what services are needed for the youth and family.

3. ***Interpretation***: Any "Yes" response to the items on the Global Assessment Results tool triggers follow-up questions regarding the frequency, recency, and severity of the topic of the question. Information gathered will provide FINS staff with key information on the necessity for immediate response, the need for additional mental health assessment, and the relevance of the issue to the referral behaviors. Questions checked on the Risk Indicator Surveys highlight further information regarding intervention targets. Results are compared from each assessment to determine consistency and to highlight additional questions that may need to be answered. It is important that results from both assessment tools be consistent and valid.

Massachusetts Youth Screening Instrument™-Version 2 (MAYSI-2)

1. ***Administration***: An important first step in administering the MAYSI is introducing the process to youth. Youth should receive a description of the purpose of the MAYSI, how the results will be used to help staff understand the youth better, who will or will not see the answers, what other purposes the results may be used for, and that answering is voluntary. (See Appendix 2 for MAYSI script.) Staff administering the MAYSI should also check for special needs of youth in completing the procedure. The MAYSI will be administered at several points in the juvenile justice system in the following manner:

- Informal Families in Need of Services (FINS): Youth referred to the Informal FINS program are administered the MAYSI-2 at the intake appointment.

- Juvenile Diversion Program: Youth referred to the District Attorney's Juvenile Diversion Program receive the MAYSI-2 at the initial intake appointment or as soon as practical afterwards.

- Juvenile Assessment Center: Upon initial contact with law enforcement, the MAYSI will be administered to all youth brought to the Juvenile Assessment Center.

- Pre-Dispositional Investigation: After adjudication for either a Families in Need of Services or delinquent offense, **the MAYSI will be administered to all pre-disposition youth who either have not been administered the MAYSI OR whose MAYSI results are greater than 30 days old**.

2. ***Scoring***: Scoring is automated through the use of a web-based platform developed by Orbis Partners, through existing MAYSIWARE programs, or manually using procedures detailed in the

MAYSI manual. Scores consist of seven scales for boys and six scales for females. Scales are Alcohol/Drug Use, Angry-Irritable, Depressed-Anxious, Somatic Complaints, Suicide Ideation, Thought Disturbance (Boys only), and Traumatic Experiences. In order of severity, scores fall into Normal, Caution, and Warning categories that are indicated automatically by MAYSIWARE.

3. ***Interpretation***: Critical cases are identified (flagged) when youth score within the CAUTION range on Suicide Ideation AND/OR within the WARNING range on any two other scales. Youth who score in the WARNING range are asked additional questions to clarify their responses in particular scales. These questions are called, "2nd Screens". Use of the MAYSI-2 Second Screening forms provides a simple way for staff to perform follow-up screening. The forms provide standard questions that can be asked regarding MAYSI-2 items that youths have endorsed on scales exceeding the WARNING cutoff. Within MAYSIWARE, *if the youth receive WARNING scores on any of the scales,* then Second Screening forms for those scales will appear after the main report. Following the Second Screening forms is a Summary Form that the MAYSI-2 user can select if there will be a follow-up with the youth and a space for the user to explain the follow-up decision. Staff can print out these forms and complete them by hand or can enter the youths' responses directly into the form within the web-based platform or MAYSIWARE then print the form.

Youth Assessment and Screening Instrument™ (YASI)

1. ***Administration***: The YASI-Pre-Screen Version is administered by mental health professionals in the Juvenile Assessment Center while youth are in the custody of law enforcement. Custody is the result of a recent arrest and is prior to adjudication or any formal court involvement. A full YASI will be performed by the Juvenile Diversion staff upon entry into the program, if youth scores moderate in the moderate or high risk categories. If a Pre-Screen was not completed in the Juvenile Assessment Center it will be completed by the assigned Diversion Counselor. If the YASI Pre-Screen was completed at the Juvenile Assessment Center, the Diversion Counselor will update the Pre-Screen with collateral information obtained in the Diversion Screening. The YASI is an administered inventory that assesses youths' daily functioning across several domains. Prior to administering, administrators shall use a structured interview based off of the YASI administration guide, or a similar version (see Appendix 3). The youth version of the software uses a 3rd grade reading level that graphs youth's results across functioning areas and protective factors, and generates a service plan for each youth. Mental health professionals use computer-generated needs to select and prioritize goals for intervention and assigns community-based services for each goal. The YASI program provides case tracking and management, and provides individual and aggregate reports. Administration time is typically one to two hours for the interview for the full screen and 30 minutes to an hour to develop the case plan.

After the youth has completed the interview, the administrator will review the answers and ask the youth if he/she would like to elaborate on any issue. Information provided will assist the case manager in developing more appropriate case plans, goals, and service recommendations.

2. ***Scoring***: Scoring is automated through a web-based computer program. There are seven content areas that include legal history, family, school, community & peers, alcohol & drugs, mental health, and aggression.

3. ***Interpretation***: The computer program automatically generates an overall risk rating along with an assessment of risk ratings for several content areas. Also, results will identify areas contributing to risk. Administrators will have opportunities to develop case plans using the YASI software that will guide interventions toward community-based services and supports.

4. *Reporting*: A copy of the YASI report will be retained in the case file for each youth. These reports will remain confidential and are not to be released to any other agency without prior permission of the youth and guardian.

Juvenile Inventory for Functioning™ (JIFF)

1. ***Administration***: The JIFF will be administered by Intake Officers in the Informal Families in Need of Services (FINS) program. The JIFF is a self-report inventory that assesses youths' daily functioning across several domains and covers mental health problems and strengths. The youth version of the software uses a self-administered voice questionnaire that graphs youth's responses across 10 areas of functioning. The program also generates a service plan for each youth. Intake Officers use computer-generated needs to select and prioritize goals for intervention and assign community-based services for each goal. The JIFF program provides case tracking and management, and provides individual and aggregate reports. Administration time is typically 25 minutes for the interview and 30 minutes to develop the case plan.

Staff members introduce the JIFF to the youth using the JIFF portion of the script in Appendix 2. After the youth has completed the interview, the case manager will review the answers and ask the youth if he/she would like to elaborate on any issue. Information provided will assist the case manager in developing more appropriate case plans, goals, and service recommendations.

2. ***Scoring***: Scoring consists of a computer-generated report that contains 10 broad domains. Reports provide case managers with both protective and risk factors impacting youths' behaviors presented in graphic form that is easy to identify areas in need of immediate response.

3. ***Interpretation***: The JIFF software includes 45 pre-programmed goals common to most youths. Case managers can add goals as they become necessary based on additional information available at the time of arrest. For example, the nature and conditions of the arrest and/or results from the MAYSI may require additional goals to be identified. Goals are prioritized as Immediate, High,

Medium, or Low. If time permits, case managers are encouraged to engage the youth and, when available, parents/guardians, in selecting goals or choosing services.

Substance Abuse Subtle Screening Inventory© (SASSI-A2)

1. ***Administration***: According to the SASSI Manual (Miller, 2013), present the SASSI to youth as a questionnaire rather than a "test". Encourage youths to be as accurate and truthful as possible based on their experiences. Emphasize that it is important to answer every question. If there are any questions about any of the items, advise the youth to answer how they think or feel. If the screen is being performed as part of an initial assessment, it is recommended to use a lifetime time frame for youth to answer. If the screen is being completed to demonstrate progress after having been in a treatment program, advise the youth to answer in a manner that represents the past six months. Present youth with True/False side first, then turn to the Alcohol/Drug Use Frequency side. Once the youth has finished, check to ensure all items have been answered.

2. ***Scoring***: Score the frequency items by adding the client responses to all items for both the alcohol and drug use questions. Enter the totals under the respective scale on the appropriate profile sheet. Note profile sheets are different for males and females. On the questionnaire side, use the Scoring Key to sum the total true/false questions marked in circles under each scale. Enter the total number of items marked in both columns of questions in the boxes along the profile graph. Circle the score corresponding to each scale score. Mark the Decision Rules according to the scores on each scale. Use the VAL and/or SCS scores to check the appropriate lines (Miller, 2013).

3. ***Interpretation***: The SASSI A-2 consists of 12 scales – two face valid scales, a validity check, a clinical severity scale, a correctional scale, and seven scales relating to various clinical aspects of substance use. Significant scale scores are interpreted using the SASSI manual and the Decision Rules, which indicate the probability of a youth having a mild or moderate to severe substance use disorder. In addition, clinical support can be obtained through the SASSI Institute by contacting 1-888-297-2774 for a free consultation on any profile. It is important to note the SASSI is not a diagnostic tool and, therefore, should not be used to diagnose a substance use disorder. However, the SASSI can indicate the need for additional assessment.

Structured Assessment for Violence Risk in Youth™ (SAVRY)

1. ***Administration***: Each person administering the SAVRY must have completed formal training in the use of the instrument. This includes a training workshop with a Master Trainer, two vignette practice cases, and two actual probation cases. The SAVRY is currently administered by probation officers on youth at the pre-disposition/post-adjudication phase, every 6 months, or at a change in supervision status. Information is gathered with a semi-structured risk interview and Pre-Dispositional Investigation (PDI) Script (see Appendix 4). Questions on the PDI script are intended to guide probation officers' questions to obtain information needed to rate SAVRY items. The questions

do not necessarily need to be repeated verbatim to youth and parents. As probation officers become more comfortable with the SAVRY, questions can be used as a guide rather than a script. Probation officers should interview parents and youth separately whenever possible using techniques consistent with Motivational Interviewing. The SAVRY MUST also be completed using collateral information about the youth, including, but not limited to, school records, psychological or mental health records, and child welfare documentation or previous placement records.
Before interviewing youth, tell him/her the information is being collected to provide better services to prevent them from coming back into the juvenile justice system. The information is not being collected to give them more legal charges. Use this or a similar statement to reduce defensiveness.

2. ***Scoring***: Thirty (30) items fall into four categories-Historical Risk Factors, Social/Contextual Risk Factors, Individual/Clinical Risk Factors, and Protective Factors. Risk items are coded Low, Moderate, or High and protective factors are coded "Absent" or "Present". Coding is based on established criteria validated through scientific research. Additional risk factors and other protective factors can be included in the coding. **Probation officers should also rate item 3a "Early Initiation of Delinquency".** Items that are considered critical are to be coded as a Critical Item on the rating sheet.

To score the SAVRY items, obtain data from multiple sources to build validity. If sources conflict, base ratings on the most credible source of information. The Summary Risk Rating on the rating form is for violence and is coded Low, Moderate, and High. **Probation officers should add and score a Summary Risk Rating for Delinquency as Low, Moderate, and High.**

Every part of the SAVRY scoring sheet should be completed to consider the test results valid, including item 3a and the addition of the officer's Summary Risk Rating for Delinquency.

3. ***Interpretation***: Use the Service Referral Matrix, SAVRY Items, and Need Areas Worksheet (Appendix 5) to determine which services are needed. Consider the rating levels (Low, Moderate, High) of each item within each Need Area, as well as protective factors. *Generally speaking*, the more risk factors rated as High and the fewer protective factors, the higher the risk level in that need area.

Dynamic SAVRY items fall into several "Need Areas", (e.g., Family Problems, Education, Disruptive Behavior Problems) which are essential for service planning. "Need Areas" are determined by identifying the most critical needs associated with violence and delinquency risk. Use the "SAVRY Items and Need Areas Worksheet" in Appendix 5. Services for each Need Area are listed in the Service Referral Matrix and Case Plan. The SAVRY items that fall within each Need Area are listed on the Service Referral Matrix and Needs Area Worksheet for convenience. Keep in mind that other services may have become available since the last update of these tools.

Services indicated are only *guidelines* for recommendations and should not be reported word for word. Recommendations should consider services already in place or already complete. For example, if school achievement and performance is a major need area for the youth, but they are

currently in an alternative school setting, receiving tutoring and doing well, then a new service if not needed.

In order to maintain quality control, probation supervisors should check and approve every SAVRY Rating Sheet and case plan to ensure the assigned services are aligned with the identified needs. Approval is documented by the supervisor's signature on the pre-dispositional report and SAVRY rating form.

When recommending services, probation officers should discuss current services and highlight progress or lack of progress, and what additional services are needed, if any.

Child Trauma Screen (CTS)

1. ***Administration***: As per the Child Health and Development Institute of Connecticut, the CTS has 4 traumatic event (exposure) items, and 6 trauma symptom (reaction) items. Even when no exposures are endorsed, the reaction items may be asked, as sometimes an event that occurred may not be reported.

The CTS can be administered as a self-report form or as an in-person interview. Generally, in-person interview is recommended as it provides an opportunity to engage the child/caregiver directly, to observe non-verbal responses, to provide a supportive response to disclosures, and to provide some information about trauma. When an in-person administration is not possible, it is important that the results of the CTS are reviewed with the child/caregiver immediately after being completed. Prior to asking the questions or asking a child/caregiver to complete the CTS, explain the purpose of trauma screening to the child and caregiver(s) as appropriate (see Appendix 3).

The caregiver report is administered with caregivers of children age 6 and older. The child report version is also administered directly with children age 7 and older. A young child version administered to caregivers of children age 3-6 is under development. It is recommended to administer both a caregiver and child report for children age 7 and older when possible, as there is relatively poor concordance between child and caregiver reports of a child's trauma exposure and reactions. It is also acceptable to complete the CTS with multiple caregivers of the same child separately in order to provide additional information.

2. ***Scoring***: The Event items (#1-4) may be summed to indicate the number of different types of potentially traumatic events a child has experienced (Event Total). The Reaction items (#5-10) are summed to provide a Reactions Total score ranging from 0 to 18.

3. ***Interpretation***: Initial analysis of validation data for the CTS in a published study was completed with a sample of 74 children seen at an outpatient behavioral health clinic. This analysis suggests that the optimal cut scores for Reactions Total on the CTS are 6 or greater on the child report or 8 or greater on the caregiver report, which indicate a high likelihood that the child may be suffering from

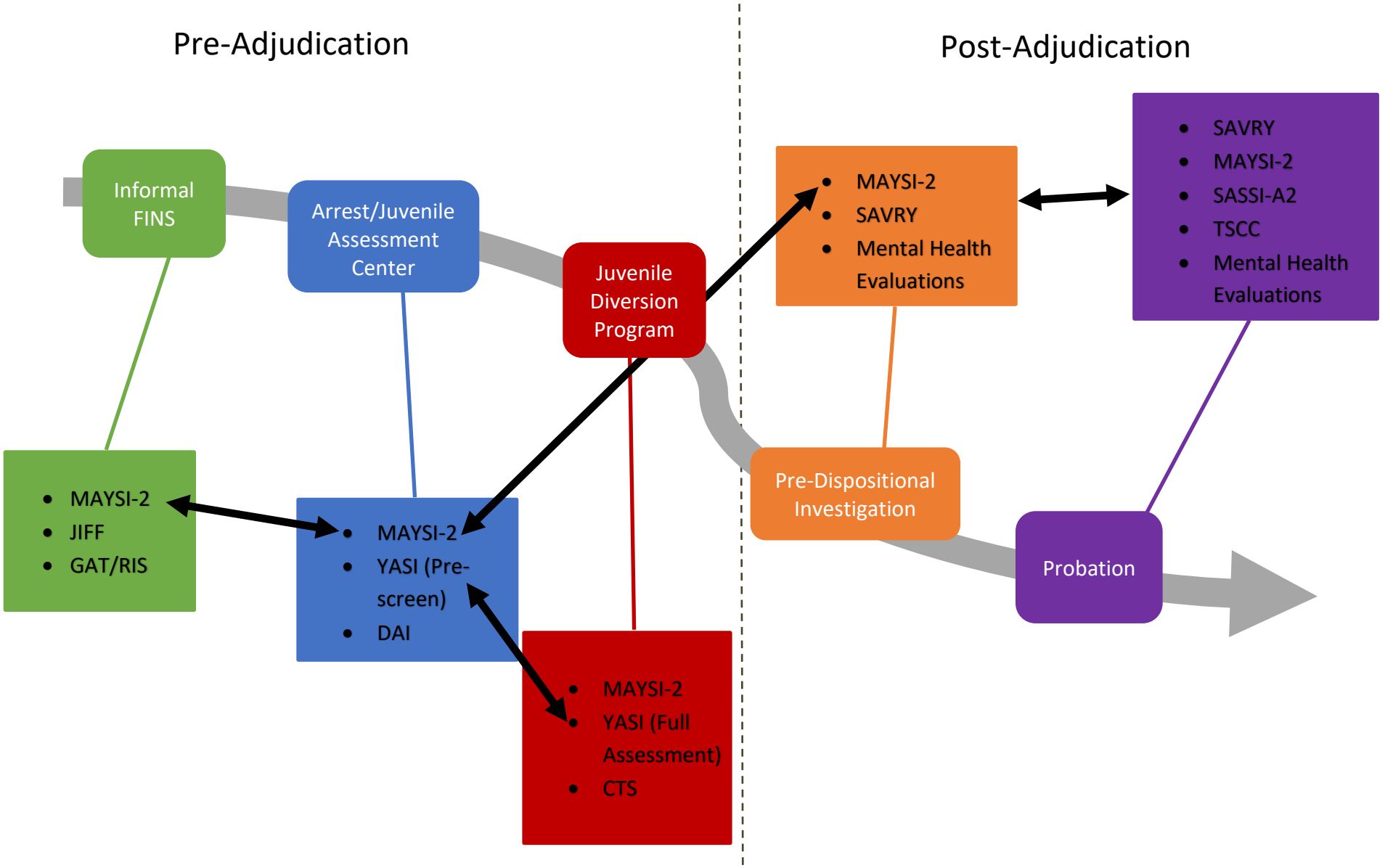
clinically significant levels of PTSD symptoms. In these cases, a clinical trauma assessment by a clinician trained in evidence-based trauma-focused treatment should be considered, including using more comprehensive standardized assessments of PTSD and traumatic stress symptoms. These optimal cut scores are developed based on optimizing and equally balancing the sensitivity (accurately predicting children who DO have high PTSD symptoms) and specificity (accurately weeding out children who DO NOT have high PTSD symptoms). Ultimately, selection of a cut point depends on the setting and purpose of the tool, as well as determinations about how to best balance sensitivity and specifity in the setting where it is used.

Trauma Symptom Checklist for Children™ (TSCC)

1. ***Administration:*** The TSCC is a 54-item test that includes two validity scales (e.g., Underresponse and Hyperresponse) and six clinical symptom scales (e.g., Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation, and Sexual Concerns). The test can be administered to youths ages 8 to 16 years of age. Validation data suggest the TSCC can be utilized for 17-year-old youths and compared appropriately to established norms; however, a 2-point downward adjustment should be applied to the Anger scale for females. The TSCC should be introduced to clients in a manner that describes that participation is voluntary, at any time the client can terminate their participation, the purpose of the tool, how the tool will be used, potential liabilities and benefits of the results, and how the results will be disseminated.

2. ***Scoring:*** Scoring is performed by ensuring the client answered every question, exposing the weighted scores on the questionnaire, adding the scale scores according to the TSCC manual, and inserting the scores and their corresponding t-scores onto the profile form for the appropriate gender and age group. Circle the appropriate number on the scales and draw lines between the clinical scale scores to create a profile graph.

3. Interpretation: The profile form shows significant cutoff limits for each scale, which provides assessment clinicians with information regarding significance of the score. These significance levels were established through prior research and highlight areas of focus. Included in the clinical symptom scales are scales for anxiety, depression, anger, post-traumatic stress, and dissociation. For these scales, t-scores over 65 are considered clinically significant. Also included are two sub-scales for sexual concerns, which have a higher t-score of 70 for clinical significance. Finally, there are eight critical items contained in the checklist. Although a positive response on these critical items does not imply a critical result, any positive response to critical items indicates the need for further assessment regarding the content of that item.



↔ Information Exchanged Pursuant to a Juvenile Justice Information-Sharing Agreement and/or Consent to Release

AGENCY PROCEDURES FOR ASSESSMENT TOOL USE

DEPARTMENT OF JUVENILE SERVICES

Detention Assessment Instrument (DAI)	
REPORTING	Scores are recorded on the DAI form. Every item should be completed on the DAI for results to be valid.
CASE MANAGEMENT	Youth who receive a score of greater than 10 (recommending Alternative Placement or Detention) shall be transported by Correctional Officers to the Rivarde Detention Center for further disposition. Youth who are indicated for Alternatives will be immediately referred to the Detention Probation Officer and Alternatives to Detention Probation Officer to determine the most appropriate Alternative to Detention.
DISPOSITION OF RESULTS	DAI scoring sheets will be given to the Juvenile Intake Center supervisor and a copy to the Rivarde Detention Center intake staff. The DAI is not validated for use beyond immediate detention screening and should not be used to determine overall risk for delinquency.
TRAINING	Training will consist of initial training using the DAI Manual for new employees and ongoing (every six months) booster training for existing employees. Training will consist of an overview of DAI development, validation, scoring, and dissemination.
QUALITY ASSURANCE	A sample of scored DAI's will be reviewed weekly by the Detention Home Manager, the Juvenile Intake Center Commander, and the Juvenile Justice Reform Coordinator. Scoring will be reviewed to determine the need for additional training or corrective action discussions with employees that score the DAI, and/or to ascertain policy revisions.

Massachusetts Youth Screening Instrument™ (MAYSI-2)	
REPORTING	Juvenile Assessment Center (JAC): Results are recorded and reported using web-based MAYSI-generated forms, including the Second Screening and Summary forms. These forms are maintained according to JAC policies. Pre-Dispositional Investigation (PDI): MAYSI results should be recorded under a separate heading with the title, **Results of MAYSI-2**, in the following manner: • *Critical Cases*: "**The MAYSI-2 was administered on <<date>> and results indicated a CRITICAL case based on <<CAUTION on the Suicide Ideation scale>> and/or <<WARNING on the <<Scale 1>>, <<Scale 2>>, and/or <<Scale 3>>. These results indicate the need for further mental health assessment and <<the youth is currently scheduled for an appointment at <<mental health provider>>** or **<<the youth is currently receiving services from <<mental health**

	treatment provider>>, or**, <<an evaluation is being requested to determine the youth's needs for mental health treatment.>>.**" Example: "The MAYSI-2 was administered on May 13, 2018 and results indicated a CRITICAL case based on WARNING on the Depressed-Anxious and Alcohol/Drug Use scales. These results indicate the need for further mental health assessment and the youth is scheduled to attend an appointment with Jefferson Parish Human Services Authority's Child and Family Services Unit on June 1, 2018**.**" • *Non-critical Cases*: "**The MAYSI-2 was administered on <<date>> and results did not indicate a critical case**."
CASE MANAGEMENT	Juvenile Assessment Center: MAYSI-2 results assist in targeting assessments and, in turn, developing case plans for arrested youth. Plans include written referrals to community agencies for the purpose of obtaining services to reduce delinquent behaviors with monthly follow-up calls to ensure services are utilized. As a reminder, MAYSI results are only valid for 30 days, so follow-up for MAYSI-flagged needs past that period may not be applicable. However, needs identified by the Youth Assessment and Screening Instrument (Pre-screen) will continue to be monitored according to existing Juvenile Assessment Center policy. Mental health professionals will incorporate Motivational Interviewing techniques when discussing case planning with assessed youth. Pre-Dispositional Investigation: MAYSI-2 results indicate to probation officers whether a mental health evaluation is necessary for adjudicated youth. **MAYSI results flagged as a "Critical Case" and indicated by 2nd Screens are to be considered in need of a mental health evaluation, unless they are already under psychiatric care.** Additional Considerations: • MAYSI-2 results reflect a two-week period prior to the screening and are considered valid for 30 days afterwards. Re-administer the screen after 30 days as indicated previously. • Training may be provided upon request to any agency regarding implementation, use, administration, and indications of the MAYSI-2 mental health screen.

	• To request a MAYSI for youth attending a pre-dispositional investigation, a copy of the PDI letter to the parent/guardian shall be provided to JAC mental health professionals to schedule the MAYSI during the PDI.
DISPOSITION OF RESULTS	Juvenile Assessment Center: MAYSI results for arrested youth will be maintained by Mental Health Professionals to target assessment areas and develop case plans and monitor cases for compliance. Results will be scanned into the Department of Juvenile Services case management system. A copy of MAYSI Scoring Summary and any Second Screening(s) will accompany youth who are detained for use by detention staff. Interpretation or explanation of results should be performed by staff trained in administration of the MAYSI. Results may be discussed with parents/guardians for the purpose of ensuring necessary community-based interventions and follow-up. Pre-Dispositional Investigation: A copy of the MAYSI Scoring Summary and any Second Screening(s) will be provided to the requesting probation officer by the JAC by scanning results into the case management system and by e-mail.
TRAINING	Training will consist of initial training using the MAYSI Manual for new employees and ongoing (every six months) booster training for existing employees. Training will utilize the National Youth Screening and Assessment Project-created MAYSI-2 PowerPoint training module and will consist of an overview of MAYSI development, validation, scoring, and dissemination.
QUALITY ASSURANCE	A sample of scored MAYSI's will be reviewed weekly by the Juvenile Assessment Center Supervisor. Scoring will be reviewed to determine the need for additional training or provide feedback to MAYSI assessment staff.

Youth Assessment and Screening Instrument™ (YASI) (Pre-screen)	
REPORTING	The YASI computer program generates a list of all youth responses that indicate problems or poor functioning. Mental health professionals select goals for services, or add goals if needed, to develop the service plan. Service plans are reviewed with the youth and caregiver whenever possible to make sure the goals fit the family's perspective and services are accessible. A copy of the service plan will be provided to the caregiver for youth released to their parents. A copy will be maintained in the youth's electronic file for monitoring.
CASE MANAGEMENT	Mental health professionals will contact the youth and/or caregiver once every 30 days to monitor compliance to the service plan, offer assistance in obtaining services, and obtain a status report on the youth and family. Monitoring will be provided for six months and will be provided to youth not engaged by other agencies. Mental health professionals will document the status of the case on progress notes in the youth's electronic file. Cases are followed for six months or until the case is supervised by another agency, such as the Department of Child and Family Services, Office of Juvenile Justice, or Department of Juvenile

	Services. Mental health professionals will incorporate motivational interviewing techniques and utilize family engagement when engaged in case planning. The timeframe used as a reference for youth taking the assessment is six (6) months. Youth will be asked to answer questions based on their experiences in the last six months. Re-assessment will be required only after three (3) months has passed since the previous assessment.
DISPOSITION OF RESULTS	Case plans will be maintained in the Juvenile Assessment Center by entering results into the DJS case management system. A copy may be provided to the detention center for detained youth, a copy shall be given to the caretaker, and a copy may be provided to the Juvenile Court, Juvenile Diversion, or probation officer upon request. Results may be discussed with parents/guardians for the purpose of ensuring necessary community-based interventions and follow-up. Under no circumstances shall results be provided to prosecutors, unless authorized specifically by the Court.
TRAINING	Training will consist of initial training using the YASI instruction guide for new employees and ongoing (every six months) booster training for existing employees. Training will consist of an overview of YASI development, validation, scoring, and dissemination.
QUALITY ASSURANCE	A sample of scored YASI results will be reviewed weekly by the Juvenile Assessment Center Supervisor. Scoring, case planning, and case monitoring will be reviewed to determine the need for additional training or corrective action discussions with employees that score the YASI, and/or to ascertain policy revisions.

Structured Assessment of Violence Risk in Youth™ (SAVRY)	
REPORTING	Pre-Dispositional Investigation (PDI) Report: Report results under **RESULTS OF SAVRY FINDINGS:** on the PDI Report. Each Social/Contextual and Individual/Clinical Risk Item rated as High or Moderate, and any present Protective items should be listed under this heading. The most critical top two (2) or three (3) need areas from the Service Referral Matrix should be targeted for services and recommended in the pre-dispositional report. The most salient or critical need area should be listed and addressed first. **If there are no moderate or high risk need areas, state this. In such cases, any services recommended should be those that focus on increasing protective factors.** These top two or three need areas should be updated as the youth progress or shows more salient needs across the duration of probation. Include a summary statement about risk and protective factors to target need for treatment. This statement summarizes the risk factors present and how they relate to delinquency/violence risk. This summary statement may be included in the existing summary statement. Be sure to include how needs

identified by the SAVRY will be addressed. See below example SAVRY section of the Report to the Court:

RESULTS OF SAVRY FINDINGS:

The following items were definitely present:

Social/Contextual Factors:

11. Peer Delinquency	**Moderate**
14. Poor Parental Management	**High**

Individual/Clinical Risk Factors:

18. Risk Taking/Impulsivity	**High**
19. Substance-Use Difficulties	**Moderate**

Protective Factors:

P1 Strong Social Support	**Present**
P4 Positive Attitude Toward Authority	**Present**

	NEED AREA	NEED LEVEL	SERVICES RECOMMENDED
1.	**Family**	**Moderate**	**Active Parenting for Teens to address poor parental management.**
2.	**Substance Abuse**	**Moderate**	**JPHSA Substance Abuse Unit for assessment and treatment.**
3.	**Disruptive Behavior Problems**	**Moderate**	**Moral Reconation Therapy to address risk taking/impulsivity and peer delinquency.**

Summary Risk Rating for Violence: Low

Information collected on John Doe indicated he has not engaged in either delinquent or violent behavior in the past. He typically handles conflict appropriately and has few behavioral problems in school. He has some delinquent friends, with whom he occasionally smokes marijuana. His parents are not available due to their work schedule and, as a result, he is rarely disciplined for his behaviors. He was previously terminated from informal FINS for failing to comply with his Informal Family Services Plan Agreement. Currently, he does have several positive adults whom he feels connected to and can speak with when he has a problem. He said he wants to do well on probation so he can continue with school.

CASE MANAGEMENT	The Summary Risk for Delinquency and Summary Risk for Violence ratings are used to determine probation supervision level in accordance with probation policies. The supervision level should be consistent with the higher of the two summary risk ratings. Treatment referrals shall be made after engaging families in developing goals for changing identified needs of the youth. Referrals shall use, whenever possible, evidence-based programs to give youth and families the greatest opportunity for improvement. The following information reflects supervision levels established by existing probation policy: (This information is superseded by any revisions to existing probation supervision policy.) Low Risk (Delinquent & FINS).....1 face-to-face contact per month Moderate Risk (Delinquent).....2 face-to-face contacts per month Moderate Risk (FINS).....1 face-to-face & 1 phone contact per month High Risk (Delinquent).....4 face-to-face contacts per month High Risk (FINS).....2 face-to-face contacts per month Case plans are documented in the pre-dispositional report and are to be reviewed with the youth and guardian each month to ensure youth is completing appropriate services. Probation Officers should document services received and whether or not identified needs are being addressed properly. When SAVRY Summary Risk Scores are not consistent with probation recommendations as a result of the nature and severity of the referral offense, probation officers should maintain the SAVRY Summary Risk Scores and explain in writing the rationale for increased or decreased levels of supervision or services. This should be explained in the Risk Classification section of the pre-dispositional report as follows: **Example: The SAVRY Summary Risk Rating indicated this youth is at Moderate Risk for re-offending. However, due to the nature and severity of the charge, it is recommended that this youth be supervised at a more intense level. Therefore, this youth is recommended for the Intensive Supervision Probation program. He will be re-assessed at a later date to determine his suitability for reduction in supervision level, if appropriate.** Additional Procedures: • SAVRY results are valid for approximately six months. Generally, re-assessment is required every six months, after a major life-changing event, or at a change in supervision status, including termination from probation. Re-assessments should be completed by looking at the original SAVRY ratings for the youth, considering any new information, and rating

	Social/Contextual, Individual/Clinical, and Protective factors based on the time since the last SAVRY was completed. • At the discretion of the probation supervisor, SAVRY's are not required for youth recommended for transfer of supervision levels or termination with less than 90 days since their last SAVRY. • To determine whether or not a youth should receive a different supervision level, a SAVRY should be administered. The highest Summary Risk rating for either Delinquency or Violence will be the basis for re-assignment to a different supervision level. • When making treatment referrals, probation officers should discuss with families results of assessments, agree on common goals to successfully complete probation, and make referrals most appropriate to the needs of youth and families that align as much as possible with their level of resources (e.g., match to identified needs, language, location, schedule, etc.). • Re-administration of the SAVRY is not required for deferred probationers since they will be considered Low Risk for delinquency and violence. However, a SAVRY is required if the youth has a major life-changing event or is being recommended for an increased supervision level. Also, if a SAVRY has been completed for a deferred probation case or the probation officer believes it is necessary to complete a SAVRY, and the SAVRY Summary Risk Rating for Delinquency or Violence is Moderate or High, the youth should be placed on the respective probation supervision level according to the relevant probation policy. • Pending Probation Supervisors' approval, probation officers are encouraged by the Court to move for early termination more frequently if youth have completed services and risk indicators have decreased based on re-assessment.
DISPOSITION OF RESULTS	The SAVRY is a valid assessment instrument for risk for recidivism and Rating Forms are to be kept confidential and not reviewed by anyone not trained in use of the SAVRY. Due to state-wide implementation of the SAVRY, SAVRY results shall be provided to the Office of Juvenile Justice during case staffings for placement following existing staffing policy.
TRAINING	Training will consist of initial training using a 12-hour SAVRY training for new employees and ongoing (every six months) booster training for existing employees. Training will consist of an overview of Motivational Interviewing techniques, SAVRY development, validation, scoring, and dissemination. In addition, SAVRY training will consist of two standardized written vignettes and

	two actual cases scored and reviewed by a Department of Juvenile Services SAVRY Trainer.
QUALITY ASSURANCE	SAVRY's will be reviewed weekly by the Department of Juvenile Services Probation Supervisors and, when necessary the Department SAVRY Trainer. Scoring will be reviewed to determine the need for additional training or corrective action discussions with employees that score the SAVRY, and/or to ascertain policy revisions.

Substance Abuse Subtle Screening Inventory© (SASSI-A2)	
REPORTING	Trained Licensed Mental Health Professionals administer the SASSI-A2 and communicate results in a written report, which is provided to requesting probation officers or Juvenile Drug Treatment Court team. The report shall summarize interpretations of each scale, Decision Rules, and overall SASSI conclusion.
CASE MANAGEMENT	Results of SASSI-A2 screening are used to assist in identifying youth who potentially need further substance abuse assessment. These results inform case workers about youths' potential need for higher levels of intervention regarding substance use. Youth who have high probability of having a Substance Use Disorder are referred for Juvenile Drug Treatment Court, intensive outpatient substance abuse therapy, or residential substance abuse treatment as guided by in-house mental health clinicians. In addition, use of the SASSI fulfills requirements for the Office of Juvenile Justice and Delinquency Prevention and Louisiana Juvenile Drug Court standards regarding use of a standardized tool for assessing the presence of substance use.
DISPOSITION OF RESULTS	Profile sheets and written reports are provided to the referring probation officer and, as applicable, the Juvenile Drug Treatment Court intake team. Only copies of the profile sheet are attached to the report. SASSI-A2 questionnaires are for clinical use only and are not to be distributed to probation, court, law enforcement, or other personnel. A copy of the SASSI profile sheet will be scanned into the DJS case management system.
TRAINING	SASSI-A2 Training consists of a two-hour in-person training and, as needed, an online SASSI training for clinicians administering the SASSI-A2.
QUALITY ASSURANCE	Quality checks are provided by in-house clinicians through consultation with each other and with on-site clinical supervisor.

Trauma Symptom Checklist for Children™ (TSCC)	
REPORTING	Trained and licensed Mental Health Professionals administer the Trauma Symptom Checklist for Children when there is suspicion of youths having a history of abuse or neglect. Evidence of abuse/neglect can be obtained through collecting a social history during the pre-dispositional investigation process, through reviewing results from the MAYSI-2 Traumatic Experiences scale, or by speaking with probation officers, teachers, mental health providers, or any other reliable informant. The TSCC includes a questionnaire

	and a profile sheet. Completed questionnaires are to be maintained in a secure location for clinical use only. Profile sheets are communicated to probation officers by scanning completed profile sheets into the DJS case management system.
CASE MANAGEMENT	In recent years, there has been increased recognition of the impact of trauma on youth, particularly youth involved in the juvenile justice system. Results of the TSCC provide clinicians with critical information regarding youths' traumatic experiences and their traumatic responses, and how these are related to criminogenic behaviors. Scores on individual scales should be considered along with supplemental information obtained from previous reports, assessments, and observations. Clinical interventions should focus on the TSCC scales and prioritize symptoms as targets for intervention. It is important that youth be referred to evidence-based trauma interventions. Case management should include engaging with families and youths regarding best course of action; monitoring progress to determine the impact of traumatic response on delinquent behaviors, family functioning, and individual impairment; and adjusting intervention intensity, duration, and frequency as needed.
DISPOSITION OF RESULTS	Profile sheets are provided to the referring probation officer and, when necessary, other clinicians involved with the case for case coordination purposes. Except when absolutely necessary for the well-being of the youth, questionnaires are not to be shared with anyone except for the person administering the tool or his/her clinical supervisor. TSCC questionnaires are for clinical use only and are not to be distributed to probation, court, law enforcement, or other personnel. Retention of original questionnaires and profile sheets are to be maintained in secure files by the clinician that administered the tool. Results may be discussed with parents/guardians and probation officers for the purpose of ensuring prioritization of trauma-based interventions.
TRAINING	Although the TSCC is designed to be administered by a wide range of professionals, interpretation of the profiles and scores should be done by individuals with graduate training in a mental health field, including training in the interpretation of psychological tests. Anyone administering the TSCC shall carefully study the administration manual prior to administering the tool and interpreting results.
QUALITY ASSURANCE	Quality checks are provided by in-house clinicians through consultation with each other and with on-site clinical supervisor.

DISTRICT ATTORNEY'S JUVENLE DIVERSION PROGRAM

Youth Assessment and Screening Instrument™ (YASI) (Full Screen)	
REPORTING	The YASI is a computer-based risk/needs assessment that produces a case summary and intervention plan. The case summary includes Overall Risk and Areas Contributing to Risk. Results of the YASI will be recorded in youths' Diversion files and in the Diversion case management system.
CASE MANAGEMENT	Results of the YASI will provide Diversion case managers and clinicians with an overall risk level and identify targets for interventions. Overall risk levels will determine the level and intensity of Diversion programming consistent with the Risk-Needs-Responsivity principle. *Areas Contributing to Risk* will specify targeted areas for intervention through in-house or community-based interventions that are commensurate with the family's resources and self-identified needs. Intervention plans include written referrals to community agencies for the purpose of obtaining services to reduce delinquent behaviors. Due to youth's fluctuating risk and protective factors, the YASI will be re-administered every 6 months for the duration of participation in the Diversion program.
DISPOSITION OF RESULTS	Diversion staff will print the computer-generated profile to identify targets for interventions. A copy of the results will be maintained in youths' Diversion file for future reference. Results may be discussed with parents/guardians for the purpose of ensuring necessary community-based interventions and follow-up.
TRAINING	Each administrator of the YASI will undergo an initial web-based training course regarding proper use, administration, and case management using YASI results.
QUALITY ASSURANCE	The Diversion program administrators will review YASI administrations at least quarterly to ensure the YASI is being administered properly. Feedback will be provided to individuals and program staff as a whole regarding constructive use of this assessment tool. Regular booster trainings and policy reviews will be incorporated into staffings and staff trainings.

Massachusetts Youth Screening Instrument™ (MAYSI-2)	
REPORTING	Results are recorded and reported using forms generated by either MAYSIWARE or web-based MAYSI, including the Second Screening and Summary forms. The MAYSI Profile Sheet and any Second Screening Forms will be recorded in youths' Diversion files and added to the Diversion case management system.
CASE MANAGEMENT	MAYSI-2 results assist in identifying youth with possible mental illnesses and developing case plans for diverted youth. Youth who obtain CRITICAL results on this screen are to be referred for mental health evaluation. If youth are already engaged in mental health treatment with a treating psychiatrist, psychologist, or other mental health clinician, consult with the clinician on

	MAYSI scales in the WARNING or CAUTION zones. As a reminder, MAYSI results are only valid for 30 days, so follow-up for MAYSI-flagged needs past that period may not be applicable. However, needs identified by the Youth Assessment and Screening Inventory (YASI) will continue to be monitored according to existing Diversion policy. Case managers will incorporate motivational interviewing techniques when discussing case planning with assessed youth and their family members.
DISPOSITION OF RESULTS	Profile sheets and Second Screening forms will be maintained in the youths' Diversion file. Results of the MAYSI-A2 will not be shared with any member of the District Attorney's Office or any other agency without proper authorization as provided by Federal law, Louisiana law, the Jefferson Parish Memorandum of Understanding for Juvenile Justice Information-Sharing, or by consent of the youth and parent/guardian.
TRAINING	Each administrator of the MAYSI-A2 will attend an initial two-hour MAYSI-A2 training developed by the National Youth Screening and Assessment Project (NYSAP). Annual trainings will be provided to ensure MAYSI administration is consistent.
QUALITY ASSURANCE	The Diversion program administrators will review MAYSI-A2 administrations at least quarterly to ensure the MAYSI-A2 is being administered properly. Feedback will be provided to individuals and program staff as a whole regarding constructive use of this screening tool.

Child Trauma Screen (CTS)	
REPORTING	Results of the CTS will be maintained in the youth's file and a summary of the results be written into activity notes along with a recommendation of further assessment and/or intervention using evidence-based interventions, such as Trauma-Focused Cognitive Behavioral Therapy or Project Loss and Survival of Trauma (Project LAST).
CASE MANAGEMENT	The CTS cutoff score is a guide to aid case management staff in determining if additional trauma assessment is necessary. Youth who score above cutoff should be engaged in additional assessment if there is evidence to support the youth has experienced significant trauma, is impaired by traumatic response, or shows signs of trauma avoidance. However, a youth who scores above the cutoff score that is currently receiving evidence-based treatment for traumatic response may not warrant additional intervention. Diversion staff will incorporate motivational interviewing techniques when discussing case planning with assessed youth and their family members
DISPOSITION OF RESULTS	Results are to be maintained in the youth's Diversion file and are not to be shared with any other agency without prior written approval of the youth and parent/guardian. Prior to obtaining permission, it is necessary to first explain potential negative impacts of sharing the results, including the potential harmful effects sharing the information may have.

TRAINING	Those administering the CTS screen should have basic training in child traumatic stress, how to use a trauma screen to engage children/caregivers, and how to manage responses and disclosures of trauma.
QUALITY ASSURANCE	The Deputy Chief of Diversion or the Program and Policy Director will review case files to determine if the CTS has been administered and utilized properly. Feedback will be provided to screeners on improving the quality of screening administration and use.

INFORMAL FAMILIES IN NEED OF SERVICES

Global Assessment Tool/Risk Indicator Surveys	
REPORTING	Results of both the Global Assessment Tool and Risk Indicator Survey are to be summarized in a single paragraph in the youth's file or FINS-AP. Needs of the youth and/or family are to be expressed in qualitative terms that indicate the severity of the issues and their contribution to the referral behaviors.
CASE MANAGEMENT	Results from both instruments inform FINS interventions and target referral behaviors. FINS staff will incorporate motivational interviewing techniques when discussing case planning with assessed youth and their family members. FINS staff are to utilize results from these tools to identify high priority targets for interventions. Priorities are to focus on behaviors that were the reason for the status referral. Further, priority targets are to be documented on the Informal Family Services Plan Agreement (IFSPA) in detail and referred to an appropriate community-based service provider. Referrals to community-based service providers should also take into account the family's ability to obtain services, the match between the services provided and priority targets, and the ability of the service to effectively address the family's needs. Following intake, Intake Officers should follow up with youth, families, and referral sources, if appropriate, to determine if there have been changes in referral behaviors. Any feedback should be communicated with service providers to aid them in addressing referral behaviors.
DISPOSITION OF RESULTS	Results of the Global Assessment Tool and Risk Indicator Surveys are to be maintained in the Informal FINS file and not shared with other agencies without consent of the youth and guardian.
TRAINING	Intake Officers and Case Managers receive training during staff meetings in reference to the administration and use of the Global Assessment Tool and Risk Indicator Survey. This training is conducted by the FINS Director as an annual review for each employee.
QUALITY ASSURANCE	The Informal FINS Director performs quality assurance checks to determine if the information that has been marked by the Intake Officer is consistent with the circumstances of the youth and family, and if the services referred match the needs identified on the Global Assessment and Risk Indicator Survey.

Juvenile Inventory for Functioning™ (JIFF)	
REPORTING	The JIFF computer program generates a list of all youth responses that indicate problems or poor functioning. Informal FINS staff select goals for services, or add goals if needed, to inform development of the Informal Family Service Plan Agreement (IFSPA). IFSPAs are reviewed with the youth and caregiver whenever possible to make sure the goals are accurate and services are accessible. A copy of the IFSPA will be provided to the caregiver

	for youth released to their parents. A copy will be maintained in the youth's file for monitoring.
CASE MANAGEMENT	Intake Officers will contact the youth and/or caregiver in accordance with Informal FINS policy to monitor compliance to the service plan, offer assistance in obtaining services, and obtain a status report on the youth and family. Monitoring will be provided for six months and will be provided to youth not engaged with other agencies. Monitoring may be extended for an additional six months at the discretion of the Intake Officer. The Intake Officer will document the status of the case on progress notes in the youth's file. Cases are followed for six months or until the case is supervised by another agency, such as Department of Child and Family Services, Office of Juvenile Justice, or Department of Juvenile Services. Intake Officers will incorporate motivational interviewing techniques and family engagement into case planning.
DISPOSITION OF RESULTS	JIFF results will be maintained by in the Intake Officers. A copy may be provided to treatment providers with signed consent of the youth and parent/guardian, and a copy may be given to the caretaker. JIFF results are not to be given to any other agency under any circumstances as provided by Federal, state law, by the Jefferson Parish MOU for Juvenile Justice Information Sharing agreement, or without consent of the youth and parent. .
TRAINING	Training will consist of initial training using the JIFF instruction guide for new employees and ongoing (every six months) booster training for existing employees. Training will consist of an overview of JIFF development, validation, scoring, and dissemination.
QUALITY ASSURANCE	A sample of scored JIFF results will be reviewed weekly by the Informal FINS Director or his designee. Scoring, case planning, and case monitoring will be reviewed to determine the need for additional training or corrective action discussions with employees that score the JIFF, and/or to ascertain policy revisions.

Massachusetts Youth Screening Instrument™ (MAYSI-2)	
REPORTING	Results are recorded and reported using forms generated by either MAYSIWARE or the web-based MAYSI platform, including the Second Screening and Summary forms. The MAYSI Profile Sheet and any Second Screening Forms will be recorded in youths' Informal FINS files and added to the FINS-AP case management system.
CASE MANAGEMENT	MAYSI-2 results assist in identifying youth with possible mental illnesses and developing case plans for diverted youth. Youth who obtain CRITICAL results on this screen are to be referred for mental health evaluation. If youth are already engaged in mental health treatment with a treating psychiatrist, psychologist, or other mental health clinician, consult with the clinician on MAYSI scales in the WARNING or CAUTION zones. As a reminder, MAYSI results are only valid for 30 days, so follow-up for MAYSI-flagged needs past that

	period may not be applicable. However, needs identified by the additional assessment tools will continue to be monitored according to existing Informal FINS policy. Intake Officers will incorporate motivational interviewing techniques when discussing the IFSPA with assessed youth and their family members.
DISPOSITION OF RESULTS	Profile sheets and Second Screening forms will be maintained in the youths' Informal FINS file and/or scanned into the FINS-AP case management program consistent with existing policy. Results of the MAYSI-2 will not be shared with any member of the District Attorney's Office or any other agency without proper authorization provided by Louisiana law, the Jefferson Parish Memorandum of Understanding for Juvenile Justice Information-Sharing, or by consent of the youth and parent/guardian.
TRAINING	Each case worker administering the MAYSI-2 will attend an initial two-hour MAYSI-2 training developed by the National Youth Screening and Assessment Project (NYSAP). Annual trainings will be provided to ensure MAYSI administration is consistent.
QUALITY ASSURANCE	The Informal FINS Director or his designee will review MAYSI-2 administrations at least quarterly to ensure the MAYSI-2 is being administered properly. Feedback will be provided to individuals and program staff as a whole regarding constructive use of this screening tool.

TREATMENT SERVICES AND THEIR USES

Below is a list of frequently-used services for juvenile justice youth through community and contract providers. The table contains a list of need domains and relevant risk factors for reference. The table also contains traits that services are not indicated for using. Initial referrals should be made for the top two or three *highest priority* need areas. More specifically, *highest priority* refers to amount of impact the need area has on delinquent behaviors. Research has shown that offenders with low risk ratings should have minimal contact with the juvenile justice system; therefore, services are not indicated for low risk youth.

Service	Used For	Not Used For
Individual Therapy (Cognitive Behavioral Therapy and/or Motivational Interviewing)	Disruptive behaviors, poor school achievement, neglect, stress & poor coping, peer rejection, peer delinquency, risk taking/impulsivity, poor compliance, low interest in school, negative attitudes, substance abuse, promiscuity, employment/career development, community disorganization, grief, trauma, sexual abuse, attention deficit. *Most useful for more 16-year-olds and older youth working toward independent living and resiliency skills beyond immediate high conflict families and/or high risk neighborhoods.*	**Tutoring; Less mature 16 year olds and younger youth – use family therapy.**
Family Therapy	Disruptive behaviors, school achievement, low interest in school, negative attitudes, poor coping, poor parental management, negative attitudes, poor compliance, low interest in school, substance abuse, mental health issues, and negative peers. *Indicated for less mature 16 year olds and younger youth based on research.*	
Functional Family Therapy (FFT)	Same as Family Therapy *plus* families with multiple siblings, youth with mental health or substance abuse involvement, and/or at risk of removal from the home.	**Lack of transportation; families needing social support services**
Functional Family Therapy-Child Welfare (FFT-CW®)	Same as Family Therapy *plus* families with multiple siblings, youth with mental health or substance abuse involvement, and/or at risk of removal from the home. FFT-CW focuses on dual-status youth and families with prior child welfare involvement with younger children.	**Lack of transportation; families needing social support services**
Ecological-Based Family Therapy (EBFT)	Same as Family Therapy *plus* families with multiple siblings, youth with social service needs, and/or at risk for removal from the home.	**Lack of transportation, mental health or substance abuse treatment**
Sexual Perpetrator Treatment	Cognitive-behavioral therapy focused on sexual perpetrators using a standardized treatment program.	**Intensive sexual perpetrator treatment**
Aggression Replacement Training (ART)	Disruptive behaviors, aggression, conflict resolution, anger management problems, poor school achievement, stress & poor coping, impulsivity/risk taking, problem-solving, negative attitudes, peer delinquency, peer rejection, lack of personal support, poor compliance, low empathy or remorse.	**Family-influenced criminogenic behaviors**

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)	History of witnessing violence, exposure to violence in the home, childhood history of maltreatment, and other behaviors tied to experiencing significant trauma. Moderate to high levels of impairment created by traumatic response symptoms (i.e., anxiety, depression, anger, hypervigilance, etc.) and/or elevated scores on Trauma Symptom Checklist for Children or Childhood Trauma Screen.	**Youth without significant traumatic symptoms**
JPHSA Substance Abuse Treatment	Youth who have submitted a positive drug screen after disposition are referred to JPHSA Substance Abuse for further assessment and evidence-based treatment.	**Youth already engaged in FFT, EBFT, or MST. Consult with in-home therapist regarding substance use**
JPHSA Mental Health	Youth determined to be in need of mental health treatment by past history or by a psychological or psychiatric evaluation. Current level of functioning should be impaired at home, school, or socially.	**Youth currently engaged in mental health care (e.g., with MHR or psychiatrist)**
Multi-Systemic Therapy (MST)	In-home family therapy that is more intensive than Functional Family Therapy or Ecological-Based Family Therapy. Youth who receive Medicaid and need services beyond FFT or EBFT. Poor parental management, peer delinquency, stress and poor coping, lack of personal/social support, risk taking/impulsivity, anger management problems, poor school attendance or behaviors, poor compliance, anger management problems, at risk of removal from the home.	**Youth without Medicaid, behaviors related to major psychiatric disorder, behaviors primarily related to sexual offending, potential for incarceration longer than 30 days**
Project LAST	School-age youth who have experienced significant loss/grief, and have post-traumatic stress. Stress and poor coping, lack of personal support, and possibly anger management problems, attention deficit, and low interest/commitment to school if these are related to recent or substantial trauma or grief.	**Youth who are actively suicidal or who are not experiencing symptoms of grief or loss**
Common Sense Parenting (CSP)	Poor parental management, lack of personal support, community disorganization	**Youth with unstable or nonexistent family structures**
Moral Reconation Therapy (MRT)	Disruptive behaviors, aggression, conflict resolution, anger management problems, stress & poor coping, impulsivity/risk taking, negative attitudes, peer delinquency, poor compliance, low empathy or remorse.	**Youth who have shown to be highly influenced by negative peers**
Dialectical Behavior Therapy (DBT)	Youth with chronic emotional regulation difficulties, such as those requiring multiple hospitalizations due to frequent disruptive emotional crises or repeated self-harming behaviors. Disruptive behaviors, conflict resolution, anger management problems, poor school achievement, stress & poor coping, impulsivity/risk taking, problem-solving, negative attitudes, poor compliance, low empathy or remorse.	
Coordinated System of Care (CSoC)	Youth with serious mental illnesses who are at risk of removal from their homes as a result of their behaviors. CSoC provides wraparound services to youth and families and is not, in itself a treatment. Rather, CSoC coordinates a wide range of interventions. Disruptive behaviors, aggression, conflict resolution, anger management problems, poor school achievement, stress & poor coping, impulsivity/risk taking, problem-solving, negative attitudes, peer delinquency, peer rejection, lack of personal support, poor compliance, low empathy or remorse.	**Youth who do not have a serious mental illness and who are not at risk of removal from their homes**

Homebuilders	Youth with serious behavioral or emotional risk factors who are at imminent risk of removal from their home. Disruptive behaviors, aggression, conflict resolution, anger management problems, stress & poor coping, impulsivity/risk taking, problem-solving, negative attitudes, parental management, lack of personal support, poor compliance, low empathy or remorse.	**Youth who are not at imminent risk for removal from their home**
Seeking Safety	Youth with co-occurring substance use disorder and/or trauma. Disruptive behaviors, aggression, conflict resolution, anger management problems, stress and poor coping, impulsivity/risk taking, negative attitudes, substance abuse, and presence of significant trauma response symptoms.	**Youth who do not have either a substance use disorder or traumatic response symptoms**

OVERVIEW OF EVIDENCE-BASED PROGRAMS

Aggression Replacement Therapy (ART): Assessments performed by probation officers frequently indicate the need for anger management and violence prevention programs for probationers. To address the identified gap in services that address conflict resolution, aggression control, emotional regulation, and anger management, ART is currently provided to juvenile probationers. ART is a standardized program that addresses conflict resolution, anger control, and moral development (Goldstein, Glick, & Gibbs, 1998). It consists of 36 sessions meeting three times per week for 12 weeks.

Cognitive-Behavioral Therapy (CBT) and Motivational Interviewing (MI): CBT (Burns, Hoagwood, & Mrazek, 1999) and MI (Miller & Rollnick, 2002) have been introduced to community-based organizations through the provision of trainings provided by the LSUHSC. These evidence-based practices provide low-cost options for community providers. They also provide an overarching therapeutic approach when providing a broad range of interventions in individual and family therapy. To insure viability of these approaches, Juvenile Services therapeutic contracts require use of CBT and/or MI with *all* individual and family sessions not utilizing another EBP, documentation of model adherence on progress notes, an agency 'resident expert' on the model, and weekly supervision meetings to insure program fidelity. In addition to expanding to treatment providers, MI training has been provided to probation officers within the Department of Juvenile Services to target their work with traditionally resistant clients and improve the quality of their contacts with youth and families.

Common Sense Parenting (CSP): Adapted from the Teaching Family Model and the Boys Town Family Home Program, Common Sense Parenting (Griffith, 2009a) is a group-based parent-training class designed for parents of youths aged 6–16 who exhibit significant behavior and emotional problems. The objective of the program is to teach positive parenting techniques and behavior management strategies to help increase positive behavior, decrease negative behavior, and model appropriate alternative behavior for children. The program consists of six weekly 2-hour sessions involving a group of 10–12 parents led by certified trainers who work from a detailed trainer's manual. Program participants work from a parent manual that provides information on CSP skills, parenting advice, scenarios, skill cards for quick reference, and a personal parenting plan workbook. Between class sessions, participants are assigned readings from the parent manual and homework activities from the workbook to supplement the training received in class and help parents become more familiar with the newly taught skills. (Adapted from the OJJDP Model Programs Guide website).

Dialectical Behavior Therapy (DBT): Dialectical Behavior Therapy (Bohus, Haaf, Simms, Limberger, Schmahl, & Unckel, 2004) is a cognitive-behavioral treatment approach with two key characteristics: a behavioral problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT has five components: (1) capability enhancement (skills training); (2) motivational enhancement (individual behavioral treatment plans); (3) generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment); (4) structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors); and (5) capability and motivational enhancement of therapists (therapist team consultation group). DBT emphasizes balancing behavioral change,

problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. Therapists follow a detailed procedural manual. (Adapted from the NREPP website).

Ecological-Based Family Therapy **(EBFT)**: This program is the Fr. Flannigan's Boys Town model for in-home family services. Reflecting a methodological shift in service provision in the New Orleans area, this program is a standardized program that utilizes in-home, wrap-around services to reduce risk and improve protective factors. Services include immediate responsiveness to a variety of emotional, behavioral, social, educational, and financial needs of at-risk families. Although not currently considered an evidence-based practice, it is a promising approach based on sound ecological and methodological principles. It is currently undergoing external empirical effectiveness studies through the Boys Town national office. This model is currently being utilized for youth on probation who possess extensive family-related risk factors. (See https://www.boystown.org)

Functional Family Therapy (FFT): Functional Family Therapy is a family-based treatment for a wide range of clinical problems including Conduct Disorder, substance abuse, and violent behaviors. This treatment has shown to be effective for adolescents at risk for out of home placement. It is designed for families with adolescents between the ages of 11 and 18. Often these families have histories of treatment failure or have had difficulty accessing services. Functional Family Therapy conducts an average of 12-14 sessions over three to five months. Functional Family Therapy clinicians work to achieve a balanced alliance with all family members and then identify specific behavior change strategies for families. They seek to provide a culturally sensitive treatment with goals which are obtainable and reasonable for each family. Finally, all treatment ends with generalization skills to assist family members in transferring new coping skills to additional environments. (FFT, 2018). In national studies, Functional Family Therapy has consistently demonstrated reduction of status offenses, delinquent, anti-social behaviors for youth that are mid-to-high risk of further delinquency.

Functional Family Therapy – Child Welfare (FFT-CW®): This adaptation of Functional Family Therapy was designed to intervene in families with children from the ages of 0-18 who are or have been involved with the child welfare system. With excellent empirical evidence regarding effectiveness, FFT-CW recognizes and focuses on increasing adaptive behaviors and eliminating maladaptive behaviors. This model provides a much-needed family-based intervention for families that have experienced neglect, abuse, and trauma (Functional Family Therapy, 2018; see also Turner, Robbins, Rowlands, & Weaver, 2017). Inclusion of this evidence-based practice in the Jefferson Parish service portfolio ensures much-needed interventions are available for youth with histories of both child welfare and juvenile justice involvement.

Homebuilders: Homebuilders® Intensive Home-based Services (IHBS) program accepts families in which one or more children are in imminent danger of being placed in foster, group, or institutional care. The IHBS program is also used for families whose children are being returned from out-of-home care, and for difficult post-adoption transitions. The Homebuilders program includes intensive, 24/7 in-home crisis intervention, counseling, and life-skills education for families who have children at imminent risk of out of home placement. Therapists provide individualized in-home services tailored to the strengths, needs, and goals of each family we serve. The intervention focuses on teaching the family new skills to improve the family dynamics, to strengthen coping skills, to empower each member, to link to

community resources to sustain the changes, and most importantly, to keep children safe. The Homebuilder's Program is listed on the National Registry of Evidence-Based Practices and Programs website. (See Institute for Family Development website).

Moral Reconation Therapy (MRT®): MRT is a 16-step program that utilizes peer-driven processes to guide youth through sequential development of moral stages. The stages include loyalty, trust, acceptance, and many other concepts relating to moral development. MRT was initially developed in detention centers and has been expanded to include high-risk adolescents with a range of associated risks including substance abuse, disruptive behaviors, poor conflict resolution, family conflicts, and negative peers. Group sessions are held weekly and can range from 16 to 32 sessions, depending on the amount of effort demonstrated by participants (Little & Robinson, 1997)

Multi-Systemic Therapy (MST): Previously used for selected sub-groups of youth, this intensive, family-based intervention is aimed at juvenile offenders with serious antisocial behaviors who are at imminent risk of out of home placement. MST therapists collaborate with the family to determine the factors in youths' "social ecology" that are contributing to the identified problems and design strategies for addressing these problems. Ultimately, the goal of MST is to empower families to cope with the challenges of raising children with emotional problems and to empower youth to cope with family, peer, school, and neighborhood difficulties (Henggeler, 1997). More recently, MST has been approved for funding through Medicaid. As a result, referrals have been expanded to include juvenile justice children. Data collected from juvenile justice treatment referrals have indicated 77% of juvenile justice-involved youth are covered by Medicaid who would now be eligible to receive MST.

Positive Parenting Program (Triple-P): Positive Parenting Program is a comprehensive parent-training program with the purpose of reducing child maltreatment and children's behavioral problems (Triple-P America. 2009). It is built upon a public health approach and as such was designed to treat large populations. The Triple-P system has five intervention levels of increasing intensity and narrowing population reach. Programs utilizing Triple-P for Jefferson Parish are certified to provide Level 4 for families with youth between 10 and 16 years of age. The five core principles taught to parents are:

- Ensure a safe and engaging environment
- Promote a positive learning environment
- Use assertive discipline
- Maintain reasonable expectations
- Take care of oneself as a parent

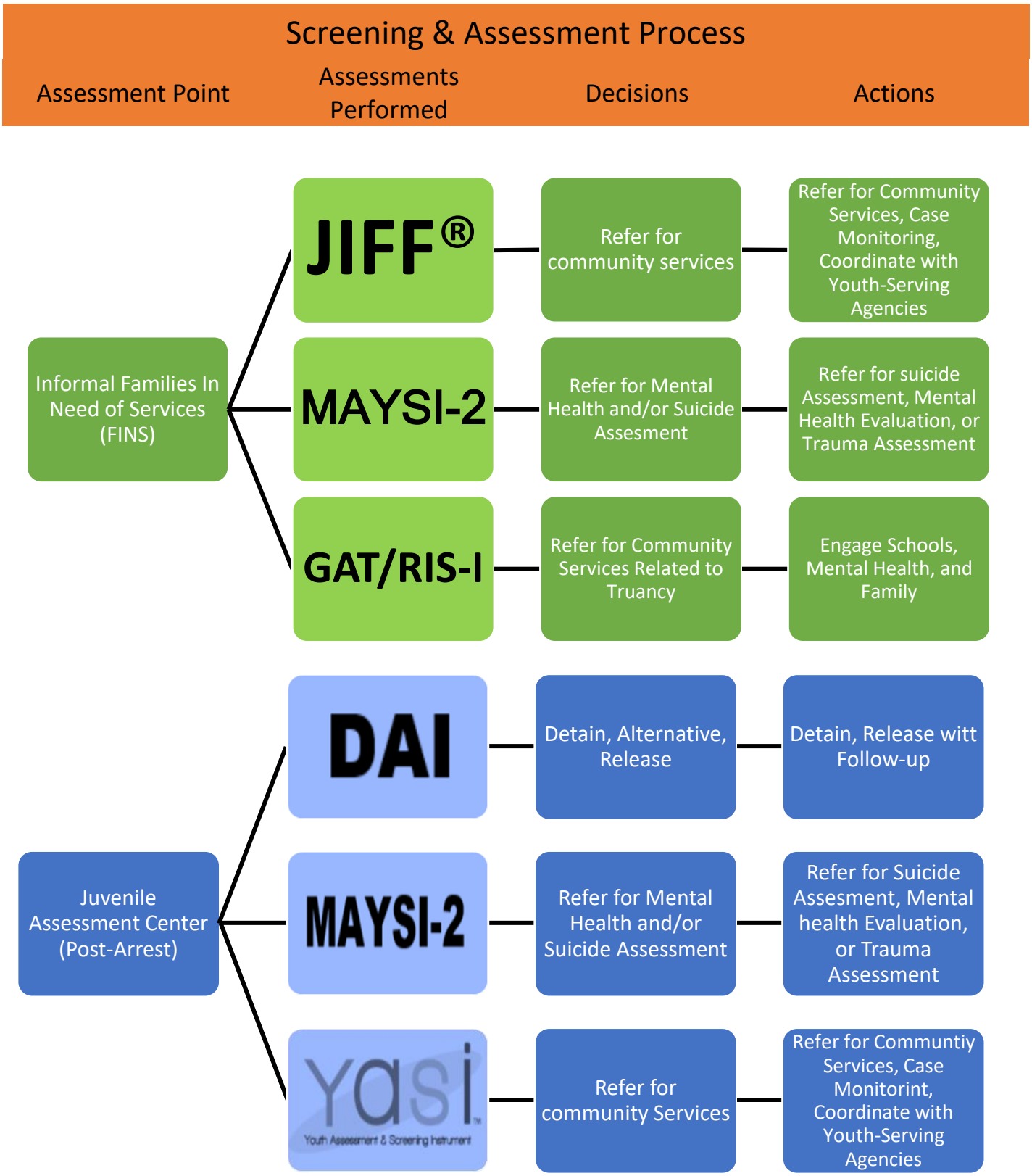
(Adapted from OJJDP Model Programs Guide)

Project Loss and Survival Team (LAST): A developmentally- and culturally-specific intervention aimed at grief and loss symptoms of school-aged youth. This program was developed to respond to the needs of children and families who witnessed or have been victims of violence. Since its initial development, the program has expanded to include school-aged youth experiencing grief, loss, and trauma resulting from a variety of traumatic experiences. The intervention involves an ecological perspective based on cognitive-behavioral therapy and narrative therapy interventions. The program is theoretically-grounded and has shown positive effects in a pilot study and a subsequent randomized comparison group study (Salloum, 2006).

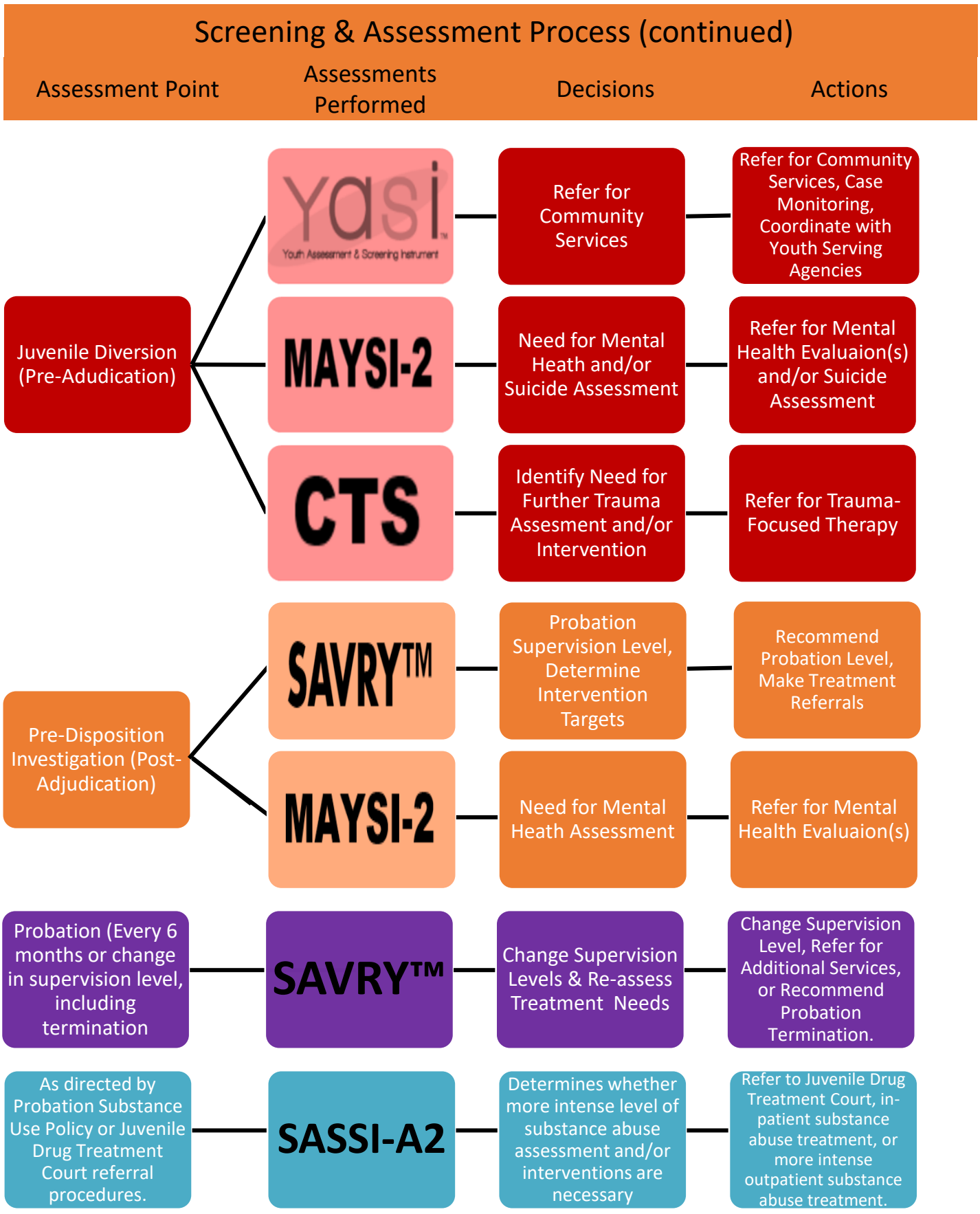
Seeking Safety: The presence of co-occurring substance use disorder and post-traumatic stress in adolescents and adult parents creates a challenge for clinical planning. The prevalence of both in the juvenile justice-involved youth further complicates legal interventions. Seeking Safety is a coping skills approach that focuses on helping clients attain safety from trauma and/or substance abuse (Najavits, 2018). Seeking Safety is an evidence-based model with positive results from a broad range of clinical populations. The model specifically addresses co-occurring substance abuse and traumatic response. The model focuses on four areas that include interpersonal, cognitive, behavioral, and combination topics.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): Recognizing the need for a program to address the growing need for treatment for trauma-related risk factors, TF-CBT was selected from agencies solicited to provide EBPs. In addition to ongoing stressors related to the 2005 hurricane season, the 2007 CYPB community assessment identified that many youth do not have access to services that address grief, exposure to violence, and trauma, which tend to be characteristic of this population. TF-CBT is widely used throughout this area and is currently utilized for youth on probation that have experienced trauma. A study by UNO Department of Education revealed nearly 85% of youth at one public school in Jefferson Parish screened positive for a traumatic event in their lives. With a large percent of juvenile arrests stemming from schools, this treatment approach is critical to addressing trauma in the juvenile justice population. (See https://tfcbt.org/about-tfcbt/)

FLOW FROM SCREENING & ASSESSMENT TO SERVICES



Screening & Assessment Process (continued)



OUTPUTS & OUTCOMES

Collection of outcomes will be accomplished in several ways. First, data that can be queried to connect outcomes to process variables, such as type of treatment referral, type of treatment completion, and length of services. Data also includes demographics, intermediate data, such as drug screen results, treatment/service completion (intensity and duration), probation violations, and probation completion, and long-term recidivism. Data captured from SAVRY administrations will show changes in risk, risk/needs, and protective factors of youth who have received treatment/interventions. Lastly, computerized assessments, such as the MAYSI-2 and YASI, will provide key data on arrested and detained youth. Examples of how data can be used to inform practice can be found in the Jefferson Parish Youth Outcomes Study (Childs, Ryals, Frick, & Phillippi, 2011) and in published research (Childs, Ryals, Frick, Lawing, Phillippi, & Deprato, 2013).

From a practical perspective data are also used to track progress of youth, success of assessment and treatment planning, and ensure appropriateness of service linkages. Repeat measures of the SAVRY will serve as an in-house measure of the effectiveness of services.

The development and use of several case management systems for each program within the juvenile justice continuum provides new capacity for collecting and analyzing data. Further, the case management system utilized by the Department of Juvenile Services, called The Hub, also includes a document management function and advanced search capabilities, giving system administrators the ability to query nearly all aspects of the system.

QUALITY ASSURANCE

Effective implementation of valid and reliable screening and assessment instruments require not only consistently applied initial training, but also ongoing monitoring and follow-up training for quality assurance. Over time, procedures and practices used to perform screenings and assessments and to make treatment referrals become tainted due to time constraints, staff turnover, and lack of sufficient oversight of the process. To minimize the impact of these factors, Jefferson Parish Department of Juvenile Services staff engaged in screening and assessment procedures will undergo semi-annual refresher trainings on screening and assessment practices. In addition, quality assurance will focus on indicators of timeliness, access, and quality of service delivery with minimal thresholds for each. Corrective action plans will be required for any findings below threshold levels to ensure proper delivery of screening and assessment practices.

Juvenile Assessment Center and Probation supervisors will be responsible for ensuring day-to-day compliance to screening and assessment procedures. Lastly, this manual shall be reviewed annually for revisions.

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APPENDIX 1 – Detention Assessment Instrument

JEFFERSON PARISH JUVENILE
DETENTION ASSESSMENT INSTRUMENT (DAI)

Juvenile – Last Name:_____ First Name:_____ DOB:___/___/___

Ethnic and Race Date Source: ☐Juvenile Self-Identification ☐Identification by Observer or Other Source Hispanic/Latino:☐Yes ☐No

Race: ☐Asian ☐Black-African-Am. ☐Native Hawaiian – Other Pacific Islander ☐North/South/Central Am. Indian-Alaskan Native ☐White

Gender:_____ Intake Date:___/___/___ Intake Time:_____ (Military Hours) Screener:_____

If arrested at school or while in secure custody, list specific name of that location:_____

☐ Completed as Part of Detention Decision ☐ Completed as Follow-Up

Arresting Agency:_____ Arrest Date:___/___/___ Arrest Time:_____ (Military Hours)

MANDATORY OVERRIDES: (Must be detained)

- ☐ A. Use/possession of firearm during current offense
- ☐ B. Escapee from secure custody
- ☐ C. Taken into custody via extradition, or is a Fugitive from another jurisdiction
- ☐ D. Juvenile is on ATD at time of arrest
- ☐ E. Juvenile is currently on Parole
- ☐ F (1). Arrested on "JU" or court docketed contempt order (excluding Traffic or FINS)
- ☐ F (2). Arrested on Law Enforcement Officer's Warrant
- ☐ G. Juvenile identified as a Code 6J (Habitual Offender) by the JPSO
- ☐ H. Juvenile is already in Secure Custody

ADMINISTRATIVE OVERRIDES:

- ☐ A. Parent, guardian, or responsible relative **cannot be located**
- ☐ B. Parent or guardian is **unable** to take custody of juvenile
- ☐ C. The juvenile is DETAINED / RELEASED for the **below REASON***:
- ☐ D. Parent of guardian **refuses** to take custody of juvenile

*_____

ADMINISTRATIVE OVERRIDE SUPERVISOR APPROVAL:_____

SELECT ONLY ONE CHOICE PER SECTION **Score**

SECTION 1 - Most Serious Current Offense LIST OFFENSE:_____
(See reverse page for list of offenses in each category)

Category A: "Very Violent" offense against persons	17
Category B: Other "Assaultive/Violent" offense against persons	14
Category C: Felony narcotics	7
Category D: Other felonies	6
Category E: Major misdemeanors against persons	5
Category F: Other misdemeanors	3
Category G: Violation of probation or Contempt of Court order	2

SECTION 2 - Additional Current Offenses

Two or more additional current felony offenses	5
One additional current felony offense	4
One or more additional misdemeanors **OR** violation(s) of probation/parole	3
One or more status offenses **OR** no additional current offense	0

SECTION 3 - Prior Criminal History

Two or more arrests for Category A or Category B offenses	6
One arrest for a Category A or Category B offense	4
Two or more prior arrests for any other felonies	3
One prior felony arrest	2
One or more prior misdemeanor arrest(s)	1
No prior arrests	0

SECTION 4 - History of Failure to Appear

Two or more warrants/detention orders for F.T.A. in past 12 months	3
One warrant/detention order for F.T.A. in past 12 months	1
No warrant/detention order for F.T.A. in past 12 months	0

SECTION 5 - History of Escape/Runaway (within past 12 months)

One or more documented escapes from secure confinement or custody	4
Two or more instances of absconding from non-secure, court-ordered placements	3
Three or more runaways from home	1
No history within past 12 months	0

INDICATED SCORE CATEGORIES

0 – 9	=	Release
10 – 14	=	Alternative
15 +	=	Secure

TOTAL INDICATED SCORE _____

Revised: 8/5/15 **ACTUAL DECISION:** ☐ RELEASE ☐ ALTERNATIVE ☐ SECURE DETENTION
E#: 158

OFFENSE CATEGORIES AND INCLUDED OFFENSES
(Includes attempts or principals)

CATEGORY A: VERY VIOLENT FELONIES AGAINST PERSONS

Solicitation for Murder, 1st Degree Murder, 2nd Degree Murder, Manslaughter, 1st Degree Rape, 2nd Degree Rape, Aggravated Kidnapping, 2nd Degree Kidnapping, Aggravated Burglary, Armed Robbery, Assault by Drive-by Shooting, Aggravated Crime against Nature, Carjacking, Terrorism, Disarming of a Peace Officer, Aggravated Assault upon a Peace Officer with a Firearm, Aggravated Assault with a Firearm, Trafficking of Children for Sexual Purposes, Home Invasion, Negligent Homicide, Vehicular Homicide, First Degree Feticide, Second Degree Feticide, Third Degree Feticide

CATEGORY B: OTHER ASSAULTIVE/VIOLENT ACTS AGAINST PERSONS

Aggravated Battery, 2nd Degree Battery, Mingling Harmful Substances, Sexual Battery, Intentional Exposure to AIDS Virus, Simple Kidnapping, Aggravated Criminal Damage to Property, 1st Degree Robbery, Simple Robbery, Illegal Use of Weapons or Dangerous Instrumentalities, Stalking, Aggravated Flight from an Officer, 3rd Degree Rape, 2nd Degree Sexual Battery, Aggravated Arson, Purse Snatching, Extortion, Aggravated 2nd Degree Battery, 2nd Degree Robbery, Human Trafficking, Domestic Abuse Aggravated Assault

CATEGORY C: FELONY NARCOTICS

Distribution or Possession of Schedule I, II, III, IV, or V drugs

CATEGORY D: OTHER FELONIES

All other Felony charges not specifically enumerated in Categories A, B, or C

CATEGORY E: MAJOR MISDEMEANORS AGAINST PERSONS

Aggravated Assault, Battery of a Police Officer (Without Injury), Battery of a School Teacher, Battery of a Child Welfare Worker, Simple Battery of the Infirm, Domestic Abuse Battery, Assault on a School Teacher, Assault on a Child Welfare Worker, Negligent Injuring, Vehicular Negligent Injuring, False Imprisonment

CATEGORY F: OTHER MISDEMEANORS

All other Misdemeanor charges not specifically enumerated in Category E

CATEGORY G: VIOLATION OF PROBATION OR CONTEMPT OF COURT ORDERS

Specific charges of "Violation of Probation" (usually arrested by DJS or OJJ), or Contempt of Court

Revised: 8/5/15
E#: 158

APPENDIX 2 – MAYSI-2 and JIFF Administration Script

"You've come to the Juvenile Assessment Center because you got in trouble with the police. One of the things we do here is find out if you are having any problems we can help with. We do this by asking you to answer some questions on the computer.

There are two sets of questions. One takes about 10 minutes and asks you about how you may be feeling right now and in the past. The second one asks you questions about experiences in your life, your interests, and what you want to do in the future. It takes a little longer. If there is an area where we can help you, like at school, at home, or with friends, we want to know about that.

It helps to be as truthful as you can when you are completing both of these sets of questions so that we can get the right assistance for you. If there is any question that is not clear, just ask me and I will explain it. After you finish these, you can also ask any questions that you might have. I will stay nearby in case you have a question or want any help with the interview, but I will give you your privacy while you answer the questions.

These questions are not intended to get you into trouble – our hope is to know how to help you better. Your answers to these questions are confidential. Nothing that you tell us can be used against you in any juvenile or criminal court hearing. Results of the first program, the one about your feelings, may be shared with <<your probation officer>> and/or <<the detention center>>. For the second one, about experiences in your life and your interests, we will be using the results to tell your parent/guardian things you might need to help you, but we will not tell them your actual answers.

Do you understand? Do you have any questions? Let's begin."

"Here's the first one. It's called the MAYSI. You will see the questions on the screen and you will hear them read to you. For each question, answer 'yes' or 'no' as to whether the question has been true for you in the last few months. (Pick a holiday or date approximately two months prior so they have a reference point.) You may also see a couple of the questions that will ask if something has EVER happened to you.

Here's the second one. It is called the JIFF and it helps us know better how to help kids and their families. For most questions, you just select your answer, like 'yes' or 'no' and many allow you to type in a personal answer if you choose. Some of the questions might be uncomfortable. If you do not want to answer a question, you are allowed to skip that question by clicking the question mark (?) button twice. If you skip too many questions your interview will not be counted – and this would mean that you would have to start the interview over from the beginning."

> *Note: If administering the paper/pencil version of the MAYSI-2, point to the right side of the answer sheet, and instruct the child to circle 'Y' for 'yes' and 'N' for 'no'. Advise the child that there are more questions to be completed on the back of the page.*

APPENDIX 3 - YASI Pre-Screen Script

(Rev. 3/7/18)

This script is lifted largely from the YASI Administration Guide. If any clarification is needed please look to the Administration Guide or consult with a supervisor.
Static items will be in bold (static items refer to all previous behaviors and circumstances or both previous and current behaviors and circumstances).
Dynamic items will be in regular font (dynamic items refer to behavior and circumstances in the past 3 months.

Section 1: Legal History

Note: NO status offenses should be included in this section *regardless* of outcome.
YASI will ask whether current or past arrests were for felony offenses, weapon offenses, or offenses against another person (felony or misdemeanor) (for definition see Admin guide page 11).

1) Tell me about the event that brought you here today?

2) **Have you ever been in contact with the police before?**
    a. **What happened?**
    b. **How old were you?**
    c. **Was that the only time?**

3) **Have you ever been placed out of the home by a legal entity (ie. DCFS, probation, court)**

4) **Have you ever been in detention before?**

5) **Has there ever been a warrant issued for a failure to appear in court?**

6) **Have you ever had a probation violation?**

Section 2: Family

There is an option to check a box if *dynamic* family items do not apply to the client. An example of this would be if the youth is in a long term residential placement, detention or DCFS custody. However, if the family is still involved with the youth, you probably should not check this box. In this circumstance you can choose not applicable if you are unable to answer the question but may be able to answer other questions. If you choose to check the box saying the family items don't apply, the static items will still apply and those will still be generated by the YASI for you to answer.
There will be a section asking if there has ever been any court finding of child neglect. This is a question that is probably best *not* solicited through interview. Please check IJJIS and see if any of the other questions about supervision and parent/child relationships reveal the needed information.

1) **Have you ever felt like running away from home?**
    a. **How many times did you actually do it?**
    b. **How long did you stay away?**

2) **Have your parents ever threatened to kick you out of the house?**

   a. **How many times have they actually done it?**
   b. **For how long?**
3) Tell me about the rules that apply to you in your family?
   a. What actually happens if you don't follow the rules?
   b. How often does that happen?
   How much influence or control over your behavior would you say your parents have?
4) I'd like to ask you about the sorts of problems member of your family might have?

   a. **Does your mother, father, brother or sisters have any problems with mental health, drinking, drugs?**
      i. Were they ever hospitalized or received help for these problems?
      ii. How are they doing with these problems right now?
      iii. Has your mother father, brother or sisters ever had trouble with the law?
      iv. Has anyone in your family ever been arrested?
         1. What happened to them?
         2. Were they locked up? Where? Still?

Section 3: School

There is a check box at the top of the school section if some of the dynamic school items don't apply. Example, if the youth is no longer in school. This should not be an automatic response just because the youth is not currently enrolled in school. It applies to youth who are unlikely to ever return to school and should not be used if there is a plan for the youth to return to school. If they aren't currently in school and there is not a response to a question you may check "not-applicable".

1) I'd like you to tell me about your school life?

2) Are you currently enrolled in school?

3) Do you feel that you are happy in school? Tell me more about that?

4) How often do you go to school?

5) How often do you skip the whole day?
   a. How often do you certain classes?
   b. Why do you skip?

For question 3- this is measured by behavior reports and calls to guardians and law enforcement if you have access to the information. If you don't have that information or need to fill in gaps ask youth the below questions. Detentions, in school suspensions or other internal write-ups should be indicated as "infraction reported". Behavior involving a parent meeting or an out of school suspension is an "intervention". Don't include write ups or meetings around truancy because that was measured in item 2.

1) Tell me about any trouble that you might have gotten into at school?

2) What happened to you?

3) Who found out about it? Your parents? The police?

Now let's talk about grades

1) What kinds of grades do you get in school?

2) Would you say you have better than a C average?

3) Have you ever gotten any A's? Are you an honor student?

4) Are you in danger of failing any classes?

5) Would you like to be doing better at school or do you feel that you are doing just fine for now?

Section 4: Community and Peers

1) I want to talk about your friends now- tell me about them.

2) Do you hang out with a certain group of kids?

3) How would you describe them?
    a. Are they enrolled in school?
    b. Have they ever been in trouble with the law?
    c. Do any of your friends or family members belong to a gang?
        i. Do you belong to a gang?
    d. Do any of your friends help to keep you out of trouble?
    e. Do your parents like your friends?

Section 5: Alcohol and Drugs

Assess whether use has disrupted functioning in any of the four major areas: Education, Family Conflict, Peer Relationships, or Health. To see definitions of disrupted functioning please look at pg. 26 of the administration guide. Additionally a definition of contributing to behavior is on pg. 27.

1) What do you think about drinking and drug use?

2) Have you ever tried alcohol or other types of drugs?

If the youth has tried substances:

1) When did you start using or experimenting with it?

2) Tell me about what happens when you use alcohol or other substances?
    a. Have you had an accident?
    b. Gotten sick?
    c. Gotten in to an argument or fight while using?
    d. Had problems at school?
    e. Had problems at home?
    f. Have you ever had to see someone, like a counselor for your use of these?
    g. Do you think you have a problem with alcohol or drugs?

i. How often do you use?

Section 6: Mental Health Pre-Screen

Note: Any indication in any of the 7 items answer may indicated need for further assessment.

If possible ask both youth and parents about any history of taking medication or receiving counseling. If able to gain access to information from service providers to verify issue and confirm diagnosis and medication information.

If youth has been diagnosed as ADHD the diagnosis should be in the school section. Do not indicated the medication in this section.

Self-harming behaviors should be in the "Other" section. See the definitions in the Administration Guide for the "Mental Health Problems" asked about in Question 1.

When you get to section about abuse, include any history that is suspected whether or not it is substantiated, exclude reports that have been proven to be false. Abuse refers to a behavior that is perpetrated by a family member or by a person within the context of the family and home environment.

1) **What would you do if another kid got in your way?**
    a. **Pushed you?**
    b. **Punched you?**
    c. **Have you ever gotten really mad?**
        i. **Got into a fight?**
        ii. **How did it happen?**
        iii. **Have you ever wanted to destroy property?**
        iv. **Hurt an animal?**
        v. **Set fire to something because you were angry or in a bad mood?**
        vi. **Have you ever done it?**

2) **Have you ever had thoughts or feelings about hurting someone else?**
    a. **How recently?**
    Did you have a plan?
3) **Some kids get very down and sometimes they feel that life is not worth living- have you ever felt this way?**

4) **Have you ever had thoughts of harming yourself?**
    a. **Have you ever had thoughts of committing suicide?**

5) **Have you ever had a boyfriend or girlfriend? How old are they?**
    a. **What are they like? How do you spend your time together?**
    b. **Have you ever gotten into any kind of trouble because of sexual behavior or your feelings about it?**
    c. **Have you ever been bothered by your sexual behavior?**
    d. **Do you think you have any problems with your attitude towards sex?**

6) **Has an adult ever beaten you up?**
    a. **Who was it?**
        i. **Why**
    b. **How often?**

i. **Last time?**

c. **Has anyone ever tried anything funny with you sexually?**
   i. **Who was it?**
      1. **How often?**
      2. **Last time?**

7) **Many kids have had problems with other kids bullying them or assaulting them? Has this ever happened to you?**

8) **What about theft? Have you ever had anything stolen from you?**

9) **Did you ever feel someone was trying to take advantage of you sexually? Kind of insisting on sexual activity?**
   a. **Who was this? How did you feel about that and what did you do?**

Section 7: Aggression

1) **What would you do if another kid got in your way?**
   a. **Pushed you?**
   b. **Punched you?**

2) **Have you ever gotten really mad?**
   a. **Gotten into a fight?**
   b. **How did it happen?**
   c.

3) **Have you ever wanted to destroy property, hurt some animal, or set fire to something because you were angry or in a bad mood?**
   a. **Have you ever done it?**

Section 8: Attitudes

Use the information collected throughout the interview to respond to these items. Pull together this information from discussions that have occurred while in discussion about the different domains. See page 39 of the Administration Guide for further explanation.

To answer Consequential thinking skills questions here are some prompts.

1) Tell me about one good and one bad thing that has happened to you?

2) Why did it happen?
   What did you have to do with it happening?

3) What did you think might happened when you think about committing a crime or making a bad decision?

END

APPENDIX 4 – Child Trauma Screen (CTS) Script

For Child

Sometimes, people may experience upsetting events. We know that people who experience very upsetting or scary things sometimes have strong physical and/or emotional reactions to them, and these reactions may cause changes in how people think, act, and feel at home and school. I'd like to ask you some questions about things that you may have experienced and about some common reactions that people can have. Is that okay? Do you have any questions?

For Parent

Sometimes, people may experience upsetting events. We know that people who experience very upsetting or scary things sometimes have strong physical and/or emotional reactions to them, and these reactions may cause changes in how people think, act, and feel at home and school. I'd like to ask you some questions about things that your child may have experienced and about some common reactions that people can have to those experiences. Is that okay? Do you have any questions?

APPENDIX 5 – Report to the Court Outline

REPORT TO THE COURT OUTLINE
Revised 1/17/19

☐ FINS REPORT
☐ DELINQUENCY REPORT

SUPPLEMENT ATTACHED ☐
EVALUATIONS ATTACHED ☐

I. SOURCES OF INFORMATION USED:

List the persons and agencies interviewed and records reviewed to obtain the information contained in this report:

- ☐ Youth Interview
- ☐ Mother Interview
- ☐ Father Interview
- ☐ School Records
- ☐ School personnel
- ☐ Law Enforcement Records
- ☐ DCFS/Child Protection Worker
- ☐ DCFS Records
- ☐ Victim Interview
- ☐ Past Mental Health Records-From?_____
- ☐ Other relative interview: Relationship:_____
- ☐ Other Service Providers

II. DEMOGRAPHICS:

NAME:_____DATE:_____COURT SECTION:____

DOB:_____AGE:_____ DOCKET NO.:_____-JU-_____

ADDRESS:_____ PH:_____ SEX:

PROBATION OFFICER:_____SS#: XXX-XX-_____

HISPANIC/LATINO: ( ) Yes ( ) No ( ) Unknown

RACE (select all that apply): ( ) White/Caucasian ( ) Black/African-American ( ) Asian
( ) American Indian or Alaska Native ( ) Native Hawaiian/Pacific Islander ( ) Unknown

Physical Description: _____is approximately ____'____" tall and weighs ____ pounds.

He/she has a _____complexion, _____hair, and _____ eyes. Birthmarks, scars,

tattoos, piercings, or other distinguishing marks (list type and location):_____

Whenever possible, conduct interviews with the child alone, then the parent alone, then together. The numbers in brackets refer to the SAVRY risk/protective factor(s) that the question is associated with.

III. JUVENILE INTERVIEW:

Neighborhood:

In the neighborhood where you live is there a lot of crime and drugs? ( ) Yes ( ) No [16]

If Yes, what?_____

Is there anyone in your extended family or in your community who can help you out when you need it? ( ) Yes ( ) No If Yes, who is it, and what do they do to help?_____[P2]

Family:

If your parents live separately, how often do you see your other parent? _____

Do you feel you see both parents often enough? ( ) Yes ( ) No

Can you tell me about that? _____

How well do you get along with your parents? With your brothers and sisters?_____[15]

Do your parents (or guardians) know where you are and what you are doing most all the time? ( ) Yes ( ) No [14]

Do your parents/guardians discipline you or enforce rules in the same way? ( ) Yes ( ) No

Tell me more about that.):_____

How do they discipline you (for example, restrictions, sent to room, removal of privileges, physical punishment):_____

What things do you do with your family regularly? *(*e.g., eat dinner, go to sporting events, watch movies, etc.*)*_____

When you were growing up, were there a lot of physical fights in your family? ( ) Yes ( ) No

Did people in your family hurt each other a lot? _____[6]

When you were young – before you were 12 years old – did a parent or someone who was taking care of you ever abuse you or physically hurt you on purpose? ( ) Yes ( ) No [7]

Tell me more about that: _____

Before you were 12 years old – were there times when no one provided food, clothes or a room for you? ( ) Yes ( ) No Tell me more about that: _____ [7]

Has a parent or guardian ever been in trouble with the law? ( ) Yes ( ) No [8]

Tell me more about that:_____

When you were growing up, did you live in foster homes or group homes or did you live away from your parents? ( ) Yes ( ) No [9]

If yes, how old were you the first time this happened? _____

If no, have you *ever* been separated from your family for a long time? ( ) Yes ( ) No

How old were you the first time this happened? _____

What happened? _____

Peers:

Who do you hang out with? Are your friends the same age as you? [11]

_____

Have any of your friends ever been in trouble with the law? ( ) Yes ( ) No [11]

If Yes, what kind of trouble? _____

Have any of your friends ever been in trouble at school or done other things that would have gotten them in trouble if they were caught? ( ) Yes ( ) No [11]

If Yes, what kind of trouble? _____

What do other kids in your school or neighborhood think about you? _____[12]

Individual:

How do you feel after you do something you know is wrong even if you don't get caught? [21]

_____

Have you done things in the past that got you in trouble with the law (reassure them you're not going to arrest them and *probe about past offenses if they don't mention it*)? What were they? How old were you? _____[1, 2, 3, 3a]

When people get beat up or taken advantage of, do you usually think they had it coming? [17]

( ) Yes ( ) No If Yes, why? _____

Is threatening or force the best way to get what you want? ( ) Yes ( ) No [17]

If yes, when it is best to use? If no, explain what how you get what you want: _____

What do you usually do when something or someone makes you really angry? _____ [20]

Do other people think you have a problem with your temper? _____ [20]

How many times have you been in a physical fight or attack where the other person got hurt with cuts, bruises, broken bones, or worse, or could easily have gotten hurt? _____[1]

If you have been in fights, who usually starts the fights?_____

How old were you the first time you got into a serious fight? _____ [3]

What happened?_____

Have you been in a fist fight in the last six months? ( ) Yes ( ) No [1]

Do you get bullied, teased, or picked on by others? ( ) Yes ( ) No [12]

What happens? _____

School:

How important is school to you? _____ [24, P5]

Has a teacher ever told you to do something that you disobeyed on purpose? ( ) Yes ( ) No

If yes, tell me more about that: _____[17]

Do you have any career goals? What are they: _____

Mental Health/Drug Use:

Have you ever tried to hurt yourself or end your life on purpose? ( ) Yes ( ) No [5]

If Yes, what happened? _____

Have you ever used alcohol or drugs in the past? ( ) Yes ( ) No [19]

If Yes, what drugs? How old were you when you started using them? How often did you use them? Any problems (gone to school high, accidents or injuries, problems at home, trouble with the law, etc.)?_____

Do you currently use drugs or alcohol? ( ) Yes ( ) No If Yes, which drugs do you use? [19]

_____

Have you ever thought about getting help to stop using drugs and alcohol? ( ) Yes ( ) No [23]

When really bad things happen, do you deal with them better than others? ( ) Yes ( ) No [13]

What do you do when you feel stressed? _____

Over the past six months or so, has anything made you feel stressed or overwhelmed? [13]

( ) Yes ( ) No If Yes, what happened? _____

How have you been handling that? _____

Do you do things other people think are dangerous? ( ) Yes ( ) No [18]

If yes, what do you do?_____

Do you often have trouble staying focused when sitting in class or doing something that is not very fun? ( ) Yes ( ) No [22]

Are you easily distracted? ( ) Yes ( ) No

Do you frequently feel restless and have trouble keeping your body still? ( ) Yes ( ) No

If yes, tell me more about that: _____

Has a doctor, counselor, or therapist ever told you that you have ADHD (Attention Deficit Hyperactivity Disorder) or any other mental health problem? ( ) Yes ( ) No

If so, what did they tell you? _____

How does it work out when people try to help you or how do you think it will work out? If it doesn't work out, why doesn't it work out? _____ [23]

Coping Skills:

Is there an adult in your life that you go to when you need help, or that you would go to if you needed help? ( ) Yes ( ) No [P2]

What about that person that makes you feel that they might help you?_____

Are you able to talk your way out of bad situations? ( ) Yes ( ) No If Yes, how do you do it?

_____

Can you think of a time when something you did caused a problem for someone else or made them feel bad? ( ) Yes ( ) No If Yes, what happened? _____ [21]

IV. PARENT INTERVIEW:

Family Strengths and Weaknesses:

How does your child behave at home? _____

How does your child respond when told to do something at home?_____ [14]

What types of punishments and rewards do you use with your child in your home? Do you think they work? Does your child react to these punishments and rewards?] _____ [14}

Who usually disciplines the youth? _____ [14]

Are there any reliable adults in his/her life that he/she trusts and turns to for support and help? ( ) Yes ( ) No Please explain: _____ [15]

Does your child turn to these adults in times of stress or trouble? ( ) Yes ( ) No [15, P3]

Please explain answer: _____

Has your child ever witnessed aggressive behavior or violence in your home or the homes of your family and friends? ( ) Yes ( ) No If yes, please explain: _____ [6]

DCFS/Child Welfare Involvement: [7]

Is DCFS currently involved with your child? ( ) Yes ( ) No

Has a child welfare agency *ever* been involved with your child? ( ) Yes ( ) No

Date of first DCFS investigation: _____

Number of previous investigations by DCFS, if any: _____

Date of first confirmed/substantiated DCFS investigation, if any: _____

Has your child ever been placed out of the home by DCFS? ( ) Yes ( ) No

If yes, date of first placement: _____Placement Type: _____

How long was your child placed?_____

Is youth currently in a DCFS placement? ( ) Yes ( ) No If yes, where?_____

(Confirm using DCFS records whenever possible)

Juvenile's Personality Traits:

Does your child have problems with any authority or important figures in his/her life?

( ) Yes ( ) No If yes please explain: _____ [P4, 17]

How does your child react to difficult situations? _____[13]

How does your child cope with stress? _____[13]

Does your child ever seem to feel guilty when he/she does something wrong? ( ) Yes ( ) No

If yes, what does he/she do when feeling guilty? _____[21]

Does your child get angry easily? ( ) Yes ( ) No If yes, what does he/she do? _____

_____ [20]

Has your child ever threatened to hurt someone? ( ) Yes ( ) No [20, 1]

If yes, what happened? _____

Does your child believe crime and violence are acceptable? ( ) Yes ( ) No [17]

If yes, please explain? _____

Does your child tend to become aggressive or violent because of harmless situations?

( ) Yes ( ) No If yes, please explain: _____ [17, 20]

Does your child react or behave without thinking ahead or considering the consequences?

( ) Yes ( ) No If yes, please explain: _____[18]

Does your child engage in risky or dangerous behaviors? ( ) Yes ( ) No [18]

If yes, please explain: _____

Do you approve of your child's friends? ( ) Yes ( ) No If no, why not? [11]

Does your child currently use drugs or alcohol? ( ) Yes ( ) No [19]

If Yes, please explain: _____

Has your child ever had problems caused by drug or alcohol use? ( ) Yes ( ) No [19]

If Yes, what problems has your child had related to drug or alcohol use? (e.g., gone to school high, accidents or injuries, problems at home, trouble with the law, etc.)?_____

Have your child ever received help to stop using drugs or alcohol? ( ) Yes ( ) No [19]

If yes, please explain: _____

Does your child understand the need for treatment to help with his/her difficulties? [23]

( ) Yes ( ) No If yes or no, please explain: _____

Does your child have a positive attitude toward people trying to help? ( ) Yes ( ) No [P4, 23]

Please explain: _____

What are good things about your child? What is he/she good at?_____

What do you need from probation to help your child stay out of trouble? What kind of services would be helpful?_____

V. LEGAL HISTORY:

A. Present Legal Involvement:

_____is appearing in Court today for a Dispositional Hearing relative to a charge of _____

Enforcement Agency: ( ) JPSO ( ) GPD ( ) KPD ( ) HPD ( ) WPD ( ) OTHER: _____
Item #: _____

Date/Time of Arrest:_____

Location of Arrest:_____

Summary of

Narrative:_____

_____

_____

Juvenile's version of the incident: _____

_____

Impression of juvenile's empathy: Remorseful / Defiant / Indifferent / Other:_____[21]

Attitude of the parent toward the child's offense (Angry / Indifferent / Other): _____

Did the child spend time in detention? ( ) Yes ( ) No If yes, where?_____

For how many days? _____

Was the child placed on an ATD? ( ) Yes ( ) No If Yes, what ATD? Any violations?_____

Disposition of companion cases arising out of this offense:

Co-defendant:_____Charge(s):_____

Outcome of legal involvement, if any (Diversion, dismissal, probation, etc.):_____

Co-defendant:_____Charge(s):_____

Outcome of legal involvement, if any (Diversion, dismissal, probation, etc.):_____

Co-defendant:_____Charge(s):_____

Outcome of legal involvement, if any (Diversion, dismissal, probation, etc.):_____

B. Offense History:

History of Delinquency and Violence

_____has the following charges on record with the Jefferson Parish Department of Juvenile Services:

DATE	CHARGE	DISPOSITION

Age at first non-violent incident/offense? _____ Age at first violent incident/offense? _____

Prior charges for violent offenses? ( ) Yes ( ) No

Has the child ever been referred to Diversion relative to the current charge or a previous charge? ( ) Yes ( ) No [4]
If yes, did the child successfully complete Diversion? ( ) Yes ( ) No If no, why not?_____

Has the child been on probation in any other parish or state? ( ) Yes ( ) No [4]

If yes, for what charge(s) and what was the outcome?_____

_____

Has the child ever been involved in the Informal FINS program? ( ) Yes ( ) No [4]

If yes, when?_____ Intake Officer's name_____

What goals were established for the child and family?_____

What services did the child receive?_____

Did the child successfully complete the program? ( ) Yes ( ) No

If no, why not?_____

VI. VICTIM IMPACT STATEMENT (Delinquent Cases Only):

_____

Amount of monetary restitution recommended:_____Number of community service hours recommended:_____

V. DEVELOPMENTAL / MEDICAL / SOCIAL HISTORY:

Place of birth (City, state, hospital if known):_____

Birth: ( ) Full term with no complications ( ) Other ( ) Explain: _____.

Developmental Milestones: Age talked;____ age walked; ____, age toilet training completed;____ age bed wetting ended; ____, history of childhood enuresis/encopresis, if applicable,_____.

Medical History: _____

Present Medical/Physical Problems: _____

Current medications, dosages, and what the medications are prescribed for: _____

If female, is she pregnant? ( ) Yes ( ) No. (If yes and under 28 weeks pregnant, refer her to the Nurse-Family Partnership Program.) _____ _____

If male, has he fathered any children? ( ) Yes ( ) No _____

Medical Insurance:

Do parents have medical insurance? ( ) Yes ( ) No (If No, refer to LACHIP.)

If Yes, type of medical insurance: ( ) Private ( ) Medicaid/LaCHIP

Name of Insurance Company:_____

Policy No.:_____

Medical Provider:
Name:
Address:
City/State/Zip:
Phone #:

Traumatic Experiences/Events: _____

Has child ever been in placement or lived outside the home? ( ) Yes ( ) No

If yes, explain:_____

Marital Status of Biological Parents:
( )Legal ( )Non-legal ( )Married ( )Never Married ( )Divorced ( )Separated ( )Widowed
Deceased? ( ) Mother ( ) Father Date:_____
If married, how long? _____
If separated, when? _____
If divorced, how long? _____
Who has legal custody of juvenile? _____

Father's Name:_____DOB:_____
Address: ( )SAJ ( ) Other:_____
Phone: ( )SAJ ( ) Other:_____Work No._____
Place of Employment:_____ Occupation:_____
Income: $_____ ( )Monthly ( )Weekly ( )Hourly ( )Yearly
Educational level attained:_____
SS#: XXX-XX-_____ Remarried: ( )Yes ( )No. Number of marriages:_____
List pertinent information regarding father or spouse if remarried:_____

Mother's name:_____DOB:_____
Address: ( )SAJ ( )Other:_____
Phone: ( )SAJ ( )Other:_____Work No._____
Place of Employment:_____ Occupation:_____
Income: $_____ ( )Monthly ( )Weekly ( )Hourly ( )Yearly
Educational level attained:_____
SS#: XXX-XX-_____ Remarried: ( )Yes ( )No. Number of Marriages:_____

List pertinent information regarding mother or spouse if remarried: _____

( )Step-father ( )Step-mother ( )Legal guardian/relationship:_____

Name:_____DOB:_____
Address: ( )SAJ ( )Other:_____
Phone: ( )SAJ ( )Other:_____Work No._____
Place of Employment:_____ Occupation:_____
Income: $_____ ( )Monthly ( )Weekly ( )Hourly ( )Yearly
Educational level attained:_____
SS#: XXX-XX-_____ Remarried: ( )Yes ( )No. Number of Marriages:_____
List any pertinent information regarding this individual: _____

BROTHERS	AGE	ADDRESS/OCCUPATION
SISTERS	AGE	ADDRESS/OCCUPATION
OTHERS IN HOUSEHOLD	AGE	ADDRESS/OCCUPATION

Supplemental Income Reported:

( ) SSI Amount: $_____

( ) Welfare Amount: $_____

( ) Child Support Amount:$_____

( ) Food Stamps Amount:$_____

( ) Other_____Amount:$_____

Family Economic Status:

Self-Rating: ( ) Good ( ) Adequate ( ) Deprived

Family Physical and Mental Health History: (disease, mental illness, criminality, alcoholism, substance abuse, physical impairment, etc.) ( ) Yes ( ) No.

If yes, include who has the problem, type of problem and relationship to the juvenile's delinquency:

Maternal Family: _____

Paternal Family: _____

VI. EDUCATIONAL HISTORY:

Child's School: _____ Grade Level: _____

Address of School: _____

( ) Presently attending ( ) Not attending Reason: _____

Number of suspensions: _____

Reasons for suspensions: _____

Presently passing? ( ) Yes ( ) No

Subjects presently failing: _____

Grades failed: _____

Reasons: _____

PREVIOUS SCHOOLS	GRADES ATTENDED	REASON FOR LEAVING

Has child ever been in special education? ( )Yes ( )No
If yes, where? _____
Classification: _____
Year first classified as special education: _____
Date of most recent evaluation (I.E.P.): _____

VIII. EMPLOYMENT HISTORY:

Does the child currently have a job? ( ) Yes ( ) No

If yes, where? _____

Has he/she ever worked? ( ) Yes ( ) No

If yes, how did the child like work? What kind of an employee is the child? Did/does he/she get along with employers/bosses?_____

If no, why hasn't the child worked? Does he/she want to work? _____

IX. MENTAL HEALTH EVALUATION/TREATMENT HISTORY:

Has he/she ever been evaluated by:

Psychologist: ( ) Yes ( ) No Psychiatrist: ( ) Yes ( ) No School Board: ( ) Yes ( ) No

If yes, where and by whom:_____

Reason for referral or evaluation: _____

Has he/she ever been in therapy? ( ) Yes ( ) No.

If so where: _____ With Whom:_____

What did therapy address?_____

Has he/she ever been hospitalized for mental/emotional reasons? ( ) Yes ( ) No

If yes, where?_____

When?_____

Reason for hospitalization: _____

Why was child discharged?: _____

Aftercare recommendations: _____

Results of MAYSI-2 (If available):

Did MAYSI-2 indicate a 'Critical Case"? ( ) Yes ( ) No

If Yes, what scales were above Caution?_____

What scales were above Warning?_____

What response was taken?_____

X. PROSOCIAL ACTIVITIES:

Religion Affiliation:_____Church attended, if any:_____

Does parent(s)/guardian(s) attend church? ( ) Yes ( ) No If Yes, how often?_____

Does the parent(s)/guardian(s) want the child to attend church? ( ) Yes ( ) No

If Yes, PO shall make church attendance a condition of probation.

Does parent(s)/guardian(s)' church or neighborhood have a youth group program? ( ) Yes ( ) No

If Yes, PO shall make participation in a youth group a condition of probation.

Extracurricular Activities/Hobbies:

Have the child ever played organized sports or been involved in school or neighborhood clubs or organizations? ( ) Yes ( ) No If yes, which ones? How involved was the child in these activities?

_____

What does the child like to do for fun?_____

XI. RESULTS OF SAVRY FINDINGS (FINS and Delinquents):

(Complete SAVRY Coding Sheet and include 3a Early Initiation of Delinquent Behavior)

The following risk/needs factors were identified as definitely present and are contributing to delinquent behaviors:

Social/Contextual Factors

Factor # and Name	Rating (Mod/High)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Individual/Clinical Factors

Factor # and Name	Rating (Mod/High)
_____	_____
_____	_____
_____	_____
_____	_____

Protective Factors (Present)

_____
_____
_____
_____

	Need Area	Need Level	Services
1.		Mod / High	
2.		Mod / High	
3.		Mod / High	

(List highest and/or most critical three (3) risk/need areas from the Service Referral Matrix that is either HIGH or MODERATE, and the services recommended. If they are all low, write, "Results of the SAVRY showed Low in all Need Areas. No services are recommended at this time.")

According to results from the SAVRY, this juvenile presents as Low / Medium / High *risk for violence* at this present time. (See Sections XIII and XIV for Risk for Delinquency.)

SAVRY Summary Statement:

_____
_____
_____

XII. SUMMARY STATEMENT (Include summary of youth's conduct and/or caretaker(s) conduct contributing to misbehaviors, services needed for the youth or family, and of actions to be taken by the youth and family to adjust behaviors: _____
_____

XIII. RISK CLASSIFICATION (FINS): The initial SAVRY Summary Risk Score indicated the juvenile is at Low / Medium / High risk for future delinquency and will minimally require one face-to-face contact monthly / one face-to-face and one phone contact monthly / two face-to-face contacts monthly.

XIV. RISK CLASSIFICATION (Delinquent): The initial SAVRY Summary Risk Score indicated the juvenile is at Low / Medium / High risk for future delinquency and will minimally require one / two monthly contacts OR referral to the department's Intensive Supervision Probation program.

XV. RECOMMENDATIONS: After taking into consideration all the available information presented to the Office of Probation of the Department of Juvenile Services, the following are the recommendations made to this Honorable Court, including any special conditions of supervision:

A. _____ be sentenced to the Office of Juvenile Justice for an appropriate period of time and the sentence be suspended (Delinquent cases only);
B. That he/she be placed on active period of probation for an appropriate period of time; and,
C. He/she is to comply with all the general conditions, and the following special conditions, of probation.

	SAVRY RISK/NEED AREA: *Report TOP THREE MOST CRITICAL Risk/Need Areas on Report to the Court with treatment indicated.*						
	Disruptive Behavioral Problems	***Mental Health / Emotional Stability***	***Substance Abuse: Alcohol or Other Drugs***	***Family***	***Education / Employment***	***Peer / Pro-Social Activities***	***Community***
Relevant Items	***17, 18, 20, 21,22, 23***	***5, 13, 20, 22***	***19***	***6, 7, 8, 14***	***10, 22, 24***	***11, 12, 15***	***16***
LOW	***Low Risk indicates low probability of future violence and/or delinquent behavior. Enhance protective factors by actively recognizing strengths and strategically building upon pre-existing strengths. Remember,*** increased exposure to the juvenile justice system increases risk ***of low risk juveniles.***						
MOD	***Refer for individual/family therapy to target specific behaviors and, Common Sense Parenting, Triple-P, ART, MRT, or school-based interventions for behavior management. For behaviors related to grief/trauma, refer to TF-CBT and/or assess with trauma screen.***	***Obtain current MAYSI-2 report from Juvenile Assessment Center or refer for MAYSI-2 if more than 30 days since last MAYSI-2.*** ***If MAYSI report shows "Warning" for any two (2) scales, refer for psychological, and, if indicated, psychiatric evaluation if youth NOT currently engaged with community mental health.*** ***If diagnosed with mental illness, refer to JPHSA, psychiatric rehabilitation provider, or MST.***	***As per Juvenile Services Substance Abuse policy, juveniles with moderate score and no positive drug screens will be monitored accordingly.*** ***Juveniles with moderate score and one or more positive drug screens, refer according to DJS Substance Abuse Policy.***	***Consider parenting-skills therapy, such as Common Sense Parenting, Triple-P or family therapy. Use FFT with high ratings on disruptive behaviors or mental health. Refer to FFT-CW if history of abuse/neglect. Use EBFT for cases needing more social support or for youth 12 years old or younger.***	***Obtain educational evaluations, if available. Recommend tutoring through Volunteer Coordinator or school-based program. Monitor school behavior and attendance weekly with disciplinarian, teacher, or school counselor. Consider referring for A/BIT to coordinate interventions.***	***Possible services include social skills training and mentoring, such as MRT or ART. Increase positive social interactions by referring to faith-based organizations, youth groups, or JP Recreation Department activities.***	***Reduce impact of community risk factors by referring for MRT or ART.*** ***With high disruptive behavior scale and 16 years old or older, refer for individual therapy.*** ***If 15 years old or under, refer to family therapy or Common Sense Parenting to address neighborhood influences on disruptive behaviors. Refer for mentoring through Mentor Coordinator***
HIGH	***Possible need for psychological evaluation if mental health scale is moderate. Use individual/family therapy, MST, FFT,FFT-CW, EBFT, MRT, CBT or ART. For youths with high levels of traumatic response symptoms, refer to Project LAST.***		***Refer to Juvenile Services Substance Abuse Policy for referral to an appropriate level of treatment. Drug test youth minimally twice per month until the youth tests negative, then drug test minimally once per month. Consider substance abuse assessment using SASSI-A2.***	***Refer for Homebuilders if youth is at risk for removal from the home, MST, FFT, FFT-CW, or EBFT. If services ineffective, consider psychological evaluation to determine if out of home placement is necessary.***	***Engage juvenile in school-related services. After hour treatment may interfere with completion of homework, so be judicious in referring. If necessary, consider MRT. Also, consider adult ed., YCP, and/or alternative schools.***	***Consider intensive services, such as MRT, ART, or individual therapy targeted to social skills enhancement. Increase leisure activities and social skills. Utilize mentoring and consider after-school activities.***	***Engage parent/guardian in housing assistance programs, when available. Refer to peer refusal skills programs, such as in MRT and ART.***
Acronyms	***FFT=Functional Family Therapy; EBFT=Ecological-Based Family Therapy; MST=Multi-Systemic Therapy; MRT=Moral Reconation Therapy; ART=Aggression Replacement Therapy; MAYSI-2=Massachusetts Youth Screening Inventory-2; JPHSA=Jefferson Parish Human Services Authority; YCP=Youth Challenge Program; FBO=Faith=Based Organization; Triple-P=Positive Parenting Program; TF-CBT=Trauma Focused Cognitive Behavioral Therapy***						

APPENDIX 7 - SAVRY Items and Need Areas Worksheet

(Rev. 11/5/18)

SAVRY ITEM #	*ITEM LABEL*	*Low*	*Mod*	*High*	*Critical*
	Disruptive Behavior Problems				
17	Negative Attitudes				
18	Risk Taking/Impulsivity				
20	Anger Management Problems				
21	Low Empathy/Remorse				
22	Attention Deficit/Hyperactivity Difficulties				
23	Poor Compliance				
	Mental Health/Emotional Stability				
5	Self-Harm or Suicide Attempts (current)				
13	Stress and Poor Coping				
20	Anger Management Problems				
22	Attention Deficit/Hyperactivity Difficulties				
	Substance Abuse				
19	Substance Abuse Difficulties				
	Family				
7	Childhood History of Maltreatment (H) (think current)				
6	Exposure to Violence in the Home (H) (think current)				
8	Parental/Caregiver Criminality (H) (think current)				
14	Poor Parental Management				
	Education/Employment				
10	Poor School Achievement (H) (think current)				
22	Attention Deficit/Hyperactivity Difficulties				
24	Low Interest/Commitment to School				
	Peer/Pro-Social Activities				
11	Peer Delinquency				
12	Peer Rejection				
15	Lack of Personal/Social Support				
	Community				
	Consider protective factors				
16	Community Disorganization				

LEGEND: Shaded areas indicate Protective Factors. (H)=Historical (Mostly Unchangeable) Factors. ONLY CONSIDER THESE IN PLANNING IF PROBLEM PERSISTS


State of
Louisiana
Jefferson Parish