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Practitioner's Guide

Best Practices For Supervising

YOUNG ADULTS ON PROBATION OR PAROLE

Multnomah County Department of Community Justice

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Introduction

Overview for Practitioners

This comprehensive guidebook brings together best practices in the research literature alongside practical advice from subject matter experts to enhance the quality and effectiveness of probation for youth and young adults 15 – 25 years of age. Readers can use this report to target improvements in a specific area of practice or as a roadmap for a more wide-ranging overhaul of the complete supervision experience, from intake through transition planning.

Who Should Read This Guidebook?

- **Adult Probation or Parole Officers serving 15 – 25 year olds on their caseloads**
- **Juvenile Probation or Parole Officers**
- **Service providers/counselors working with young adults involved in the criminal justice system**
- **Researchers and academics in community corrections or juvenile justice**

Background

In 2015, the Multnomah County Department of Community Justice received a Smart Supervision grant through the Bureau of Justice Assistance to help identify and align a variety of emerging best practices in supervision. These best practice focus areas included the case management approach Effective Practices in Supervision (EPICS), trauma informed care (TIC), brain development science, and an Equity and Empowerment Lens (E & E Lens) with a racial justice focus. All of these focus areas are applicable to the supervision of 15-25 year olds, who are uniquely served in both the adult and juvenile supervision systems.

There has been a continued expectation that officers stay current on the latest trends in corrections research, as the field of Probation and Parole has evolved from the "Nothing Works" era of the 1970s to the age of evidenced-based practices that defines practice today. Yet challenges remain for officers who want to implement best practices. The literature supporting each practice area is vast and ever growing. Often, the broad research recommendations of experts are not translated into operational practices. Likewise, the practice of supervision itself is also broad. Many studies do not cover all of the activities that comprise supervision and thus leave gaps in daily practice.

This guidebook seeks to help address these challenges for policymakers and field staff working with 15-25 year olds on community supervision. Drawing on both research literature and practical advice from subject matter experts, we offer a comprehensive view of each focus area and list actionable steps for implementation. In some cases, experts provide contradictory advice to officers, which we highlight for transparency and to encourage more rigorous exploration in the field. The majority of recommendations overlap and align closely, making it possible to serve young adults with the best practices emerging from EPICS, TIC, brain development science, and the E & E Lens.

Methodology

Defining Supervision

In order to review best practices in community supervision, one first has to define what is meant by "supervision". It is commonly understood that parole and probation officers serve a variety of functions, ranging from law enforcement officer to social worker. This collection of activities needed to be defined and categorized in order to structure best practice recommendations for this guidebook.

To define supervision, we brought together 6 managers representing units who serve 15-25 year olds in both adult and juvenile supervision systems. Our goal was to determine categories that were common to supervision in both systems. A 90-minute work session was facilitated with the managers to brainstorm activities and then organize them into categories. Development of the categories was iterative, with managers brainstorming individually in a small group and then together with the entire group. Consensus was achieved using Technology of Participation (ToP) facilitation methods.

In total, 14 categories of supervision components were identified. Each of these categories were further developed into its own focus area for subsequent literature searches, key informant interviews, and practice recommendations.

Defining Current Practice

Throughout the guidebook, best practice is compared and contrasted with current practice (i.e., business-as-usual). This helps create context for the new recommendations and underscore needed shifts in operations. To better describe and understand current practice, we conducted a focus group with 8 parole and probation offers. Recruitment for this focus group was targeted to officers who were not associated with the BJA grant that funded this project, who therefore had not yet received any of the specialized training in best practices funded through the grant. Participation was voluntary and consent forms were collected. Participants received no compensation, but the groups were conducted on paid work time and refreshments were served.

The officers were split into two groups of four participants, with each group focused on describing their day-to-day work in the 14 categories of supervision as defined in the section above. These discussions were audio recorded and then transcribed. Descriptions of current practice were then coded and integrated into this guidebook.

Defining Best Practices

This guidebook looks across four practice focus areas: Effective Practices in Supervision (EPICS) case management, Brain Development Science, Trauma Informed Care (TIC), and an Equity and Empowerment Lens (E & E Lens) with a racial justice focus. Literature searches for each of these areas were conducted to include grey matter from general internet searches as well as peer-reviewed articles from academic journal databases. Articles were reviewed for both general content as well as recommendations pertaining to the 14 categories of supervision components identified by this project.

Many areas of supervision were not specifically addressed in the literature, although practice recommendations could often be inferred from broader recommendations in the results. To further fill these gaps, subject matter experts (SMEs) in each practice focus area were located and recruited for key informant interviews (see Appendix: Meet the Subject Matter Experts). Scripts for these interviews were developed around the 14 components of supervision defined by this project. Interviews lasted approximately 60 – 90 minutes. All conversations were audio recorded and transcribed. Specific practice recommendations were then integrated into this guidebook. Though a stipend was made available to SMEs who were eligible, none of the experts requested compensation. Each SME preferred to share their knowledge with the field through inclusion in this guidebook.

Focus Areas: Which Best Practice Areas Apply to Supervision?

This guidebook looks across four practice focus areas: Effective Practices in Supervision (EPICS) case management, Brain Development Science, Trauma Informed Care (TIC), and an Equity and Empowerment Lens (E & E Lens) with a racial justice focus. Literature searches for each of these areas were conducted to include grey matter and peer-reviewed articles from internet searches and academic journal databases. Articles were reviewed for both general content as well as recommendations pertaining to the 14 categories of supervision components identified by this project. To fill in gaps in the research, subject matter experts in each practice focus area were also recruited for key informant interviews (see Appendix: Meet the Subject Matter Experts). Specific practice recommendations from the literature and these interviews were integrated into the next section of this guidebook.

Effective Practices in Supervision (EPICS)

Effective Practices in Community Supervision (EPICS) was developed by the University of Cincinnati Corrections Institute, grounded in the principles of effective intervention and research on community supervision and implementation (Smith, Schweitzer, Labrecque, & Latessa, 2012). This model has been used in more than 80 state and local community corrections agencies since 2006.

The EPICS model of supervision takes a structured approach in face-to-face interactions between community supervision officers and clients. The model uses a Risk-Needs-Responsivity (RNR) methodology, prescribing higher treatment dosages of intervention to higher risk clients. By focusing on RNR, officers can divert resources from lower level clients, who are negatively impacted when dosages are too high, and concentrate those resources of time and services to clients who have a higher likelihood of reoffending. Supervision officers are also trained to focus on criminogenic needs and use a cognitive behavioral therapy approach to interrupt the criminogenic thought-behavior link that leads to repeat offenses. The model is further supported by systematically engaging supervisors and peer coaches in the supervision process.

An EPICS session consists of four steps:

1. **Check-in:** Corrections Supervising Officer works to build trust and rapport with the client, determine any acute needs that can be addressed to ensure client success, and assess the client's level of compliance with current court orders.

2. **Review:** CSO and client discuss the skills that were learned in the last EPICS session to determine whether the client has been able to implement those skills and to troubleshoot challenges in implementation.

3. **Intervention:** CSO helps the client learn new skills to overcome obstacles towards success, targeting the client's highest risk areas and teaching through a variety of methods, including role-playing.

4. **Homework:** CSO assigns the client homework to provide them with an opportunity to practice the interventions through writing exercises and any real-world applications.

Clients supervised by CSOs who adhere closely to the EPICS model have demonstrated significantly fewer incidences of recidivism (arrests and incarcerations) than those supervised by less adherent CSOs (Latessa, Smith, Schweitzer, & Labrecque, 2012). Developing a good relationship between CSOs and clients is also important, as clients in a trusting relationship with their supervising officer have had significantly lower rates of new crime arrests (Smith e al., 2012). Clients supervised by officers trained in EPICS also show reductions in antisocial attitudes and beliefs over time (Labrecque, Smith, Schweitzer, & Thompson, 2013).

Brain Development Science

Recently, juvenile justice researchers have been placing more emphasis on the role of brain development in youth criminality and recognizing that youth differ from adults in ways that are important to consider in the criminal justice system (Steinberg, 2017). As people age through adolescence, stages of brain development can influence their behaviors and decision-making. The prefrontal cortex is in a phase of development during this time, which leaves youth susceptible to poor choices as that part of the frontal lobe controls decision-making and impulse control (Toga, Thompson, & Sowell, 2006). The limbic system is also forming at this time, which influences the emotional regulation of youth in this age range and is responsible for mood swings and poor impulse control (Giedd, 204). As dopamine levels shift, adolescents find that they must seek riskier behaviors to achieve the same "high" they got in younger years (Spear, 2003). These aspects of brain development are crucial to consider for those supervising youth ages 15-25, as the prefrontal cortex and limbic system are continuously developing throughout this age range.

A series of key court cases in the 2000s reflect this evolving knowledge of brain development, particularly that youth are different than adults and have a capacity to grow and change. In Roper v. Simmons, the Supreme Court ruled that sentencing a minor to capital punishment is a violation of the eighth Amendment, due in part to the understanding that adolescents have higher risk seeking behaviors, lower impulse control, and a more difficult time coming up with alternatives compared to adults (Krause, 2015). Advancements in medical technologies have allowed more in depth understanding of brain development to inform criminal justice policy. For instance, in their amicus brief in support of Roper v. Simmons, the American Psychological Association pointed to brain differences between adults and youth found in magnetic resonance imaging. In Graham v. Florida, the Court found juvenile life without parole to be unconstitutional for youth who have committed non-homicide offenses. Citations in the decision referenced youth's limited behavior control due to brain region development and that life without parole does not allow a youth to demonstrate their capacity to change. In Miller v. Alabama, the Court ruled further that mandatory life without parole is unconstitutional for youth regardless of the type of crime they committed, citing research on youth brain development (Macarthur Foundation, 2017). Finally, in Montgomery v. Louisiana, the previous ruling of Miller v. Alabama was applied retroactively to youth previously sentenced in order to extend them the possibility of parole.

Differences between youth and adult brain development and culpability highlighted in Roper v. Simmons (Krause, 2015) include:

1. **Youth lack maturity and have less sense of responsibility which are associated with impetuous and poor decisions.**
2. **Youth have an increased susceptibility to negative influences and external pressures and a reduced capacity to control or leave their environment.**
3. **Youth have a less fixed character that is not as well formed as an adult's character.**

Trauma Informed Care

In the 1990s, Kaiser Permanente conducted a study to understand the connection between adverse childhood experiences (ACE) and risk-taking behaviors in adulthood. Researchers found that higher ACE scores were correlated with more risky behaviors and health problems in adulthood (Felitti et al., 1998). For example, trauma is closely correlated with substance abuse, poor impulse control, and heart disease. The orientation toward trauma informed care (TIC) emerged out of the awareness of childhood trauma and its impact on adulthood demonstrated by this study.

TIC is a framework of treatment and organizational practices that operates on the assumption that historical trauma affects seemingly unrelated facets of a person's thought patterns and behaviors. The five principles of TIC are:

1. **safety**
2. **trustworthiness**
3. **collaboration**
4. **empowerment, and**
5. **choice (Fallot & Harris, 2006).**

TIC seeks to provide support to people who have experienced trauma and the caregivers and practitioners who interact with them. Adherents to this framework understand that trauma can occur in many different circumstances and that trauma responses can manifest in numerous ways. Practitioners of TIC strive to interact with clients and coworkers in ways that will not lead to re-traumatization. TIC has been practiced in mental healthcare and is gaining momentum in education, physical healthcare, and criminal justice.

Guiding principles of TIC include the physical, mental, and emotional safety of everyone involved, organizational operations that promote trustworthiness and transparency, a spirit of collaboration and mutuality between staff and clients in decision-making, interactions that prioritize clients' empowerment, voice, and choice, and organizational services in line with the clients' cultural identities (SAMHSA, 2014). The use of TIC is associated with improved subjective and measured prevalence of health and chronic illness (Weissbacker & Clark, 2007). For children and adolescents in psychiatric care settings, TIC has also been associated with decreases in the use of restraints and seclusion (Azeem, Aujla, Rammerth, Binsfield, & Jones, 2011) and in counter-aggressive actions between youth and staff (Bloom et al., 2003).

Trauma is especially important to consider when working with adolescents and young adults in the community justice system. There is a strong correlation between trauma and justice involvement (Abram et al., 2004). Furthermore, justice system involvement risks re-traumatizing a youth (Ford, Chapman, Mack, & Pearson, 2006). For instance, shackling a client can be traumatic if the person experienced restraint as a part of their abuse. Observing a client during a urine analysis helps ensure accuracy, but for a victim of sexual abuse, such surveillance may be distressing. If a probation officer understands the fundamentals of TIC, community corrections can serve as a place of healing and regrowth instead and officers can communicate more effectively with their clients (Ko et al., 2008).

Equity and Empowerment Lens

The Equity and Empowerment Lens (E & E Lens), with a racial justice focus, is a transformative quality improvement tool used to improve planning, decision-making, and resource allocation and lead to more racially equitable policies and programs (Balajee et al., 2012). It is a set of principles, reflective questions, and processes that focuses on deconstructing issues in racial equity, reconstructing and promoting what works, shifting decision-making processes and approaches to equity work, and healing and transforming system structures, environments, and the people within them.

Racial equity refers to the fair and just distribution of resources and opportunities for individuals, businesses and organizations, and larger economic and social systems that are sustainable for all people (Balajee et al., 2012). It requires the meaningful engagement of communities of color in planning, decision-making, and evaluation processes to support shifts in perceptions and values. It also involves a long-term commitment to addressing the root causes of racism and barriers to racial equity among individuals, organizations, institutions, and systems.

The E & E Lens was developed by the Multnomah County Health Department in 2012. It was intended to help leaders and organizations examine conditions that promote or diminish equity and act to rectify inequities resulting from their policies, procedures, and practices. The E & E Lens is grounded in concepts of cultural humility (Guskin, 1991), targeted universalism (Powell, 2008), quality improvement, social determinants of health (Daniels, Kennedy, & Kawachi, 1999), and the socio-ecological model (McLeroy, Bibeau, Steckler, & Glanz, 1988) to identify and address inequities at individual, institutional, and systemic levels.

The E & E Lens is intended to:

- **proactively seek to eliminate inequities and advance equity**
- **identify clear goals, objectives, and measurable outcomes**
- **develop mechanisms for successful implementation**
- **pose questions about who would benefit or be burdened by a given decision, its potential unintended consequences, and who is involved in its development and implementation**

Equity and Empowerment Lens (continued)

The E & E Lens is formatted as a working logic model to support conversation about what transformative change involves to promote racial equity. It consists of a series of questions about different aspects of the organization in terms of its resources, activities, outputs, and outcomes within five domains (the 5 Ps) for quality improvement. After a topic (e.g., policy, decision, program, or practice) is selected for consideration by the model, it is described and the data or evidence that guides the topic is identified.

Then the following questions are considered and described within each of the 5 P domains:

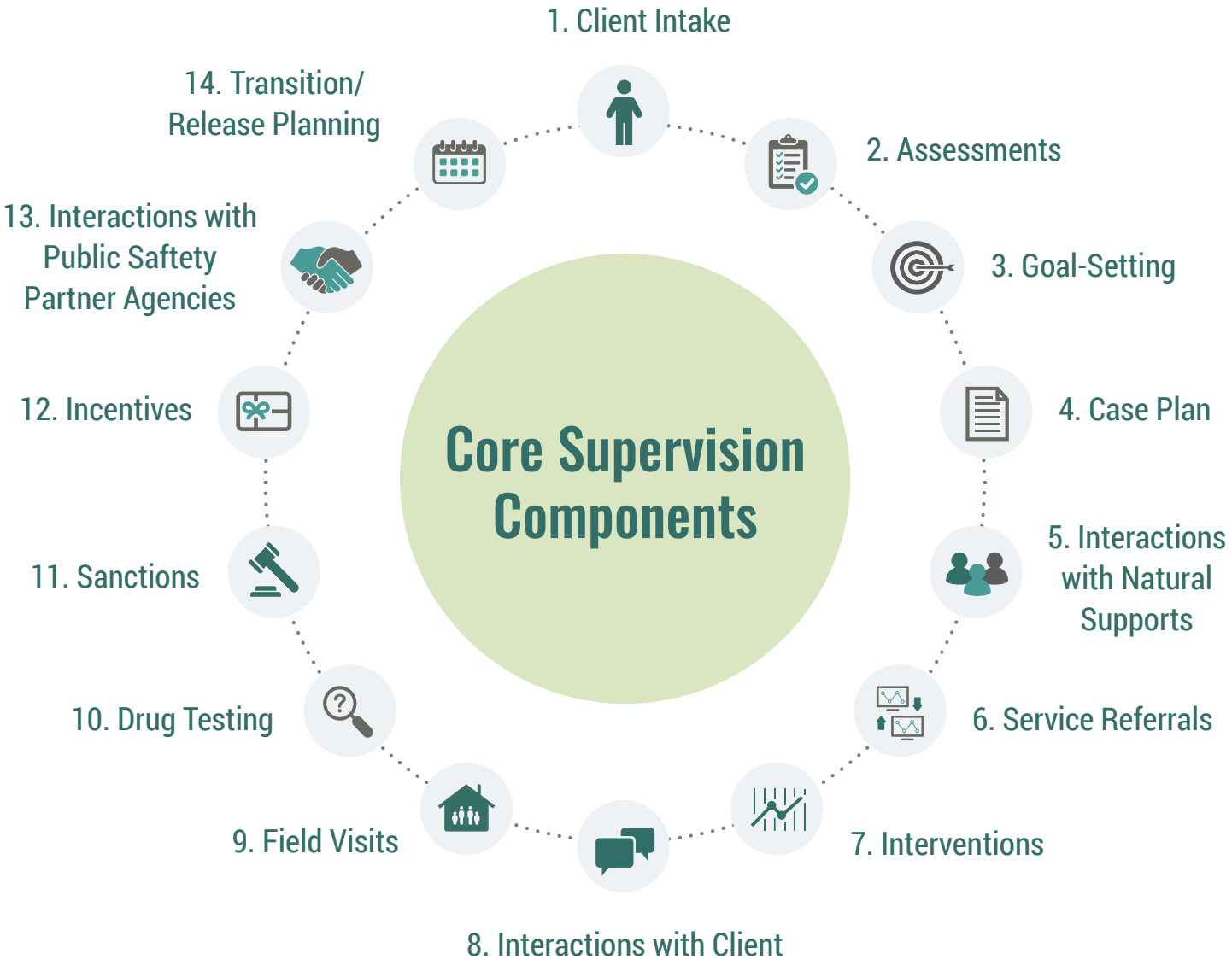
1. **People (e.g., groups that will be most affected by and concerned with this policy, who is positively and negatively affected by the policy and how)**
2. **Place (e.g., how are public resources and investments, such as funding, housing, education, and transportation, distributed geographically with respect to this policy)**
3. **Process (e.g., what barriers do staff face in making changes related to equity and racial justice)**
4. **Power (e.g., how does the policy build capacity in communities most affected by inequities)**
5. **Purpose (e.g., defining individual and institutional purposes to align all partners around transformative values, relationships, and goals that promote racial equity)**

Although the rate of youth commitments to juvenile facilities has decreased in the United States by close to fifty percent in recent estimates, racial disparities in the juvenile justice system persist. While rates of commitment declined from 2003 to 2013, the racial gap between black and white youth in secure commitment increased by 15% (Sickmund, Sladky, Kang, & Puzzanchera, 2015). Youth of color remain much more likely than White youth to have contact with police and to be arrested (Crutchfield, Skinner, Haggarty, McGlynn, & Catalano, 2009), to be detained preadjudication and to be adjudicated delinquent (Leiber, 2013), and to receive disproportionately punitive treatment (Engen, Steen, & Bridges, 2002). African American, American Indian, and Hispanic youth are particularly over-represented at each stage of the criminal justice system.

Detention puts youth at greater risk of experiencing mental illness, failing to return to school after release, reduced success in the labor market, and further engagement in delinquent behavior (Holman & Ziedenberg, 2006) and youth incarceration can further impair health into adulthood (Barnert et al., 2017). The negative impacts of detention on youth's mental and physical well-being and deficits into adulthood make this a key issue to address and reduce unnecessary disproportionate contact at every stage of the juvenile justice system for youth of color.

Defining Supervision: What are the Components of Supervision?

This section lists the categories of supervision that were identified as common to both adult and juvenile supervision systems. These categories were iteratively developed in a 90-minute facilitated work session with a group of probation managers whose units supervise 15-25 year olds in either the adult or juvenile supervision system (see Methodology: Defining Supervision). In total, 14 categories of supervision components were identified. The components are listed below and the traditional practices for each component are described in more detail in the next section of this guidebook.



Defining Best Practices: How to Apply Best Practice Focus Areas to Supervision

This section compares and contrasts traditional practice (i.e., current or business-as-usual practice) with best practice recommendations. First, the specific details of the day-to-day work involved in supervision are for each of the 14 categories of supervision identified in this project. These details were gathered from a focus group with 8 parole and probation officers (see Methodology: Defining Current Practice). Next, specific practice recommendations are listed for each of the four focus areas identified as salient to the supervision of 15-25 year olds. These recommendations were integrated into this guidebook based on information gathered from the literature searches and key informant interviews with subject matter experts (see Methodology: Defining Best Practices). These practical tips for fieldwork provide information on how to tailor the practice/apply best practices from each of the four focus areas to each supervision component.

Practical Tips for Fieldwork

1 *Client Intake*

Traditional Practice

- Focus on clarifying roles and responsibilities
- Understand the client's criminal risk level
- Determine where the client will be supervised
- Treat the client as a person
- Establish goals and values
- Inform the client of conditions and what they need to do to get off of supervision

Best Practice Focus Area	Recommendations
EPICS	• Allow trust-building to begin at the first meeting • Begin relationship building skills, motivational skills, and role clarification skills • Administer paperwork in a professional manner
Trauma-Informed Care	• Catalogue traumatic events and known stressors • Catalogue how the client responds to stress and their coping mechanisms • Highlight the client's strengths
Brain Development Science	• Try to determine whether the client can read required paperwork and comprehend instructions - Provide assistance if needed - Break information down into manageable amounts, tailored to the client's reading level • Make the physical environment as stress-free and informal as possible
Equity & Empowerment Lens	• Note any barriers to service a client may face • Provide cultural context whenever possible • Value and reflect the client's identity • Be mindful of how the client experiences interactions and of language used • Do not judge clients by their worst day • When possible, have some similarity in lived experiences (e.g., understanding of historical context, norms, and values) for staff who work closely with clients

2 Assessments

Traditional Practice

- Look for previous assessment materials on the client
- Explain the risk assessment process to clients
- Conduct required risk assessment tools
- Record assessment information

Best Practice Focus Area	Recommendations
EPICS	• Use evidence-based practices in assessment to ensure reliable measures • Conduct a brief check-in with the client to identify and address any acute needs • Maintain continuity of officer relationship with client from intake if possible - Having the supervising officer conduct the intake may increase their investment in the accuracy of the assessment, as their relationship with the client will have begun before the risk assessment • Conduct a risk/needs assessment, as EPICS does not require risk/needs/responsivity - Responsivity is first on the list when working with a client to address immediate needs though, as other changes will not likely happen until barriers to treatment are addressed • Match dosage to risk level - Higher risk clients receive higher dosage - EPICS is intended for moderate- to high-risk clients - If the client is high risk across the board, prioritize the top four areas: attitudes, values, beliefs, and peers/antisocial personality traits
Trauma-Informed Care	• Be aware that if the crime stemmed from an event that was traumatic for the client, they may feel fearful and anxious • Do everything possible to ensure that the assessment process does not re-traumatize the client • Practice self-care as an officer to ensure they themselves do not suffer from secondary trauma • Provide the tools and support needed for self-care to officers by the supervision unit through training and assessments

2 Assessments (continued)

Brain Development Science	• Conduct assessments in a neutral space to prevent additional stress • Clients should be asked about trauma at birth, which can affect brain development • Keep the differences between youth and adults in mind when conducting assessments - Young adults have a heightened sense of risk that tends to decrease with age, so RNR assessments should be periodically re-administered with young adults - Teenagers cannot fully grasp the consequence of their actions, so they may show less remorse or have more trouble accepting the outcome as fair than older clients
Equity & Empowerment Lens	• Use cultural context when conducting assessments - Activities that are counter to mainstream societal norms may fall into acceptable behaviors for the client's culture • Have translator on hand who can understand the contextual language of the client's culture

3 Goal-Setting

Traditional Practice

- Connect goals to risk assessment tool
- Create both short- and long-term goals
- Talk with clients about their goals and motivations
- Try different goals for different client situations
- Know that goals are fluid and dynamic over the course of the case

Best Practice Focus Area	Recommendations
EPICS	• Align goals with the client's individual needs and outline the consequences of failing to meet goals • Build a collaborative relationship with the client - A collaborative relationship is a necessary but not sufficient condition of acting as a change agent • Support goals with interventions and role-playing • Offer flexibility in the time and day of office visits, but insist on a prescribed frequency and duration - May be able to have flexibility in where community service is completed
Trauma-Informed Care	• Frame goals positively. Focus on desired behavior, not on the behavior the client is trying to overcome • Build goals around client strengths • Set goals in collaboration with the client's natural supports if possible
Brain Development Science	• Provide short-term, attainable, concrete goals • Clearly outline consequences of behavior • Acknowledge the difficulty in upholding goals when away from the supervising officer and with peers • Ask about the client's cognitive functioning and learning style to tailor goals and goal tracking to the best methods for client success • Support the goal with role-playing - For this age range, the brain operates differently when situations have any emotional valence, so a role-play that elicits even a semblance of that real-life valence will give the client the opportunity to practice the needed skill
Equity & Empowerment Lens	• Set goals in collaboration with the client's natural supports if possible and ideally with the client's voice - Goals should be culturally appropriate • Use a translator when possible who understands the contextual language of the clients

4 Case Plan

Traditional Practice

- Review the results of risk assessments and share those results with the client
- Discuss and decide the focus area(s) for the client over the next 6 – 12 months
- Establish goals for the client that align with the focus area(s)

Best Practice Focus Area	Recommendations
EPICS	• Write the case plan in clear language • Build in accountability - Define goals, define what success might look like and what failure might look like, and identify some potential consequences of success and failure • Build plan based on the prioritized criminogenic needs from risk assessment - If there are many competing needs, focus on the top four: attitudes, vice, beliefs, and peers/antisocial personality characteristics • Identify the need area and identify a goal for targeting in that need area • Case planning should be collaborative between the officer and client • Include both long-term goals (like heroin abstinence) and short-term goals to help reach them
Trauma-Informed Care	• Resist shame-based descriptions of the client • Have outcomes for the victim to encompass their rights as well • Focus on short-term successes • Make sure the client understands the case plan and can repeat it to the officer • Make sure the client understands the consequences of not following through with the case plan • Give the client some control over who is and is not allowed to see their records if possible
Brain Development Science	• Create concrete goals and outcomes • Clearly outline consequences of behavior
Equity & Empowerment Lens	• Write the case plan using clear language that is understood by all members of the team • Include natural supports in the case plan where appropriate • Include culturally specific providers as a best practice

5 Interactions with Natural Supports

Traditional Practice

- Determine if collaterals are natural supports or enablers
- Deal with outsider expectations of what supervision consists of
- Negotiate client privacy while trying to engage support from collaterals

Best Practice Focus Area	Recommendations
EPICS	• Build collaborative relationship with support people along with client (if possible) - Natural supports can provide help and accountability - Start with the client and then add family members to EPICS sessions • Train family members on the types of changes the client is trying to make (if possible) • Teach family members how to recognize anger triggers • Teach family members how to prompt the client to use new skills and how to give positive reinforcement when the client uses new skills
Trauma-Informed Care	• Understand that the client may have had a traumatic relationship with natural supports • Communicate with natural supports through a trauma informed lens, as they may have high levels of trauma or adverse childhood experiences themselves - People who have had trauma draw on past experiences to make decisions and those decisions are made with an eye to self-protection • Pay attention what trauma looks like in different regions • Take accountability for the role the organization has had in historical trauma • Have training for officers to recognize signs of trauma in natural supports • Have an open and transparent conversation if the natural supports have caused or allowed trauma for the client - Certain people can be supportive in one area and not in another, so it is important to determine what supports are and are not available • Provide clients and supports with choices that are actual choices, can be given, and are not coercive - Be aware of the power dynamic when offering choices - Provide three choices whenever possible (e.g., coffee, tea, or water are three choices that can be offered and fulfilled)

5 *Interactions with Natural Supports (continued)*

Brain Development Science	• Provide learning resources to help natural supports understand brain development, its effects on youth, and how to set appropriate boundaries from this perspective - Although poverty can alter the brain development of adolescents (e.g., leading to less grey matter in the hippocampus, frontal lobe, and temporal lobes), behaviors by parents may be able to off-set those changes
Equity & Empowerment Lens	• Learn basic words of the language and know basic norms of the client's culture as an officer • Have translators on hand who speak the language of the family and understand the context of the words

6 Service Referrals

Traditional Practice

- Link services to the case plan
- Consider using mentors to help clients navigate services
- Prefer services co-located in the offices
- Negotiate Releases of Information (ROIs) with providers
- Know there is a lack of access to information on the outcomes of service providers

Best Practice Focus Area	Recommendations
EPICS	• Partner with outside community health agencies - Provider knowledge of EPICS is helpful but not required • Ensure that mental health professionals use cognitive behavioral therapy when appropriate
Trauma-Informed Care	• Work with service providers who are trauma informed - Look for sites that have low turnover and value continuity of care
Brain Development Science	• Work with service providers who understand or specialize in working with this age group • Work with service providers who understand the neurological causes of impulsivity and addiction disorders • Address mental health and substance abuse issues before employment or housing referrals • Ideally, provide mental health, substance abuse, and family counseling each by a separate provider or therapist
Equity & Empowerment Lens	• Contract with a diverse group of services who have cultural humility towards their clients • Ensure the service provider is culturally compatible when needed

7 Interventions

Traditional Practice

- Plan interventions to do with a client
- Conduct the intervention with client
- Record client participation in the intervention
- Follow up with intervention progress

Best Practice Focus Area	Recommendations
EPICS	• Work with providers who practice cognitive behavioral therapy techniques to promote pro-social behavior • Work with providers who practice a strengths-based approach when interacting with the client • Work with providers who use praise and encouragement when appropriate
Trauma-Informed Care	• Open a line of communication between the supervision officer and service providers with the client's permission if possible - This open communication could reduce noncompliance or re-traumatizing the client in response to trauma • Alert each member of the service team (supervision officers and providers) to known triggers and new traumas that have occurred
Brain Development Science	• Teach young adults about brain development to help them learn why they make the choices they do and provide knowledge to help them change their own behaviors • Understand that interventions may have to occur more than once for the same topic, as the developing brain requires repetition to solidify learning
Equity & Empowerment Lens	• Contract with a diverse group of service providers who have cultural humility towards their clients • Ensure the service provider is culturally compatible when needed

8 Interactions with Client

Traditional Practice

- Try to develop rapport at each meeting and ask clients how they are doing
- Make sure your greeting is respectful and you address the client in the way that they prefer
- Assess if a client is in crisis
- Pay attention to what the client says, but also attend to non-verbal cues
- Follow up with any homework or issues from the previous meeting

Best Practice Focus Area	Recommendations
EPICS	• Use the 4-step intervention model with each client interaction: - Check-in: Assessment, rapport building, compliance inquiry - Review: Progress report, problem-solving of challenges to skill-building goals - Intervention: Needs and risks identified, trends discussed, role-playing - Homework: Assignment designed to bring skills learned to client's real world situations • Teach clients the behavior chain and use cognitive restructuring to promote prosocial behaviors - Officer takes on a helper role and an accountability role • Use Cost-Benefit Analysis exercises with clients to help encourage prosocial decision making • Work with the client to ensure the client is aware of the value of the skill when skill-building
Trauma-Informed Care	• Offer a wide variety of physical space options to provide for clients' needs (e.g., lighting, noise level, movement) • Pay attention to client body language • Check in to make sure the client is engaged with the process and is not in distress • Ask the client's permission when appropriate before giving advice or suggestions • Use cognitive behavioral therapy when applicable • Use role modeling to promote prosocial behaviors • Use redundancy when teaching new skills • Give as much information as clearly as possible with the goal of promoting trust and compassion - The activated brain does not respond well to vague information, but needs full details and clear choices

8 *Interactions with Client (continued)*

Brain Development Science	• Use role-playing in skill-building and tie the role-playing to situations that have real life significance for the client in order to aid in the client's learning and retention of the skills • Link new skill-building exercises to previous ones, as linking lessons together helps increase retention • Use the client's learning style in skill-building whenever possible • Stimulate the senses to enhance learning (e.g., through sight, hearing, touch)
Equity & Empowerment Lens	• Use topics that are culturally relevant • Check body posture and language to ensure the officer is not giving any indications of discomfort from the perspective of the client's cultural lens

9 Field Visits

Traditional Practice

- Plan for officer safety
- Check for warrants and what is known about the location pre-visit
- Plan a route and wear appropriate gear (e.g., uniform)
- Be clear on the purpose of your visit
- Communicate about your visit with dispatch, a partner, your supervisor, and other agencies

Best Practice Focus Area	Recommendations
EPICS	• Use as an opportunity for skills-building practice - EPICS can be used anywhere - If in the client's home, possibly do some role-playing and problem solving with both the client and family members/friends • Refer to the progress report for topics of skill-building • Tailor the frequency of field contacts to the client's risk level
Trauma-Informed Care	• Prepare for the field visit as an officer by reminding themselves of the client's traumas and triggers before embarking on the field visit • Give clear guidelines to the client about the visit, including what will happen during the visit, what rooms they will visit, and approximately how long the visit will take - Keep in mind that a field visit may take place at a site of past trauma and this may cause the client to shut down or be more combative than usual - The client may be very scared and resistant to let the officer into their home • Give the client a chance to ask questions about the field visit process before and during the visit

9 *Field Visits (continued)*

Brain Development Science	• Help clients identify aspects of their environment that make them more susceptible to risk • Do not arrive in uniform with a weapon, as that will set off stress due to concerns about peer judgment and ostracism • Collaborate and negotiate with the client about where to meet • This does not cede power on the part of the officer because they have the right to say no • Try to promote youth success outside of the family if possible - Family is likely not very relevant to people in this age group - Family members may be engaging in similar behaviors that the client cannot separate from
Equity & Empowerment Lens	• Inform decisions about site visits with information about the client's community and its contexts • Enter the client's home with respect and honor their cultural norms • Ideally allow the client to pick the location for field visits that works best for them - Give a range of different location options rather than leaving it as an open-ended question, as the frustration of trying to agree on a location may lead back to the original option by default - Building a relationship with the client will help in a lot of these decisions • Use knowledge of client's cultural circumstances to build a preliminary profile of the client before making decisions about case management

10 Drug Testing

Traditional Practice

- Decide when to test clients
- Choose the method for testing (urine or oral mouth swab)
- Observe specimen collection for accuracy
- Communicate the frequency of drug testing to judges and crime victims
- Decide how to respond to test results

Best Practice Focus Area	Recommendations
EPICS	• Explain the reason for the drug test and thank the client for compliance • Officer takes on a helper role and an accountability role - In this task, the officer is holding the client accountable, but they can also help the client by ensuring the client knows what is expected - Officer should be courteous and professional throughout • If the test shows substances are present, express disapproval of the action - Do not use drug treatment as a sanction - However, the sanction should be connected to the violation, and the connection should be spelled out • Officer can use Cognitive Restructuring to help the client succeed going forward
Trauma-Informed Care	• Clearly explain the reasons and procedures for the collection • Use mid-stream collection as an effective and less invasive screening practice than other approaches - Best practices for accurate screening such as supervision of the testing (clothing removal, bodily inspection, cough requirement), and asking client to squat and cough can re-traumatize clients who have suffered abuse • Emphasize that testing is part of the therapeutic model and is not a punishment • Ensure the officer doing the collection is professional and gender-appropriate and provide ongoing training to and accountability of officers in this regard • Use non-stigmatizing language - For example, refer to drug tests as “positive” or “negative,” instead of “clean” or “dirty”

10 Drug Testing (continued)

Brain Development Science	• Clearly articulate the reason and procedures for testing • Consider age as a factor in this aspect of supervision - Teenage boys are more impulsive and at higher risk of substance abuse • Rewards can be more effective than punishment, so frame as a therapeutic tool
Equity & Empowerment Lens	• Pay attention to implicit bias that may influence who is given a urinalysis test - Frequent, mandated, surprise screenings can negatively impact low income workers, those who lack adequate transportation, or parents in need of childcare

11 Sanctions

Traditional Practice

- Sanction based on the client's behavior as soon as possible
- Consider the array of sanction options and try to match to behavior observed
- Complete required reports and get supervisor approvals
- Provide notice of rights to clients

Best Practice Focus Area	Recommendations
EPICS	• Give a warning before a sanction if possible • Act swiftly to administer the sanction as close to the time of the offense as possible • Administer sanctions each time the offense is made - Sanctions should be consistent and consistently enforced • Connect the sanction clearly to the violation and specify what is objectionable about the behavior to avoid misunderstanding • Encourage the client to reflect on the short- and long-term consequences of the behavior and problem solve with the client to identify prosocial strategies for avoiding the behavior in the future • Do not follow the sanction with a reward, but instead space them out • Interventions for change should not be used as sanctions
Trauma-Informed Care	• Deliver sanctions without shaming language - Use compassionate accountability and help the client process why the behavior might have occurred - Speak to clients in a way that helps them cool off, gives them the words for an outburst or action driven by cortisol from fear or rage, and provides tools to avoid it in the future • Clearly connect the sanction to the violation and explain the connection in detail to avoid misunderstanding • Use caution with sanctions such as GPS and community service - Sanctions can bring up past and generational traumas, such as evoking shackles with GPS monitoring - Take care that community service is not to take place where the client may encounter past abusers • Respect the client's understanding of the truth even if it differs greatly from that of the officer by avoiding words like "lie" and "truth" • Provide a list of trauma resources to the client and try to make sanctions as trauma-free as possible

11 Sanctions (continued)

Brain Development Science	• Clearly connect the sanction to the violation and explain the connection in detail to avoid misunderstanding - Sanctions should be consistent and consistently enforced - Delaying a sanction allows the client to feel like they have gotten away with something, so immediacy here is best
Equity & Empowerment Lens	• Consider the social and geographic location of the client when choosing a sanction - Sanctions should not be culturally insensitive • Take care that sanctions do not place undue burden on the client or their natural supports

12 Incentives

Traditional Practice

- Provide lots of positive verbal reinforcement when the officer observes the client doing something right
- Know there is disagreement among officers on whether tangible rewards are useful or how they should be used in supervision
    - Bus tickets, hygiene kits and snacks are frequently used as tangible incentives
    - It is uncertain whether providing service referrals and bus tickets to clients is considered a reward or incentive

Best Practice Focus Area	Recommendations
EPICS	• Use positive verbal reinforcements right away, explain why the behavior is worthy of praise, and have the client think about the use of praise and what earned it • Use low-cost incentives when possible • Learn what motivates individual clients and tailor reinforcements to them when possible • Use social reinforcements - These could include praise, expressed approval, and increased positive attention • Use a 4:1 Reward to Sanction ratio and effective reinforcement - The type of reinforcement does not matter
Trauma-Informed Care	• No guidelines are provided for incentives in this area - A tangible show of gratitude without connecting it to desired consequences fits better with this area (e.g., passing a bag of treats while thanking clients for showing up) - Incentives can be tied to fear and shame if the client was previously asked to keep a transgression quiet in exchange for a reward (e.g., "I will give you a cookie if you don't tell")

12 *Incentives (continued)*

Brain Development Science	• Incentives can be an effective way to promote prosocial over antisocial behaviors - Learned antisocial behaviors can produce dopamine and endorphins, so rewarding positive behaviors can have similar effects and increase the desire to conduct prosocial behaviors • Use rewards as an immediate response to behavior - Rewards should never be taken away as a sanction later • Ideally, implement rewards in a meaningful way for this age group - For example, install an app on the client's phone that gives them points or coins when they have made progress towards their goal and use the app as a tool during check-in
Equity & Empowerment Lens	• Learn what motivates individual clients and tailor reinforcements to them when possible • Use social reinforcements that take the client's cultural environment into account - These could include praise, expressed approval, and increased positive attention

13 Interactions with Public Safety Partner Agencies

Traditional Practice

- Prepare different types of information updates about a client depending on the partner agency
  - Prioritize communication to treatment providers regarding how the client is attending supervision and treatment appointments, the quality of participation in treatment, and drug test results
  - Prioritize communication to the courts regarding compliance with supervision conditions
  - Prioritize communication with law enforcement regarding where people live, who they are spending time with, and new crime violations

Best Practice Focus Area	Recommendations
EPICS	• Client advocacy can be seen as a low-cost reinforcement tool • Educate Public Safety Partner Agencies in the EPICS model
Trauma-Informed Care	• Educate Public Safety Partner agencies on trauma informed care if needed • Ensure that adjudicating bodies are aware of new or recurring traumas by including these agencies on the communication circuit with the client's service providers • Train people in trauma education statements so they can be more comfortable advocating and do not have to feel like they are experts in trauma (e.g., "You know what we know about trauma?") • Train judges to help de-escalate emotions, as they have the power and therefore the are the least activated in court - Advocates become activated when they enter the courtroom or interact with attorneys, which can lead them engage in self-protection and pass down or blame the issue on the client so that the advocate can save face or because the advocate's perception of facts is hindered due to activation

13 Interactions with Public Safety Partner Agencies (continued)

Brain Development Science	• Present brain development literature to authorities when appropriate • Conduct a formal client evaluation before court hearing - Many kids make it through their school years without being evaluated for intellectual disabilities or other functioning issues • Prepare clients for their courtroom appearances by taking them into court and showing them the layout, letting them sit in on a public hearing if possible, and telling them what to expect • Educate the judge on the impact environment has on brain development and decision making
Equity & Empowerment Lens	• Have translators on hand who speak the contextual language of the clients • Explain the judicial process in small steps and plain talk, letting the client know what to expect at each meeting. • Allow natural supports to attend all meetings, if appropriate.

14 Transition/Release Planning

Traditional Practice

- Use discretion in transition planning
  - There is generally no structured, formal process for transitioning clients
  - Transition planning is typically informal
  - Some specialty caseloads may have a completion ceremony, but this is not traditional practice
- Choose whether or not to recap the progress a client has made over the course of supervision at the last scheduled meeting

Best Practice Focus Area	Recommendations
EPICS	• Connect the client to long-term social services that can help ease the transition and ensure future success • Praise good behavior in later EPICS meetings when the client is doing well - This is often missing in later meetings but is a necessary part of the model for long term success • Implement graduated practicing of skills so the client can recognize risky situations and act accordingly - For example, practice how to cope when friendships are disrupted because of the client's new behaviors
Trauma-Informed Care	• Ensure the client has supports in place to continue to succeed, even when immersed in familiar environments that may have trauma triggers • Work with the client to come up with a list of prosocial coping mechanisms to employ when under duress
Brain Development Science	• Work with the client to create concrete, manageable goals • Use the client's learning style when giving them information about available resources to increase retention success
Equity & Empowerment Lens	• Have translators on hand who speak the contextual language of the clients • Work with natural supports when possible to ensure the client's needs are met and increase post-release accountability

Conclusion

This guidebook presents information gathered from a wealth of sources on how probation and parole officers can apply emerging best practices to their supervision of young adults. Some of the recommendations may be hard to reconcile with traditional practices, such as conducting home visits in plain clothes instead of in uniforms. In these situations, we hope these conflicts spark important discussions about whether changes to existing practices are appropriate or needed in your jurisdiction. However, many of the recommendations are easy to integrate with traditional practice. For example, drug testing is a typical supervision activity. Officers can better align their drug testing procedures with best practices by taking the time to explain the drug testing process to clients beforehand and the reason for the tests.

Some best practice recommendations apply to multiple components of supervision and are thus presented in the guidebook multiple times. This repetition is intentional to reinforce the importance of these practices and to identify opportunities to use these practices at multiple stages of supervision. For example, the recommendation to contract with a diverse group of service providers who have cultural humility and are culturally compatible is a recommended way to apply the Equity & Empowerment Lens (E & E Lens) to both service referrals and interventions (components #6 and #7 identified in this guidebook). In addition, taking the time to clearly outline the consequences of behavior for clients is recommended in the Brain Development Science focus area in both the goal-setting and the case plan supervision components.

Throughout the guidebook, you will find that many of the recommendations are highly consistent, making it easier for officers to align their practice with multiple approaches. For example, when role plays are introduced thoughtfully into supervision, these activities can be consistent with EPICS, Brain Development Science, Trauma Informed Care, and the Equity Lens.

In summary, this guidebook integrates practical tips to enhance the quality and effectiveness of supervision. Readers can interact with this guidebook in multiple ways:

1. Compare multiple practice area recommendations for a specific component of supervision,
2. Focus on the recommendations of a particular practice area across all supervision components, or,
3. Use the guidebook as a comprehensive overview on applying best practices throughout the entire supervision experience.

Appendix

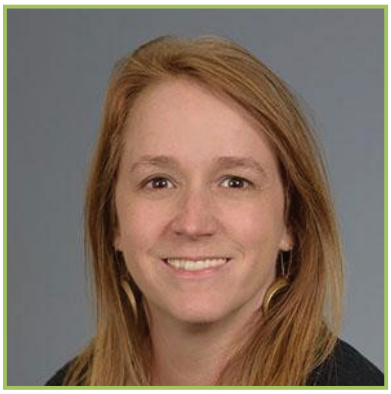
Meet the Subject Matter Experts

Dr. Alisha Moreland-Capuia

Dr. Alisha Moreland-Capuia graduated from Stanford University in 2002 with a B.S. in biological sciences and a minor in urban studies. She earned her doctor of medicine from the George Washington University School of Medicine in 2007. Dr. Alisha completed four years of psychiatry residency and an addiction fellowship at Oregon Health and Science University. She is a board certified addiction psychiatrist who has facilitated systems change through community education/training/ engagement and influencing policy that impacts youth. She is the co-founder of The Capuia Foundation – through the Foundation she and her family built a primary care clinic in Angola, Africa which provides subsidized care to thousands of Angolans annually.

Dr. Alisha has worked with judges, parole officers, school teachers, community members and faith based institutions training in the areas of cultural responsivity, brain development and trauma informed approaches and practices. She built a program entitled Healing Hurt People Portland – a hospital based, trauma informed, community focused youth violence prevention program that serves young males of color between the ages of 15-33 who've been stabbed, shot and or assaulted. She has committed her professional career to changing systems to optimally serve youth and families. Her working motto is that systems change when people change and people change when they feel something.

Dr. Mandy Davis



Dr. Mandy Davis is an Associate Professor of Practice at Portland State University's School of Social Work and a licensed clinical social worker. She is Director of Trauma Informed Oregon, a program primarily funded by the Oregon Health Authority, to advance trauma informed care throughout organizations and systems through training, consultation, and implementation resources. Dr. Davis teaches and lectures on implementing trauma informed care and trauma specific services. Her current interests include measuring change when organizations and systems implement the principles of trauma informed care, the impact of toxic stress on the workforce, intersectionality between equity work, and the impact of systemic oppression.

Dr. Bonnie Nagel

Dr. Bonnie Nagel is Professor of Psychiatry and Behavioral Neuroscience at Oregon Health & Science University, where she serves as the Vice Chair for Research in the Department of Psychiatry, directs the Developmental Brain Imaging Laboratory, and is the Director of pediatric neuropsychology and a practicing neuropsychologist within the Division of Child and Adolescent Psychiatry. Dr. Nagel's research focuses on adolescent brain and cognitive development in healthy and at-risk populations. Her work has primarily focused on understanding the development of executive, emotional, and reward-based networks in the brain using neuroimaging and how perturbations to these systems may result in a heightened vulnerability for mental illness during the adolescent years. More specifically, her lab has been conducting longitudinal neuroimaging studies of Portland-area youth for more than a decade, with aims toward identifying neurobiological markers of risk and resilience for psychopathology, including addiction, and hopes of ultimately informing more targeted intervention and prevention efforts. She is a Principal Investigator on several federally-funded National multi-site projects toward that end, including the National Consortium on Alcohol & Neurodevelopment in Adolescence (NCANDA) and the Adolescent Brain Cognitive Development Study (ABCD).

Cara Thompson, M.S.

Cara Thompson holds a Masters of Criminal Justice from the University of Cincinnati and is a current doctoral candidate with the University of Cincinnati. Miss Thompson is currently an independent contractor with the University of Cincinnati Corrections Institute and previously acted as the Evidence-Based Practices Analyst with the Multnomah County Department of Community Justice (DCJ). Her experience includes providing technical assistance to correctional and treatment agencies, project management, training on risk/needs assessments, curricula, and core correctional practices, clinical coaching, implementation, and program evaluations of prison and community correctional agencies.

Ben Duncan

Ben Duncan is the Chief Diversity and Equity Officer for Multnomah County. He has been with the county since 2004 when he began his career in Environmental Health as a community health worker. He has since worked as a health educator, policy analyst and manager of the Health Equity Initiative. In each of these roles, his work has always focused on the relationships between our social, economic, and environmental conditions and racial and ethnic disparities.

Ben Duncan was a founding board member of OPAL Environmental Justice Oregon, an organization that organizes low income and people of color to build power for environmental justice and civil rights in the community. He also serves on the Oregon Commission for Black Affairs, the Oregon Environmental Justice Task Force, and is Chair of Oregon Public Health Institute's Board.

Ben Duncan lives with his better half, Dr. Katherine Rodela and their eight year old son, Rudolfo, in SE Portland.

References

Abram, K. M., Teplin, L. A., Charles, D. R., Longworth, S. L., McClelland, G. M., & Dulcan, M. K. (2004). Posttraumatic stress disorder and trauma in youth in juvenile detention. ***Archives of General Psychiatry***, 61(4), 403–410.

Azeem, M. W., Aujla, A., Rammerth, M., Binsfield, G., & Jones, R. B. (2011). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. ***Journal of Child and Adolescent Psychiatric Nursing***, 24, 11–15.

Balajee, Sonali S., et al. (2012). ***Equity and Empowerment Lens*** (Racial Justice Focus). Portland, OR: Multnomah County.

Barnert, E. S., Dudovitz, R., Nelson, B. B., Coker, T. R., Biely, C., Li, N., & Chung, P. J. (2017). How does incarcerating young people affect their adult health outcomes? ***Pediatrics***, 139(2), 1–9.

Bloom, S. L., Davis, M., Farragher, B., McCorkle, D., Martini, K., & Wellbank, K. (2003). Multiple opportunities for creating sanctuary. ***The Psychiatric Quarterly***, 74, 173–190.

Citywide Equity Committee, Office of Equity and Human Rights. Equity Roadmap. City of Portland, Oregon. (released Fall, 2014).

Crutchfield, R.D., Skinner, M.L., Haggarty, K.P., McGlynn, A. & Catalano, R. F. (2009). Racial disparities in early criminal justice involvement. Race and Social Problems, 1, 218-230.

Daniels, N., Kennedy, B. P., & Kawachi, I. (1999). Why justice is good for our health: The social determinants of health inequalities. ***Daedalus***, 128(4), 215–251.

Engen, R. L., Steen, S., & Bridges, G. S. (2002). Racial disparities in the punishment of youth: A theoretical and empirical assessment of the literature. ***Social Problems***, 49(2), 194-220.

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care: A self-assessment and planning protocol. (Community Connections. Washington, D.C.) Retrieved from http://www.theannainstitute.org/CCTICSELFASSPP.pdf

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. ***American Journal of Preventive Medicine***, 14(4), 245–258.

Ford, J. D., Chapman, J., Mack, J. M., & Pearson, G. (2006). Pathways from traumatic child victimization to delinquency: Implications for juvenile and permanency court proceedings and decisions. ***Juvenile and Family Court Journal***, 57(1), 13–26.

Giedd, J. N. (2004). Structural magnetic resonance imaging of the adolescent brain, Annals of the New York Academy of Sciences, 1021(1), 77-85.

Guskin, A. (1991). Cultural humility: A way of being in the world. ***Antioch Notes***, 59(1), 1–11.

Holman, B. & Ziedenberg, J. (2006). ***The dangers of detention: The impact of incarcerating youth in detention and other secure facilities***. Baltimore, MD: Annie E. Casey Foundation.

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., … Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. ***Professional Psychology: Research and Practice***, 39(4), 396–404.

Krause, Lindsey. (2015). One size does not fit all: The need for a complete abolition of mandatory minimum sentences for juveniles in response to Roper, Graham, and Miller. ***Law and Inequality: A Journal of Theory and Practice***, 33(2), 481–506.

Labrecque, R., Smith, P., Schweitzer, M., & Thompson, C. (2013). Targeting antisocial attitudes in community supervision using the EPICS model: An examination of change scores on the Criminal Sentiment Scale. Federal Probation, 77(3), 15–20.

Latessa, E. J., Smith, P., Schweitzer, M., & Labrecque, R. M. (2012). Evaluation of the Effective Practices in Community Supervision model (EPICS) in Ohio. Cincinnati, OH: University of Cincinnati.

Leiber, M. J. (2013). Race, pre- and postdetention, and juvenile justice decision making. ***Crime & Delinquency***, 59(3), 396–418.

MacArthur Foundation. (2017). How should justice policy treat young offenders? MacArthur Foundation Research Network on Law and Neuroscience. Retrieved from http://www.lawneuro.org/adol_dev_brief.pdf

McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. ***Health Education Quarterly***, 15, 351–377.

Powell, J. (2008). Post-racialism or targeted universalism? ***Denver University Law Review***, 86, 785–806.

Sickmund, M., Sladky, T.J., Kang, W., & Puzzanchera, C. (2015). Easy access to the census of juveniles in residential placement (EZACJRP). Retrieved from http://www.ojjdp.gov/ojstatbb/ezacjrp/

Spear, L. P. (2003). Neurodevelopment during adolescence. In D. Cicchetti & E. F. Walker (Eds.), ***Neurodevelopmental mechanisms in psychopathology*** (pp. 62-83). New York, NY: Cambridge University Press.

Steinberg, L. (2017). Adolescent brain science and juvenile justice policymaking. ***Psychology, Public Policy, and Law***, 23(4), 410-420.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). ***Trauma-Informed care in behavioral health services: Treatment improvement protocol (TIP) series 57*** (HHS Publication No. SMA 13-4801). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Toga, A. W., Thompson, P. M., & Sowell, E. R. (2006). Mapping brain maturation. ***Trends in Neurosciences***, 29(3), 148-59.

Weissbecker, I., & Clark, C. (2007). The impact of violence and abuse on women's physical health: Can trauma-informed treatment make a difference? ***Journal of Community Psychology***, 35, 909–923.

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