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Engaging in Effective Behavioral Health Treatment Methods: The Importance of Building Trust and Relationships with High and Proven Risk Men with a History of Childhood Trauma(s)

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Abstract

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Nearly 60% of youth involved in the juvenile justice system in the United States have a diagnosable mental illness (Buffington, 2010; SAMHSA, 2012). These high and proven risk youth have fallen through the cracks in the behavioral health system, with a lack of prevention, intervention, and effective treatment methods being provided to them prior to incarceration. This paper presents connections between childhood trauma, undiagnosed and untreated mental illnesses, and delinquency in adulthood for high and proven-risk young men. It also investigates barriers to engaging high and proven risk young men in treatment with the concepts of stigma, and hyper-masculinity introduced. In addition to the literature, an analysis of the behavioral health programming of the Safe and Successful Youth Initiative (SSYI) in Worcester, MA focuses on exploring the importance of clinicians using trust and relationship building techniques within their therapeutic models to produce higher rates of engagement with high and proven risk youth.

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I. Introduction:

A mental and behavioral health crisis is underway in juvenile detention centers across the United States, with young men experiencing high rates of Complex Trauma, Post Traumatic Stress Disorder, Substance Abuse, and Depression (Howell, 2005; Hughes, 2015; Corcoran, 2005; Harris, 2013; Coid, 2013; National Mental Health Association, 2004) According to the Substance Abuse and Mental Health Services Administration, nearly 60% of youth in the juvenile justice system suffer from diagnosable mental health disorders (Buffington, 2010; SAMHSA, 2012), with 57% of these youth having reported experiencing four or more types of childhood traumatic events before reaching adulthood (SAMSHA, 2012).

However, this public health crisis does not begin within the juvenile justice system, it is solely the first point of entry where high[1] and proven risk[2] youth are identified and diagnosed with having mental and behavioral health disorders (Howell, 2005; Hughes, 2015; Corcoran, 2005; Harris, 2013; Coid, 2013; Buffington, 2010). With the majority of high and proven-risk youth with a history of childhood trauma and having an untreated mental illness due to this unresolved trauma, this can cyclically lead them to be at higher risk for future delinquency, gang membership, and engagement in the juvenile justice

[1] High-Risk Youth are exposed to similar risk factors as at-risk youth*, and are exposed to additional risk factors such as school failure or early school leaving; substance abuse, court-involvement, witnessing violence, or violent victimization (Clark University Research Team, 2016)

[2] Proven-Risk Youth are identified as those youth being perpetrators or victims of shooting or stabbing violence (Clark University Research Team, 2016)

*At-risk youth are in danger of engaging in risky behaviors because of the presence of risk factors in their environment (either home or community). These factors include but are not limited to: lack of healthy role models; poor education outcomes; high rates of community substance abuse; high rates of community violence; and high unemployment and/or poverty rates (Clark University Research Team, 2016)

system. These high and proven-risk youth have fallen through the cracks in the receiving timely and effective behavioral and mental health interventions throughout their childhood and teenage years.

This behavioral health epidemic is not only seen in high and proven risk youth on a global and national scale, but trends can be found locally in Massachusetts. Around seventy percent of Massachusetts children and youth who need mental health services do not receive them (Massachusetts Society for the Prevention of Cruelty to Children, 2006). More specifically, the demand for mental health services in Worcester, Massachusetts is high, with the Department of Children and Family Services reporting in 2012 of 3,056 open cases of substantiated abuse and neglect cases concerning children and youth under age 18 (DCF, 2012).

Due to the implications of high behavioral and mental health diagnosis of high and proven risk young men with a history of childhood trauma, this paper seeks to explore, understand, and further research the following questions: (a) What are the barriers to treating high and proven-risk young men? (b) What are recommendations for effective methods of treatment and care? In addition to an extensive literature review, an analysis of the Safe and Successful Youth Initiative[3] Program is explored through qualitative interviews with clinicians, educators, case managers, and outreach workers involved in the program.

[3] The Safe and Successful Youth Initiative (SSYI) is "a multifaceted strategy for reducing youth violence. SSYI provides funding to support a coordinated intervention strategy in partnership with community- based organizations, education, training, and workforce development programs that also include street outreach, trauma counseling, and case management support" (Commonwealth Corporation, 2016).

Findings include the importance of the connection between childhood trauma, and untreated symptomology of mental health diagnosis, leading to increased violence and higher risks of being involved in future delinquency and crime. Additionally, findings showcase the significance of building relationships with youth prior to any attempts at treatment, and integrating trust as a cornerstone to therapeutic models.

Implications of findings include the importance of clinicians altering traditional models of therapy and treatment to be more effective in engaging with high and proven risk youth, which may include the controversial usage of clinician self-disclosure, and changing the dynamics of the provider-clinician relationship to model after an outreach worker-youth relationship dynamic, for better engagement, and trust from youth.

Lastly, it is important to acknowledge discrimination and inherent racism within the juvenile justice system, and lack of behavioral health support for youth of color. Young men of color are disproportionately represented and identified in the research as being high or proven-risk youth. For example, adolescent African-American men between the ages of 12-17 represent only 15% of the United States total population but represent over 46% of the population involved in the juvenile justice system and 52% of juveniles who are later transferred to adult juvenile court systems (The National Mental Health Association, 2004, 11). Additionally, young African American youth have the lowest utilization of mental health services, the highest misdiagnosis' from providers of mental health illnesses, and one of the highest needs for mental and behavioral health services, due to disproportionately high cases of adverse childhood experiences compared with the general

population (Cunningham, 2013; Gary, 2005; Atdjian, 2005; Rawal, 2004; National Mental Health Association, 2004).

II. Literature Review/Conceptual Framework:

Introduction:

The literature review addresses the history of childhood trauma that is common amongst high and proven-risk youth, and how untreated trauma symptomology directly impacts their risk for future violence, delinquency, and gang membership. Additionally, barriers to engaging these youths in effective treatment methods are addressed conceptually in terms of hyper-masculinity, and stigma. The conceptual framework of the paper addresses the relationship between trauma and delinquency and the need for trauma-informed services for high and proven risk men, particularly men of color.

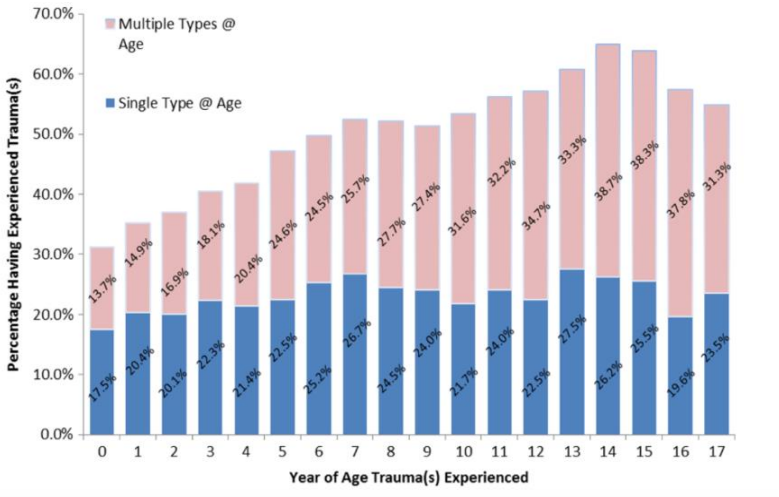
A Life Cycle of Continuous Trauma and The Unique Behavioral Health Implications

What are the unique behavioral and mental health needs of high-risk young men?

The majority of young men involved in the juvenile justice system first appear in childhood in the Department of Child and Family Services due to exposure from chronic and persistent childhood maltreatment, neglect, violence, emotional or physical abuse, and/or victimization (Citizens for Juvenile Justice, 2014; Dierkhising, 2013; Administrative Office of the Courts, 2014). This phenomenon of childhood trauma is not an uncommon finding, and as shown in Table One (below), according to research reports from the National Child Traumatic Stress Network, by the age of six, 25.2% of youth who become involved in the Department of Child and Family Services have already

experienced one traumatic experience[4], and 24.5% of youth have experienced multiple traumas either individually or co-currently (Dierkhising, 6).

Table One: Childhood Trauma by Age (Dierkhising, 2013)



These traumatic life events that occur specifically during childhood are serious, and can have detrimental developmental and behavioral health implications if left untreated. Any trauma or maltreatment that happens between the critical developmental ages of 0-6, can cause irreversible developmental delays and brain damage (Children's Services Working Group, 2015; Kerig & Becker, 2010; Buffington, 2010; Administrative Office of the Courts, 2014). "Toxic stressors cause persistent elevations of stress hormones and altered levels of key brain chemicals, i.e., cortisol and adrenaline, that disrupt the developing brain and put the child at high risk for developing mental, emotional, and behavioral disorders and physical illness" (Children's Services Work Group, 4). The constant elevation of stress

[4] A traumatic experience or event is defined as having a direct encounter with a dangerous or threatening event, or involving witnessing the endangerment or suffering of another living being (Buffington & Dierkhising, 2).

hormones, and of a child being in a persistent state of distress can also lead to disruptions between the exchange of information between the brain's left and right hemispheres (Kerig & Becker, 2010). This disruption can cause a child to develop a lower IQ in adulthood, and to have emerging and lifelong issues with emotional processing, emotional regulation, and interpersonal communication (Kerig & Becker 2010; Buffington 2010).

Additionally, the CDC-Kaiser Adverse Childhood Experiences Study (ACE) concluded that childhood traumas increase the risk for the following disorders and health complications: alcoholism, substance abuse, chronic obstructive pulmonary disease, suicide attempts, illicit drug use, liver disease, ischemic heart disease, poor academic achievement, and financial stress (Centers for Disease Control and Prevention, 2016). Behaviorally, these children may display symptomology of increased anger, aggression, disassociation, withdrawal, depression, hyper arousal, and distrust of people (Children's Services Work Group, 2015; Kerig & Becker 2010). They may be clinically diagnosed with Post Traumatic Stress Disorder[5], Complex Trauma[6], and/or Acute Stress Disorder[7] (Children's Services Work Group, 2015).

It should be noted that children who receive immediate intervention and treatment from traumatic experiences and who have the right family and community support systems, have the ability to cope and heal, without further developmental harm and

[5] Post Traumatic Stress is a disorder that can be developed after an individual experiences or witnesses a life threatening event, such as combat, a natural disaster, a car accident, or sexual assault (NIMH, 2017).
[6] Complex Trauma describes "both a child's exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long term impact of this exposure (NAMI, 2017).
[7] Acute Stress Disorder is characterized, "by the development of severe anxiety, and disassociation that occur within one month after exposure to an extreme traumatic stressor or event (Psych Central, 2017).

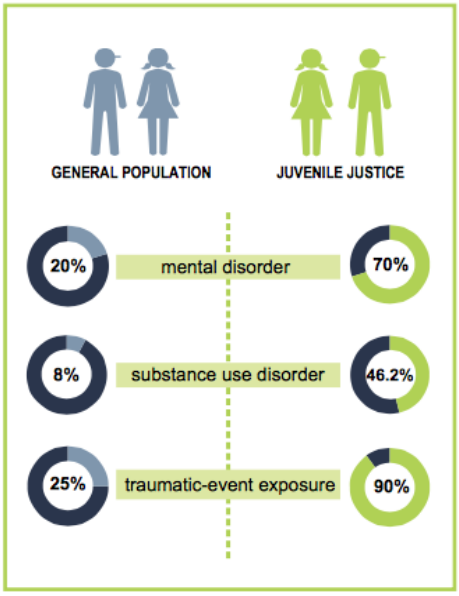
behavioral issues in adulthood (Cohen, 2010; Buffington, 2010; Howell, 2005; SAMHSA, 2014). However, sadly the literature points to large gaps in services, especially for children of color, who have experienced multiple traumas in childhood, and never receive the mental health services and support they need to recover (Rawal, 2004; The National Mental Health Association, 2004; Children's Services Working Group, 2015). According to a study done by Purva Rawal, which examined prior mental health utilization history of minority youth who are now involved in the juvenile justice system, "Caucasian youth had higher rates of prior, current, and overall mental health treatment histories than did African American and Hispanic youth. Hispanic youth had the lowest rate of prior, current, and overall mental health service utilization" (250). Further conclusions from the study were drawn that minority youth were not receiving the behavioral health services they need in childhood, and simultaneously were experiencing higher rates of trauma than their Caucasian counterparts (Rawal, 2004).

Life Cycle: Adolescence

By the time that a majority of children who are deemed "high-risk" reach adolescence, the amount of traumatic experiences a youth has endured has multiplied. According to a research study of youth in the juvenile justice system conducted by Kerig and Becker, "93% of boys in the sample had experienced a traumatic life event, with a typical youth having experienced 14 traumatic stressors over the life course" (11). These youths now not only have untreated childhood traumas, but now have a multiplicity of traumatic experiences in their lives, leading to more complex mental and behavioral health issues. Overall, the more traumatic experiences an adolescent has in childhood, the worse

the developmental delays and behavioral issues can become in adulthood (Kerig & Becker, 2010; Buffington, 2010)

Table Two: (SAMHSA, 2014)



Childhood trauma and maltreatment is important to highlight, because extensive research has been done to provide a strong correlation between untreated childhood trauma and undiagnosed behavioral and mental health issues which can lead to higher risks of a child later in life joining a gang, becoming involved in the juvenile justice system, and being a participant in delinquent behaviors. (Hughes 2015; Howell 2005; National Gang Center, 2015; Madden, 2013; Harris 2013; Children's Services Work Group, 2015; SAMHSA, 2014) "Between 65 percent and 70 percent of the 2 million children and adolescents arrested each year in the United States have a mental health disorder" (Harris, 2). As shown in Table Two, young men and women involved in the juvenile justice system present and are diagnosed with over three times the amount of mental health disorders then the general population (SAMHSA, 2014).

Common diagnosis' of high and proven risk young men include but are not limited to Post Traumatic Stress Disorder (PTSD), Complex Trauma, Conduct[8] and Oppositional

[8] A Conduct Disorder is a "repetitive and persistent pattern of behavior in children and adolescents in which the rights of others or basic social rules are violated. This can include aggressive behavior towards others that causes or threatens harm" (MHA, 2017)

Defiance Disorders[9] (ODD), Attention-Deficit/Hyperactivity Disorder[10] (ADD/ADHD), Depression, Psychosis[11], Generalized Anxiety Disorders, and Suicidal Idealization. Studies have also pointed to a high prevalence of youth in the juvenile justice system who also have co-occurring substance abuse alongside PTSD and Complex Trauma Disorders (Madden, 2013; Coid, 2013; Corcoran, 2005; Harris, 2013; The National Conference for State Legislators, 2011; Kerig & Becker, 2010; Dierkhising, 2013).

Post Traumatic Stress Disorder accounts for one of the highest mental health concerns for youth involved in gangs, the juvenile justice system, the Department of Family and Child Services, or youth deemed "high-risk" (Dierkhising, 2013; Buffington, 2010; SAMHSA, 2012; Kerig & Becker, 2010). This is highly problematic because symptomology and the way in which youth try and cope with the trauma, often leads to behaviors that may directly increase their likelihood of engaging in delinquent behaviors' and future arrest (Kerig & Becker, 2010; SAMHSA, 2012). Complex PTSD symptomology that may cause behaviors that increase criminal activities and involvement with law enforcement include avoidance, hyper arousal, disassociation, and re-experiencing the trauma. These symptoms can lead to opposition behavior, increased impulsivity and risky behaviors, aggression, rage, and irritability. As Kerig and Becker further explain, "Each of these factors may contribute to a propensity to be easily

[9] Oppositional Defiant Disorder is a "childhood disorder that is characterized by negative, defiant, disobedient, and often hostile behavior toward adults and authority figures" (Psych Central, 2017).
[10] Attention-Deficit/Hyperactivity Disorder (ADHD), is a brain disorder "marked by an ongoing pattern of inattention, impulsivity, and/or hyperactivity that interferes with functioning or development (NIMH, 2017).
[11] Psychosis is characterized as a "severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality" (NIMH, 2017).

provoked, to perceive situations to be more threatening than they are in actuality, and to act impulsively, all of which increase the risk of antisocial behavior" (7). Youth who do not have the ability to cope with their past traumas in healthy ways may act out in behaviors that may be misconstrued by law enforcement as Conduct or Oppositional Defiance Disorders instead of Complex PTSD and Trauma Disorders (Kerig & Becker, 2010; Cohen, 2010; Administrative Office of Courts 2014).

Life Cycle: Young Adulthood

Gang Membership and Behavioral Health Implications:

Children with a history of trauma and involvement with the Department of Family and Child Services have overlapping risk factors of developing complex behavioral health issues and of subsequently becoming gang members (Howell, 2005; Hughes, 2015; Corcoran, 2005; Harris, 2013; Coid, 2013, National Gang Center, 2015). Once high and proven-risk youth are involved in gangs, behavioral and mental health issues can become exacerbated due to the potential for increased exposure to violence which can lead to additional traumas (Howell, 2005). As a gang member, risks of being perpetrators and/or victims of violence increases, due to violence in gangs commonly being used as a tool to build and maintain status, as a tactic of fear or retaliation, of enforcing group cohesion, and in the regulation of the drug market (Coid, 2013). Youth involved in gangs may have more Complex Post Traumatic Stress Disorder, increased co-morbidity disorders with substance abuse and PTSD, a higher rate of suicide attempts, depression, and psychosis than the general population.

High-risk youth are placed in a cyclical cycle with childhood trauma leading them to be at a higher risk for joining a gang, which then leads to re-traumatization and increased exposure to violence (whether as victims or perpetrators), causing more trauma, within gang membership. Howell further explains this phenomenon, "This sequence is not specifically unidirectional but is rather bidirectional where current behaviors are influenced by antecedent risk variables, which in turn diminish the chances of alleviating risk and extricating gang-involved youth (247). This continuous cycle of trauma and exposure to violence can be extremely debilitating and harmful to a youth's mental health.

Section Two: Stigma and Hypermasculinity- Barriers to Identification & Treatment

Young men of color have the highest underutilization of mental and behavioral health services compared with the general population, with African Americans and Latinos leading in statistical reports of low mental health service usage (Cunningham, 2013; Gary, 2005; Atdjian, 2005; Rawal, 2004). This underutilization is not due to lack of need of behavioral health services, but is arguably due to perceived stigma in receiving services. Stigma has been viewed as one of the key components and barriers to urban male youth of color seeking out and receiving behavioral health services, with a combination of community, individualized, and family stigma (Cunningham, 2013; Gary, 2005; Atdjian, 2005; Rawal, 2004). High stigma has been attributed to a mistrust of the behavioral health system, tensions with hypermasculinity, and cultural differences.

From a historical context, mistrust of institutional health systems has been pervasive in communities of color for decades, with many families and high and proven-risk youth refusing to engage in services due to a long history of unethical treatment of

people of color in the scientific and health community. From the infamous Tuskegee Syphilis Study[12] to current discouraging reports of African Americans being the most widely misdiagnosed group by providers in the general population, there is a lack of confidence in the medical field when it comes to medical and cultural competency in caring for people of color (Whaley, 2001; Freimuth, 200l; Brandon, 2005; Rawal, 2004; Atdjian; 2005; Eiser, 2007). Many scholars have discussed this pertinence of systematic racism within healthcare services that many youth and families of color may feel, leading to further mistrust of the system, and disengagement from services all together. "Disparities exist in both access and quality of mental health care for racial and ethnic minority groups in the United States" (Atdjian, 2005, 1600). Atdjian has further discussed many people of color viewing the system as discriminatory, and unsupportive of different cultural and socioeconomic backgrounds, alluding to the lack of diverse mental health professionals, and the high expenses of engaging in services (Atdjian, 2005).

In many young male communities, having a hyper-masculine identity and bravado is seen as a form of protection and self preservation. These bravado and machismo attitudes can gain respect from other men in the community, whereas the high stigma of mental illness, can destroy a man's or youth's reputation. "It can diminish their reputations and status in the community, and jeopardize their relationships with neighbors and the

[12] The Tuskegee Syphilis Study or experiment was conducted between 1932 and 1972 by the U.S. Public Health Service. Investigators enrolled 600 impoverished African Americans from Alabama, with the intention to study the effects of untreated syphilis. Researchers did not inform participants with syphilis in the study that they would not be receiving treatment, even though penicillin became known to researchers as an effective treatment method, leading to a gross violation of ethical standards of practice and malpractice within the medical community (Whaley, 2001; Freimuth, 2001).

public" (Cunningham, 2013, 987). Living in a community where there may be a perceived sense of danger, and lack of safety, having a hypermasculine identity can help a youth as a coping strategy and survival skill, especially if they feel like they lack the safety supports of their families and community members (Cunningham, 2013; Gary, 2005; Seaton, 2007; Cassidy, 2005). Thus a youth who may live in a challenging urban environment may refuse to seek mental health services due to the damage it may cause to their reputation and personal safety concerns because of the high stigma placed on mental illnesses (Cunningham, 2013; Gary, 2005; Seaton, 2007; Cassidy, 2005; Rawal, 2004).

Additionally, families, communities, and individual men may not seek out mental health services or decline services due to cultural differences and a concept called "double stigmatization". Double stigmatization refers to the stigma and discrimination felt by youth of color as a part of an identified minority group, where they can be subject to discrimination and racism; having a mental illness adds on another layer of stigma for these youth, causing the phrase to be named double stigma (Gary, 2005). Because youth of color are already facing societal challenges due to racism, they may shy away from mental health services due to the fear of being further stigmatized and alienated (Gary, 2005). Culturally, the literature also points to a gap in services in having diverse mental health providers which may lead young men of color to feel uncomfortable with their provider if they chose to seek help, and to have at times a clashing of worldviews (Gary, 2005; Rawal, 2004). It is highly encouraged that psychiatrists and mental health professionals engage in consistent cultural competency trainings to reflect on their own cultural bias, to have a better understanding of how to work with clients who may come from different

backgrounds then themselves. “The need for psychiatrists to understand their own cultural biases as they bear on the therapeutic relationship is as essential as having undergone personal analysis is to the practicing psychoanalyst” (Gary, 980). Additionally, the mental workforce needs to be diversified, and companies and educational organizations need to work on recruitment and retention strategies to bring in diverse mental health professions who can help with the barriers of service entry for youth of color (Gary, 2005; Seaton, 2007; Cassidy, 2005; Rawal, 2004).

Methods of Prevention, Intervention and Treatment:

Prevention

Juvenile justice centers in the United States currently have the burden of being one of the only sources of mental and behavioral health support for the majority of high and proven risk youth, leading for the strong need for prevention and early intervention strategies to be advocated for to help youth before they enter detention centers (Juvenile Justice Guidebook for Legislators, 2011; Rawal, 2004; Belitz, 1994; Kerig & Becker, 2010; Buffington, 2010; Dierkhising, 2013; SAMHSA, 2012; SAHSMA, 2014, The National Mental Health Association, 2004) From the literature, there appears to be a substantial gap in essential prevention services and education programming in relation to mental health and trauma. (Juvenile Justice Guidebook for Legislators, 2011; Rawal, 2004; Belitz, 1994; Kerig & Becker, 2010; Buffington, 2010; Dierkhising, 2013; SAMHSA, 2012; SAHSMA, 2014, The National Mental Health Association, 2004). This gap can start to close through educating community members on the impacts of community violence on children, and a basic understanding of trauma, and mental health disorders, it opens up the opportunity for

parents and families to find new ways to support and help their children with a prior history of trauma (Buffington, 2010). Since studies have shown that youth who have endured multiple traumas, especially youth of color, have a large underutilization of mental and behavioral health services, communities need to be aware of the resources available to youth. (Children's Services Work Group, 2015; Rawal, 2004; Cohen, 2010). In addition, there needs to be universal screening tools and assessments done in community school systems, recreational centers, and youth centers to screen, assess, diagnose, and help youth who may be dealing with an undiagnosed mental and behavioral health issue, due to past trauma. Evidence-based tools and assessments that can be used to screen for children and/or youth who may have mental and/or behavioral health problems due to trauma exposure include the UCLA Reaction Tool, CANS, CAPS-CA, and CAPA-C (Buffington, 2010; SAMHSA, 2014).

Intervention

As schools tend to be a community focal point, having mental and behavioral health programming available to students, has grown in popularity over the past decade due to demand and need from parents, teachers, and students. Utilizing school Wraparound Program Models[13] can be a great evidence-based intervention strategy to help divert young children with mental and behavioral health issues from later being involved in the juvenile justice system (PBIS, 2017). This model helps school staff and teachers to refer children who they may think could use extra support in terms of positive behavioral interventions,

[13] Wraparound is a philosophy of care with defined planning process used to build constructive relationships and support networks among students and youth with emotional or behavioral disabilities (EBD) and their families. It is community based, culturally relevant, individualized, strength based, and family centered (PBIS, 2017)

and helps the child to develop positive coping skills, and ways to better understand and regulate their emotions (PBIS, 2017). This holistic model connects family members, the school, the child, and the community with the supports and resources needed to best help a child with mental health challenges.

Although early intervention to address a youths mental and behavioral issues should happen prior to juvenile justice involvement, gaps in community support systems often lead many youths to have their first point of assessment for treatment for mental health through the juvenile justice system. It has been addressed that many youths who end up in the juvenile justice system, are suffering from untreated mental and behavioral health issues, due to past traumatic experiences (Cohen, 2010) With this in mind, intervention needs to be more proactive, which includes youth being diverted from the juvenile justice system once they have been screened for mental illnesses, and sent to community based mental health centers for appropriate treatment. "Typically, gang involved youth are seen in correctional settings rather than in mental health settings. Gang youth are often viewed as being so ingrained in an antisocial lifestyle that they are not considered amendable to mental health services" (Belitz & Valdez, 57-58).

Treatment Methods

As this is a unique population with specific and complex behavioral and mental health needs, treatment needs to be, "community based, family-driven, youth-guided, individualized, coordinated, and culturally and linguistically competent" to be most effective (The National Mental Health Association, 2004**)**. Formalized and traditional methods of treatment such as one-on-one counseling may not only be ineffective but

discourage a youth from continuing to seek further treatment and help (Madden, 2013). As the majority of these youth have been in traumatic situations were they may have felt disempowered, it is essential that therapy feels safe, and that it feels like a choice for the youth (Belitz & Valdez, 199). One therapy method that has been found to be extremely effective for high and proven risk youth with a prior history of trauma, is Trauma-Focused Cognitive Behavioral Therapy (TB-CBT)[14]. "In a high-risk population CBT demonstrates the strongest record of success with ethnic minority youth" (Children's Services Working Group, 24) TB-CBT works on modifying disruptive thinking patterns to create alternative thoughts, and also focuses on triggers from prior trauma that may lead to aggressive behavior. (National Mental Health Association, 2004). Paradoxically, While TB-CBT can be done in a group or individualized setting, few studies have been done to compare or show effectiveness of group CBT treatment methods, and more empirical evidence has been placed on the overall effectiveness of individualized therapy for trauma survivors. (Cohen, 2010; Kerig & Becker, 2010) However, group therapy approaches should not be discounted, as many studies have been done that report on the positive outcomes and influence of peer support groups, and better treatment outcomes with peer to peer support and engagement. **(**Solomon, 2004; Yalom, 2005; Dennis, 2003; Castelein; 2008**)**

Having positive parental involvement and support while a child or youth is going through treatment, has been correlated to stronger and more beneficial treatment outcomes. (The National Mental Health Association, 2004; Administrative Office of the Courts,

[14] TB-CBT is defined as an evidenced-based treatment from children, adolescents, and adults impacted by trauma, and is based on the theory that thoughts, beliefs, and attitudes determine emotion and behavior (National Mental Health Association, 2004).

2014; Cohen, 2010; SAMHSA, 2014). For youth with strong family support systems, Multi-Systemic Therapy[15] can be an alternative and effective evidence-based strategy to TB-CBT. With the knowledge that trauma is often intergenerational in families, multi-systemic therapy includes parents and families in treating their own trauma histories, while simultaneously treating the youth with their current trauma(s). This method has been found to have a 70% reduction in long term rates of re-arrest, and has been seen as an empowering method of therapy for families and youth (The National Mental Health Association, 2004). It should be noted that Multi-Systemic Therapy may be inappropriate and even detrimental to a youth whose trauma history includes parents or family members who are perpetrators against the youth in forms of neglect, maltreatment, abuse, and violence (The National Mental Health Association, 2004; Administrative Office of the Courts, 2014; Cohen, 2010, SAMHSA, 2014).

With any treatment method, it is also important to highlight that for therapy to be most effective, it needs to be developmentally appropriate and culturally informed. (SAMHSA, 2014; Eiser, 2007; Carney, 2003; Rawal, 2004) It is also essential that when a youth starts treatment, that it be continuous care, without any gaps in services provided (SAMHSA, 2014).

Technology and Treatment

[15] Multi-Systemic Therapy derives from a family and community based treatment approach, that, "focuses on addressing all environmental systems that impact chronic and violent juvenile offenders, their homes and families, schools and teachers, neighborhoods and friends". (Cohen, 2010; National Mental Health Association; 2004)

With the emergence of new technology, treatment options for behavioral health have expanded to include telecommunications and telehealth[16] opportunities for patients and providers. Benefits of virtual behavioral therapy can involve the decrease of stigma of services, can provide rural populations or areas with decreased mental health providers with much needed services, and allow patients with severe mental illnesses to do treatment in the familiarity and comfort of their homes (Backhaus, 2012). Weaknesses of the therapy, include patients citing a lower rate of therapeutic relationships with their provider, as well as the possibility for increased distractions and competing stimuli in the room during the teletherapy session (Backhaus, 2012). In terms of trauma related treatment and therapy with youth and young adults, the literature is conflicting in the use of technology for treating complex trauma in patients, citing the technology can provide the benefits of youth feeling less intimidated by a provider through the screen, but it can also lead to easier avoidance of questions and behaviors, exacerbating symptoms of Post Traumatic Stress Disorder (Backhaus, 2012). It should also be noted, that few studies of telehealth have addressed or discussed ethnic and racial differences that may be present in teletherapy, and how this can impact treatment and service outcomes (Backhaus, 2012). More research is needed to assess and evaluate the effectiveness of treatment outcomes in comparison to traditional modes of therapy (Backhaus, 2012).

Universal System of Care

[16] Telehealth refers to the use of technology to provide health care when providers are geographically distant from patients. This can involve mental health professionals using telephones, email, and web forums to communicate with patients (Backhaus, 112).

A Trauma-informed System of Care also needs to be implemented and followed for anyone who interacts with youth with a history of trauma and complex behavioral and mental health issues in DYS, the juvenile justice system, probation, case management, and outreach services. The juvenile justice system needs to be reformed to be trauma informed at all levels (Buffington, 2010). "Staff who have direct contact with justice-involved youth, should be trained to understand trauma and post-traumatic reactions so they are best equipped to recognize potential emotional distress and PTSD reactions" (Dierkhising, 9). Any adult who interacts with high and proven-risk youth needs to be aware that they may have a history of trauma, which may lead the youth to act aggressively in any situation that the youth may feel re-triggered, or traumatized. Having the ability for staff to recognize triggers and warning signs in youth could be essential in de-escalating a situation, and making a situation feel safer for both the youth and the provider, as it is extremely important for youth with trauma histories to be in environments that are safe and predictable (SAMHSA, 22-43).

Summary:

The literature addresses substantial connections between childhood trauma(s) and youth later being identified as high or proven-risk due to increased violence, and delinquency from untreated and complex behavioral and mental health issues. As this is a unique population with differential needs, effective treatment methods can be difficult to implement, and engagement with youth can be thwarted due to issues with hyper-masculinity and stigma for addressing mental health illnesses. An analysis of the Safe and Successful Youth Initiative Program will now be conducted to showcase how case

mangers, outreach workers, clinicians, and educators are working with high and proven risk youth in Worcester, Massachusetts to engage in behavioral and mental health treatment methods.

III. Methodology:

This paper investigates the following research questions, (a) What are the barriers to treating high/ proven-risk young men? (b) What are recommendations for effective methods of treatment and care?

The initial approach to research was to draw findings from an extensive literature review to explore current research trends and academic literature pertaining to high and proven risk young men in terms of childhood trauma, engagement in future delinquency, and effective treatment methods for unresolved mental and behavioral health issues.

Following the literature review, an analysis of The Successful Youth Initiative Program (SSYI) in Worcester, Massachusetts was chosen to investigate how this program was engaging with high and proven risk youth on a local level and if the literature review was in alignment with what these youths were experiencing in terms of trauma and mental health, and how SSYI was engaging the youth in terms of behavioral health treatment. Forty-five minute interviews[17] were conducted with three outreach workers, four clinicians, and one educational practitioner to investigate any unique behavioral and mental health needs of high and proven risk men involved in SSYI, and any background histories

[17] Interview questions for case managers, outreach workers, and clinicians can be found in Appendix A and B

Interview Number:	Interviewee Role:
1	Case Manager/Outreach Worker
2	Clinician
3	Clinician
4	Case Manager/Outreach Worker
5	Clinician
6	Clinician
7	Educator
8	Case Manager/Outreach Worker

of trauma. The interviews additionally addressed any gaps in services and treatment as well as whether interviewees believe current treatment methods and programming to be effective.

Analysis of interviews included transcribing and coding recorded and unrecorded interviewees, to learn about patterns and trends of all interviewees responses. Extensive hand written notes where taken for interviewees who declined being recorded. Once major themes where identified, such as the importance of trust and relationship building with the youth, additional literature reviews were conducted to investigate if there was current academic research available to showcase interviewees viewpoints.

Information was additionally gathered during monthly case manager and outreach worker meetings in the form of typed notes, where SSYI youth were discussed, behavioral and mental health was strategized, trainings were conducted, and programmatic updates and reports were presented.

Lastly, data collection was drawn from The Safe and Successful Youth Initiative research partner database to find out youth participant demographic information. This includes information about youth educational attainment, race, age, criminal history, and participation in therapeutic individual sessions and/or group therapy. Broader research was also collected through statewide databases such as the Massachusetts Department of

Education and Massachusetts Department of Public Health on the most current demographic information for the city of Worcester to assess community risk factors.

Limitations of research included time constraints in data collection, with the inability to interview additional essential programmatic individuals involved in the SSYI Program. The small sample of interviewees, (8), does not showcase the complete breadth of knowledge and excludes the opinions and input of several key staff members. Additionally, due to the high nature and risk of vulnerability of the youth discussed, no high or proven risk youth were interviewed at this time, leaving out the potential for the researcher to know if the youth are in agreement with clinicians and case managers about effective strategies of treatment for behavioral and mental health needs.

Additionally, the literature itself is incomplete and at times inconclusive in terms of the breadth and depth of current research being evaluated on the effectiveness of treatment methods for high and proven risk youth in terms of group cognitive behavioral therapy, and telehealth.

III. Program Study: SSYI Program in Worcester, Massachusetts

Community Risk Factors:

The National Gang Center, has researched and found important links between community risk factors that can increase a youth's risk of delinquent behavior and gang membership. Community or neighborhood factors that can increase risk can include economic deprivation, high poverty rates, exposure to violence and racial prejudice, high-crime neighborhoods, high drug dealing and substance abuse, neighborhood disorganization, and availability of firearms (National Gang Center 2016; Howell, 2012).

As a case study, Worcester, Massachusetts has several established community and neighborhood risk factors that can increase a youth's risk of gang membership. A five-year American Community Survey (2011-2015) has estimated that 22.4% of residents living in Worcester are currently living below poverty level, with 34.3% of single family, female household led homes living in economic distress. Additionally, according to the Massachusetts Department of Education, as of 2016, youth in the Worcester Public School systems considered economically disadvantaged are 57.2% of students compared to 30.2% of students in Massachusetts (Massachusetts Department of Elementary & Secondary Education, 2016).

In terms of violence and crime, Worcester has one of the highest violent crime rates in Massachusetts (FBI Crime in the US Report, 2013). From reports from the 2013 FBI Database, Worcester's violent crime rate was 1,750 incidents per 100,000 compared to the state rate of 391 (FBI Crime in the US Report, 2013). According to SSYI Worcester Briefs, the Worcester Police Department estimates that Worcester has 20-25 active gangs, most notably neighborhood gangs such as Main South, Eastside, and Providence Street Posse. There are an estimated to be 1,000 active gang members, with half being under the age of 25. In 2015, gang members were found connected to the homicide of five youth in their mid-twenties, in addition to various assaults, home invasions, and stabbings (Clark University Research Team Report, 2016).

Additional risk factors include high levels of public school in and out of school suspension rates of over 7.0%, with 10% of youth being suspended with disabilities, and 5.9% of youth being suspended of economically disadvantaged backgrounds. Additionally,

African American and Hispanic/Latino youth were two times more likely to be suspended or disciplined than their Caucasian classmates (Massachusetts Department of Elementary & Secondary Education, 2016).

Introductory Grant Background Information:

According to Commonwealth Corp, the Safe and Successful Youth Initiative is, "a multifaceted strategy for reducing youth violence. SSYI provides funding to support a coordinated intervention strategy in partnership with community- based organizations, education, training, and workforce development programs that also include street outreach, trauma counseling, and case management support" (Commonwealth Corporation, 2016). Funded by the Massachusetts Executive Office of Health and Human Services, SSYI provides services and outreach to 106 young men ages 17-24 who are considered to be proven-risk due to their prior and/or current involvement in being perpetrators and/or victims of gun or knife violence. The SSYI program in Worcester partners with the Worcester Youth Center (WYC), Straight Ahead Ministries (SAM), Friendly House, Worcester Community Action Council (WCAC), Worcester Public Services, LUK Behavioral Health Services, and the Massachusetts Society for Prevention of Cruelty to Children (MSPCC).

In 2016, a behavioral health component was added to the SSYI grant. LUK and MSPCC were chosen as the lead behavioral health partners, and two clinicians were hired to support the behavioral and mental health needs of SSYI youth by working collaboratively with staff from Straight Ahead Ministries, Friendly House, and the Worcester Youth Center.

Demographics of SSYI Men:

Common Profile of an SSYI Proven-Risk Youth:

Race:

As of the Worcester Youth Violence Prevention and Reduction Strategic Plan and Needs and Resources Analysis of 2014, 95% of youth involved in SSYI have been identified as Black, Latino, or Multiracial; following national trends of high rates of youth of color being identified as high or proven risk, with the acknowledgment that systemic racism and discrimination play a role in a higher percentage of youth of color being involved in the juvenile justice system (Cunningham, 2013; Gary, 2005; Atdjian, 2005; Rawal, 2004; National Mental Health Association, 2004).

Economic Background:

The majority of youth struggle with consistent employment, homelessness and unstable housing, and low-income backgrounds. Many of the youth have children, and additional individuals and family members to support, leading to increasing economic burdens (Clark University, 2014).

School Background:

A small minority of youth involved in SSYI have a high school diploma or a GED, with the majority of high and proven risk men in need of additional educational support. Most youth engaged in SSYI, have been transferred to local alternative schools or a DYS facility. As public schools in Worcester have recently introduced a controversial addition of having police officers within schools, with the ability to arrest youth for infractions that prior to school law enforcement engagement would have resulted in a school suspension, high risk youth are now at an increased risk of being expelled from school and/or of receiving a criminal offense on their record (Mass Live, 2015).

Mental Health/Substance Abuse:

Many SSYI youth have had trauma histories, with a high engagement of police contact prior to age 13 as a victim due to domestic abuse, childhood abuse, and ambulance calls (Clark, 2014, 27). The majority of youth have been identified has having substance abuse issues, in addition to complex mental and behavioral health disorders that have been left untreated (Clark, 2014, 27).

Involvement with Law Enforcement: High and proven risk youth involved in SSYI have had substantial police contact. The most common reasons for arrests include warrant arrests, disorderly conduct, disturbing the peace, resisting arrest, trespassing, assault and battery, drug violations, motor vehicle related violations, and gun related charges (Clark University, 2014, 27).

Findings:

Interview Number:	Interviewee Role:
1	Case Manager/Outreach Worker
2	Clinician
3	Clinician
4	Case Manager/Outreach Worker
5	Clinician
6	Clinician
7	Educator
8	Case Manager/Outreach Worker

Unique Behavioral Health Needs of SSYI Youth:

All interview respondents agreed that high and proven-risk young men engaged in the SSYI program have differential and unique behavioral and mental health needs then the general population. Interview respondents identified that youth in SSYI are struggling with the following behavioral and mental health disorders; Post Traumatic Stress Disorder,

Complex Trauma, Substance Abuse, Dissociative Disorder[18], Bipolar[19], Anxiety, Depression, Attention Deficit Hyperactive Disorder, and issues with low self-esteem. Key Informants 5 and 6 also stressed the significance of co-occurring disorders and substance abuse with the youth currently being served.

All respondents attribute these behavioral health issues due to multiple and complex traumatic experiences their youth have witnessed or been involved in during childhood, and/or throughout adulthood. Key informants 2 and 3 both estimated that over "87 percent of the young men in the SSYI Program had prior engagement with the Department of Youth Services, and over 90% of the youth had additional engagement with the juvenile justice system, prior to being involved in the adult prison system". When asked to elaborate on specific childhood traumas, Key informants 1 and 4 discussed how youth were coping with the trauma of seeing their family and friends shot and murdered in front of them, witnessing continuous community violence, physical, mental and emotional abuse, and neglect. Key information 8 described the trauma and lifestyle that youth endure as, "being on a constant lookout for their lives, and that any day that they do not get arrested or shot, is a good day for them".

Key informant 7, an educator in Worcester Public Schools, discussed their worries over how desensitized the youth have become to witnessing a multiplicity of traumatic

[18] Dissociative Disorder criteria for diagnosis includes experiencing high levels of depersonalization or derealization (NAMI, 2017)

[19] Bipolar Disorder criteria for diagnosis includes manic and major depressive episodes, persistent elevated, or irritable mood for at least one week, and at least three of the following symptoms: inflated self-esteem, decreased need for sleep, increased talkativeness, flight of ideas or racing thoughts, distractibility, increase in risky behavior (NAMI, 2017)

events and community violence. The informant went on to explain that during a field trip several years back, a student was shot and killed in front of classmates. After the student was shot, the educator found that the youth were more interested in retaliating against the gang members who shot him, than going to the counseling services provided by the school. When the educator pressed several students about how they felt about their friend's death and the violence they witnessed, they responded with, "We live in Main South, we are surrounded by this type of violence on a daily basis".

When asked how untreated trauma and mental health affects a youth's behavior, interview responses varied from rearrests, jail time, death, and a feeling of a foreshadowed future. With trauma, "youth have the inability to assess risks and their impulse control is off". Key informant 1 went on to state that this can be incredibly concerning, as youth who do not have alternative thinking skills, will more often than not get themselves into trouble through acting in violent and aggressive ways as a response from fear induced by prior traumas. Other interviewees also described youth as having a decreased quality of life, and inability to maintain stable employment. Another impact of trauma, especially of violent victimization, is wanting to be safe and protect yourself. Several interviewees stated that youth carried around weapons, not specifically because they want to hurt anyone, but felt that they had no other options if they were to be attacked. A youth reiterated this with the educator, when a weapon was confiscated stating "I need it for my protection because no one else will help me".

Introduction & Current Systems of Care:

In January of 2016 two clinicians were assigned to provide youth support for mental and behavioral health issues to Friendly House, Straight Ahead Ministries, and The Worcester Youth Center. Both clinicians interviewed expressed different styles of systems of care and highlighted their processes below however all agencies have the opportunity to utilize the clinicians through a system of referrals. Clinicians in this program can provide assessments, individualized and group therapy.

One clinician has built a strong relationship of mutual respect with the case manager/outreach worker at the agency. This has worked as a strategy to build trust and engagement with the youth over time. Through months of engaging with the case manager in outreach and at the agency, as well as through introductions to the youth and from building communications, the clinician was able to have a breakthrough in relationships with the youth. At the beginning of the process, the clinician decided to approach behavioral health with the men in terms of one-on-one counseling but after a one-week trial, felt it was evident that the men in the program were not responding to this approach. The clinician decided to try a new approach that they thought would be less threatening or invasive and engaged the youth in group therapy, more informally known as the men's group. This clinician describes the men's group as a free flowing support group with similar attributes to an Alcoholics Anonymous meeting. The clinician and outreach worker run the group together and engage the men in conversations about mental and behavioral health through the use of guest speakers, specific topic weeks, and team building activities. The men's group has steadily grown to 12-15 members on any given week, with the

clinician and outreach worker both excited to see how it has developed and molded into a successful therapeutic approach for these men.

The second clinician has had more difficulties in breaking barriers with the youth and with agency staff. The clinician described their frustrations and various approaches' with working with the SSYI Men. The clinician initially went weekly to the agency to make introductions and engage with youth, but found that most of the youth were not coming directly to the center, but were being engaged through outreach services. After several weeks of the inability to find locations to seek the youth out, the clinician and agency outreach workers decided to have the clinician attend weekly basketball and sports games that SSYI youth were involved in to start to make connections. Although connections have been made, the clinician described the process of getting youth to go to one on one counseling services and to engage with them in topics about behavioral health and substance abuse has been a challenge. The clinician has had some success with agency staff providing them with youth referrals, but personal engagement with youth has been low. Agency staff and clinician are currently considering piloting mental and behavioral health services in which services would be provided over the phone, with the hopes that it would reduce stigma, and issues with transportation and time management.

Family Background & Support

The literature emphasizes the importance of family and community support in terms of behavioral health treatment and recovery for high and proven risk youth (National Mental Health Association, 2004; Howell, 2005; Administrative Office of the Courts, 2014; Cohen, 2010) As stated earlier, strong family support and community engagement can

make a difference in a child's recovery outcomes in adulthood, and a difference in recidivism rates for adults. When asking about parental involvement and support in behavioral health services for youth, interviewers presented several obstacles.

First, there is a huge distrust of institutionalized systems and youth are taught from a young age not to be "snitches"[20] and express their feelings and problems, especially if that involves discussing family members. One interviewee that was a former employee of DYS, discussed how a large majority of youth being familiarized with the Department of Youth and Family services at a young age, and that talking or "snitching" for some of these youth to providers is correlated to memories of youth being taken away from their families. Many of these youth have already engaged and interacted with providers many times throughout their lives, and have been disappointed with previous serious and may question why any new provider will be different.

This distrust of institutions is not only seen from the viewpoint of youth in SSYI, but also from their family members. One clinician described the families and parents as at times being barriers for a youth having the ability to engage in behavioral health services. The clinician went on to explain a situation in which they were able to build a relationship with a youth who was having trouble with their mental health, and through months of engagement, was finally able to convince the youth to attend a one on one counseling session with the clinician. However, since the youth was under 18, they needed to obtain

[20] "Snitch" refers to a popular slang term used by youth to describe a person who secretly tells someone in authority that someone else has done something bad; an informant (Cambridge Dictionary, 2017)

parental consent for the counseling services, and the mother refused to give it, stating that she didn't feel it was necessary for her youth to have the services.

The case managers and educator also described parents and family members as oftentimes themselves trying to find ways to cope with their own prior traumas, noting that trauma is often intergenerational with its effects passed on from parent to youth. Some parents of the youth have addiction and substance abuse issues as a potential coping mechanism, which can lead youth to not feel as supported in the home in receiving help. In the household for these youth, it is not uncommon for youth to witness substance abuse, and domestic violence, one interviewee went further to say it is seen as a normalized behavior whereas seeking help from a stranger (clinician) is seen as dangerous. The educator described family and parental support within the school system as extremely low, with school staff providing tremendous outreach to parents for parent-teacher conferences and back to school nights with little success in attendance. The educator recalled an incident when several youths got in trouble in school, and the teacher told the youth that parents will be called youth often respond with, "My mother doesn't care. My mother is a heroin addict".

Community Background and Support Systems

From a community support standpoint, numerous interviewees discussed the frustrations, disappointments, and concerns with the negative community views of the youth in the SSYI Program. Key informant 2 stated that from a young age, "these are seen as the throwaway kids that no one wants to deal with". In school, youth with familial ties to gang membership, are often labelled negatively and unfairly by teachers as future gang

bangers. A case manger went on to further explain that this labeling puts the child on a list, where these kids are watched and easily suspended, and sent to alternative schools. Frustrations from the case manager grew, as they expressed the seemingly lack of care or intervention for these youth. “Schools don’t intervene and help these kids when they are six, they wait until these kids are thirteen and just have them kicked out”. The schools are not the only disappointing and unsupportive systems for these youth, as another interviewee expressed their disappointment with the local Boys and Girls Club banning many SSYI youth from entering their facilities. This interviewee discussed how the youth have no where to go, and nothing to do because they have been blocked from community services. “The community doesn’t give these kids a chance, as adults we could do more for them”. In addition to being barred from various community venues, outreach workers have also expressed concerns of negative portrayals of the youth from local media sources and community members. All case managers expressed frustrations of community members negatively labeling SSYI youth as criminals, thugs, and gang bangers. One outreach worker spoke of a conversation they had with a local which the individual expressed that the youth should just be locked up. The media creates no alternative narratives either, instead it fabricates and facilitates further negative conversations about the youth.

Strategies with working with SSYI Youth:

All interviewees had commonalities in various strategies and approaches for working with this unique population. When asked, every interviewee commented on the importance of transparency, flexibility, consistency, and predictability when working with SSYI Youth. Being transparent, and honest with the youth was found to be an extremely important

attribute for both clinicians and outreach workers in building trust and relationships with youth. One clinician went on to express the importance of honestly in their work with the youth, and specifically in not pretending to know or understand experiences the youth have been through. “Kids will see fakeness, and attribute it to danger, having a different background than the youth in many ways, can cause challenges in treatment, but being honest and transparent about those differences has gone a long way in building relationships with SSYI Men”. Case managers highlighted that they felt more connections and understanding of the youth, then perhaps the clinicians, do to having prior trauma experiences themselves. The case managers said they used their prior trauma as a strategy to build connections with the youth and let them know that they are not alone, that they have been through similar experiences, and that they will be there for them.

Another outreach worker highlighted the importance of perseverance and consistency with the youth in telling a story about a youth that they were trying to engage in outreach. The youth called the outreach worker and said they were interested in services, when the outreach worker arrived at their house, the youth said they were not home. This happened on four separate occasions, until one time the youth came outside to great the outreach worker. Through later conversations the youth revealed to the outreach worker that they knew the outreach worker was there the whole time, the youth was testing them to see if they would continue to come back because other prior services had not. Every interviewee highlighted this theme and added that working with this population will take time, relationships will not build over night. These youths have had people and agencies walk in and out of their lives that said they would help and never did. Any provider or

clinician working with these youths have to understand that trust is gained over time, and that there is already a degree of skepticism from the beginning from the youth towards any new providers.

One agency's strategy for its outreach workers is to use Cognitive Based Therapy. Outreach workers are given trainings throughout the year on the approach, and pass this technique down to the youth through modeling behaviors. One outreach worker described this approach as transformational for the youth and staff because it opened up the youth to shift perspectives and negative thought processes. This therapy has also lead outreach workers to be more aware of their own triggers and how to recognize when they may be becoming re-traumatized with working with the youth. If a staff member feels they are being triggered, other staff members support them through a "tap in tap out" process, where another staff member steps into the conversation with the youth while the triggered staff member can take some time to decompress.

All interviewees also identified knowing the youth's family and support system as important in engaging the youth in services, and having family buy in to agency support. Outreach workers added on to this expressing the importance of meeting the basic needs of the youth and their families is the first step to engaging them in future services. If a youth does not have enough to eat, doesn't have warm clothes, or shelter, they are not going to want to engage in tutoring, recreational, or any other services we have available.

Lastly, interviewees felt that involving youth in traditional screenings, intakes, assessments and individualized therapy would not be effective. Having traumatized youth sit in a chair for 45 minutes taking about past traumas may be seen as more detrimental to

developing trust with the youth than being helpful. Both clinicians agreed with this statement, saying that they have altered their intake process to be more informal and to take several weeks instead of one sitting, because they felt the initial assessments to be too invasive and inappropriate to administer to an initial visit with a youth. For behavioral and mental health therapy, outreach workers discussed the importance of clinicians having flexibility and being creative with their approaches with the youth. Several outreach workers commented that having the youth go to scheduled appointments, in foreign offices, where they sit in a chair for an hour may not be the best way to engage youth, and that flexibility in meeting the youth where they are at, and how they would like their treatment to be, is essential to successful interventions. Case managers and clinicians have found the group therapy dynamic approach so successful because it allows youth to meet in a safe space that they are familiar with, with an outreach worker they trust, and in a flexible yet consistent environment.

Barriers to working with SSYI Youth:

Stigma was described as the number one barrier from all interviewees in engaging youth with behavioral and mental health needs. This includes a negative stigma of behavioral health services not only from youth, but from their families, and community members. Being a man and owning one's masculinity was seen to clash with the feminine stigma of talking and discussing one's feelings to another person. When talking to one outreach worker, they discussed how culture, pride, and family ties also factor in to resistance from engaging in mental health services. Boys are taught from a young age not to cry, and that bad things will happen to them if they let out their emotions. In a culture of

"no snitching", boys are told to keep their feelings to themselves as a form of self protection. Stigma for behavioral health is high in African American and Latino communities, with fear that other community members will label them as "crazy", destroying their hard reputations. One DYS worker further described how the fear of stigmatization, can led to the fear of safety for these men if they are labeled as having a mental illness. "Having a tough bravado is what keeps them alive", and since mental illness is so widely seen as a weakness in society, and to these men, it can be dangerous for them.

Meeting with a clinician, seems very foreign and intimidating to many of these families and youth, and breaking that stigma of seeking help is hard to overcome. One clinician described strategies with engaging with stigma and behavioral health services for the men by rewording and relabeling stigmatized therapy terms. For example, the clinician has called the group therapy sessions, the "men's group" with no mention of the word "therapy". This clinician markets the group to the men, as a space with a similar vibe of an AA meeting, where the men can get together and casually bring up and discuss any issues they feel like discussing freely. The free flowing structure, has allowed the men to engage in therapy and difficult discussions without realizing they are engaging in therapy.

Additional Problem areas:

Both clinicians and outreach workers described a tension and clashing between the roles, responsibilities, and effectiveness of each other in working with this population. The clinicians described their relationship with their youth as having to be ethically "one-directional" while the outreach workers described their relationship as give and take, and

more in terms of a friendship with self disclosure, and vulnerability as a cornerstone. Outreach workers expressed concerns over the mismatch between the clinicians and youth stating that the clinicians were different in age, gender, race, socioeconomic status, educational attainment, criminal history, and life experiences, describing them as someone who is un-relatable to the youth, and thus someone not to be trusted. Clinicians described the outreach workers as at times having boundary issues with the youth, seeing the relationship to be too close.

Additionally, clinicians and case managers both expressed frustrations in the restrictiveness of the grant, with an overall feeling that the strict rules and regulations regarding reporting and care has limited the effectiveness of providers. For the clinicians, they felt that not having the ability to work full time on the grant, as well as not having additional funds for the youth to engage in activities outside of group counseling was deterring the creation of building trust and stronger relationships. They also felt that reporting on "tangible" behavioral health outcomes was difficult as behavioral and mental health takes time.

Summary:

All interviewees expressed and re-emphasized the importance of the addition of the behavioral health component to the grant, but didn't feel that the behavioral health model is currently as effective at reaching the youth as it could be. One case worker expressed that, "behavioral and mental health looks great on paper as a new addition to the grant, but hasn't worked out all its kinks yet". Several outreach workers discussed their wishes that they could receive additional training in regards to mental health and substance abuse, and

felt that they could have the ability to reach and engage their youth more so than the clinicians. While the clinicians wished that they could have more agency and partner support in order to gain connections with the youth, and engage them in behavioral and mental health services.

One major contributor to the interviews was the finding of the significance of the relationship between the outreach workers and the clinicians and the impact this relationship had on youth engagement. The agency that had a strong relationship between the case manager and clinician, had high youth engagement, with the insight that youth respond better to a clinician who has gained the trust of the case manager, someone the youth trust. Through the strong relationship, this clinician was able to gain trust, and has had a steady involvement of youth in group therapy sessions. It is highly recommended that future staff and clinicians think about engaging this way, because it has produced such great results for the men in the program and for the clinician helping them.

Additionally, the significance of using alternative methods of therapy and engagement with the youth, can not be undermined. Group therapy was found to be way more effective in engaging the youth than individual therapy sessions, and again having the case manager participate in the group therapy process provided youth with a sense of safety, and trust towards the clinician and the therapeutic process. For future therapy, it is highly recommended that new and current clinicians to use the group therapeutic model as a starting point to engage the men in therapy, and to build out different therapy models from there.

VI. Discussion Section:

Reflecting back on the literature, the SSYI high and proven-risk youth participants present trauma histories, and behavioral and mental health attributes in alignment with academic research. Through untreated behavioral and mental health symptomology, many of these young men have engaged in violence and hyper-masculinity as a negative coping mechanism for the trauma they have had to endure (Kerig & Becker, 2010; Corcoran, 2005; Children's Services Working Group, 2015; Dierkhising, 2013, SAMHSA, 2014) Interviewees and academic researchers both agreed that trauma histories have led these youths to be more vulnerable to future gang membership, and involvement within the juvenile justice system if left untreated (Howell, 2005; Children's Services Working Group, 2015; Kerig & Becker, 2010; Dierkhising, 2013, SAMHSA, 2014)

Treatment methods and recommendations in ways that clinicians should engage with youth is where there is contention within the literature and interview responses. While the literature promotes engaging with high and proven risk youth from an individualized cognitive behavioral therapy and multi-systemic therapy approaches, (Administrative Offices of the Courts, 2014; National Mental Health Association, 2004; Cohen, 2010; SAMHSA, 2012) there is dissonance between what is recommended and what is seen effective in the field in SSYI. Any kind of individualized therapeutic approach in SSYI has led to extremely low engagement and interest from men. Additionally, the Multi-systemic therapy approach may be even seen as an inappropriate treatment method for this population, as many of these high and proven risk men have had prior histories of abuse, and neglect from family members, negating the effectiveness of having family involved positively in treatment (National Mental Health Association, 2004) Clinicians, outreach

workers, and case managers have all seen the value of group therapy as an effective strategy to initially engage the youth in behavioral and mental health services, with the insight, that it is a less stigmatizing and intimidating approach for the men.

However, one major gap and struggle that interviewees addressed was finding out ways to engage the youth in group and individualized therapy, so they could get more support, and treatment. As discussed, resistance to individualized therapy has been high, and the literature does not provide much in terms of how to further engage and transition high and proven risk youth to more intimate therapeutic approaches. The clinicians addressed the value of group therapy as a way to get men engaged initially to therapy, but also addressed the importance of moving men towards smaller therapeutic groups, and more personalized therapy approaches and individualized goals to help with more complex trauma and PTSD.

Additionally, it is recommended that trust and the value of relationships for high and proven-risk youth should be further researched and investigated in the academic field to better inform clinicians in how to better connect with this population. Due to a long history of systematic and institutionalized racism and discrimination in the United States, many youth of color and their families need clinicians and case managers to step up and prove to them that they can be trusted (Whaley, 2001; Freimuth, 200l; Brandon, 2005; Rawal, 2004; Atdjian; 2005; Eiser, 2007) Clinicians need to be aware that they have to work within this paradigm of trust in order to begin to build a relationship with the youth, and that this building of trust will not be instantaneous. Additionally, clinicians need to address how to appear less threatening and intimidating to youth, with the thought of using

self-disclosure as a tool for building trust with the youth.(Myers, 2006; Hill, 2002) The formality of the current structure of clinicians keeping an arms length away from clients without using self-disclosure may not only hold them back from creating relationships with high and proven risk youth, but may lead to a youth's immediate mistrust and perceived lack of relatability with the provider.

Through interviews with the clinicians, they all expressed initial frustrations with their inability to engage with the youth and their behavioral health initially, with later reflections on realizing the population that they are working with is different than the typical clientele they may have in the general population. One clinician realized that the only effective way to engage with the youth was for them to build strong relationships with other adults that the youth trust and see as role model figures, such as their case mangers and outreach workers. Once the youth slowly see the relationship with their case managers and outreach workers build, it was found that they were more apt to engage with the clinician and participate in group meetings and therapy. Having the outreach worker and/or case manager on board and in alignment with the clinician on the importance of mental and behavioral health, and treatment methods is essential as well. When the clinician involved the outreach and case managers in group therapy, the young men in SSYI were described as feeling more comfortable, and open to therapy.

Both the literature and interviews additionally stress the high need and importance for cultural competency and consistent trainings (Eiser, 2007; Brandon, 2005; National Mental Health Association, 2004; Rawal, 2004) Especially with the current lack of diversity in the mental health field, clinicians may need additional trainings on how to

engage with a population that is very different from themselves, and to understand the historical contexts surrounding decades of systematic racism and discrimination from the medical field that may people of color have experienced which may lead to a current perception of mistrust of clinicians.

Lastly, the interviews further enhanced the findings of the academic literature that not enough programming is happening in terms of prevention, early intervention, and early screenings in terms of trauma and behavioral health. It is unacceptable that for the majority of youth of color struggling with mental and behavioral health diagnosis due to childhood trauma, that they are receiving their first mental health intervention and treatment in the juvenile justice system (Whaley, 2001; Harris, 2013; Corcoran, 2005; Rawal, 2004; Atdjian; 2005; Buffington, 2010; Hughes, 2015) Communities, schools, public health centers, law enforcement, and city officials need to do more to ensure that high and proven risk youth receive the treatment they deserve in a timely manner. Early intervention could help children with trauma to not become another statistic in the juvenile justice system, if they receive care immediately for potential serious mental and behavioral health conditions at the initial onset period of the illness.

VII. Final Conclusions and Recommendations

Overall, high and proven-risk young men have many behavioral and mental health needs that are currently not being met or addressed. From a young age, the majority of high and proven-risk young men experience multiple complex traumatic experiences, leading to a lack of diagnosis' of many serious mental health illnesses such as PTSD, and Complex Trauma, which can increase the risk for future gang membership, future arrest,

and delinquency in adulthood if left unaddressed. (Howell, 2005; Kerig & Becker, 2010; Children's Services Working Group, 2015; SAMHSA, 2012) "The mentally ill are frequently criminalized, and are housed in confinement facilities such as jails and prisons where they may or may not receive the necessary treatment" (Gary, 986). As seen in the literature, oftentimes more than not, trauma and mental illness is left unaddressed, and little successful intervention is done, especially with young men of color (Whaley, 2001; Freimuth, 200l; Brandon, 2005; Rawal, 2004; Atdjian; 2005; Eiser, 2007). Disparities in the treatment of young men of color in mental health services is present, with additional issues involving hypermasculinity, and high stigma of mental illness', that has led to the underutilization of mental health services. Oftentimes, the first point of screening and intervention done for mental health, is not until a youth is involved in the juvenile justice system (Rawal, 2004; Atdjian; 2005; Eiser, 2007) Within the juvenile justice system itself, retraumatization is present, and youth are grossly underserved due to resource limitations and time constraints.

With gaps in the prevention, intervention, and treatment of high and proven risk youth, the literature addresses early intervention, mental health literacy, and an expansion of mental health screenings being done for youth in schools, and community centers. If a youth experiences a traumatic event early in their life, and the community is able to provide immediate support through Cognitive Behavioral Therapy, or Multi-Systemic Therapy, a youth can potentially be diverted from the juvenile justice system later in life, and learn positive coping strategies and mechanisms (The Administrative Office of the Courts, 2014; The National Mental Health Association, 2004; Cohen, 2010, Kerig &

Becker, 2010) However, with high and proven-risk youth, therapists need to be aware of how to work and engage in a way that the youth will respond as traditional methods of therapy and counseling may be ineffective. Therapists need to learn how to use creative ways to build trust, safety, and support with a traumatized child or youth.

From analyzing the behavioral health component of the Safe and Successful Youth Initiative program in Worcester, Massachusetts, clinicians and case managers are using innovative and effective ways to engage with their high and proven risk youth. Through SSYI, the program understands the importance of behavioral and mental health services, through putting these services directly into the grant. From further investigation, the high and proven-risk youth served through SSYI match very closely to the high and proven-risk youth described in the literature in terms of behavioral and mental health needs. Both groups of youth have had multiple traumatic childhood experiences, that have led to teenage delinquency, gang membership, and at times involvement with the juvenile justice system. Many of the men in SSYI have struggles with co-depending disorders such as substance abuse with PTSD or Complex Trauma.

The delivery and process of behavioral and mental health services differs between clinical agencies in SSYI, but there is an understanding across the board between clinician's, educators, and case managers that approaching high and proven-risk youth must be done differently than with other populations of youth. The introduction of mental health services must be done with caution, with relationships with case managers and clinicians as the best way to create strong relationships and a foundation of trust with the young men. Creating an alternative intake process, a men's group that isn't labelled as a

mental health group, and focusing on building connections with youth as a way to engage in treatment, has been found to be successful. It is understood, that time is needed for behavioral and mental health services, and positive outcomes and treatment is not instant, which can be difficult for clinicians who work with a grant process that is success driven and outcomes based.

Parts of the literature and academic research have also yet to catch up to the successes from the SSYI Program. For example, the success of group therapy using Cognitive Behavioral Therapy and telehealth as an additional technique to reduce stigma, have yet to have been extensively researched in the academic field, but have been found to be successful alternative modes of therapy in practice.

For future recommendations, SSYI should continue to work in a unique framework when it comes to delivering and treating mental and behavioral health for high and proven-risk men. It is recommended that all staff who interact with youth become trauma-informed, and take part in continuous educational trainings in cultural competency. For clinicians and case managers, their relationship to each other is important for the youth to see. How they interact with each other can have a direct effect on whether or not a youth decides to engage with a clinician. Having a strong working relationship between clinicians and case managers can lead to more beneficial engagement for the youth in terms of mental and behavioral health treatment. Additionally, clinicians should test out different methods of therapeutic models that may work best for the youth, including using self-disclosure as a way to gain trust with a youth, keeping in mind that traditional models may be ineffective.

Overall, the right tools, methods, and practices are available to help high and proven risk youth to heal from their childhood traumas and prevent them from entering the juvenile justice system later in life, they just need to be utilized in a supportive, communal way, that will engage behavioral health specialists, outreach workers, schools, communities, families, and youth. These high and proven risk youth deserve every effort to be provided to them with the screening, intervention, and treatment they need for recovery, and as a community we must work harder to address current gaps in the systems in place.

VIII. Appendix A: Interview Questions for Clinicians

1. What is your role in the SSYI initiative? What is your relationship/interactions to the young men who are served?

2. For the SSYI grant, what is the process that is taken in regards to identifying young men with mental health illnesses and substance abuse to finding them appropriate treatment and care?
    a. How does the referral system work? Screening process? How is a counselor matched with a young man? What steps then occur? How often are therapy sessions? What does a generic treatment plan look like?
    b. How are counselors initially interacting with young men?

3. What are the most common and frequent types of mental health issues that you see in young men? In young men in the SSYI program? Do you think this is specific/unique to the population- why or why not?

4. What are some of the barriers for high-risk or proven risk youth to receive mental health services?

5. Specific to Worcester and specific to gang members, what are some variables that are influencing mental health issues for young men in SSYI program? What obstacles and struggles have young men in Worcester had to face and how has this influenced their mental health? (ej: exposure to violence & trauma)

    a. How does victimization and perpetration of violent crimes affect mental health?

6. What are the consequences for young men with mental illnesses who do not receive treatment for PTSD? Conduct Disorders? What are the benefits for young men who receive treatment?

7. How is stigma of mental health connected to receiving services? Is there a stigma specifically for young men being diagnosed with a mental illness and/or when attempting to receive treatment?

8. What are the current strategies you have been using to engage young men in SSYI program in mental health services? What do you believe has and/or hasn't been successful? (ej: individual vs. group therapy, outreach)

9. How do you make sure that your interventions and therapy is culturally sensitive and developmentally appropriate?

10. How can we incentivized young men to seek mental health services? To have more "buy-in" in regards to health needs?

IX. Appendix B: Questions for Youth Workers/Outreach Workers

1. What is your role in the SSYI initiative? What is your relationship/interactions to the young men who are served?

2. What are the most common and frequent types of mental health issues that you see in young men in general? In young men in the SSYI program? Do you think this is specific and unique to the population- why or why not?

3. What are some of the common struggles and hurdles that these young men have had to overcome and continue to deal with? Do you think this affects their mental health?

4. How many of the young men that you are working with have been victimized? Have childhood trauma experiences? (estimate)

5. What strategies have you found to be effective in engaging the men in conversations about mental health and substance abuse? (Fishing trip, basketball games)

6. What do you think are some of the barriers of engaging men in mental/behavioral health services? (cost, location, trust issues) Of having them seek treatment? Is their stigma involved?

7. What are some hopes and wishes that you have for the young men in this program? What are some of their strengths?

8. For the SSYI grant, what is the process that is taken in regards to identifying young men with mental health illnesses and substance abuse to finding them appropriate treatment and care? What does your referral system look like?

9. How can we incentivized young men to seek mental health services? To have more "buy-in" in regards to health needs?

10. What recommendations would you make for helping young men to address their mental health, as well as for a better understanding of their unique mental health illness

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