Juvenile Re-entry Occupational Therapy Life Skills Program Summary and Evaluation

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Introduction

Occupational justice promotes the belief that individuals have the right to engage in occupations to sustain a healthy quality of life (Durocher, Gibson, & Rappolt, 2014). During incarceration, this right becomes tarnished as occupational opportunities are limited as many are told how to occupy their time. According to the American Occupational Therapy Association (AOTA), these injustices can present in a community that lacks accessible and inclusive physical environments and provides limited services and supports, making participation difficult or even dangerous for people who have disabilities (AOTA, 2020). Juvenile correctional facilities are full of restrictive guidelines and individuals present with disabilities. It's imperative that occupational therapy practitioners are implementing occupational justice into their everyday practice so that clients are given equitable opportunities to be able to successfully participate in their occupations.

Furthermore, occupational therapists have been provided with a guide, Occupational Participatory Justice Framework, to combat these injustices and decrease the risk and effects of incarceration (Jaegers et al, 2020). With other tools such as assessments, activity analysis and client-centered, occupation-based interventions occupational therapists can 1) identify limitations that are preventing independence to community reentry, 2) create goals to eliminate those limitations, 3) teach skills necessary for successful community reentry, and 4) develop and implement programs that can combat the needs of the institution (Bradbury, 2015). By using these strategies, occupational therapists could further prevent recidivism if given rehabilitation access to juvenile offenders.

There is a high prevalence of incarcerated youth that present with disabilities; this can range from single digits to upwards of 90% of the juvenile population (Morris & Morris, 2006). Zhang et al (2011), presented that youth with disabilities are a vulnerable group in juvenile facilities: they are referred to the facilities earlier than those without disabilities; they are referred for more serious crimes than youth without disabilities; and lastly, they experience a shorter time between recidivisms when compared to those without disabilities. Occupational therapists are a part of the rehabilitation team that are taught to meet each individual where they are at on a cognitive, physical, and spiritual level to obtain the highest level of independent functioning. Developing programs that focus on adapting everyday life activities for these individuals could be the key to their success while in the facility and when transitioning back into the community.

In addition, successful integration into a community after release from prison is the largest predicting factor of recidivism (Woods et al., 2013). Findings from Wiesner et al (2010), show a detrimental significance between the number of juvenile arrests and the occurrence of mental health problems on subsequent unemployment into the twenties. Employment is another crucial factor for influencing recidivism rates (United States Department of Justice, 2011). The main reasoning for unemployment was the individual's lack of self-control, leading to a higher rate of substance abuse (Wiesner et al, 2010). Vocational rehabilitation has been shown to discourage future delinquency and involvement with the justice system as high as 85 percent (Office of Juvenile Justice and Delinquency Prevention, 2010). By implementing a life skills program that builds on skills such as conflict-management, problem-solving, time management, and much

more, individuals can work on obtaining self-control through gaining independence in basic life and work-related competencies.

Lastly, U.S. taxpayers pay an additional 8-21 billion dollars on long-term youth confinement. This amount does not account for daily or monthly rates for short-term confinement (Justice Policy Institute, 2014). The amount is even higher when looking at the adult facilities, which is where many juveniles could end up without proper rehabilitation. A cost-benefit analysis reported that every dollar invested in prison education programs yields a five-dollar reduction in incarceration costs during the first three post-release years (Davis et al, 2014). Recidivism will continue to place both financial and public safety concerns across communities. Occupational therapy can reduce recidivism rates and society burdens by facilitating successful community reentry programs (Bradbury 2015). In order for these individuals to transition into the community successfully, they need a professional that will create holistic interventions that include everyday life activities to promote independence and vocational skills: an occupational therapist.

During the time period of January 2022- April 2022, a Doctor of Occupational Therapy (OTD) candidate interning with the Iowa Department of Human Rights Division of Criminal and Juvenile Justice Planning (CJJP) developed and implemented an occupation-based life skills development curriculum aligned with the Occupational Participatory Justice Framework. The purpose of this curriculum was to support youth in their readiness for reentry to their community upon release from out-of-home placement. Participating youth were adjudicated delinquent and ranged in ages from 14-17 years old. The topics covered in the curriculum included: community transportation, healthy relationships, housing, insurance/ community safety, meal planning & preparation, medication management, money management, community resources, self-regulation, time management, and work readiness.

Research Questions

To evaluate the effectiveness of the life skill curriculum, the OTD student and staff members from CJJP developed the following research questions:

1. Is there a difference in youth's readiness for re-entry and the dosage/ duration of the skill-building groups?

2. Is there a relationship between youth's participation in OT life skill-building intervention and their readiness for independence and successful re-entry?

3. What interventions best address the social-emotional needs of youth?
    a. Short term measure: Below average scores on the SSIS-SEL

4. Is there a specific life skill(s) and/or intervention that influenced youths' readiness?

Program structure (Methodology)

Youth selection

Clinical staff and facility case managers identified youth (N= 22[1]) for participation in the program. Upon identification, youth were placed in the following groups:

- Youth discharging within 90 days of program start- N= 5 (90-day discharge group)
- Youth discharging within 30 days of program start- N= 11 (30-day discharge group- 2 groups)
- Girls group- N= 5

Additional youth (N=1) participated in individual sessions with the OTD student.

Interventions

Prior to the start of the program, the OTD student met individually with each youth to complete an Occupational Profile. This profile assists the OTD student in identifying the youth's goals, strengths, and needs to determine the dosage and duration for interventions to be provided individually or in a group setting.

The domains and questions addressed in the Occupational Profile are:

- Activities of Daily Living (ADLs)
    - How did you sleep last night? Do you ever wake up during the night? What's causing you to wake up (bathroom, caffeine intake, etc.)?
    - Tell me what a typical day looks like for you? –Showering, brushing teeth, etc.

- Instrumental Activities of Daily Living (IADLs)
    - Do you have any work experience? What went well? What was difficult?
    - What was school like for you? Did you find it hard to ask for help?
    - Do you have any experience with managing money? Do you have a bank account? Have you used a Credit card/debit card?
    - Did you grow up doing any chores? What kind of chores do you do now? Do you enjoy them? How often do you do them? Meal preparation/grocery shopping/Laundry
    - Have you ever used public transportation? How did it go for you?
    - What are some of your hobbies or interests/things you enjoy doing?
    - Are you currently taking any medications? Do you know what they are? Can you tell me how often you are supposed to take them? Any precautions or things you aren't supposed to do with them?

[1] 18 youth had both the pre-/post- EFPT assessments completed. Four youth had only the pre- assessment.

- Other
    - Tell me about what brought you here?
    - Any history of substance abuse?
    - Any history of delusions/hallucinations…have you ever heard voices or seen something that other people didn't hear/see
    - What are some of your most important values/beliefs? –What are some things that make you, you?
    - How is your relationship with your family/friends? Anyone that you count on the most?
    - What are some of your goals for the future?
    - What/who are your biggest supporters?
    - What are some barriers or challenges that you see impacting your future?
    - Is there anything else I should know about you?

Upon completing the Occupational Profile, the OTD student performed an assessment to observe each individual participant's ability to perform various life skills and determine what specific cognitive functions may be impacting their independence. In addition, these individualized assessments helped the OTD student better prepare for how to best implement interventions, based on the type or level of assistance the individual required. The Executive Function Performance Test was chosen for this individualized assessment because it is a standardized performance test for ages 13+ (as participants age ranges were 14-17) and it has an enhanced version that would help the OTD student to determine if interventions were effective in follow-up post-testing.

After each participant was assessed, the OTD student began facilitating the groups (2x/week for 10 weeks). Following the initiation of the groups, the OTD student asked youth which skill(s) they wanted to focus on during the next session. This process allowed youth voice and choice over the content they saw as most important for their transition back to the community. The list of interventions for each group is identified in Figure 1.

Figure 1: Interventions by Group

	First 30-day group (n=5 boys)	Second 30-day group (n=6 boys)	Girls group (n=5)	90-day group (n= 5 boys)
Money management session 1 (Budgeting)	x	x	x	x
Money management session 2 (Banking, Bills, Taxes)	x		x	
Money management session 4 (Preventing Scamming/Fraudulent Activity)				x
Housing	x	x	x	x
Interviewing/ Resume rough draft	x		x	x
Health insurance	x		x	
Cooking	x	x	x	x
Meal planning session 1 (Learning 5 food groups and meal planning)	x			x
Meal planning session 2 (Building a grocery list, grocery map routing)	x			x
Meal planning session 3 (Staying within a budget when grocery shopping)				x
Time management (Prioritizing conflicting events, planning ahead)	x	x		
Car insurance		x	x	x
Healthy relationships (Roommate Agreements)		x	x	x
Medication management (Health Literacy, Pill Sorting)		x	x	x
Self-regulation session 1 (Hearing & Taste)			x	
Community transportation (Walking, Driving, Busing-planning ahead)			x	
Community safety				x
Total Amount of Groups	**6 minimum**	**7**	**9**	**12**

Measures

The development of the OT program was measured using the following tools. Effectiveness of interventions was also measured using the EFPT/EFPT-E. A description of how each tool was administered in the structure of the program is included below the description.

Social Skills Improvement System- Social Emotional Learning Edition (SSIS-SEL) Assessment

The SSIS-SEL is a self-reported assessment that takes 15-20 minutes to complete. The participant must be 12-18 years old. The SSIS can be administered by any health professional with a master's degree or higher including occupational therapists, occupational therapy assistants, mental health counselors, social workers, case managers, psychologists, etc.

The SSIS-SEL evaluates self-awareness, self-management, social awareness, relationship skills, responsible decision making, and core skills. The core skills assessed include: Listening to others, saying please and thank you, following the rules, paying attention to work, asking for help, taking turns when you talk, getting along with others, staying calm with others, doing the right thing, and doing nice things for others.

- Self-Awareness-the self-awareness scale assesses the participants ability to recognize how their thoughts can impact their behaviors. Participants that score below average or well below average for this category are likely to experience social anxiety, ignore meaningful social interactions, and/or show immature behaviors.
- Self-Management-the self-management scale assesses the participants ability to self-regulate their thoughts, feelings, or behaviors during different situations: stress management, impulse control, self-motivation, and goal setting. Here participants that score below average or well below average may have difficulties with the following: following directions, attention, staying calm, refraining from bothering others, responding to negative situations, impulse control issues, and lack of effective planning skills.
- Social Awareness-the social awareness scale assesses the participants ability to empathize with others, understand social and ethical norms, and identifying supports. Participants that score below average or well below average tend to have difficulty understanding other people's problems or emotions and lack the ability to provide comfort to individuals experiencing these issues.
- Relationship Skills-the relationship skills scale assesses the participants ability to form and maintain healthy relationships with others. Participants that score below average or well below average may have skill deficits with the following: communication, listening to others, cooperation, peer pressure, and asking for help.
- Responsible Decision Making-the responsible decision-making scale assesses the participant's ability to make decisions about their behavior and interactions taking into consideration ethical standards, safety, social norms, consequences, and well-being of self and others. Participants that score below average or well below average tend to struggle to take responsibility for their actions and act responsibly.

The SSIS- SEL was scored using a raw/standard score and percentile rankings. The raw score was determined by summing the scores of the items for each scale. Because the number of items on each scale varies, scale raw scores were transformed into standard scores to make them more interpretable. The standard score was found by relating the individual's raw score to the distribution of raw scores in their normative group (considering age and gender). Standard scores represented an equal-interval scale that had a mean of 100 and a standard deviation of 15. The percentile ranks ranged from 1 to 99 to indicate the percentage of individuals in the normative group who scored at or below a given raw score. Individual scores were flagged if they were falling into lower categories (responding not true or a little true).

To administer the SSIS-SEL, each participant was given a paper packet containing all 46 questions where they were to respond using a Likert scale (not true, a little true, a lot true, very true). Each packet was completed with a case worker or the occupational therapy student present to ensure proper understanding of questions. Responses were manually entered through Pearson's website, producing scores and a generated report with skill recommendations for each individual.

Executive Function Performance Test (EFPT)/ Executive Function Performance Test Enhanced (EFPT-E) Assessment

The EFPT/ EFPT-E is an observation-based task assessment that takes 30-45 minutes to complete. Participants must be 13+ years. This assessment can be administered by anyone with access to the administration manual.

To complete the EFPT/ EFPT-E, participants were asked to complete four different tasks: simple cooking, telephone use, medication management, and bill payment. This test evaluated which executive functions impacted independence and helped determine the amount of assistance needed. According to the EFPT, if the participant is not familiar with a checkbook, the bill payment task is to be excluded. None of the youth included in the OT program had experience with a checkbook so that task was excluded from this assessment. It should also be noted that the EFPT-E does not include the telephone tasks. To allow for pre-/post- comparison, participants were engaged in a graded-up telephone task where they were asked to recall three pieces of information instead of one and were not given a specific vendor to find.

The EFPT/EFPT-E is scored through five constructs: initiation, organization, sequencing, judgment and safety, & completion (refer to Figure 2 for definitions/expected behaviors). Each construct can be scored from 1-5 based on the level of cueing provided by the administrator (refer to Figure 3 for cue types and descriptions). The administrator uses each cue type twice with the participant before moving to the next cue type. After completion of each task, each participant is then given a total score of the task, based on the cues provided for each construct. This number can range from 0-25, zero being completely independent and twenty-five being completely dependent in the task. Finally, a total score is given for all tasks completed. Because three tasks were examined participants' total score would range from 0-75, a lower score indicating that the participant is more independent.

Figure 2: Components of the Executive Function Performance Test

Executive Function Component	Definition	Expected Behavior
Initiation	The start of motor activity that begins a task.	The individual moves to the materials table to collect items needed for the task.
Execution	The proper completion of each step, consisting of three requirements: organization, sequencing, and safety and judgment (see below).	The individual carries out the steps of the task.
Organization	The physical arrangement of the environment, tools, and materials to facilitate efficient and effective performance of steps.	The individual correctly retrieves and uses the items that are necessary for the task.
Sequencing	The coordination and proper ordering of the steps that comprise the task, requiring a proper allotment of attention to each step.	The individual carries out the steps in an appropriate order, attends to each step appropriately, and can switch attention from one step to the next.
Judgment and Safety	The employment of reason and decision-making capabilities to intentionally avoid physically, emotionally, or financially dangerous situations.	The individual exhibits an awareness of danger by actively avoiding or preventing the creation of a dangerous situation.
Completion	The inhibition of motor performance driven by the knowledge that the task is finished. The person does not perseverate and keep going	The individual indicates that he/she is finished or moves away from the area of the last step.

Figure 3: Levels of Cueing Provided on Executive Function Performance Test

Cue Type	Cue Description
No Cues Required	The participant requires no help or reassurance, does not ask questions for clarification, goes directly to the task and does it. Self-cueing is acceptable. Ex. speaking to oneself.
Indirect Verbal Guidance	The person requires verbal prompting, such as an open-ended question or an affirmation that will help them move on. Indirect cues are also not task specific and should come in the form of a question: Do you need anything else?, Is there anything you need to do first?, Do you need another item?, What do you need to do next?, Is there another way to do that?, Is there anything you forgot?, Anything else you need to consider? **Avoid** direct phrases such as "read the instructions" or "turn on the stove."
Gestural Guidance	The person requires gestural prompting. At this level, you are not physically involved with any portion of the task. Instead, you should make a gesticulation that mimics the action that is necessary to complete the subtask, or make a movement that guides the participant, e.g., you may move your hands in a stirring motion, point to where the participant may find the item, point to the appropriate level on the measuring cup, etc. You may not physically participate, such as handing the participant an item.
Direct Verbal Assistance	You are required to deliver a one-step command, so that you are cueing the participant to take the action. For example, say, "pick up the pen" or "pour the water into the pan."
Physical Assistance	You are physically assisting the participant with the step, but you are not doing it for him/her. You may hold the cup while he/she pours, hold the check book while he/she writes, loosen the cap on the medicine container, etc., but the participant is still attending to and participating in the task.
Do for the Subject	You are required to do the step for the subject.

Before meeting with the participant, the administrator reviews the EFPT checklist to ensure that all assessment materials are placed in a storing bin. Prior to completing any tasks, participants are asked a series of pre-test questions to determine their previous experience with each task and to indicate how much help they think they will need. This series of questions tests self-awareness. After completing the pre-task questions, participants are given standardized instructions prior to initiating each task. The test begins with the cooking task, followed by the telephone task, and finally the medication task. The administrator does not initiate conversation, "cheer lead", or provide feedback to the participant during the test.

Youth Satisfaction Survey

The Youth Satisfaction Survey was given to each participant at the end of the program. Participants were notified that their participation in the survey was anonymous. The Youth Satisfaction Survey was a measure developed by the OTD student and asked youth to rate their confidence for each skill targeted through the interventions (money management, meal planning, work readiness, housing, insurance, self- regulation, time management, medication management, and cooking). Youth indicated their need for help in the future for each skill targeted through the interventions (money management, meal planning, work readiness, housing, insurance, self- regulation, time management, medication management, and cooking). Finally, the youth indicated their agreement/ disagreement with the following statements:

- After participating in occupational therapy group, I have a better understanding of what occupational therapy is.
- We spent enough time learning each skill in occupational therapy group.
- The way information was taught to me in occupational therapy group matched the way I learn best.
- Participating in occupational therapy group has better prepared me to transition back to my community.
- Facilities like Woodward Academy should have an occupational therapist on staff.
- Occupational therapy group was helpful.
- Occupational therapy group improved my life skills.
- The number of occupational therapy groups was enough.

Findings

During the administration of the Occupational Profile youth identified the following needs/ goals: obtaining housing, obtaining a driver's license and vehicle, getting and maintaining a job, completing school, paying off restitution, completing requirements of probation, learning money management skills, and acquiring health insurance. Additionally, youth identified barriers and challenges. Youth noted a difficulty establishing and maintaining healthy relationships with their friends in environments that historically provided little support. Youth acknowledged the challenges associated with overcoming their legal involvement, getting and managing money, and mitigating substance abuse triggers. Youth also noted they are a barrier to their own progress due to issues with motivation, impulsivity, and anger.

EFPT-E results

After analyzing pre- and post-assessment changes, 50% (N=14) of youth showed an increase in independence with their total scores. When looking at specific tasks, 92.8% (N=14) improved their cooking skills, 78.5% (N=14) improved their problem-solving skills with telephone usage, and 64.2% (N=14) improved their independence with medication management.

Research question 1: *Is there a difference in youth's readiness for re-entry and the dosage/ duration of the skill-building groups?*

When comparing groups, 42.9% (N=7) of the second 30-day boys group showed overall improvement; 75% (N=4) of the 90-day boys group had overall improvement; and 100% (N= 4) of the girls group had overall improvement. These results show that youth participating longer than 30 days had better improvements with their life skills and executive functioning. It should be noted that the EFPT-E does account memory into score calculations, under sequencing. However, this can be misleading as many of the participants showed improvements with their ability to follow instructions accurately, but could not recall the information associated with each task.

Research question 2: *Is there a relationship between youth's participation in OT life skill-building intervention and their readiness for independence and successful re-entry?*

With the exclusion of memory, 92.9% (N=14) of youth showed overall improvement, specifically with sequencing & judgment and safety. Common mistakes that were seen included: forgetting to turn off the burner, knowing when to reduce heat, forgetting to set a timer, effective planning to allow for the spaghetti and sauce to be done simultaneously, forgetting the size and/or kind of pizza requested, forgetting what day/time they were asked to recall for the medication, placing two tablets instead of four tablets for "take two tablets twice daily."

SSIS-SEL results

When analyzing results for all youth participants, 44.4% (N=18) were considered below average or well below average for core skills (listening to others, saying please and thank you, following the rules, paying attention to work, asking for help, taking turns when you talk, getting along with others, staying calm with others, doing the right thing, and doing nice things for others). Additionally, 38.9% (N=18) were below average in self-management and relationship skills, 27.8% (N=18) were below average in self-awareness and social awareness, and 11.1% (N=18) were below average in responsible decision making.

Research question 3: *What interventions best address the social-emotional needs of youth?*

The top areas for intervention were indicated through the SSIS-SEL questions where more than 50% of youth (N >= 10) responded with not true or a little true. These questions were:

- "I tell others when I'm not treated well,"
- "I show others how I feel,"
- "I ask others to do things with me."

The next areas of skills that should be supported through intervention were indicated by the following questions where at least 50% of youth (N = 9) responded with not true or a little true.

- "I say please when I ask for things,"
- "I ask for help when I need it,"
- "I stay calm when I disagree with others,"
- "I feel bad when others are sad."

It's recommended that these skills, along with the core skills be addressed in future life skills curriculum.

Youth Satisfaction Survey results

Research question 4: *Is there a specific life skill(s) and/or intervention that influenced youths' readiness?*

The Youth Satisfaction Survey asked youth to indicate their confidence for each skill targeted through intervention during the group. The results for each skill are displayed in Figure 4.

Figure 4: Youth Reported Confidence in Targeted Skill Areas (N=17)

	Very Confident	A Little Confident	Not Confident	Did Not Learn Skill	No Answer
Money Management	76.5% (N=13)	23.5% (N=4)	--	--	--
Meal Planning	76.5% (N=13)	17.6% (N=3)	--	5.9% (N=1)	--
Work Readiness	58.8% (N= 10)	41.2% (N=7)	--	--	--
Housing	70.6% (N= 12)	29.4% (N=5)	--	--	--
Insurance	47.1% (N=8)	47.1% (N=8)	5.9% (N=1)	--	--
Self- Regulation	58.8% (N=10)	17.6% (N=3)	--	23.5% (N=4)	--
Time Management	94.1% (N=16)	--	--	5.9% (N=1)	--
Medication Management	82.4% (N=14)	17.6% (N=3)	--	--	--
Cooking	76.5% (N=13)	11.8% (N=2)	5.9% (N=1)	--	5.9% (N=1)

The Youth Satisfaction Survey also asked youth to indicate their need for future help with each skill targeted through intervention during the group. The results for each skill are displayed in Figure 5.

Figure 5: Youth Reported Need for Help in Targeted Skill Areas (N=17)

	No Help Needed	A Little Help Needed	Moderate Amount of Help Needed	Need a Lot of Help	Total Assistance Needed	Did Not Learn Skill	Did Not Answer
Money Management	29.4% (N=5)	23.5% (N= 4)	17.6% (N=3)	23.5% (N= 4)	5.9% (N=1)	--	--
Meal Planning	64.7% (N=11)	5.9% (N=1)	11.8% (N=2)	11.8% (N=2)	5.9% (N=1)	--	--
Work Readiness	35.3% (N=6)	35.3% (N=6)	11.8% (N=2)	5.9% (N=1)	11.8% (N=2)	--	--
Housing	23.5% (N=4)	23.5% (N=4)	11.8% (N=2)	29.4% (N=5)	5.9% (N=1)	5.9% (N=1)	--
Insurance	29.4% (N=5)	23.5% (N=4)	5.9% (N=1)	23.5% (N=4)	11.8% (N=2)	--	5.9% (N=1)
Self- Regulation	35.3% (N=6)	17.6% (N=3)	17.6% (N=3)	5.9% (N=1)	5.9% (N=1)	--	--
Time Management	58.8% (N=10)	17.6% (N=3)	--	11.8% (N=2)	5.9% (N=1)	5.9% (N=1)	
Medication Management	58.8% (N=10)	5.9% (N=1)	5.9% (N=1)	23.5% (N=4)	5.9% (N=1)	--	--
Cooking	58.8% (N=10)	17.6% (N=3)	--	5.9% (N=1)	17.6% (N=3)	--	--

Finally, the results for the statements which youth were asked to agree/ disagree with are summarized in Figure 6.

Figure 6: Youth Satisfaction/ Agreement

Statement	Agree	Do not Agree	Did Not Answer
After participating in occupational therapy group, I have a better understanding of what occupational therapy is.	100% (N=17)	--	--
We spent enough time learning each skill in occupational therapy group.	94.1% (N=16)	5.9% (N=1)	--
The way information was taught to me in occupational therapy group matched the way I learn best.	88.2% (N=15)	5.9% (N=1)	5.9% (N=1)
Participating in occupational therapy group has better prepared me to transition back to my community.	88.2% (N=15)	11.8% (N=2)	--
Facilities like Woodward Academy should have an occupational therapist on staff.	94.1% (N=16)	5.9% (N=1)	--
Occupational therapy group was helpful.	100% (N=17)	--	--
Occupational therapy group improved my life skills.	100% (N=17)	--	--
The number of occupational therapy groups was enough.	82.4% (N=14)_	17.6% (N=3)	

Sustainability

Following the completion of the program, the OTD student developed the following considerations for sustainability of similar programs facilitated by an OTD. These considerations ensure the program receives adequate funding and implementation support.

- There is assistance with funding, as OT is a billable service through Medicaid.
- All materials purchased to implement the program were reusable with the exception of cooking ingredients and writing utensils.
- Facility staff encourage and support the use of sensory tools as a coping mechanism for youth.
- Having 1-2 (3 hours total) training sessions for staff to understand topics included within the curriculum, the objective behind sessions, and how interventions will be executed so that the staff can appropriately refer youth to OT based on their needs, rather than on discharge date.
- Ensure appropriate staffing ratios for groups to stay within individual facility's safety protocols (example: having available staff to gather and return youth for sessions; having staff nearby or an assistant when group sessions are taking place).
- The average OT productivity ratio, based on an 8-hour day, is 1:10 on an individual basis. This ratio can increase when conducting group sessions 1:15.
- Allow youth to be provided with choices prior to each session to increase buy in and participation.

Summary of Recommendations

Start-Up

- Allow for adequate time to screen/assess youth before the programming begins. This would allow the OT to have a better understanding of particular skills that need to be addressed.
- Allow youth to opt/test out of a skill they know or are opposed to learning. This would likely keep students interested in specific skills.

Interprofessional Communication

- Ensure that interprofessional communication and collaboration is occurring from the moment a youth is referred. This includes: teachers, therapists, case workers, vocational rehabilitation, juvenile court officers & other court services.
    - Teachers: It's imperative for the OT to meet with the teacher(s) to figure out what students are already learning in regards to money management and/or personal finance. In addition, OT can help assist both the youth and the teacher with IEPs, and any behavioral issues or deficits that are impacting the individual's ability to function independently in the classroom.

- Therapists: It's important for the OT to meet with any therapist(s) the youth may have. The OT can gain insight as to what might trigger the youth and want coping skills or strategies to help the youth to function better in sessions. The therapist can also report any mood changes witnessed that may be due to OT interventions.
- Case Workers: Case workers tend to have the most contact with youth's family and/or guardian(s). It's crucial to meet regularly with the case worker to discuss any deficits the youth may have and ensure proper support is being given upon discharge.
- Vocational Rehabilitation: Vocational rehabilitation and OTs can work together to determine what work readiness skills and tasks the youth needs to have intact to be as independent as possible when working. OTs can report deficits witnessed and provide vocational rehabilitation with compensatory strategies or products that can promote independence with work duties. Together, they can collaborate on accommodations that the youth may need.
- JCO/Court Services: It's necessary for youth's JCO to be informed of any deficits and/or improvements that the individual is having in OT. By relaying this information to the court, they can determine what assistance, supervision, and/or resources the youth might need. OTs can also assist in discharge planning through providing professional recommendations to make sure youth's safety (in regards to any deficits) is being considered when choosing appropriate discharge location.

Forming Groups/Dosage

- When forming groups, consider the following:
  - Age-some skills may not be relevant for youth amongst discharge (ex: employment, insurance, housing). It's recommended that ages in groups are as listed: 9-11 years old, 12-14 years old, 15-17 years old.
  - Behavioral concerns that may arise due to certain youth being placed amongst each other. This can impact the ability for others to maintain attention and can pose safety risks.
  - Cognitive abilities-If one or two youth are severely delayed when compared to peers, it's recommended that they are seen individually or in a smaller group as it may impact the OTs ability to equally assist youth in need during intervention.
  - Youth Schedules-It's important to compare youth's schedule weekly to ensure that they are not frequently missing sessions. It's recommended to look at the following as it applies to each facility: standardized/school testing, extracurricular activities, medical appointments, court dates, & home passes.
- It is recommended that youth be seen twice a week for a minimum of twelve weeks after being evaluated & assessed to allow for full coverage of topics included in the curriculum. However, having repetition with tasks often improves performance and promotes long-term retention. In addition, OTs can make interventions more challenging

for youth to increase problem-solving skills. Because of this, fourteen to sixteen weeks would be more appropriate.

Curriculum Changes

- When looking at the SSIS-SEL results as well as looking at common barriers witnessed/expressed by youth, it's recommended that social skills be included:
    - Listening to others
    - Saying please and thank you
    - Asking for help
    - Letting someone know that you feel unsafe
    - Expressing angry feelings
    - Expressing positive feelings
    - Disagreeing with someone's opinion without arguing
    - Finding common interests (asking others to things with me)
    - Asking questions about medication
- Due to frequently seeing youth having deficits with working and short-term memory, it is recommended that interventions are created to address.
- It is recommended that work readiness skills be taught on an individual basis so that they can be more client-centered, targeted interventions.

Other

- It is recommended that the EFPT/EFPT-E has a separate section for memory, as many participants improved their ability to follow directions step by step, but many were unable to recall information. Because memory is considered part of the steps and falls under 'sequencing' it makes it difficult to show what cognitive impairments are truly impacting the individual's independence.

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